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National Association of State Mental Health Program Directors

Weekly Update

SAMHSA Advisory Committees Meet to Discuss SAMHSA Initiatives, Priorities

SAMHSA last week held a series of National Advisory Council meetings in Bethesda, Maryland to discuss current and future initiatives, as well as receive Council feedback on how to continue to provide appropriate programming for those in need of substance use disorder and mental health treatment.

The February 24 Center for Mental Health Services (CMHS) National Advisory Council (NAC) meeting opened with CMHS Director Paolo del Vecchio providing an overview of CMHS's budgetary and programming focus for Fiscal Year (FY) 2016 and FY 2017. Director del Vecchio reported that FY 2015 saw the awarding of 245 new grants and 7 new contracts, with only $125 of appropriated monies left unspent for the fiscal year. CMHS plans to publish 12 Funding Opportunity Announcements (FOAs) in FY 2016.

Director del Vecchio highlighted the major new programs included in the FY 2016 budget, some of which have been previously reported here:

- an increase of $10 million to $65 million for Project Aware, to address trauma arising from civil unrest;
- a $25 million increase to $30 million for Tribal Behavioral Health Grants, with $10 million marked for CMHS and $15 million for the Center for Substance Abuse Prevention (CSAP);
- a newly authorized $15 million for state Assisted Outpatient Treatment programs; and
- an increase of $50 million for the 10 percent Mental Health Block Grant (MHBG) set-aside for First Episode Psychosis (FEP) early interventions, raising the total MHBG to a total of $532 million.

In addition, suicide prevention initiatives will receive $28 million in FY 2016, crisis systems $10 million, and peer workforce initiatives $10 million. Other initiatives that Director del Vecchio said will be a CMHS focus in 2016 include the § 223 Certified Community Behavioral Health Clinic (CCBHC) Planning Grants, coordinating serious mental illness (SMI) programs through the SMI Behavioral Health Coordinating Committee, clinical treatment expert panels, and public awareness and education outreach. The CMHS Advisory Committee also heard from Public Health Officer Andy Hunt and Behavioral Health Equity Office Director Larke Nahme Huang on SAMHSA efforts on behavioral health disparities among minorities and tribal members specifically. CMHS is looking at the challenges faced by tribal members with a lack of access to culturally competent care and a lack of infrastructure to support a continuum of services and supports.

To combat tribal health disparities, CMHS is targeting grants to those communities. In 2015, CMHS tribal grants totaled: 44 for youth suicide prevention; 25 to develop and implement comprehensive service systems for children, youth, and young adults with mental health issues; 9 to promote early childhood mental health with Project Launch; and 1 for child traumatic stress treatment under the National Child Traumatic Stress Initiative. Tribal grants will increase by 125 percent in FY 2016, with 70 of the current 77 grants continuing, and 94 new Tribal Behavioral Health Prevention (Native Connections) grants added. With an additional funding of 5 to 10 new grants for Systems of Care, the number of CMHS tribal grants will eventually total between 170 and 190.

The presentation on tribal health disparities was followed by an update on the § 223 CCBHC demonstration program by SAMHSA Public Health Officer David Morrissette. As previously reported, in October 2015, there were 24 planning grants awarded with a timeline for submission of demonstration applications of October 2016, and the selection of 8 states to participate in the full two-year demonstration by December 31, 2016. The Demonstration Program will start between January and July 2017 and end in 2019. A Final Report is due to be submitted to Congress by December 2021.

Survey Report on State Peer Workforces

NAC members then learned from Regional and National Policy Director Anne Herron and Office of Consumer Affairs Director Keris Jän Myrick *(Cont'd on next page)*

SAMHSA National Advisory Councils Meet

(Cont'd from page 1) that, from March to May 2015, SAMHSA Regional Administrators surveyed states to obtain information on each state's behavioral health workforce. All states described some type of peer workforce initiative, and recognized the need to further increase the use of peers. Director Herron reported that SAMHSA found no single or leading model for the use of peers, but many successful examples. However, one challenge to implementation was the low wages paid peers, with a national average part-time wage of $15.42, and $16.36 for full-time employment.

The survey did identify some promising practices using evidence-based technical assistance centers and State certification for peer specialists. The Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) program promotes an increase in the number of addictions peers in the workforce. Other innovations identified included state behavioral health contracts stipulating access to a continuum of services that includes peer services, and including an emphasis on the value of peers in recovery practice.

Center for Substance Abuse and Treatment NAC

The National Advisory Council for the Center for Substance Abuse Prevention (CSAP) met simultaneously with the CMHS Advisory Council. CSAP Director and Council Chair Francis Harding opened the meeting with a presentation on *Aligning Mental and Substance Use and Misuse Disorder Prevention with Health*, followed by breakout sessions for discussion.

Carter Roeber, social science analyst for the Center for Behavioral Health Statistics and Quality (CBHSQ) updated the CSAP NAC on the ongoing revision of the National Registry for Evidence-Based Practices and Programs (NREPP). Roeber reported that the open period for developers to submit practices for inclusion on the NREPP had just closed, with a total of 125 submissions. In addition, SAMHSA recently closed an open comment period on the appropriate prioritization of items included in the NREPP, during which it had received 724 comments.

As reported previously, Roeber said the NREPP will no longer rely exclusively on practices and programs voluntarily submitted by developers, but will post all practices found, with independent reviews and effectiveness ratings. The new ratings are intended to address concerns that site users have been treating a program's presence on the NREPP as an endorsement. The revised NREPP will include an accompanying learning center that contains a glossary of terms, tutorials on how to use evidence-based practices with fidelity, and videos of developers discussing their experiences.

The NREPP presentation was followed by a CSAP budget update from Office of Program Analysis and Coordination Director Jewel Marsh. Unlike SAMHSA's other Centers, the President's proposed FY 2017 budget does not include an increase in funding for CSAP Programs of Regional and National Significance and under the Substance Abuse Prevention and Treatment Block Grant. However, the budget does include a new $12 million for discretionary grants to 10 states to reduce opioid overdose-related deaths by helping those states purchase naloxone, equip first-responders in high-risk communities, support education on the use of naloxone and other overdose death-related strategies, and cover expenses incurred from dissemination efforts. The FY 2017 budget also includes an additional $10 million for strategic prevention in the abuse of prescription drugs. That funding would be used to raise public awareness, raise the awareness of the pharmaceutical and medical communities on the risks of overprescribing, and develop capacity and expertise in the use of data from prescription drug monitoring programs (PDMPs) to identify abusers by geography and population group.

The CSAP budget presentation was followed by an overview of SAMHSA activities from Acting Administrator Enomoto.

Joint National Advisory Councils Meeting

On February 25, SAMHSA held a Joint Meeting of the SAMHSA National Advisory Council (NAC), the CMHS NAC, the Center for Substance Abuse Prevention (CSAP) NAC, the CSAT NAC, the SAMHSA Advisory Committee for Women's Services, and the SAMHSA Tribal Technical Advisory Committee. Acting Administrator Enomoto briefed attendees at that full-day meeting on FY 2016 funding and the FY 2017 budget. Kim Johnson, the CSAT Director then discussed the proposed 42 CFR Part 2 substance use treatment privacy regulations published for public comment, as well as SAMHSA's international efforts in curbing substance abuse in Ukraine, Southern Africa, and Vietnam.

Next, CMHS Director del Vecchio discussed his Center's priorities and initiatives, focusing on the doubling of the FEP MHBG set-aside, a proposed 10 percent Children's Mental Health Initiative set-aside with an early intervention, prodromal focus, the Assisted Outpatient Treatment initiative, and other initiatives discussed the previous day in the smaller CMHS Advisory Council. Daryl Kade, Acting Director for CBHSQ, presented that Center's ongoing development of a research framework and its work in identifying measurement gaps. In addition, Ms. Kade said CBHSQ is focusing on a redesign data strategy to obtain information from sources like social media. The Joint Council then heard from Richard Kronick, Director of the Agency for Health Care Research and Quality (AHRQ) on the AHRQ's research in engaging patients in quality behavioral health care. AHRQ's research includes research in opioid *(Cont'd on page 3)*

SAMHSA Advisory Councils Meet

(Cont'd from page 2)

overuse in adults, as well as research on Medication Assisted treatment (MAT) to help rural communities and primary care providers address needs and provide support. Last year's four AHRQ grants to research MAT will be cut to three in FY 2016, due to an 8 percent cut in Congressional funding. AHRQ research also has focused on patient engagement and how integration of physical and behavioral health leads to better outcomes.

Frances M. Harding, CSAP Director, then reported on the National Heroin Taskforce. National data on overdose death rates in 2014 emphasized that more than 27,000 overdose deaths involved opioid medications and/or heroin. Congress in FY 2015 provided appropriations to the Department of Justice to convene a multi-agency task force with experts from law enforcement, medicine, public health, and education to develop a coordinated response. The National Heroin Task Force has four committees: Education and Community Awareness, Law Enforcement Responses, Coordinated Community Responses, and Treatment and Recovery Support. The Task Force will look to mitigate the heroin overdose problem and measure the impact of collective efforts on overdose deaths, with sustained action to implement recommendations across government, community, and private partners.

Following lunch, attendees broke into four workgroups on (1) the development of CCBHCs, (2) efforts to address SMI, (3) Mental Health Parity and Addiction Equity, (4) SAMHSA and CMS initiatives to address the national prescription opioid crisis, and (5) integration of social determinants of health into behavioral health. Martha Beadle, Director of the Office of Tribal Affairs and Policy (OTAP), ended the day with a briefing on the Tribal behavioral health agenda.

SAMHSA National Advisory Council

The SAMHSA National Advisory Council (NAC) held its 59th annual meeting on the final day of Advisory Council meetings, February 26. Acting Administrator Enomoto led the group's discussion and reflections on issues and recommendations raised during the previous two days of meetings. She proposed the creation of a subcommittee of the NAC, as well as working closer with AHRQ and professional communities.

After Acting Administrator Enomoto presented the SAMHSA Strategic Initiatives for 2015-2018, several NAC members expressed frustration with the Screening, Brief Intervention, and Referral to Treatment (SBIRT) practice and challenges presented by its application and use in the field, suggesting it should no longer be a SAMHSA priority. The NAC also discussed SAMHSA's difficulties in setting priorities, preparation, and planning in the face of uncertain Congressional funding and often intense Congressional direction and oversight.

Upcoming SAMHSA-Sponsored Webinar: Americans with Disabilities Act (ADA) and Employment Rights & Protections

When and Time: March 10, 3 p.m. EST

Registration Link:

https://nasmhpd.adobeconnect.com/protections_reg/event/event_info.html

Description: Work can be an important part of recovery, offering income, stability, a daily routine and a sense of purpose. While people with mental health conditions work successfully in all sectors of the economy, they remain unemployed and underemployed at higher rates than the general population. Stigma and discrimination are very real barriers in the workplace.

This webinar examines the relationship between employment and recovery, and the rights of individuals with psychiatric disabilities under the Americans with Disabilities Act, the Federal Rehabilitation Act, and similar antidiscrimination laws. In particular, this webinar will address the concept of "reasonable accommodation" and disclosure of disability, give examples of commonly requested accommodations, and walk through the process of requesting accommodations. Finally, it will address available remedies for individuals who may have experienced discrimination in the workplace.

Presenters: **Lou Orslene and Claudia Center**

Lou Orslene is the Co-Director of the Job Accommodation Network (JAN), the leading source of free, expert and confidential guidance on workplace accommodations and disability employment issues. As a service of the U.S. Department of Labor's Office of Disability Employment Policy (ODEP), JAN's professional consultants manage more than 48,000 inquiries and conduct more than 160 trainings annually.

As a part of his leadership role at JAN, Lou provides training throughout the U.S., facilitates the strategic planning process, manages strategic partnerships, and works closely with outreach and education staff. Lou has also taken on the role of assisting other interested countries in replicating the JAN model.

Claudia Center is a Senior Staff Attorney in the Disability Rights Program of the national ACLU Foundation. She was previously the director of the disability rights program at the Legal Aid Society – Employment Law Center, where she founded the Workers' Rights Disability Law Clinic at the Ed Roberts Campus. She litigates cases advancing rights for persons with disabilities, and is actively involved in appellate and legislative work.

This webinar is a presentation of the National Alliance on Mental Illness.

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

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

FOA Number: SM-16-009

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

Anticipated Total Available Funding: $52,905,470

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

Anticipated Number of Awards: Up to 53

Application Due Date: Monday, April 25, 2016

Length of Project: Up to 4 years

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), is accepting applications for FY 2016 Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances.

The purpose of the program is to improve behavioral health outcomes for children and youth (birth to 21) with serious emotional disturbances (SED) and their families. This program will support the wide-scale operation, expansion, and integration of the System of Care (SOC) approach by creating sustainable infrastructure and services required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative (CMHI)).

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

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

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

Eligibility

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

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

Cost-Sharing and Match Requirements

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

Application Materials

- FOA document Part I (PDF | 711.49 KB)
- FOA document Part I (DOC | 421 KB)
- FOA document Part II (PDF | 446.67 KB)
- FOA document Part II (DOC | 160.5 KB).

Note: *Grantees that received funding under the SOC Cooperative Agreements in FYs 2013, 2014, and 2015 are NOT eligible to apply for this announcement. Nor may eligible state applicants for this grant choose local jurisdictions that have received an SOC Cooperative Agreement in FYs 2013, 2014, or 2015. If a state applicant submits an application with a local jurisdiction that is a current grantee, the application will be screened out and will not be reviewed. Any grantees or communities who have questions about their eligibility for the RFA should contact Diane Sondheimer at SAMHSA, Diane.Sondheimer@samhsa.hhs.gov.*

CMS Innovation Acceleration Program Selects 8 States for Housing Partnership Technical Assistance Program

In February, the Center for Medicaid and CHIP Services Innovation Acceleration Project (IAP), in partnership with the US Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the US Interagency Council on Homelessness (USICH), announced targeted program support to state Medicaid agencies seeking to promote State Medicaid-Housing Agency Partnerships.

The IAP will begin working with California, Connecticut, Hawaii, Illinois, Kentucky, New Jersey, Nevada and Oregon in May 2016. This six-month program support opportunity is designed to be intensive and hands-on in order to move selected states closer towards building collaborations with key housing partners in their states. CMCS will be working closely with its federal partners on planning and coordination of the program support that will be provided. CMCS' IAP will also offer program support to 31 states, beginning in February, through a three-session webinar series focused on Supporting Housing Tenancy.

Webinar Opportunity: Suicide Prevention Legislation and Schools

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

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

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

This webinar series by Kognito will:

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

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

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

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

Joint Commission Issues New Sentinel Event Alert on Suicide Ideation

On February 24, the Joint Commission issued Sentinel Event Alert #56: Detecting and Treating Suicide Ideation in All Settings, aimed at assisting health care providers in better identifying and treating individuals with suicidal ideation. *Alert #56* focuses on the full healthcare continuum and replaces two previous Sentinel Event Alerts, Issues #7 and #46.

The Joint Commission is bringing awareness to suicide because it is among the top ten reported sentinel events. The Sentinel Event Database received 1,089 reports of suicides occurring from 2010 to 2014. The Commission found that one of the primary reasons was lack of screening, particularly psychiatric assessment. In 2014, 21.4 percent of Commission-accredited behavioral health care organizations and 5.14 percent of accredited hospitals were non-compliant with the National Patient Safety Goal.

The alert stresses the importance of detecting and identifying risk factors for suicide since many patients do not manifest overt ideation. The risk factors listed by the Joint Commission include: mental or emotional disorders; previous suicide attempts or self-inflicted injury; history of trauma or loss; serious illness or physical or chronic pain; alcohol or drug abuse; social isolation or a history of aggressive or antisocial behavior; discharge from a psychiatric facility within the first year, particularly the first few weeks or months of discharge; and access to lethal means paired with suicidal ideation.

The alert recommends screening patients for suicidal ideation using a brief, standardized, evidence-based screening tool such as Patient Health Questionnaire (PHQ-9), the Emergency Medicine Network's ED-SAFE Patient Safety Screeners and the Suicide Behaviors Questionnaire-Revised (SBQ-R). The alert then gives guidelines on how to take immediate action and safety planning for a patient who scores positive for suicidal ideation. It also provides great resources and links, such as the "Zero Suicide" initiative, to help health care professionals develop safety nets.

In addition to the alert, the Joint Commission has published an infographic and chart, accessible at: http://www.jointcommission.org/sea_issue_56/.

The Joint Commission periodically publishes Sentinel Event Alerts to identify sentinel and adverse events, provide an overview of common underlying causes, and make recommendations to reduce risk and prevent future events. The topics are determined by the Joint Commission's Patient Safety Advisory Group, which is comprised of external subject matter experts.

CMS Issues New Guidance Permitting Federal Funding for "Non-Facility" Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible AI/AN

On February 26, the Centers for Medicare & Medicaid Services (CMS) issued a State Health Official Letter updating CMS policy on the circumstances under which 100 percent federal funding is available for services furnished to Medicaid-eligible American Indians and Alaska Natives (AI/AN) through facilities operated by the Indian Health Service (IHS) or Tribes.

In the letter, CMS re-interprets its payment policy with respect to services "received through" an IHS/Tribal facility, and expands the scope and nature of services that qualify for the 100 percent federal matching rate.

Under the agency's previous interpretation, in order to be "received through" an IHS/Tribal facility, and thereby qualify for the 100 percent FMAP, the service had to be a "facility service." That meant it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, or nursing facility) could provide under Medicaid law.

Under CMS's new interpretation, the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS).

As described in the letter, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish services for their patients who are AI/AN Medicaid beneficiaries. Reimbursement paid for services requested by facility practitioners under those agreements would be eligible for the enhanced federal match on execution of the agreement.

The reinterpretation will be effective immediately for states for the expenditures for services furnished under a care coordination agreement.

HHS Secretary Burwell, SAMHSA Acting Administrator Enomoto Defend Mandatory Spending Budget Designation

SAMHSA Acting Administrator Kana Enomoto testified March 2 on her agency's proposed budget in the House Labor-HHS Appropriations Subcommittee and, like Health and Human Services Secretary Sylvia Burwell the previous week, faced questions from Subcommittee members about the designation of various SAMHSA funding increases as "mandatory" spending.

Ms. Enomoto told Subcommittee members she was unaware of any discussion within the Administration regarding the mandatory designation, but said it is her belief the new spending is fully offset within the President's proposed FY 2017 budget. She said she'd welcome a conversation about the increase in mandatory spending within the SAMHSA budget.

Secretary Burwell appeared on March 3 before the Senate Labor-HHS Appropriations Subcommittee to also face continued questioning about the designation of new spending as "mandatory". Subcommittee Chair Roy Blunt (R-MO) warned that a designation as "mandatory" could cause a program to have its funding permanently limited or to be eventually terminated if its appropriation is not considered annually by Congress as a discretionary program. He also noted that the increase in mandatory spending required the Administration to cut $2 billion in discretionary spending from the budget, including $1 billion from funding for the National Institutes of Health.

Upcoming Webinar:

Proposed Changes to 42 CFR Part 2: Overview and Discussion with State Policymakers

Thursday, March 17, 4 p.m. EDT

Registration

On February 5, 2016, the U.S. Department of Health and Human Services announced proposed revisions to 42 CFR Part 2 with the goal of facilitating information exchange while addressing privacy concerns of individuals that seek treatment for substance use disorders. This webinar will provide an overview of the proposed rule and thoughts from leading state policymakers on how these changes may help or hinder state health reform initiatives.

Moderator: Kitty Purington, Project Director, National Academy for State Health Policy (NASHP)

Speakers include:

- Karla Lopez, Staff Attorney, Legal Action Center
- Dr. Joe Parks, Director, MO HealthNet Division, Missouri Department of Social Services

National Webinars under the SAMHSA State Technical Assistance Project

Upcoming SAMHSA-Sponsored Webinar:

Team-Based Treatment for First Episode Psychosis is Cost-Effective: Implications for Policy and Practice

Tuesday, March 22 from 2 p.m. to 3:30 p.m. EDT

Registration

Presenters: The webinar will feature the following speakers, and time will be provided for audience questions:

- Robert Rosenheck, M.D. Professor of Psychiatry, Yale University
- Howard Goldman, M.D., Ph.D. Professor of Psychiatry, University of Maryland

Dr. Rosenheck will discuss a recently published analysis of the NIMH-sponsored Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program (ETP) initiative that shows that "coordinated specialty care" (CSC) for young people with first episode psychosis is more cost-effective than typical community care. A series of multi-stage analyses were used to estimate the monetary value of these health benefits, which showed that the CSC treatment program is a better value than standard care. Since some of the medication used in the study to minimize metabolic effects will soon become generic, costs will soon be reduced further while benefits will be unchanged. Serving individuals earlier in their episode of illness further increased cost-effectiveness of the program. In this webinar, Dr. Rosenheck will review study methods and results and—along with discussant, Dr. Goldman—will consider their implications for policy and practice.

Recently Archived Webinar:

On February 23, Delbert Robinson, MD, Professor of Molecular Medicine & Psychiatry at Hofstra North Shore-LIJ School of Medicine conducted a webinar on *Working with Clients Experiencing a First Episode of Psychosis: Considerations for Prescribers*.
This archived session covered: the scientific background for first episode treatment; the framework for medication treatment; approaches to client engagement for this target population; strategies to treat the initial psychotic episode and keep people well; choosing the proper medications and their dose; applying research evidence into what is prescribed; and assessment and tools/supports for prescribers to make the best treatment decisions. Interested individuals who were unable to participate in the webinar can view the archived recording at the above link.

Center for Trauma-Informed Care: Upcoming Sessions

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, and 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.
Below is a listing of upcoming trainings.

District of Columbia
Washington – March 21 - DC Recovery Network

Washington – March 31 - DC CARE

Illinois
Rockford – March 10 – Rosecrance Health Network & Rockford Health Council

Chicago – March 31 & April 1- Trilogy Behavioral Healthcare

Maryland
Baltimore – March 22 – Baltimore City, Recreation and Parks

Baltimore – March 29 & 30 - Multi Agencies for Baltimore City

Rhode Island
Warwick – March 24 – Department of Behavioral Health and Hospitals

West Virginia
Weston – March 16 – West Virginia Department of Health and Human Resources (WV DHHR)

Huntington – March 17 - WV DHHR

Charleston – March 18 - WV DHHR

CMS Okays Michigan Medicaid Waiver for Flint Children, Pregnant Women Exposed To Lead in City Water System

The Centers for Medicare and Medicaid Services (CMS) on March 3 approved Michigan Governor Rick Snyder's (R) waiver request to extend Medicaid coverage to children and pregnant women exposed to lead in the contaminated Flint, Michigan water system.

The waiver, requested by Governor Snyder on February 13, expands Medicaid and Children's Health Insurance Program (CHIP) eligibility for children below age 21 and pregnant women in the area, coordinates comprehensive benefits and resources through Targeted Case Management (TCM) services, and provides for lead-blood level monitoring. The TCM services will include assistance in gaining access to needed medical, social, educational, and other services. All state plan services, except for Targeted Case Management Services, will be delivered through the state's existing systems.

The expansion will mean 15,000 more children and pregnant women are eligible for Medicaid and 30,000 current Medicaid beneficiaries in the area will be eligible for the waiver's expanded services.

Coverage is available to individuals at any income level, but those with family incomes above 400 percent of the federal poverty level will need to buy into the program to get full benefits. Benefits for individuals above 400 percent of the federal poverty level will not receive a Federal match.

To be eligible, a pregnant woman or child must have been served by the Flint water system between April 2014 and the date the system is announced to be safe. Coverage includes any children born to pregnant women affected by the crisis and any woman pregnant between the date of approval of the waiver and when the system declared safe.

While CMS told the state in its approval notice it could not accommodate the state's request for lead abatement activities through a § 1115 Medicaid demonstration waiver, it did promise to work with the Governor and his staff in designing and expeditiously processing an alternative option through a targeted and time-limited health services initiative under CHIP. The promised initiative would support specified lead abatement activities that would complement other state and local efforts to remove lead hazards from the homes of Medicaid and CHIP eligible children and pregnant women.

Snyder said in a press release that "Providing important health resources to Flint residents will help us better mitigate the risks of lead exposure and identify long-term health challenges. ...Together with the health care community, we are working to ensure that Flint residents receive a full range of health and social support today and in the future. I appreciate that our federal partners expedited the review and granted this waiver."

If the water system is not declared safe earlier, the waiver expires on February 28, 2021.

Senate Continuing to Consider Comprehensive Addiction and Recovery Act

The Senate on March 7 at 4 p.m. is scheduled to continue its days-long consideration of S. 524, the Comprehensive Addiction and Recovery Act (CARA). There will be a vote on the Senate Judiciary's Committee's amendment in the nature of a substitute bill at 5:30 p.m. that evening.

The bill, which was sent to the Senate Floor by the Judiciary Committee on February 22, passed cloture—a vote to cut off debate—by 89-0 on February 29, and moved on to a consideration of more than 100 amendments.

CARA passed its biggest hurdle to consideration on March 2 when Democrats—including the bill's prime sponsor Sheldon Whitehouse (D-RI)—dropped their opposition to passage if $600 million in emergency funding was not included. They said they would support the bill whether or not Sen. Jeanne Shaheen's (D-NH) amendment to add the emergency funding was passed. The Shaheen amendment, co-sponsored by Sen. Whitehouse, had been ruled out of order earlier in the day on March 2. It was rejected 48-47 in a March 3 vote.

Consideration of the Shaheen amendment was one of three compromises announced the night of March 2 that were part of an agreement to get the bill moving toward Senate approval. Sens. Dianne Feinstein's (D-CA) amendment, co-sponsored by Sens. Chuck Grassley (R-IA), Kelly Ayotte (R-NH), and Maria Cantwell (D-WA) adding to the Department of Justice's toolkit for targeting extraterritorial drug trafficking activities, passed 94-0. A Medicare pharmacy lock-in amendment aimed at "doctor-shopping," and sponsored by Sen. Pat Toomey (R-PA) with Sens. Rob Portman (R-OH), Tim Kaine (D-VA), and Sherrod Brown (D-OH), was agreed to in the Senate by a voice vote.

After the White House objected Tuesday to a provision calling for a feasibility study on educating prescribers on best practices for pain management and opioid prescribing, the provision was removed. The White House had noted that the Centers for Disease Control and Protection (CDC) is developing an opioid prescribing guideline, and said the "unnecessary" feasibility study would delay provider training.

CARA would authorize $77.9 million a year for Fiscal Years 2016 through 2020 for grants by the Health and Human Services (HHS) and Justice departments (DOJ) for treatment and recovery services, alternatives to prison for nonviolent offenders, law enforcement initiatives, and programs to prevent overdose deaths and improper prescriptions. Entities eligible for grants would include state, local, and tribal governments, educational institutions, and nonprofit groups. Some programs would assist specific populations of opioid users such as prisoners, youth, and pregnant women.

The bill's provisions would direct HHS and DOJ to coordinate with each other on grant decisions, support evidence-based practices, provide technical assistance to grant recipients, and ensure an equitable geographic distribution of funds.

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Medical Directors Link of Note:

SAMHSA Advisory: Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update

This Advisory reviews the use of sublingual and transmucosal buprenorphine for the medication-assisted treatment of opioid use disorder. The intended audiences are prescribing physicians, other healthcare professionals, and healthcare policymakers. Topics include new formulations of buprenorphine, the effectiveness and safety of buprenorphine treatment, contraindications and cautions (including medication interactions), informed consent and treatment agreements, treatment monitoring, and indications of diversion and misuse.