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National Association of State Mental Health Program Directors

Weekly Update

As Promised, FY 2017 Executive Budget Contains New $500 Million for Mental Health Programs, $1 Billion for Opioid Abuse

The FY 2017 Executive Budget released February 9 includes the $500 million in funding for behavioral health programs promised by President Obama when he announced his gun safety initiative in December.

The Budget proposes a two-year initiative to expand access to mental health services. The initiative includes: the addition of states in the § 223 Certified Community Behavioral Health Clinic (CCBHC) demonstration; increased access to early intervention programs that address serious mental illness through a Children's Mental Health Services set-aside; expansion of programs to increase the behavioral health workforce; suicide prevention initiatives; and enhancements to behavioral health services in Indian Country.

The FY 2017 Budget requests $4.3 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), $590 million above the FY 2016 funding level for the agency. It continues to provide $533 million for the Mental Health Block Grant (MHBG), the FY 2016 funding level. It maintains the $1.9 billion for the Substance Abuse Prevention and Treatment Block Grant allocated for FY 2016, but also includes a $1.1 billion initiative to expand access to treatment for opioid use disorders and reduce prescription opioid abuse.

The Budget includes a new 10 percent set-aside within Children's Mental Health Services funding to test new interventions that include youth and young adults at risk of, or before, the first episode of psychosis (FEP). This $11.9 million initiative will be focused on prodromal efforts. Minimum grants will be $700,000.

The existing FEP program continues to be funded in full at $50 million through the 10 percent MHBG set-aside.

The Budget also includes $239 million in FY 2017, an increase of $135 million, to add 6 states to the 8 already authorized to participate in the CCBHC Demonstration established under § 223 of the Protecting Access to Medicare Act of 2014.

Suicide Prevention

The SAMHSA Budget includes $60 million and the Centers for Disease Control and Prevention's (CDC's) Injury Control Research Centers budget includes $30 million—an increase of funding for suicide prevention programs of $28 million from FY 2016—to implement the recommendations of the National Strategy for Suicide Prevention through the Zero Suicide Initiative. State pilots focused on reducing key risk factors by increasing referral and treatment for suicidal behavior, and addressing access to lethal means by individuals at greatest risk of harming themselves and others, will be funded through a partnership between SAMHSA, the CDC, and state health departments. The initiative will include a 20 percent--$5 million--set-aside for suicide prevention in tribal communities.

The SAMHSA budget also would expand funding for the Project AWARE State Grants Program by $7.1 million to a total of $72 million. That program works to improve local coordination of resources and responses to youth with signs of mental illness.

The Budget also proposes to add psychiatric hospitals, community mental health centers, residential and outpatient mental health and substance use disorder treatment clinics, and psychologists to the Medicare and Medicaid Electronic Health Record Incentive Programs designed to increase meaningful use by providers of health information technology.

Behavioral Health Workforce

The Budget includes an additional $82 million in FY 2017, for a total of $132 million, for programs that expand, train, and improve the behavioral health workforce. Funded programs would include:

- $45 million for the Loan Repayment Program for additional awards for behavioral health clinicians practicing in underserved communities;
- $6 million in new funding for the Behavioral Health Workforce Education and Training program administered by SAMHSA in partnership with the Health Resources and Services Administration (HRSA) to support clinical training for behavioral health professionals. In FY 2017, this funding would support an additional 2,650 behavioral health professionals and 2,750 additional paraprofessionals; and
- $10 million for a Peer Professionals program in SAMHSA to increase the number of peers, recovery coaches, mental

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New Grant, Technical Assistance & Training Opportunities

Webinar Scheduled on Initial Findings from Multi-State Evaluation of Self-Direction in Behavioral Health

The Boston College National Resource Center for Participant-Directed Services and Human Services Research Institute (HSRI) are conducting a three-year multi-state *Demonstration and Evaluation of Self-Direction in Behavioral Health*, funded by the Robert Wood Johnson Foundation with support from the Substance Abuse and Mental Health Services Administration.

Self-direction, also called self-directed care, consumer direction, and participant direction, is a model for organizing services and supports in which the service user manages a flexible budget with assistance from a specially trained support broker.

The evaluation involves two main components, a formative process evaluation and a system-level outcome evaluation focusing on service utilization and cost. Through the process evaluation, HSRI will document program design, implementation successes and challenges, strategies for overcoming challenges, and generate a set of guidelines for program replication and sustainability.

In a February 17 webinar, entitled *Exploring Self-Directed Care: Description and Early Implementation Findings from the Demonstration and Evaluation of Self-Direction in Behavioral Health*, members of the evaluation team will present early findings from the process evaluation, including a description of current self-direction efforts and key lessons learned in the first year of the project. During the webinar, HSRI will document program design, implementation successes and challenges, strategies for overcoming challenges, and how to generate a set of guidelines for program replication and sustainability.

Exploring Self-Directed Care: Description and Early Implementation Findings from the Demonstration and Evaluation of Self-Direction in Behavioral Health

Webinar Date: February 17, 2016
Time: 2:00 – 3:30pm EST

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. Through targeted modules and expert instructors, the program shines a light on the high-risk juvenile offender population and helps leaders begin or accelerate systemic change to improve outcomes for youth in custody in their jurisdictions.

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 culmination of the onsite instruction. Participants continue their commitment to reform through the development and implementation of a grassroots Capstone Project, and induction into the prestigious CJJR Fellows Network.

Applicants are encouraged to consider passing along information about this opportunity to colleagues and partners. Visit the CJJR Youth in Custody Certificate Program website to find detailed information about the program, including:

- Application and guidelines
- Curriculum and instructors
- Tuition and available subsidies
- Selection criteria

Applications are due by March 18, 2016**.** Questions should be directed to jjreform@georgetown.edu or directly to Jill Adams at jill.adams@georgetown.edu.

CMS Approves Alabama § 1115 Medicaid Transformation Waiver

Alabama on February 9 was given the go-ahead by the Centers for Medicare and Medicaid Services to implement a Medicaid § 1115 waiver known as the *Alabama Medicaid Transformation* under which 11 locally led regional care organizations (RCOs) in five state regions will serve Medicaid patients as managed care organizations.

The five-year agreement with CMS begins April 1. The RCOs, authorized under legislation enacted by the state legislature in 2013, are scheduled to begin providing Medicaid benefits to more than 650,000 Medicaid beneficiaries on October 1. At that time, Alabama Medicaid will begin paying a set monthly amount to each RCO for its own costs and provider reimbursement. RCOs that meet specified reporting, operational, and quality targets in managing patients' cases will be allowed to keep a share of the funding remaining at the end of the year.

CMS has agreed to provide up to $328 million in federal match to a "Transitional Pool" over three years to help the RCOs start up and pay for projects that boost access to medical care, improve quality, and reduce cost. Alabama could qualify for an additional $420 million in federal money over a five-year period if outcomes specified in the waiver's terms and conditions are met.

About-thirds of Alabama's Medicaid population will be served by the RCOs. Covered populations will include those beneficiaries in the aged, blind and disabled (ABD) category, pregnant women and children under age 19 (formerly known as SOBRA recipients), and parent/caretaker relatives. Foster children and duals will receive their services through FFS Medicaid.

Most services now covered by Medicaid will be RCO-covered services: behavioral health services, hospital inpatient and outpatient care, emergency room services, primary and specialty medical care, services provided by a federally-qualified health center or rural health clinic, lab and radiology services, eye care, maternity care, and transportation. Home- and community-based waiver services (HCBS), targeted case management, nursing home care, long-term services and supports, pharmacy services, dental care, and school-based services will be provided outside the RCO system.

The following community-based services must be provided to individuals with mental illness and intellectual disabilities:

- Intake evaluation
- Physician/medical assessment and treatment
- Diagnostic testing
- Crisis intervention
- Individual, family, and group counseling
- Adult, adolescent, and child intensive day treatment
- Rehabilitative day program
- Mental health consultation
- Adult, child, and adolescent substance abuse intensive outpatient services
- In-home intervention
- Partial hospitalization and pre-hospitalization screening
- Basic living skills
- Family support
- Assertive community treatment
- Methadone treatment

By state law, RCOs must be nonprofit entities, incorporated in Alabama. They are to be governed by a board of risk-bearing (12) and non-risk-bearing (8) members. The risk bearers must contribute cash, capital, or other assets. Non risk-bearing members must include five medical professionals who provide care to Medicaid recipients in the region in which the RCO operates: three primary care physicians, including one from a federally-qualified health center (FQHC), one optometrist, and one pharmacist. The RCO board must also include a business executive who works in the region and is nominated by a Chamber of Commerce in the region.

State law requires each RCO to have a Citizens' Advisory Committee (CAC) that reflects the demographics and diversity of the region. The Citizens' Advisory Committee chair serves on the RCO's governing board, as does a CAC member who represents either Alabama Arise or a group that is part of the Disabilities Leadership Coalition of Alabama.

Medical Directors Council Link of Note

A study published online February 8 in the *Canadian Medical Association Journal* found that concussions resulting from every day and recreational activities triple long-term suicide risk.

The authors had performed a longitudinal cohort analysis of adults with a diagnosis of a concussion in Ontario, Canada, over a 20-yr period, excluding severe cases that resulted in hospital admission.

The increased risk of suicide applied regardless of the patients' demographic characteristics, was independent of past psychiatric conditions, became accentuated with time, and exceeded the risk among military personnel. Half of the patients had visited a physician in the last week of life.

President's Budget Delivers $500M for Mental Health, $1B for Opioid Abuse

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health /addiction specialists, prevention specialists, and pre-Master's level counselors.

Tribal Behavioral Health

The FY 2017 Budget includes an additional $67 million in new investments, to a total of $363 million, to address high rates of mental illness, substance abuse, and suicide in tribal communities.

The Budget provides $30 million in SAMHSA for Tribal Behavioral Health Grants to tribal entities to promote mental health and address substance abuse among American Indian and Alaska Native young people. In collaboration with the Indian Health Service (IHS) and in consultation with tribal leaders, this funding would help tribes implement evidence-based suicide prevention programs and integrate systems that address issues of child abuse and neglect, family violence, trauma, and substance abuse.

To support IHS's focus on changing the paradigm of mental health and substance abuse disorder services by incorporating them into the patient-centered medical home, $21 million would be provided to integrate primary and behavioral health care in the IHS system.

The Generation Indigenous program to improve access to behavioral health treatment for Native Youth would receive a $15 million funding increase.

The Budget also proposes $15 million for a new crisis response fund to assist tribes experiencing behavioral health crises such as mass shootings, high rates of alcohol- and drug-related death rates, school violence, suicide clusters, and other emergencies. This funding would provide tribal communities with specialized crisis response staffing, technical assistance, and community engagement services.

In addition, the Budget includes $4 million to implement the Zero Suicide initiative in IHS facilities in 10 pilot projects and $20 million to support the development, modernization, and enhancement of IHS' Health IT systems.

The Budget also includes $2 million in new funding to support aftercare pilots for Native Youth who have been discharged from Youth Regional Treatment Centers, to ease the transition to the community once residential treatment is completed.

In addition, the Budget includes a $4 million expansion of the Domestic Violence Prevention Program (formally the Domestic Violence Prevention Initiative). The program includes referrals for counseling services and clinical behavioral health services.

SAMHSA Posts 42 CFR Part 2 Revisions

The Substance Abuse and Mental Health Services Administration on February 9 published the long-awaited revisions to the 42 CFR Part 2 regulations governing confidentiality and disclosures of patient records for patients of substance abuse treatment programs.

During the 2015 "listening sessions" on the revision, NASMHPD, the Medicaid Directors, and a number of other stakeholders had recommended aligning the 42 CFR Part 2 protections with protections afforded under privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). However, SAMHSA dismissed that request in the preamble to the regulations, stating that Part 2 is intended to provide more stringent federal protections than most other health privacy laws, including HIPAA. SAMHSA said the original intent of the governing statute (42 U.S.C. 290dd-2) was to protect the confidentiality of substance abuse patient records so as not to make an individual receiving treatment for a substance use disorder in a Part 2 program more vulnerable by virtue of seeking treatment than an individual who does not seek treatment.

SAMHSA also elected not to address e-prescribing and prescription drug monitoring programs (PDMPs) in the proposed regulations because, it said, e-prescribing and PDMPs technologies are not ripe for rulemaking and because the majority of Part 2 programs are not prescribing controlled substances electronically.

At the same time, SAMHSA said it was striving, with the proposed regulations, to facilitate information exchange within new and emerging health and health care models. One change that conceivably could make the exchange of information easier is the use of a new defined term, "treating provider relationship," to allow a patient having such a relationship with a provider to consent to disclosures to that provider of protected information using a general description of the providing individual or entity. Absent such a relationship, consents to disclose would have to specifically name the individuals or entities to which disclosure may be made.

However, in a statement released the day after the regulations were published, the National Association of State Medicaid Directors said the revisions did not go far enough in addressing the fact that most aspects of 42 CFR Part 2 are a major barrier to providing seamless, coordinated care for those with substance use disorders covered by Medicaid. They reiterated that "their concerns with 42 CFR Part 2 "can best be remedied by aligning substance use disorder privacy regulations, to the greatest extent possible, with the federal requirements found under [HIPAA]."

Comments are due on the regulations by April 11. NASMHPD will be providing SAMHSA with feedback.

Cooperative Agreements to Benefit Homeless Individuals

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

Grants 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 FY 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 will be expected to provide a coordinated, multi-system approach designed to combine 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. SAMHSA will use discretion in allocating funding for these awards, taking into consideration the specific drug court model (Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts), as appropriate, and the number of applications received per model type.

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.

This grant is not intended for Juvenile or Family Dependency Treatment Drug Courts. Applications received for Juvenile or Family Dependency Treatment Drug Courts will be screened out and will not be reviewed.

LA and Boston Area Transportation Authorities Launch Campaigns to Fight Pedestrian Fatalities by Suicide

In the wake of increased pedestrian fatalities on two of the busiest commuter rail systems in the United States, the cities of Los Angeles and Boston have launched educational campaigns targeted to people who are considering suicide.

In January, the Massachusetts Bay Transportation Authority (MBTA) partnered with Samaritans Inc. of Boston to launch an anti-suicide educational campaign, "You Are Not Alone." The message "Hopeless? Lonely? Desperate? We're here to listen," along with the Samaritan's phone and text support line, scrolls across MBTA's notification boards every two hours. Samaritan's helpline is promoted on 80 digital screens in seven of the busiest subway stations in Boston and Cambridge, and the phone number for the helpline is periodically announced over the MBTA's public address system.

Riders can also expect to see 400 placards posted throughout buses and subway trains, inside commuter rail coaches, and at commuter rail station platforms.

In October 2015, Samaritans Inc. launched texting support to reach people who prefer to text rather than to speak to someone. Since inception of that service, Samaritans has received over 500 text messages from people seeking help.

The Los Angeles County Metropolitan Transportation Authority (L.A. MTA) has worked with the Didi Hirsch Suicide Prevention Center in developing an educational campaign to target the 22-mile metro rail Blue Line that transports 27 million passengers annually.

The LA campaign promotes the center's crisis hotline by posting signs at stations, platforms, crossings, and high-risk locations. In addition, L.A. MTA has trained 15 safety "ambassadors" on the Blue Line to monitor for people engaging in risky behaviors near trains.

The initiative is part of a broader strategy to improve overall pedestrian safety in the Los Angeles rail system.

In the last three years, 28 people lost their lives to suicide on MBTA tracks—16 on commuter rail and 12 on the subway system. In 2013, the LA Blue Line reported four deaths by suicide.

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Older Persons' Division Links of Note

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers

Treatment of Depression in Older Adults: Evidence Based Practices (Video)

Financing & Medicaid Division Links of Note

CMCS Informational Bulletin on 2016 Federal Poverty Level Standards

2016 Dual Eligible Federal Poverty Level Standards