NASMHPD

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National Association of State Mental Health Program Directors

Weekly Update

House and Senate Appropriations Staff Members Respond to Administration's Budget Proposal by Seeking a Better Understanding of Prodromo Early Intervention

When SAMHSA Acting Administrator Kana Enomoto briefed the House Appropriations' Labor-HHS Subcommittee on March 2 on the President's proposed FY 2017 budget, her mention of the Administration's proposed Children's Mental Health Initiative (CMHI) 10 percent set-aside for prodromo early intervention programs raised a number of questions for the Appropriations Committee staff responsible for SAMHSA program funding.

What could the proposed $11.9 million set aside adequately fund? Would funding of prodromo programs from a funding source different from the block grant set-aside funding source for First Episode Psychosis (FEP) programs disrupt the ability to create a continuum of care? What is the evidence base for prodromo interventions? How does the program accurately target those youths truly in need of the treatment and services provided in a prodromo program?

To help clear up some of those questions, NASMHPD invited the creator of the Portland Identification and Early Referral (PIER) and Early Detection and Intervention for the Prevention of Psychosis Program (EDIPP) prodromo programs, Dr. William R. McFarlane, to travel to Washington, D.C. to brief the Republican and Democratic staff for the House Appropriations Labor-HHS Subcommittee and the Democratic staff for the Senate Appropriations Labor-HHS Subcommittee on the effectiveness of prodromo programs throughout the U.S.

Over the course of the afternoon of April 13, Dr. McFarlane presented results from the initiatives he has established in communities as disparate as Queens, Ann Arbor, Sacramento, Albuquerque, Portland (Maine), and Salem (Oregon), as well as more recently in the states of Utah and Washington and in the California counties of San Diego, Santa Clara, San Jose, and Ventura.

In doing so, he allayed staff concerns about the accuracy of program outreach by noting that less than 10 percent of youths recruited to participate in the program by providers, school staff, and others were not subsequently diagnosed as having schizophrenia or some other type of mental illness, such as depression or bipolar disorder. He also told staffers how teachers, guidance counselors, clergy, pediatricians, college health service providers, family members, and the military are trained to recognize the signs of declining cognitive function.

Dr. McFarlane told Congressional staffers that the rate of psychosis onset in his programs has proved to be less than one-quarter the level expected, with three-quarters of graduates functioning in social, school, and employment settings up to 10 years later. In the four California county programs, the onset of psychosis after 12 months is 3 percent, well below the projected 21 percent baseline. Subsequent hospitalizations of California participants have been half the projected 13 percent, and suicide attempts among California participants have been one-quarter of the projected 8 percent. Dr. McFarlane also said peer support from among the more than 3 million program graduates has increased as the programs have matured.

Dr. McFarlane detailed for each staffer the multi-disciplinary treatment approach taken in the prodromo programs, and how family members are educated and then involved in problem-solving and the monitoring of behaviors. He noted the prodromo treatment approach does not vary significantly from the approach taken in FEP treatment, except for the greater inclusion of family and significantly lower levels of antipsychotics.

Dr. McFarlane assured the staffers that the differing revenue sources for the FEP and proposed prodromo programs were unlikely to be problematic, as state and community mental health programs are accustomed to blending funding streams. He said the providers and participants would likely remain unaware of the diversity of funding sources. In addition, he assured the staffers that the beneficiaries of CMHI program services—often children in foster care or juvenile corrections—would benefit from prodromo interventions.

Regardless of the efficacy of Dr. McFarlane's discussions with Congressional staff, the inclusion of the set-aside in the final FY 2017 SAMHSA appropriations will depend largely on what sequestration limits allow. The Senate Appropriations Committee has proposed cutting the funding for Labor-HHS by about $200 million.

Washington State Passes Safer Homes Act to Combat Suicide by Firearms and Rx Drugs

The state of Washington's suicide rate is 14 percent higher than the national average. On average, two young people between the ages of 10 and 24 die by suicide every week in the state. Almost one-quarter of those who die by suicide are veterans, and many of the state's rural and tribal communities have the highest suicide rates.

Over half of all suicides are by two means: 40 percent by firearms and 19 percent by prescription poisoning or overdose. To reduce the state's suicide rate by those two means, Washington Governor Jay Inslee in March signed the Suicide Awareness and Prevention Education for Safer Homes Act (HB 2793 – Chapter 90 of 2016). The legislation was drafted with input from the firearms industry, gun rights groups, suicide prevention experts, and pharmacists.

The act creates a "Safe Home Task Force" with two subcommittees, one focused on suicide by firearms and the other on suicide by prescription drugs. The Task Force is to be co-chaired and staffed by the University Of Washington School of Social Work, guided by the university's Forefront: Innovations in Suicide Prevention program.

The Task Force is mandated to:

1. develop and prepare to disseminate online training on suicide awareness and prevention for firearms dealers, firearms range owners, and their employees;
2. in consultation with the Department of Fish and Wildlife, review the firearm safety pamphlet produced by that department and, by January 1, 2017, recommend changes to the pamphlet to incorporate information on suicide awareness and prevention;
3. develop suicide awareness and prevention messages for posters and brochures, for distribution to firearms dealers and firearms ranges and pharmacies;
4. in consultation with the Department of Fish and Wildlife, develop strategies for creating and disseminating suicide awareness and prevention information for hunting safety classes, including messages to parents that can be shared during online registration, in follow-up email communications, or in writing;
5. develop suicide awareness and prevention messages for schools of pharmacy and provide input on training developed for community pharmacists; and
6. create a website that is a clearinghouse for the newly-created suicide awareness and prevention materials developed by the Task Force.

By July 1, 2017, the Department of Fish and Wildlife is required to update its firearms safety pamphlet to incorporate the information on suicide awareness and prevention recommended by the Task Force.

The firearms subcommittee is to be comprised of a representative of the state Department of Health, two individuals who are either suicide attempt survivors or who have experienced suicide loss, two representatives of law enforcement agencies, one representative from the Department of Veterans Affairs, a representative of veterans, and two representatives each from gun rights organizations (including the National Rifle Association) and the firearms industry.

The pharmacy subcommittee is to include two representatives each from the Washington State Pharmacy Association and retailers who operate pharmacies, a faculty member from the University of Washington School of Pharmacy and a faculty member from the Washington State University School of Pharmacy, a representative of the Department of Health, a representative of the state's Pharmacy Quality Assurance Commission, two representatives from the state poison control center, a representative of the Department of Veterans Affairs, and an individual representing veterans.

In 2012, Washington State's HB 2366—Chapter 181 of 2012 required the following health professionals certified or licensed by the state, at least once every six years, to complete six hours of training in suicide assessment, treatment, and management: advisers/counselors, chemical dependency professionals, marriage and family therapists, mental health counselors, occupational therapists, psychologists, advanced social workers and independent clinical social workers, and advanced or independent clinical licensed social worker associates.

Each chiropractor, naturopath, osteopathic physician, surgeon or licensed assistant, physical therapist or licensed assistant, physician or physician's assistant, or licensed practical nurse, registered nurse, or advanced registered nurse practitioner (other than a certified registered nurse anesthetist) is required to complete a one-time, six-hour training in suicide assessment, treatment, and management. The 2016 act adds pharmacists to the second list of providers, but requires only three hours of training for pharmacists.

Under the 2012 act, the Department of Health is required to develop model training for the licensing or certification boards to use by July 1, 2017. That training is to be updated at least once every three years, and to include standards relevant to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors. Each licensing authority may approve training that includes only screening and referral elements if appropriate for the profession in question, based on the profession's scope of practice. An employee of a licensed community mental health agency or a certified chemical dependency program is exempt from the licensing board training if he or she otherwise receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years, either in one six-hour block or spread among shorter training sessions. The 2016 act *(cont'd on next page)*

Washington State Combats Suicide by Firearms, Prescription Drugs

(cont'd from previous page) requires specific training for pharmacists that includes content related to the assessment of issues related to imminent harm via lethal means.

The 2016 act also requires the schools of pharmacy at the University of Washington and Washington State University to convene a workgroup to jointly develop a curriculum on suicide assessment, treatment, and management for pharmacy students. The curriculum must include material on identifying at-risk patients and limiting access to lethal means. When developing the curriculum, the schools are required to consult with experts on suicide assessment, treatment, and management, and with the Task Force on appropriate suicide awareness and prevention messaging. The schools of pharmacy must submit a progress report to the Governor and relevant committees of the state legislature by December 1 of this year.

In addition, by January 1, 2017, the Department of Health and the Pharmacy Quality Assurance Commission are required to jointly develop written materials on suicide awareness and prevention that pharmacies may post or distribute to customers. When developing the written materials, the Department and the Commission must consult with experts on suicide assessment, treatment, and management, and with the Task Force.

The bill also establishes a pilot program in the two counties with the state's highest suicide rates, focused on gun safety education and suicide prevention training, as well as distribution of safe gun storage devices and medication disposal kits.

In signing the bill, the Governor vetoed, at the request of the sponsors, a section that would have required the Department to develop and administer a Safe Homes Project specifically for firearms dealers and firearms ranges to encourage voluntary participation in a program to implement suicide awareness and prevention strategies. To acquire certification as a "Safe Homes Partner" under that section, a firearms dealer or operator of a firearms range would have had to post suicide awareness and prevention posters, distribute suicide awareness and prevention brochures to customers and purchasers, complete suicide awareness and prevention training, and offer safe storage devices for sale at cost. The Task Force would have been required to recommend incentives for encouraging dealers and ranges to participate in the Safe Homes Project.

State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

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 that 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. 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.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or Pat Shea at NASMHPD at 703-682-5191 or pat.shea@nasmhpd.org.

Note that technical assistance under this project cannot be specifically focused on institutional/hospital- based settings.

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 an upcoming training.

Tennessee
Johnson City – April 25 & 26
Dept. of Psychology, East Tennessee State University

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.

New CDC Grant Opportunity – National Violent Death Reporting System (NVDRS)

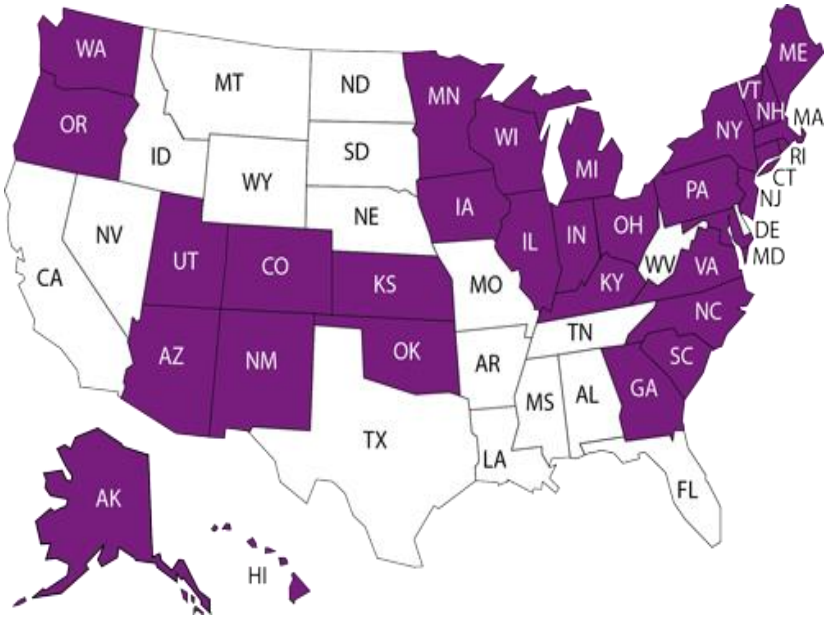
Due Date of Letter of Intent: April 26, 2016
Due Date for Applications: May 27, 2016
Date of Informational Conference Call: April 19 at 2 p.m. EDT
Call-in Number: 855-644-0229*; Conference id:* 5247155
Webinar URL: https://webconf.cdc.gov/zud5/V7K2L26T?sl

In 2014, over 59,000 violent deaths were reported, mainly by suicide and homicide, at an estimated cost of nearly $70 billion in lost wages and medical care.

On March 25, the Centers for Disease Control and Prevention (CDC) announced a new funding opportunity to expand the number of states and territories participating in the National Violent Death Reporting System (NVDRS). The grant program, Collecting Violent Death Information on Using the National Violent Death Reporting System, will award an estimated total of $16,500,000 to approximately seven states/territories to join NVDRS, with an individual award ceiling of $878,000.

Created in 2002, NVDRS is an ongoing state-based surveillance system that collects comprehensive information on violent deaths—suicides, homicides, deaths from legal intervention, deaths of undetermined intent, and unintentional firearm deaths—from various sources such as death certificates or reports from coroners or medical examiners, law enforcement, crime labs, and hospitals. The NVDRS is the first system to: 1) provide detailed information on circumstances precipitating all types of violent deaths, including brief narratives that summarize what happened in the violent death incident, 2) combine information across multiple data sources, and 3) link multiple deaths that are related to one another (e.g., multiple victim homicides, suicide pacts, and cases of homicide followed by the suicide of the suspect). Elements of the data include victim demographics, injury and death information, geographic information, toxicology, criminal activity, life stressors, mental health, weapon information, circumstances surrounding the death (ex. suicide, homicide, undetermined), and rich narratives from coroners, medical examiners, and law enforcement. The online data helps states and communities guide and target violence prevention programs, policies, and practices with the goal of reducing violence. Several states have used the data they have collected to examine suicide rates in their state.

For example, using NVDRS, Ohio examined utilization patterns of suicide decedents that were Medicaid recipients. They looked at the characteristics of the suicide decedents and found that the majority were Caucasian, adult males between the ages of 30 and 49, living in an urban area, who had complex psychiatric and medical conditions. Over 50 percent classified as disabled, and 40 percent did not have a mental health diagnosis. The researchers examined the timing and types of health visits prior to the suicide, and reported that 50 percent had a health visit in the month prior to the suicide and 27 percent had a health visit within a week. It was also noted that the majority of adult suicide decedents had physical health visits rather than mental health visits. Of those that had a mental health visit within 30 days, 32 percent met with a case manager and 19.2 percent went in for pharmacy management.



As the map to the left illustrates, 32 states currently participate in NVDRS. The new funding opportunity aims to expandi the number of states and territories that participate in the surveillance system and ultimately help the CDC reach its goal of including all 50 states, all U.S. territories, and the District of Columbia.

For additional information on this grant opportunity, please visit grants.gov and search "CDC-RFA-CE16-1607".

The CDC contact for additional information is Rebecca Wilson.

Maine Legislature Passes Medicaid Expansion, but by Margin Too Small to Overcome Expected Sixth Veto by Governor LePage

The Maine House of Representatives voted April 13 to approve L.D. 633, an expansion of Medicaid, but the vote fell short of the margin needed to overcome an expected veto by Governor Paul LePage (R).

The 85-64 vote was largely along party lines and came one day after the Republican-controlled Senate narrowly endorsed, by 18-17, the bill's "private option" approach of using federal funds to purchase private insurance coverage for low-income Maine residents. Three Senate Republicans, two of them the bill's sponsors—Senators Thomas Saviello (R-Wilton) and Roger Katz (R-Augusta)—joined the 15 Senate Democrats in approving expansion.

The bill would require program beneficiaries to pay premiums and cost-sharing that could not total more than 5 percent of their income. Premiums alone could not total more than 2 percent of income.

The expansion appears to be headed for a sixth-straight veto by Governor LePage, who has argued every year that Medicaid expansion would cost the state more than it can afford after the Federal match is phased down under current law or even potentially eliminated by Congress in future years. Maine Health and Human Services Commissioner Mary Mayhew said in February that her in-house analysis had calculated that expansion would cost the state $315 million over the next five years.

The "private option" model has been adopted in states such as Iowa and Arkansas. However, the latter state's legislative Joint Budget Committee voted April 14 not to continue to fund, in 2017, the private option expansion, which was first adopted in Arkansas in 2014 and has been renewed annually by legislators.

Expanding Medicaid would provide coverage to more than 70,000 additional Maine residents who earn between 100 percent and 138 percent of the Federal Poverty Level.

The two sides in the House debate each cited statistics and estimates illustrating that expansion would save or cost Maine money in the long run. A 2015 study by Manatt Health Solutions found Maine would realize a net savings of $27 million from expanding Medicaid.

Democrats also cited the surge in heroin and opiate addictions as a reason to expand Medicaid, saying it would help more people receive drug treatment. But Representative Richard Pickett (R-Dixfield), a former law enforcement officer, pointed out that neighboring expansion state New Hampshire is struggling with an even worse opiate epidemic than Maine.

The outcome in the Democrat-controlled House was known long before Wednesday's vote. In fact, lawmakers read the same speeches and asked the same questions as had their Senate colleagues just one day earlier.

Legal, Forensic, Older Persons, and Financing & Medicaid Divisions Links of Note

The Legal Action Center has released a report, *Medication-Assisted Treatment in Drug Courts: Recommended Strategies*, which shares successful strategies for use of medication-assisted treatment (MAT) in drug courts. The report features three in-depth profiles of drug courts with effective MAT programs and a section on "Nine Components of Successful MAT Programs," reflecting lessons from 10 courts in urban, rural, and suburban settings. The report's nuts-and-bolts strategies can help courts across the country successfully incorporate evidence-based treatment for opioid addiction. The report was produced with the Center for Court Innovation and New York State Unified Court System.

Hogg Foundation podcast, *Into the Fold: Issues in Mental Health, Episode 23: Talking About Forensic Mental Health*: In this episode of Into the Fold, two experts on forensic mental health, Neil Gowensmith of the University of Denver's Graduate School of Professional Psychology, and Larry Fitch of the University of Maryland Medical School, have an in-depth conversation on forensic mental health, and ways that the judicial and mental health systems can interface in a more cost-effective and humane way.

The *ASPE Issue Brief: Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits*, issued by the Assistant Secretary for Planning and Evaluation on April 12, finds that average ObamaCare premiums rose 8 percent, from $356 a month to $386 a month, from 2015 to 2016. Once the ObamaCare tax credits that help 85 percent of consumers afford their plans are factored in, the average premium increase was $102 to $106, or 4 percent.

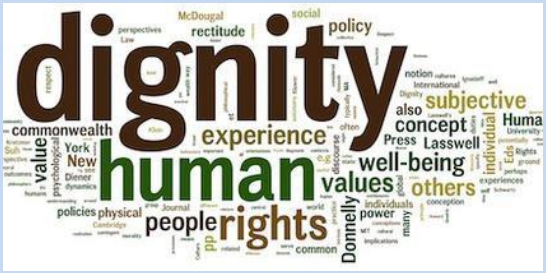
Paying Minimum Wage & Overtime to Home Care Workers, issued by the Department of Labor's Wage-Hour Division, is a guide for consumers and families to the minimum wage and overtime requirements under the Fair Labor Standards Act, now applicable to home care workers.

CMS Gives States 90 More Days for Plans to Monitor Medicaid Provider Access

On April 8, CMS allowed states three additional months, until October 1, to submit plans showing how they will ensure Medicaid beneficiaries have sufficient access to providers.

In 2015, the Supreme Court ruled in *Armstrong v. Exceptional Child Center* that the Department of Health and Human Services, not the courts, should ensure Medicaid provider reimbursement rates are sufficient to enlist enough providers so that care and services are available to beneficiaries at the same level as they are to the general population in the same geographic area. Following that decision, CMS finalized a regulation on November 2, 2015, *Methods for Assuring Access to Covered Medicaid Services*, first proposed in 2011, requiring states to monitor, on a rotating basis, beneficiary access to primary care, physician specialists, behavioral health, pre- and post-natal obstetrics, and home health. On March 16, CMCS released FAQs on application of the monitoring process.

CMS initially asked states to submit their monitoring plans by July 1, but Medicaid directors said it was not practical for states to draft those plans so quickly, and asked for a delay in the deadline for submitting those initial plans until at least January 2017.



"Save the Dignity" Dates

May 1—National Mental Health & Dignity Day

Mental Health & Dignity Day is meant to promote the dignity of every person and recognize that mental health is something we all have in common. Individuals who have experienced a mental health diagnosis will come together to celebrate the positives that come from experiencing wellness, demonstrate they have a voice, and confirm they are equal members of society.

October 10, 2016—Destination Dignity: March for Dignity & Change in Mental Health

The moment has come to reframe mental health as a basic right that must be realized in the context of human dignity. The Destination Dignity March, a collective effort of thousands affected by mental health conditions, is intended to be a crucial step in this direction.

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of last year, 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.

Just One Week Left!

Nominate film and television productions that feature positive depictions of people with behavioral health issues for a 2016 SAMHSA Voice Award at http://bit.ly/NominateFilmAndTV.

SAMHSA Funding Opportunity Announcement (FOA) Information
Resiliency in Communities after Stress and Trauma (ReCAST)

FOA Number: **SM-16-012** ***Posted on Grants.gov:*** **Friday, April 8, 2016** ***Application Due:*** **June 7, 2016**

Description

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2016 Resiliency in Communities After Stress and Trauma (ReCAST Program) grants. The purpose of this program is to assist high-risk youth and families and promote resilience and equity in communities that have recently faced civil unrest through implementation of evidence-based, violence prevention, and community youth engagement programs, as well as linkages to trauma-informed behavioral health services. The goal of the ReCAST program is for local community entities to work together in ways that lead to improved behavioral health, empowered community residents, and reductions in trauma and sustained community change.

Eligibility

Eligible applicants are local municipalities (e.g., counties, cities, and local governments) in partnership with community-based organizations that have faced civil unrest within the past 24 months.

For the purposes of this FOA, "civil unrest" is defined as demonstrations of mass protest and mobilization, civil disobedience, community harm, and disruption through violence often connected with law enforcement issues.

Award Information

***Funding Mechanism*: Grant**
***Anticipated Number of Awards:* Up to 11**
***Length of Project:* 5 years**
***Anticipated Total Available Funding:* $10,000,000**
***Anticipated Award Amount:* Up to $1,000,000**
***Cost Sharing/Match Required?* No**

Proposed budgets cannot exceed $1,000,000 in total costs (direct and indirect) in any year of the proposed project. Given the limited funding available, applicants are encouraged to apply only for the grant amount which they can reasonably expend based on the activities proposed in their application.

Contact Information

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Application Materials

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

FOA document Part I (PDF | 535.74 KB)
FOA document Part I (DOC | 297.5 KB)
FOA document Part II (PDF | 448.41 KB)
FOA document Part II (DOC | 167.5 KB)
Pre-Application Webinar Announcement (PDF | 248.43 KB)

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Children, Youth and Families Division Link of Note

The *Data Collection Study Final Report of the Street Outreach Program (SOP)*, published by the Family and Youth Services Bureau (FYSB) of the Administration on Children, Youth and Families, provides a portrait of homeless street youth aged 14 to 21—both those served by FYSB's 11 SOP grantees and street youth in the same age group who are not using SOP services. The SOP grantee sites are Austin, TX; Boston, MA; Chicago, IL; Minneapolis, MN; New York City, NY; Omaha, NE; Port St. Lucie, FL; San Diego, CA; Seattle, WA; Tucson, AZ; and Washington, D.C.

While FYSB acknowledges that the study sample is not nationally representative, it says the data provides detailed information about the experiences and service needs of the 873 street youth from around the country who participated in the study. The Administration hopes that data will be used to inform service design and policy to better meet the needs of street youth who obtain and access services through street outreach programs.