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National Association of State Mental Health Program Directors

Weekly Update

National Council Says CMMI Innovation Initiatives Neglect Behavioral Health

A lead spokesman for the National Council for Behavioral Health says the Center for Medicare and Medicaid Innovation (CMMI) has not adequately factored behavioral health into its aggressive efforts to create demonstrations that test new value-based payment models.

Chuck Ingoglia, National Council's Senior Vice President for Public Policy, told *Inside Health Policy* this week that CMMI should include behavioral health organizations in demonstrations, laying out specific performance measures and explicit criteria for psychiatric or other behavioral health professional involvement in practice teams. He said there are 70 demonstrations listed on CMMI's website, but only one behavioral health-specific one—the Medicaid Emergency Psychiatric Demonstration mandated by Congress under the Affordable Care Act and extended this year under S. 599.

Ingoglia specifically pointed out a lack of behavioral health quality measures in all the CMMI demonstrations. He noted that, as an example, the Medicare Shared Savings program has only two measures—one for screening depression and one for remission of depression. Ingoglia said CMMI focuses more on Medicare, and because only psychiatric hospitals are defined as providers under the Medicare program, most mental health providers are excluded. Entities participating in demonstrations tend to be those defined as Medicare providers—hospitals, nursing homes, and dialysis clinics. The National Council spokesman said accountable care organizations' (ACOs') mental health focus has been limited to serious mental illness.

Ingoglia acknowledged there has been some mental health focus in Medicaid innovation efforts, such as the State Innovation Model grants and delivery system reform incentive payment (DSRIP) programs, but told *Inside Health Policy* the amount of attention in this area varies by state. He called the Texas DSRIP initiative "pretty transformative."

In response, CMMI told *Inside Health Policy* that it is testing ways to connect individuals with mental or behavioral health needs to community resources through its recently announced Accountable Health Communities Demo.

NQF Population Health Framework Open for Comment through June 22

As part of an ongoing project funded by the Department of Health and Human Services, the National Quality Forum (NQF) has been refining the Community Action Guide — a common framework for population health improvement. In order to make the Guide useful for different groups and communities with varying needs, NQF is seeking public feedback through June 22 at 6 p.m. ET.

The Guide offers practical, plain-language guidance about how communities can work with public health and clinical care systems to improve population health. It is structured around ten key elements to improve population health, such as collaborative self-assessment, prioritizing health improvement activities, measurement, and developing a plan for program sustainability. Each element includes key steps and recommendations on how the element can be accomplished, along with examples and key resources.

Over the past year, NQF has incorporated updates to Element 7 of the Guide, *Selection and Use of Measures and Performance Targets*, based on feedback from groups in the field who are actively working to improve population health in their communities.

To learn more about the Community Action Guide and NQF's work in population health, as well as to provide comments on the Guide, visit the Population Health Framework project page. Questions can be addressed to the project team at populationhealth@qualityforum.org.

NIH Funding Opportunity: Development of Technology to Support Zero Suicide

Title: ***Products to Support Applied Research Towards Zero Suicide Healthcare Systems***

Open Date (Earliest Submission Date): *August 5, 2016.* **Due Date:** *September 5 (Cycle I); January 5 (Cycle II); and April 5 (Cycle III).*

Letter of Intent: *Due 30 days prior to the application due date.*

Funding: *$1,500,000 for FY 2017 to fund approximately 4 to 6 projects. Future funding amounts beyond FY 2017 will depend on annual Congressional appropriations.*

Award Project Period: *Phase I—up to 2 years; Phase II—up to 3 years*

Applicants are encouraged to contact Adam Haim by email or at 301-435-3593 for further guidance.

Government Watchdog Finds Mental Health Stigma Endures in Military Service

An April Government Accountability Office (GAO) Report, *Human Capital—Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma*, finds mental health stigma still exist within the Department of Defense (DOD) despite the DOD's efforts to reduce stigma and improve treatment.

The GAO reaches that conclusion after analyzing available data from a DOD-wide survey, responses from 23 non-generalizable focus group interviews with service members conducted between June 2015 and April 2016, responses from three focus groups with deployed or about-to-be-deployed civilians at six locations, and interviews with DOD and service officials. All of the GAO's conclusions about civilian perceptions are derived from the focus groups because the GAO found that none of the department-wide surveys measured deployed civilians' perceptions of mental health care or stigma.

Service members voiced concerns to GAO about being called "malingerers" for seeking counseling. One focus group shared that, at their military installation, the mental health clinic's only elevator is known as the "elevator of shame"—stigmatizing anyone who visits the clinic.

The GAO analysis from the department-wide survey found that about 37 percent of active duty service members in 2011 (approximately 600,000 troops) and 39 percent of reservists during the 2010 to 2011 time frame thought seeking mental health care through the military would probably or definitely damage a person's career.

The GAO report cites a 2014 RAND study, *Mental Health Stigma in the Military*, which found 203 DOD policies that create a stigmatizing environment. DOD policies for job assignments and security clearances discriminate against anyone who seeks mental health counseling. For example, an Army policy requires verification that a soldier has no record of emotional or mental instability to be eligible for a recruiting position.

The policy is unclear as to what diagnoses constitute "instability", and whether a service member responding well to treatment would be barred from future recruiting duty opportunities.

The report says service members that seek mental health services are at least temporarily losing their security clearances—despite the Secretary of Defense's 2012 directive that seeking mental health treatment should not impact security clearance or career mobility.

GAO says DOD is not well positioned to measure the progress of its mental health care stigma reduction efforts for several reasons. First, DOD has not clearly defined the barriers to care it generally understands as "mental health care stigma" and does not have related goals or performance measures to track progress. Second, multiple DOD- and service-sponsored surveys that contain questions to gauge stigma use inconsistent methods, which precludes the analysis of trends over time in order to determine effectiveness of stigma reduction efforts. Finally, responsibilities for mental health care stigma reduction are dispersed among various organizations within DOD and the services, hampering information-sharing. No single entity is coordinating department-wide efforts to reduce stigma.

GAO says without a clear definition of "mental healthcare stigma," goals and measures, and a coordinating entity to oversee program and policy efforts and data collection and analysis, DOD cannot ensure that its efforts are effective and that resources are most efficiently allocated. The Pentagon agreed with the GAO conclusions.

The GAO conducted the study after the report of an August 2010 DOD task force on suicide prevention concluded that mental health stigma impedes service members from seeking treatment in the military.

The Pentagon reported in late April that the suicide rate in 2015 remained at an all-time high for the seventh consecutive year. Last year, 265 active-duty service members took their lives--19.9 per 100,000 in comparison to 12.93 per 100,000 for the national civilian rate. Suicides among reserve troops in the Army, Navy, Air Force and Marine Corps and the National Guard numbered 210 in 2015. That was an increase from 170 suicides in 2014.

Vermont Supreme Court Rules Hospital Inpatient and Outpatient Treatment Providers Had Duty to Warn and Train Custodial Parents of Patient with Schizophrenia

The Vermont Supreme Court on May 6 ruled that an inpatient psychiatric facility from which a patient with schizophrenia had been discharged and the outpatient program treating him at the time had both apparently failed in their duties to warn the patient's custodial parents of the potential violent danger their son posed to others and to train the parents in how to handle their son's actions.

At the same time, the court, in the case of *Kuligoski v. Brattleboro Retreat and Northeast Kingdom Human Services (NKHS)*, rejected the plaintiff's claims that the providers had failed a duty to protect the public by improperly releasing into the community a patient, who, after his release, violently assaulted a technician working on property belonging to the patient's grandparents.

The sharply divided appeals court reversed the lower Vermont Superior Court's finding that the plaintiff had failed to state a legal claim and remanded the case to the lower court for a finding on the merits of three of the counts claimed—that that the Retreat and NKHS had a duty to inform the parents of patient "E.R." of his mental health and status, his potential danger to others, and how to perform their caretaker role in light of these warnings.

E.R. was voluntarily admitted in October 2010 to the Psychiatric Department at Central Vermont Medical Center (CVMC) after having threatened young children in his home. During his first few days at the CVMC, physician notes indicate he was easily agitated, made threats, and reported auditory hallucinations. He was tentatively diagnosed with a schizophreniform disorder. Within a week, he was involuntarily committed in restraints to Vermont State Hospital, where the doctor who examined him concluded he was a danger to others and, if released, would pose a danger to his family.

While at the Vermont State Hospital, E.R. was administered anti-psychotic and anxiety medication. He repeatedly asked to leave the hospital, once tried to escape, threatened to punch out a window, and was observed reacting to unseen auditory stimuli. After he reported feeling unsafe at the hospital, a social worker made a referral for his transfer to the Brattleboro Retreat, a psychiatric hospital.

E.R. was examined by a physician at the Retreat who confirmed the state hospital's diagnosis, reporting that E.R. "had verbalized homicidal ideation toward staff." E.R. was placed on a staff-intensive treatment plan but continued to exhibit "grossly psychotic" behavior, lack of insight, and severely impaired judgment. His physician noted he "required an in-patient level of care to prevent further decompensation—the failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance or disintegration, especially that which causes relapse in schizophrenia. The physician also reported that E.R. evidenced auditory and visual hallucinations, menacing behavior, and homicidal and suicidal ideation.

The Retreat physician noted that "E.R. continued to be floridly psychotic, probably paranoid, guarded and gradually improving," but that he remained sufficiently ill that he totally lacked insight into his illness and would likely be non-compliant with treatment outside of the hospital. The physician further noted that E.R. should be allowed out only for brief intervals.

On November 12, 2010, E.R. stopped taking his medication and began hearing voices commanding him to kill himself. E.R. said of the commands, "I feel like I should do it." Nevertheless, he was discharged the same day.

What the parents, with whom E.R. lived and who monitored E.R. throughout his treatment, were told at the time of discharge was disputed in testimony, although the court said it appears they were told that E.R. "might have schizophrenia." They understood that E.R. was "going through a phase and would recover." E.R.'s parents believed his mental health was related to his breakup with a girlfriend in 2009 or possibly resulted from a bout with mononucleosis. E.R.'s mother believed E.R.'s condition had considerably improved at the time of his release.

Prior to his discharge, the Retreat developed an aftercare treatment plan with E.R.'s parents that involved regular visits to NKHS. E.R. was also prescribed daily medication, which his mother was told to administer. On December 1, 2010, E.R. met with a treatment team at NKHS and signed a cognitive remediation therapy plan. A week later, a member of the treatment team stated "E.R. was a high risk for Dimension 3 of the Client Placement Criteria (emotional, behavioral or cognitive conditions/complications) because E.R. had recently been diagnosed with a psychotic disorder and had minimal insight surrounding the diagnosis."

In mid-December, E.R. told his mother that he had stopped taking his medications. When she called NKHS, one of the physicians on the treatment team told her this was a cause for concern, but that E.R. had to decide to take care of himself. E.R. did not meet with anyone at NKHS between mid-December 2010 and March 2011, and no one at NKHS reached out to E.R. during that time.

On February 26, 2011, E.R. accompanied his father to an apartment building owned by E.R.'s grandparents. Plaintiff Michael Kuligoski was working on the furnace in the basement of the building. E.R. went down to the basement and assaulted Mr. Kuligoski, causing serious injuries.

In the lower court, the plaintiff's complaint alleged: (1) the Retreat was negligent in discharging E.R. knowing of his dangerous tendencies and that he was a high risk for decompensation; (2) the Retreat was negligent in failing to warn E.R.'s parents that he *(cont'd on next page)*

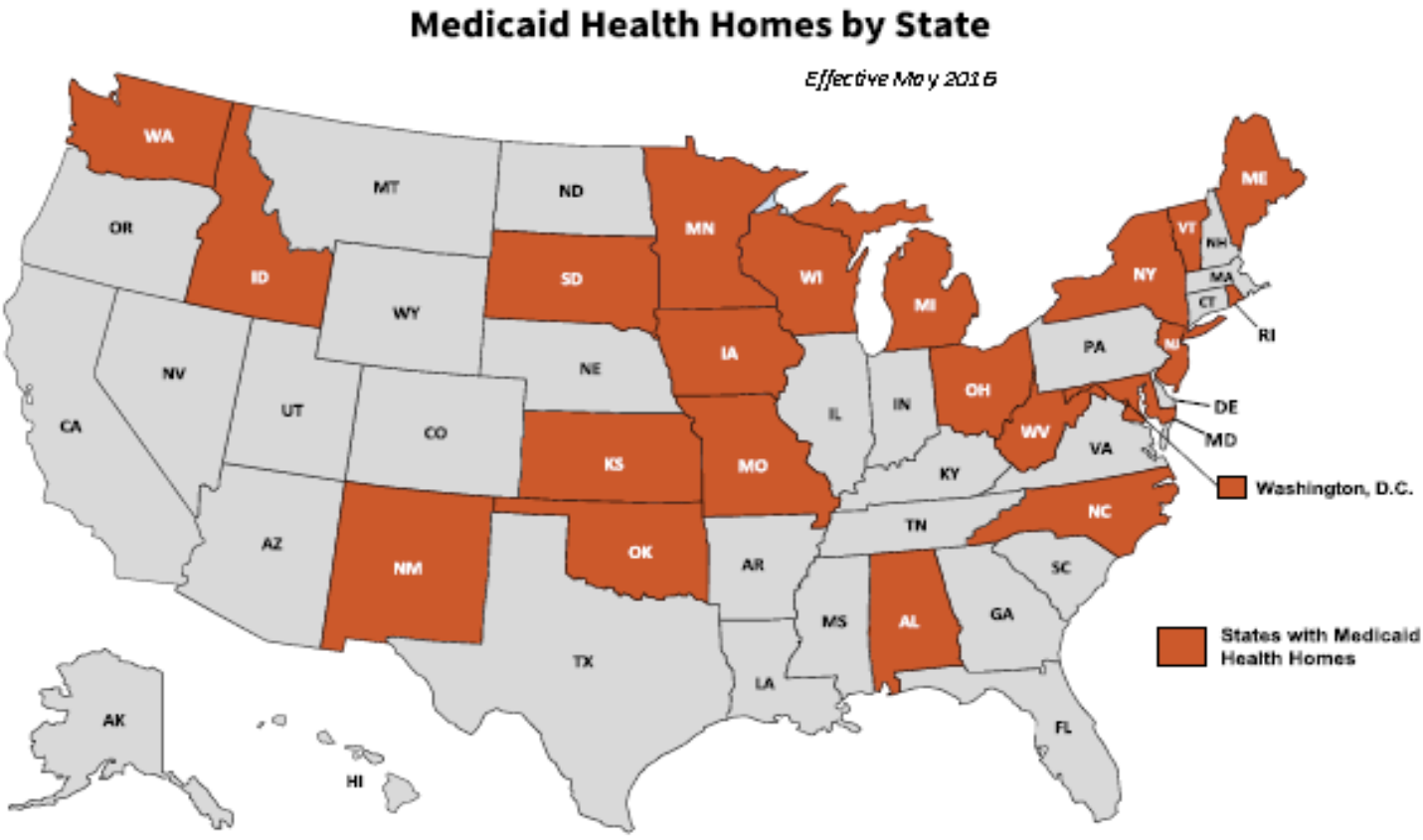
Vermont Supreme Court Imposes New Duties on Inpatient, Outpatient Programs

(cont'd from previous page) posed a risk to the general public; (3) the Retreat was negligent in failing to train E.R.'s parents in how to supervise him, monitor and manage his medications, and take necessary and appropriate measures to protect potential victims; (4) the Retreat was negligent in its undertaking "to render a service that it recognized or should have recognized as necessary for the protection of third persons;" (5) NKHS was negligent in failing to warn E.R.'s parents that he posed a risk to the general public; (6) NKHS was negligent in failing to take "immediate and affirmative steps" to treat E.R.; and (7) NKHS was negligent in undertaking its duty to render services to E.R. The plaintiff emphasized in the Superior Court, as well as the appeals court that the counts were based on a common "duty of reasonable care to act to avoid needless risk to the safety of third parties" based on the "special relationship" that existed between the Retreat and NKHS and their patient.

In its decision, the appeals court dismissed counts (1), (4), (6), and (7), essentially holding that the providers had no duty to prevent the release of a patient receiving inpatient treatment in order to protect the public. In reaching that conclusion, the appeals court looked to prior case law and the public policy supporting rehabilitation in a non-institutional setting.

The appeals court said that mental health provider liability of the type sought by the plaintiff would cause an increase in unjustified commitments and abandonment of the policy of treatment in the least restrictive environment. The court also suggested that mental health professionals cannot predict dangerousness with sufficient accuracy to act on their predictions by refusing release.

The appeals court rejected the plaintiff's claim that the defendant Brattleboro Retreat could be held liable for negligent performance of an undertaking under § 324A of the Restatement (Second) of Torts, which holds that, for a defendant to be held liable for a failure to exercise reasonable care, the failure must increase the risk of harm. The appeals court said the plaintiffs could not show, and had not alleged, that the defendant's care increased the risk to third persons in general.



As of May 2016, 21 states and the District of Columbia have Medicaid health home programs. Some states have submitted multiple health home state plan amendments (SPAs) to target different populations or conditions, with 30 health home models in operation. Nearly a dozen additional states are planning to implement health homes. More than one million Medicaid beneficiaries have enrolled in health homes thus far. *Source: Center for Health Care Strategies, Inc. May 2016 Fact Sheet: Medicaid Health Homes, Implementation Update.*

UPCOMING WEBINARS

Medicaid IAP Targeted Learning Opportunity - CDC Guideline for Prescribing Opioids for Chronic Pain

Monday, June 13 -- 3:30 p.m. to 5 p.m. ET

The next TLO session for the Medicaid Innovation Accelerator Program will focus on disseminating key points and recommendations from the recently published CDC opioid prescribing guideline for primary care providers who are treating adult patients for chronic pain in outpatient settings. The goal of the guideline is to help providers and patients—together—assess the benefits and risks of opioid use. It encourages providers to consider the unique needs of each patient in order to provide safer, more effective pain treatment while reducing risks of addiction and overdose. The webinar will highlight how different state Medicaid agencies are implementing strategies to reduce opioid prescribing while meeting the clinical needs of their beneficiaries.

Register HERE.

Workshop on Implementing Evidence-Based Prevention by Communities for Children's Behavioral Health

Thursday, June 9, 8:30 a.m. to 4:30 p.m. ET & Friday, June 10, 8:30 a.m. to 1:15 p.m. ET

Communities represent the front line in addressing many behavioral health conditions experienced by children, adolescents, young adults, and their families. The National Academies of Sciences, Engineering, and Medicine will host a 2-day workshop on progress, challenges, and opportunities that exist for communities in implementing interventions that promote cognitive, affective, and behavioral in health in children and adolescents. Workshop panels will explore: the use of evidence by communities to select interventions; core components of evidence-based prevention in communities and their local adaptation; engagement of communities into programs and sustainability of prevention interventions; methodological developments in implementing and evaluating prevention interventions in communities; implementing principles versus programs; and universal versus selective preventive interventions. These issues will be examined during the workshop with a particular effort to engage experts working in the community environment, exploring the gaps between current research evidence and practice needs.

A workshop agenda and additional information can be downloaded HERE.

Register HERE to attend in person at NAS, 2101 Constitution Ave., Room 120, in Washington, D.C. or to join by webcast. Space is limited.

Contact **Anthony Janifer** at the National Academy of Sciences for answers to any questions about the event.

NASMHPD Links of Note

Substance Abuse and Mental Health Data Archive (SAMHDA) has been enhanced with new features and is back online. In late summer 2016, the SAMHDA website will add a user-friendly, online analysis tool. Users will be able to create cross-tabs and perform logistic regression, chi-square tests, and t-tests from their web browsers. They will also be able to download output and underlying data in .csv format. In early winter 2016, approved researchers will be able to access restricted-use data through a secure data portal. A new call for the data portal will follow once all approved researchers from the first three calls have access. Answers to questions or technical assistance can be obtained by contacting the SAMHDA Help Desk through the online technical assistance form or by calling 1-888-741-7242.

CMS on May 25 released the **March 2016 Monthly Report on State Medicaid and Children's Health Insurance Program (CHIP) Eligibility and Enrollment Data**.

Avalere Health released the following analysis on May 24: **Early Analysis Finds 2017 Proposed Exchange Premiums in 9 States Exceed 2016 Increases But Vary Widely By State**.

Call for Applications
Healthiest Cities & Counties Challenge Project

Award Information: The Aetna Foundation, the American Public Health Association, and the National Association of Counties has launched ***The Healthiest Cities & Counties Challenge Project***, a new initiative to provide recognition to cities, counties, and tribal communities showing measurable changes in health and wellness.

The Challenge will identify innovative projects that have the potential to become best practices and can be replicated and sustained in communities throughout the country. The Challenge will reward innovation with awards totaling $1.5 million. 50 Healthy Community finalists will be recognized nationally and locally, with each receiving $10,000 in seed awards to participate.

Application Information: Applications are due ***Tuesday, May 31, 2016*** by 5 p.m. ET. Finalists will be announced August 1.

For more information about The Challenge, and find out how to submit an application, visit the Healthiest Cities & Counties Challenge website. To get answers to questions about the Challenge, email hccc@ceosforcities.org or call Healthiest Cities & Counties Challenge Director Debbie Nadzam at 216-523-7348.

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.

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.

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

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

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, 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)

FOA: Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness

Funding Opportunity Announcement Number: SM-16-011

Posted on Grants.gov: Monday, April 18, 2016 *Application Due Date: Thursday,* June 16, 2016

Anticipated Total Available Funding: $13,250,000 *Anticipated Number of Awards:* Up to 15 awards

Anticipated Award Amount: Up to $1 million/year *Length of Project:* Up to 4 years

Cost Sharing/Match: No

Description

The Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2016 Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness. This 4-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI). This program is designed to work with families and courts, to allow these individuals to obtain treatment while continuing to live in the community and their homes.

This pilot program was established by § 224 of the Protecting Access to Medicare Act of 2014 (PAMA), enacted April 1, 2014. Under that Act, AOT is defined as "medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a state or local court to order such treatment." AOT (also known as involuntary outpatient commitment, conditional release, and other terms) involves petitioning local courts to order individuals to enter and remain in treatment within the community for a specified period of time. AOT is intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI who are under court order as authorized by state mental health statute.

Grants will only be awarded to applicants that have not previously implemented an AOT program. "Not previously implemented" means that even though the state may have an AOT law, the eligible applicant has not fully implemented AOT approaches through the courts within the jurisdiction that they are operating in. In addition, grants will only be awarded to applicants operating in jurisdictions that have in place an existing, sufficient array of services for individuals with SMI such as Assertive Community Treatment (ACT), mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma informed care. A portion of the grant funding may be used to enhance the array of services.

The AOT grant program is one of SAMHSA's services grant programs. SAMHSA intends that its services grants result in the delivery of services as soon as possible after award. Service delivery should begin by the 4th month of the project at the latest. SAMHSA has consulted with the National Institute of Mental Health, the Department of Justice, the HHS Assistant Secretary of Planning and Evaluation and the Administration for Community Living on the FOA. This announcement addresses Healthy People 2020 Mental Health and Mental Disorders Topic Area HP 2020-MHMD and Substance Abuse Topic Area HP 2020-SA.

Eligibility

Eligible applicants are: states, counties, cities, mental health systems (including state mental health authorities), mental health courts, or any other entity with authority under the law of the state in which the applicant grantee is located to implement, monitor, and oversee AOT programs. Applicants must operate in jurisdictions that have in place an existing, sufficient array of services for people with SMI such as ACT, mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma informed care.

Proposed budgets may not exceed the amount listed in the tier chart in the FOA in total costs (direct and indirect) in any year of the proposed project. The amount of each grant will be based on the population of the area, including the estimated number of individuals to be served under the grant. 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.

Contacts

Program Issues: Mariam Chase, Community Support Programs Branch, Center for Mental Health Services, SAMHSA, 240-276-1904. **Grants Management and Budget Issues:** Gwendolyn Simpson, Office of Financial Resources, Division of Grants Management, SAMHSA, 240-276-1408

Application Materials: You must respond to the requirements in both the FOA PART I and PART II.

FOA document Part I (PDF | 515.5 KB) FOA document Part I (DOC | 317 KB)

FOA document Part II (PDF | 433.03 KB) FOA document Part II (DOC | 156.5 KB)

Pre-Application Webinar Announcement (PDF | 65.85 KB)

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Technical Assistance on Preventing the Use of Restraints and Seclusion

For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

SAMHSA's National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to your state.

To Apply for Technical Assistance, Click Here:

We look forward to the opportunity to work together.