Trump Administration Again Reduces Funding for Navigator Grants, Suspends Risk Adjustment Payments to Federally Facilitated Exchange-Participating Insurers

The Trump Administration this week reduced the money available for 2019 payments to organizations providing navigators in Federally Facilitated Exchanges (FFEs) by 72 percent, after reducing those payments in 2018 by 57 percent.

Under the Affordable Care Act (ACA), navigators are charged with: conducting public education activities to raise awareness about the Exchange; facilitating enrollees in selecting a Qualified Health Plan (QHP), as defined by the ACA; providing information in a manner that is culturally and linguistically appropriate to the needs of the population served by the Exchange, including individuals with limited English proficiency, and ensuring accessibility and usability of navigator tools and functions for individuals with disabilities; and referring enrollees with a grievance, complaint, or question regarding their health plan, coverage, or a determination to the appropriate office of health insurance consumer assistance or health insurance ombudsman. Navigators are required to comply with applicable training and conflict of interest standards; and to obtain the authorization of applicants for Exchange coverage prior to accessing their personally identifiable information.

The $10 million total being made available this year for navigator grants, reduced from $63 million in the last year of the Obama Administration, is to be divided up among grant recipients in the 34 states with FFEs, with minimum grants set at $100,000. In addition to drastically reducing the moneys to fund navigators, the Centers for Consumer Information and Insurance Oversight (CIIO) in its July 10 Funding Opportunity Announcement (FOA) says it plans to prioritize grants to entities that agree to facilitate enrollment in coverage options in addition to Qualified Health Plans under the ACA, such as association health plans and short-term, limited-duration insurance.

CIIO explains that it has reduced the amount of funding because “when Exchanges were in their infancy, and public awareness and understanding of coverage options was low, the U.S. Department of Health and Human Services (HHS) encouraged Navigators to cast a wide net and to provide intensive face-to-face assistance to consumers. The FFES have been in operation since 2013 for the 2014 open enrollment period, and the public is more aware of the options for private coverage available through them. Certified application counselors, direct enrollment partners, and Exchange-registered agents and brokers serve as additional resources to consumers. It is appropriate to scale down the Navigator program to reflect the enhanced public awareness of health coverage through the Exchanges.”

Under § 1311(i) of the Affordable Care Act, entities eligible for navigator grants include trade, industry, and professional associations, except those representing the insurance industry; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused nonprofit groups; chambers of commerce; unions; resource partners of the Small Business Administration; other licensed insurance agents and brokers; and other entities capable of meeting program requirements. Eligible applicants may choose to partner with other entities and/or individuals to form a consortium of subrecipients in order to target a larger total portion of the “left behind” population.

In a press announcement, CIIO notes that fewer than 1 percent of enrollees in the FFEs were enrolled by navigators during the 2017 and 2018 Open Enrollment Periods. During grant year 2016-2017, 17 of those navigators enrolled fewer than 100 people, at an average cost of $5,000 per enrollee. In addition, CIIO says that nearly 80 percent of navigators failed to reach their enrollment goal. In contrast, agents and brokers assisted with 42 percent of FFE enrollment for Plan Year 2018, which cost the FFEs only $2.40 per enrollee to provide training and technical assistance.

In addition, the FOA encourages navigator grant applicants to leverage volunteers as well as strategic partnerships with public and private organizations to target consumers who would benefit from Exchange coverage and more efficiently meet their enrollment goals.

In its FOA, CMS notes that the HHS Notice of Benefit and Payment Parameters for 2019 Final Rule amended 45 C.F.R. § 155.210(c)(2), effective June 18, to eliminate the previous requirements that each Exchange must have at least two Navigator entities and that one of those entities must be a community and consumer-focused non-profit.

The degree to which the reduced role for navigators impairs the ability of applicants to find and enroll in Exchange plans could be exacerbated by CMS’ recent elimination of multiple ACA enrollment references on the Medicaid.gov website.

(Continued on page 3)
## Table of Contents

- Trump Administration Again Reduces Funding for Navigator Grants, Suspends Risk Adjustment Payments to Federally Facilitated Exchange-Participating Insurers
- October 7 National Meeting in Boston on Advancing Early Psychosis Care in the United States
- Blog (Michael F. Hogan, Ph.D.): To Prevent Suicide, Address It Directly
- July 23 National Council-Sponsored Webinar: Staff Self-Care in Crisis Response and Suicide Prevention
- Center for Trauma-Informed Care Trainings
- EIP Resource Center: Snapshot of State Plans for Using the Community Mental Health Block Grant Ten Percent Set-Aside to Address First Episode Psychosis
- SAVE THE DATE: NASMHPD Annual Commissioners Meeting July 29 to July 31
- Uniformed Services University National Center for Disaster Medicine and Public Health Disaster Health Core Curriculum
- Register for the University of Maryland Training Institutes, July 25 - 28
- July 25 SAMHSA-Sponsored Webinar- Addressing Trauma and PTSD in First Episode Psychosis

### 2017 NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS

- August 15-17 National Association of State Health Policy Conference
- August 9 SAMHSA-Sponsored Webinar - Emerging Best Practices for People with an Intellectual/Developmental Disability Co-Occurring with Mental Illness
- Administration for Community Living Funding Opportunity: Innovations in Nutrition Programs and Services

### TA Network Webinars

- Call for Presentations for November 1 through 3 National Federation of Families for Children’s Mental Health Conference
- SAVE THE DATE – September 2019 International Initiative for Mental Health Leadership (IIMHL) & International Initiative for Disability Leadership (IIMDL) Leadership Exchange in Washington, DC

### HRSA Funding Opportunity Announcement:

- Pediatric Mental Health Care Access Program
- State Opioid Response Grants
- Tribal Opioid Response Grants
- Technical Assistance on Preventing the Use of Restraints and Seclusion
- Technical Assistance Opportunities for State Mental Health Authorities

- July 24-26 Georgetown University Health Policy Institute Center for Children and Families Annual Conference in D.C.
- New SAMHSA-Sponsored CME Course: Clozapine as a Tool in Mental Health Recovery
- NADD Nominations Sought by August 31 for Annual Awards
- SAMHSA-Sponsored Recovery to Practice Two-Part Initiative on Recovery-Oriented Use of Medications

**NASMHPD Board & Staff**

**NASMHPD Links of Interest**
Trump Administration Again Reduces Funding for Navigator Grants, Suspends Risk Adjustment Payments to Federally Facilitated Exchange-Participating Insurers

(Continued from page 1) On July 7, CMS announced it would suspend $10.4 billion in risk adjustment (RA) payments due to insurers annually who serve high-risk enrollees, such as those with chronic conditions. CMS said it was suspending the payments due to a February 28 decision by Federal judge Judge James O. Browning in New Mexico in a case challenging the methodology for calculating the payments. Risk adjustment reduces the incentives for issuers to avoid high-risk enrollees through cherry-picking, and lessens the potential influence of risk selection on the premiums that plans charge.

When enacting the RA program under the ACA, Congress did not specifically dictate how it should be administered, but the Obama administration opted to run it as a budget-neutral program, i.e. using no taxpayer dollars. Several insurers—smaller plans and the ACA-created health co-ops—sued the Department of Health and Human Services, contending that they were disadvantaged by the approach taken, which calculates risk adjustment transfers based on the average statewide premium.

In one case in Massachusetts – Minuteman v. HHS – the court ruled the Administration had the authority to implement the RA rules as written. However, in a second case involving New Mexico Health Connections, the state co-op, Judge Browning agreed with the plaintiffs that the rule did not properly explain the agency’s reasoning for using the methodology, but did not say the formula was illegal. Judge Browning said the payment formula was flawed because federal officials “assumed erroneously” that collections and payments under the risk adjustment program had to offset each other so there would be no new cost to the Federal government. He asked that collections and payments be suspended until the case is resolved. CMS asked the court to reconsider its ruling and is awaiting a decision from a June 21 hearing.

The regulatory deadline for insurers to report the data impacting risk adjustment was June 30. However, the payments to insurers would not be due until October.

Nevertheless, America’s Health Insurance Plans (AHIP), the industry trade group, warned suspending the payments would lead to market disruptions. The Blue Cross Blue Shield Association said the CMS choice to freeze the payments would “significantly increase 2019 premiums for millions of individuals and small business owners and could result in far fewer health plan choices.” BCBSA also noted that risk adjustment is a mandatory program under federal law.

Various observers have suggested CMS could have simply issued an interim rule explaining or modifying the RA formula before payments were due, or could have suspended collection and payment in New Mexico only, where the judge rendered his order, rather than suspending the payments nationwide.

On Monday, CMS released its report on risk adjustment payments for the 2017 benefit year. The payment program “functioned smoothly,” CMS said, although the number of insurers participating in the program dropped from 767 in 2016 to 654 in 2017. The report said that nationwide, the absolute value of total risk adjustment transfers across markets was about 8 percent of total premiums, slightly less than the 9 percent of total premiums in the 2016 benefit year.

National Meeting on Advancing Early Psychosis Care in the United States
Pre-Conference Kick-Off for the
11th Conference of the International Early Psychosis Association
Westin Copley Place
10 Huntington, Avenue, Boston, Massachusetts
Sunday, October 7, 8:30 a.m. to 3:30 p.m. E.T.

We invite you to register to attend a national meeting on Advancing Early Psychosis Care in the United States! The cost to attend is $150 if you register by September 6.

This meeting will serves as a pre-conference and kick-off for the 11th Conference of the International Early Psychosis Association. Social workers, psychologists, counselors, and nurses can earn 5 continuing education credits for $50.

This is an opportunity to be part of the conversation about the work we all do. You will get to talk with people from all over the country who are working to develop and maintain first episode psychosis programs in their communities, and also hear from the national and international leaders who are shaping and supporting the field. More than 140 people have registered so far – but don’t worry, the Westin has plenty of space.

Finally, many of you may wish to stick around for the main conference and understand the really big picture of how international research is shedding new light on the causes of and treatments for mental illness. Those who attend the FEP meeting will be eligible to receive a discounted “group rate” on IEPA conference registration.

Register HERE For the Pre-Conference Meeting
Blog: To Prevent Suicide, Address It Directly

Michael F. Hogan, Ph.D.

Published Online in the July Psychiatric Services 2018; 69:737

In [the July issue of Psychiatric Services], Dr. [Fredrick A.] Walby and colleagues present a meta-analysis of suicide rates among patients receiving mental health services, confirming that only about a quarter of suicide decedents had received mental health care just prior to death. Commenting on service and policy implications, the authors note that expanding access to mental health care should be a priority, because most individuals who died by suicide were not receiving such care. They also discuss the need to improve detection of suicide risk among patients receiving primary care and note that improvements in mental health care quality might help reduce suicide deaths.

Improving access to mental health care can reduce morbidity and improve health of those who receive such care. However, improving access is a challenging and complex goal; obstacles include stigma, the supply of professionals (especially psychiatrists), and coverage and utilization barriers in health insurance programs. Emerging evidence also suggests that access to routine mental health care may insufficiently protect patients from the risks of suicide. Analyses of suicide patterns found that suicide rates among those who received care are much higher than rates for the general population as well as rates for veterans and other groups often considered high risk. Usual care may not be sufficiently protective. What actions could feasibly be implemented to reduce suicide among people receiving health care?

The National Action Alliance on Suicide Prevention (NAASP) recently released a report from its Transforming Health Systems Initiative Work Group (of which I was a member) to address this problem. Recommended Standard Care for People With Suicide Risk: Making Health Care Suicide Safe considers the evidence on feasibility and effectiveness of measures that should be standard in modal care settings (primary care, emergency departments [EDs], and outpatient and inpatient mental health and addiction treatment). The report acknowledges that excellent suicide care, such as full implementation of the Zero Suicide care model or replication of the Henry Ford Health System's Perfect Depression Care program, which reduced suicide over 75% in that system's mental health programs, may not be feasible in all organizations. However, the report discusses evidence about the effectiveness of brief interventions that can be implemented in any health care organization to prevent suicide and recommends that these effective, brief interventions be used much more broadly in ordinary settings. A review of these interventions will orient readers to the emerging potential of suicide prevention activities in ordinary health care settings.

The accuracy of screening to identify individuals needing support for suicide risk compares favorably with screening to identify other health conditions, such as elevated cholesterol or blood pressure, as risk factors for cardiovascular disease. Simon and colleagues reviewed suicide deaths in a population of over 80,000 individuals who had completed the widely used nine-item Patient Health Questionnaire. Over 60% of the individuals who died by suicide over the period that followed had elevated responses on item 9, which asks about suicidal thoughts. The Action Alliance Group recommends suicide screening in primary care and EDs of all individuals who have behavioral health diagnoses or are receiving behavioral health treatments and additionally screening within EDs the patients who have self-harmed. A possible barrier to broader suicide screening is the belief that complex, highly expert care is required for patients at risk of suicide. Counteracting this perception is the reality that several brief interventions have been shown to reduce suicide risk.

For example, the Safety Planning Intervention developed in 2009 by Stanley and Brown is a brief (30- to 40-minute) intervention that aims to give patients tools to manage suicidal thoughts and feelings. In a recent large trial in the Veterans Health Administration, safety planning coupled with follow-up calls reduced suicidal behaviors and increased participation in treatment. A critical part of the intervention is identifying and collaboratively reducing access to potential means of self-harm. Safety planning can be conducted by mental health or health care professionals who have received brief training.

Another brief intervention with demonstrated effectiveness in reducing suicide attempts and deaths is brief supportive interactions (sometimes referred to as “brief non-demand caring contacts”). Effectiveness has been demonstrated for letters, phone calls, and other means of contact, including text messages, postcards, and visits. Caring contacts appear to be especially useful when patients are vulnerable and in transition (e.g., after inpatient discharge, ED visit, or missed appointment). The practice is very similar to next-day follow-up calls after ambulatory surgery.

The NAASP report suggests that suicide screening coupled with brief interventions should be standard in health care settings. To reduce suicide, we should endorse and implement actions directly targeted at this goal.

Dr. Hogan is with the Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland. Send correspondence to Dr. Hogan (e-mail: dr.m.hogan@gmail.com).

1 Contact with Mental Health Services Prior to Suicide: A Systematic Review and Meta-Analysis
Webinar Opportunity
Staff Self-Care in Crisis Response and Suicide Prevention
Monday, July 23 – 2:00 p.m. to 3:30 p.m. E.T.

Sponsored by the National Council on Behavioral Health

Crisis centers face high staff turnover due to compassion fatigue, vicarious trauma and burnout. This is costly and can decrease the quality of suicide prevention care. For organizations to have healthy, dependable, successful staff that deliver exceptional care, they need to develop a staff self-care program that mitigates the effects of crisis response. Luckily, there are tools, resources and examples available from other organizations.

Attend the “Staff Self-Care in Crisis Response and Suicide Prevention” webinar on Monday, July 23 from 2 – 3:30 p.m. ET. After this webinar, you will better understand the importance of self-care for crisis workers and the potential impact of ignoring it, as well as their special needs and how to address them. You will hear from National Suicide Prevention Lifeline staff who will demonstrate Lifeline’s tools and resources to address staff self-care. Finally, organizations who have successfully addressed these issues will discuss their experiences.

Presenters:
- Cheryl Sharp, MSW, ALWF – Consultant, Trauma-Informed Services and Suicide Prevention, National Council for Behavioral Health
- Matt Taylor, MA – Program Manager, Network Development, National Suicide Prevention Lifeline
- Rebecca Zeitlin, AMFT – Assistant Program Director, Didi Hirsch Mental Health Services
- Beth Brady, LAC – Director, Training and Public Relations, Crisis Response Network

Register HERE

CENTER FOR TRAUMA-INFORMED CARE

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.

July Trainings
South Carolina
July 19 & 20 - G. Werber Bryan Psychiatric Hospital, Columbia

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

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

Snapshot of State Plans for Using the Community Mental Health Block Grant 10 Percent Set-Aside to Address First Episode Psychosis

As a condition of receiving a Community Mental Health Services Block Grant (MHBG), states are required to ensure that 10% of their MHBG funding is set used to support programs for people with early serious mental illness, including first episodes of psychosis. The Snapshot of State Plans provides an overview of each state's funding, programs, implementation status, and outcomes measures under the set-aside.

To view the Snapshot or other new resources to support early intervention in psychosis, visit the What’s New section of the NASMHPD website here: https://www.nasmhpd.org/

To view the EIP virtual resource center, visit NASMHPD’s EIP website.
SAVE THE DATE: NASMHPD ANNUAL 2018 COMMISSIONERS MEETING
Sunday, July 29 – Tuesday, July 31
Westin Arlington Gateway Hotel, 801 North Glebe Road, Arlington, Virginia 22209

This year’s meeting will be a meeting of State Mental Health Commissioners/Directors and will build on the previous year’s concept of Beyond Beds and intersect with the recommendations in the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) report.

In addition, we are delighted that Tuesday, July 31 will be in partnership with Westat and will focus on the Social Security Administration’s 20-state Supported Employment Demonstration. This important study will determine if providing evidence-based mental health and vocational services to individuals who have applied for and been denied Social Security disability benefits (SSI or SSDI) leads to better outcomes. Applicants denied benefits are at high risk for disability, and the goal of the Demonstration is to help them find jobs and avoid long-term disability.

Further details on registration for the NASMHPD Annual 2018 Commissioners Meeting and other logistics will be provided in the near future. In the meantime, if you have any questions, please contact Meighan Haupt at meighan.haupt@nasmhpd.org.

DISASTER HEALTH CORE CURRICULUM

The Uniformed Services University National Center for Disaster Medicine and Public Health is proud to announce a free, eight-hour, online Disaster Health Core Curriculum for All Health Professionals intended for a wide range of health care professionals.

The course consists of eleven, 30-minute to one-hour online training lessons covering a variety of disaster health topics such as personal or family preparedness, communication, ethical and legal issues encountered in disasters, and much more.

This curriculum is free and designed to be taken in pieces or as a whole to be flexible for our busy healthcare professional learner.

The foundation of this curriculum is the Core Competencies for Disaster Medicine and Public Health.

Click Here to Access the Lessons

The Training Institutes offer an extensive array of sessions designed to provide practical, hands-on training and strategies that can be applied to the systems of care in states, tribes, territories, and communities. The Training Institutes is an opportunity for leaders in the field of children’s services to share the latest research, policy, and practice information and resources and learn from one another.

Click HERE for the Agenda

PREREGISTRATION UNTIL JULY 23 - $925; REGISTRATION AFTER JULY 23 - $1,025

Sessions will focus on approaches that are relevant, adaptable and innovative within critical areas in children, youth, and young adult service systems. Presenters and attendees will include experts and leaders in the field of children’s services, including state, county, tribal, and territorial children’s system leadership, direct service providers, state purchasers from Medicaid, behavioral health, child welfare, juvenile justice, and public health, parents, youth, and young adults, policymakers, clinicians, researchers, and evaluators.

Register HERE
As a policy maker, researcher or practitioner committed to improving the way our communities respond to the mental health issues of their citizens don't miss this challenging and comprehensive event.

Register now for LEPH2018 and hear:

- Professor Sir Michael Marmot deliver the 2018 LEPH Oration on 'Social Justice and Health Inequities'.
- Major sessions on 'Models of law enforcement and mental health collaboration to improve responses to persons with mental illnesses' or 'Working across sectors to develop an evidence based approach to mental health policing and distress in Scotland'
- Tom Stamatakis' timely paper addressing the 'The mental health of police personnel should be recognized as a 'mission critical' priority

Or participate in a session charged with 'Crossing the divide: searching for innovations in learning between criminal justice and public health'.

And much more - see the DRAFT PROGRAM at www.leph2018toronto.com/program

Register HERE

SAMHSA-Sponsored Webinar from the Center for Mental Health Services (CMHS)
Addressing Trauma and PTSD in First Episode Psychosis Programs
July 25 – 12:30 p.m. to 2:00 p.m. E.T.

A significant percentage of clients with first episode psychosis (FEP) have experienced one or more traumatic events. Determining if and how those traumatic experiences are related to the client’s first episode of psychosis is a critical part of the clinical formulation, and without effective trauma treatment, clients whose mental health has been affected by trauma may be hampered in their recovery. Addressing PTSD and other consequences of trauma in a FEP program require both a trauma-informed organizational culture and effective trauma-specific treatment. This webinar will support FEP providers and program leadership in thinking about how to introduce trauma-informed approaches and effective trauma-specific interventions in their programs.

Presenters:
- Andrea Blanch, Ph.D., Senior Consultant, SAMHSA National Center on Trauma-Informed Care
- Kate Hardy, Clin. Psych.D., Assistant Professor and Director of Inspire Clinic, Stanford University Department of Psychiatry and Behavioral Health
- Rachel Loewy, Ph.D., Associate Professor, UC-San Francisco Department of Psychiatry
- Tara Niendam, Ph.D., Associate Professor, UC-Davis and Executive Director, UC-Davis Early Psychosis Programs

Register HERE
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our *Beyond Beds* series of 10 white papers highlighting the importance of providing a continuum of care.

Following are links to the reports in the *Beyond Beds* series.

*Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*
*Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment*
*Older Adults Peer Support - Finding a Source for Funding Forensic Patients in State Psychiatric Hospitals: 1999-2016*
*The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders*
*Crisis Services' Role in Reducing Avoidable Hospitalization*
*Quantitative Benefits of Trauma-Informed Care*
*Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014*
*The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity*
*The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System*
*Forensic Patients in State Psychiatric Hospitals – 1999 to 2016*
This webinar is intended to provide information about emerging best practice in serving individuals who have mental illness co-occurring with an intellectual/developmental disability. The session will cover clinical practices and illustrate an inter-systems model of care for this underserved population.

The outline below is intended to provide information on the content of the webinar.

I. What is NADD
   a. 501(c)3 membership organization
   b. Provides training, consultation, journals, book publishing, accreditation and certification

II. Clinical Practices
   a. Assessment practices
      i. Assessment requires gathering information from multiple sources
      ii. Obtain data from family collaterals and the team. This can be a case-management function
      iii. Relevant information to be organized into a 3-5 page document
   b. Diagnostic Practices
      i. Employ a bio-psycho-social model
      ii. Developmental perspective
      iii. Use of the DM-ID-2
   c. Adapting Psychotherapy Practices
      i. Principles of psychotherapy do not change, but approaches need to be modified
      ii. Nine (9) adaptations to psychotherapy practices will be addressed

III. An Inter-System Model
   a. The inter-disciplinary approach within the context of an inter-system model is a “best practice” within a person-centered approach to planning for an individual
      i. “The team” encompasses the person/family, representatives of IDD and MH fields and others
      ii. Using a system of care model for children and adults
         1. The right people at the table

Presenter:
- Dr. Robert J. Fletcher, Founder & CEO Emeritus, NADD – an association for persons with developmental disabilities and mental health needs. His vision and leadership have brought NADD to a position where it is recognized as the world’s leading organization in providing educational resources, conferences, trainings, consultation services, as well as accreditation and certification programs in the field of dual diagnosis.

Moderator:
- Lynda Gargan, Ph.D., Executive Director, National Federation of Families for Children’s Mental Health

Register [HERE](#)

Closed Captioning is Available for this Webinar
We do not offer CEU credits. However letters of attendance are offered upon request.

Questions? Contact NASMHPD’s Kelle Masten via email or at 703-682-5187
Administration for Community Living Funding Opportunity:
Innovations in Nutrition Programs and Services

ACL just released a new funding opportunity for the aging services network. This opportunity supports the testing and documentation of innovative and promising practices that enhance the quality, effectiveness, and proven outcomes of nutrition services programs.

Innovations could include a nutrition effort combined with addressing a local or national need such as: reducing falls; improving chronic conditions; improving oral health; increasing social connections; reaching OAA target populations; decreasing anxiety, depression, emotional disturbances or suicide; improving overall physical and mental health symptoms; and increasing activity involvement.

Approaches must have the potential for broad implementation throughout the network and demonstrated value. Examples of value could be cost savings or addressing a national need. Applicants must explain how they see their proposal as innovative, how broad implementation can be done, and the potential effect on the network.

ACL plans to award approximately four cooperative agreements to domestic public or private non-profit entities for a 24-month project period. Applicants may request a total maximum of $250,000 for each of the two 12-month budget periods.

This Funding Opportunity closes on July 17, 2018.

TA Network Webinars

Cultural and Linguistic Competence Peer Learning Exchange – Lessons from the Field: Implementing Behavioral Health Equity Programs
Thursday, August 9, 2:30 p.m. to 3:30 p.m. E.T.

This webinar will be an opportunity to share and discuss what we have learned implementing various behavioral health equity programs, including the CLAS Standards.

Presenter: Catalina Booth, Executive Director, Center for Community Learning, Inc.

Register HERE

Preparing Young People for Workplace Success

During a recent webinar discussion, experts from the Annie E. Casey Foundation and Child Trends examined new ways to help prepare young people for workplace success. The session focused on Positive Youth Development — an approach that helps organizations create environments where young people can advance their skills while cultivating connections to school, family, work and community.

The panelists also touted a new assessment instrument, the PILOT Tool. Developed by Child Trends, a nonprofit research center dedicated to improving outcomes for children, the Pilot Tool helps workforce development organizations apply Positive Youth Development strategies to set the stage for youth success.

Watch NOW
The National Federation’s Annual Conference brings together family members, young adults, and professionals and focuses on current issues and trends pertaining to children’s mental health, from the perspective of a family-driven and youth-guided approach.

Join hundreds of mental health advocates and professionals from across the nation to share your expertise in: Family and Caregiver Support, Supports for Special Populations, Collaboration and Integration of Services Across Multiple Systems, Trauma Informed Care, Research to Practice, Engaging Youth and Young Adults, Organizational Development and Sustainability, Evidence Based Practices, Parent Peer Support Today or Providing Services and Outreach in the Digital Age.

Early Bird registration rates apply for presenters! There is also still time to be a conference exhibitor or sponsor. Learn more here.

Submit Your Presentation HERE
HRSA Funding Opportunity Announcement

Pediatric Mental Health Care Access Program (HRSA 18-122)

Funding Mechanism: Grant
Anticipated Award Amount: up to $445,000
Cost-Sharing or Matching Requirement: 20 percent each year
Length of Project: 5 years
Anticipated Number of Awards: up to 20
Anticipated Total Available Funding: $8,900,000
Closing Date for Applications: August 13, 2018

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2018 Pediatric Mental Health Care Access Program. The purpose of this program is to promote behavioral health integration in pediatric primary care by supporting the development of new or the improvement of existing statewide or regional pediatric mental health care telehealth access programs.

For purposes of this funding opportunity, telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, clinical consultation, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

For purposes of this funding opportunity, a pediatric mental health care telehealth access program for which funding may be used, will be required to perform the following activities—

(A) be a statewide or regional network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;
(B) support and further develop organized state or regional networks of pediatric mental health teams to provide consultative support to pediatric primary care sites;
(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers’ preferred mechanisms for receiving consultation, training, and technical assistance;
(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;
(E) provide rapid statewide or regional clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;
(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;
(G) provide information to pediatric providers about, and assist pediatric providers in accessing, pediatric mental health care providers, including child and adolescent psychiatrists, and licensed mental health professionals, such as psychologists, social workers, or mental health counselors as well as assisting with scheduling and conducting technical assistance;
(H) assist with referrals to specialty care and community or behavioral health resources; and
(I) establish mechanisms for measuring and monitoring increased access to pediatric mental health care services by pediatric primary care providers and expanding the capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

Eligibility:
- State governments
- Native American tribal organizations (other than Federally recognized tribal governments)
- Others (see text field entitled “Additional Information on Eligibility” for clarification)
- Native American tribal governments (Federally recognized)

Additional Information on Eligibility: States, political subdivisions of states, and Indian tribes and tribal organizations (for purposes of this section, as defined in § 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)).

HRSA has scheduled the following technical assistance:
Webinar Day and Date: Friday, July 27, 2018
Time: 2 p.m. to 3 p.m. ET
Call-In Number: 1-888-600-4866 Participant Code: 556514
Web link: https://hrsa.connectsolutions.com/pmhcap_u4c_ta_session/
Playback Number: 1-888-203-1112 Passcode: 1390598
Contact: Madhavi Reddy, MSPH, Maternal and Child Health Bureau, HRSA at (301) 443-0754 or by email.
The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2018 State Opioid Response Grants (Short Title: SOR). The program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). These grants will be awarded to states and territories via formula. The program also includes a 15 percent set-aside for the ten states with the highest mortality rate related to drug overdose deaths.

Grantees will be required to do the following: use epidemiological data to demonstrate the critical gaps in availability of treatment for OUDs in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly and adequately address the gaps in their systems of care; deliver evidence-based treatment interventions that include medication(s) FDA-approved specifically for the treatment of OUD, and psychosocial interventions; report progress toward increasing availability of medication-assisted treatment for OUD; and reducing opioid-related overdose deaths.

The program supplements activities pertaining to opioids currently undertaken by the state agency and will support a comprehensive response to the opioid epidemic. The results of the assessments will identify gaps and resources from which to build upon existing substance use prevention and treatment activities as well as community-based recovery support services. Grantees will be required to describe how they will expand access to treatment and recovery support services. Grantees will also be required to describe how they will advance substance misuse prevention in coordination with other federal efforts. Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and recovery activities in their state. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

State allocations for the Opioid SOR grants are calculated by a formula based on the equal weighting of two elements: the state’s proportion of people with abuse or dependence on opioids (prescription opioids and/or heroin) who need but do not receive treatment (NSDUH, 2015-2016) and the state’s proportion of drug poisoning (overdose) deaths (CDC National Vital Statistics System, 2016). Each State, as well as the District of Columbia, will receive not less than $4,000,000. Each territory will receive not less than $250,000. See below (from Appendix K of the Announcement.) In addition to this base distribution, $142.5 million in funding is being distributed to the ten states with the highest mortality rates due to drug poisoning deaths. This set-aside takes into account the state’s ordinal ranking in the top ten; it is not distributed equally among 10 states.

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Annual Award Amount</th>
<th>State/Territory</th>
<th>Annual Award Amount</th>
<th>State/Territory</th>
<th>Annual Award Amount</th>
<th>State/Territory</th>
<th>Annual Award Amount</th>
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<tr>
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<td>Nevada</td>
<td>$7,114,956</td>
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</tbody>
</table>

Annual continuation awards will depend on the availability of funds, recipient progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

**ELIGIBILITY:** Eligible applicants are the Single State Agencies (SSAs) and territories. Please note that Tribes will be eligible to apply for opioid response funding under a separate announcement.

**CONTACTS:** Program Issues & Grants Management Issues: Email [OPIOIDSOR@samhsa.hhs.gov](mailto:OPIOIDSOR@samhsa.hhs.gov).
The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2018 Tribal Opioid Response grants (Short Title: TOR). The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose related deaths through the provision of prevention, treatment and/or recovery activities for OUD.

The program supplements current activities focused on reducing the impact of opioids and will contribute to a comprehensive response to the opioid epidemic. Tribes will use the results of a current needs assessment if available to the tribe (or carry out a strategic planning process to conduct needs and capacity assessments) to identify gaps and resources from which to build prevention, treatment and/or community-based recovery support services. Grantees will be required to describe how they will expand access to treatment and recovery support services as well as advance substance misuse prevention in coordination with other federally-supported efforts. Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and/or recovery activities. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

**ELIGIBILITY:**

An applicant must be a federally recognized American Indian or Alaska Native tribe or tribal organization. Tribes and tribal organizations may apply individually, as a consortia, or in partnership with an urban Indian organization. These entities are defined as follows:

Indian Tribe, as defined at 25 U.S.C. § 1603(14) is any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C.A. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Tribal Organization, as defined at 25 U.S.C. § 1603(26) is the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities. Provided that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.

Urban Indian Organization, as defined at 25 U.S.C. § 1603(29), operating pursuant to a contract or grant with the Indian Health Service is a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in [25 U.S.C § 1653(a)].

A consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

**CONTACTS:**

Program Issues & Grants Management Issues: Email OPIOIDTOR@samhsa.hhs.gov.
Technical Assistance on Preventing the Use of Restraints and Seclusion

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

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

To Apply for Technical Assistance, Click Here. We look forward to the opportunity to work together.

Technical Assistance Opportunities for State Mental Health Authorities

Through NASMHPD, SAMHSA supports technical assistance (TA) for state behavioral health agencies to improve mental health service systems and facilitate effective use of the Mental Health Block Grant. Under the State TA Contract, states can request off-site (such as telephone and web-based) or on-site TA, including in-person training and consultation on issues important to promoting effective community-based services. TA is provided by national experts selected jointly by the state and NASMHPD, and SAMHSA provides support to pay for consultant fees and travel expenses. States can request TA on a broad range of topics, including:

- **Improving Services & Service Delivery Systems.** Examples include tailoring care to specific groups such as older adults; implementing programs for persons in early stages of psychosis; expanding the use of person-centered treatment planning; developing crisis response services; implementing and ensuring fidelity to evidence-based practices; increasing early identification & referral to care for young people; and promoting trauma-informed, recovery-oriented care.

- **Systems Planning/Operations.** Examples include support for strategic planning; merging mental health and substance abuse agencies; leadership development; staff development; cross sector collaboration; and integration of behavioral health and primary care.

- **Expanding the Peer Workforce.** Examples include training and certification of peer specialists; peer whole health training; supervision of peer specialists; and using peer specialists to work with individuals who are deaf and hard of hearing.

- **Financing/Business Practices.** Examples include maximizing Medicaid coverage; addressing behavioral health under a managed care model; drafting performance-based contract language with providers; rate-setting practices; and compliance with Mental Health Block Grant requirements.

State Mental Health Commissioner/Directors or designees may request TA by submitting a TA request directly into SAMHSA’s online TA Tracker at http://tatracker.treatment.org/login.aspx. If you’ve forgotten your password or have other questions about using the online system, please send an e-mail to tatracker@treatment.org.

For assistance in developing a TA request, please contact your SAMHSA Project Officer or Jenifer Urff, NASMHPD Project Director for Training and Technical Assistance, at jenifer.urff@nasmhpd.org or by phone at (703) 682-7558. We’re happy to discuss ideas and ways that we can support you in strengthening the mental health service system in your state.
CCF Annual Conference
July 24 - 26, 2018
Washington Marriott Georgetown
1221 22nd St NW
Washington, DC 20037

We hope you will join us this year for our Annual Conference, happening July 24-26, 2018! The conference will be located at the Washington Marriott Georgetown (1221 22nd St NW) in Washington, D.C. We will send more e-mails in the coming months with information on registration and booking hotels. If you have any questions, please reach out to Kyrstin at Kyrstin.Racine@georgetown.edu.

Please note that space is limited and priority is given to state-based children's advocacy organizations.

New On-Demand Continuing Medical Education (CME) Course:
Clozapine as a Tool in Mental Health Recovery

This one-hour course offers information and resources for physicians, clinicians, and other practitioners serving people experiencing psychotic symptoms who are considering exploring the use of clozapine. Through a "virtual grand rounds," this course will help you better understand the FDA guidelines, which individuals might benefit from clozapine, the risks and benefits of the medication, and how to engage in shared decision-making with individuals about using clozapine.

In this course, you'll meet Robert, a young man with hopes of attending college and becoming a writer, who also struggles with psychotic symptoms. The course will explore the scientific evidence and best practices for how clozapine may be used as a tool to help him move closer to achieving his goals; as well as how to engage with Robert in a strengths-based, recovery-oriented way.

The faculty are national experts in recovery-oriented pharmacology, who present tips on how to engage with individuals experiencing psychotic symptoms and using clozapine as an effective tool to help them move closer to achieving their goals.

REGISTER HERE!

Course Objectives

After viewing, learners will be able to: explain some of the benefits of initiating clozapine for psychotic symptoms and advancing recovery; articulate how shared decision-making has a role in initiating clozapine; describe the clozapine Risk Evaluation and Mitigation Strategy (REMS); and identify methods for recognizing and managing benign ethnic neutropenia, or BEN, for primary care and psychiatry providers.

Professionals will receive 1 CME credit for participation in this course. (CME provided by American Academy of Family Physicians.)
NADD Award Nominations Sought By August 31

NADD presents five awards annually, at the NADD Annual Conference, which this year will be in Seattle, Washington, October 31 to November 2. The deadline for submitting nominations for these awards is August 31.

Frank J. Menolascino Award for Excellence - This prestigious award is given annually in the memory of Dr. Frank J. Menolascino to an individual who has demonstrated long standing excellence in the field of dual diagnosis.

Earl L. Loschen Award for Clinical Practice - This award is given to a person whose contribution in the area of clinical practice has resulted in significant improvement in the quality of life for individuals with intellectual and developmental disabilities as well as mental health needs.

NADD “Member of the Year” Award - This award is given to a person who has supported the mission of NADD through various activities that have resulted in a positive impact on NADD.

NADD DSP Award for Excellence - This Award is given annually to acknowledge a Direct Support Professional (DSP) whose contribution to supporting people who live in our communities has resulted in significant improvement in the quality of life for individuals with intellectual and developmental disabilities and mental health needs.

NADD Research Award - This award is given to recognize research that improves our understanding of mental health issues in people with intellectual and other developmental disabilities.

Click here for details.

Recovery to Practice (RTP) Initiative invites you to attend...

Recovery-Oriented Use of Medications:
A Two-Part Series

Wednesdays, 1:00 p.m. to 2:00 p.m. E.T.

This final series for Recovery to Practice will look at the role medication can play in an individual’s recovery from serious mental illness, and how programs and providers can support overall health, health literacy, and choice when prescribing and managing medication. Medication is an important tool for someone seeking recovery and is most effective when combined with other tools such as therapeutic interventions, community and family supports, and other recovery approaches.

Archived: *What Non-Prescribing Team Members Need to Know About Medication as a Tool for Recovery*

Kim T. Mueser, PhD, a clinical psychologist and Professor at the Center for Psychiatric Rehabilitation at Boston University and Melody Riefer, MSW, a Senior Program Manager at Advocates for Human Potential will address what non-prescribing team members need to know about person-centered pharmacology, psychotropic medication as a tool for recovery, engaging individuals in decisions about medications, and ways practitioners can help ensure medications help individuals meet personal goals.

Archived: *A Psychiatrist's View: The Role of Medication in a Recovery-oriented Framework for Care*

Lisa Dixon, MD, MPH, a professor of Psychiatry at Columbia University Medical Center and the director of the Center for Practice Innovations (CPI) at the New York State Psychiatric Institute will discuss the importance of including prescribers in decisions about person-centered approaches, understanding how individuals may view the role of medication in their lives, and integrating medication recommendations with holistic healthcare.

Click on the Name of Each Session Above to Register

You may attend one or both the webinars in this series. Registration will be necessary for each session. A one-hour continuing education credit, through NAADAC, is available for each session after completion of a brief quiz. Each session will be recorded and archived for future viewing.

NAADAC statement: This course has been approved by Advocates for Human Potential, Inc., as a NAADAC Approved Education Provider, for 1 CE. NAADAC Provider #81914, Advocates for Human Potential, Inc., is responsible for all aspects of their programming.
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Jeremy McShan, Program Manager, Center for Innovation in Trauma-Informed Approaches

NASMHPD Links of Interest

The National Evaluation of the MFP Demonstration, Kate Stewart and Carol V. Irvin, Math. Mathematica Policy Research for the Centers for Medicare and Medicaid Services

Predicting Barriers to Treatment for Depression in a U.S. National Sample: A Cross-Sectional, Proof-of-Concept Study, Chekroud A.M. Ph.D. et al., Psychiatric Services, July 2

A Systematic Review of the Attributes and Outcomes of Peer Work and Guidelines for Reporting Studies of Peer Interventions, Alicia Jean King, B.Occ. Thy., and Magenta Bender Simmons, Ph.D., Psychiatric Services, July 2

Outcomes of a Peer Mentor Intervention for Persons With Recurrent Psychiatric Hospitalization, O’Connell M.J. Ph.D. et al., Psychiatric Services, July 2018

Perspective: Moving Addiction Care to the Mainstream — Improving the Quality of Buprenorphine Treatment, Brendan Saloner, Ph.D., Kenneth B. Stoller, M.D., & G. Caleb Alexander, M.D., New England Journal of Medicine, July 5

Working through Workplace Stigma: Coming Back After an Addiction, Peter Grinspoon, M.D., Harvard Health Blog, January 5

Revisiting the Rationale and Evidence for Peer Support, Larry Davidson Ph.D., et al., Psychiatric Times, June 29

The Boons of — and Barriers to — Behavioral Health Integration, Les Masterson, Healthcare Dive, July 5

Broken Heart Syndrome – Illness After Loss, Amy Florian, Next Avenue, June 25

Child Separation Among Families Experiencing Homelessness, Office of Planning, Research, and Evaluation, Administration for Children and Families, April 27

Opioid Prescribing to Adolescents in the United States From 2005 to 2016, Henke R.M., Ph.D. et al., Psychiatric Services, July 9

Legislators’ Sources of Behavioral Health Research and Preferences for Dissemination: Variations by Political Party, Purtle J, Dr.P.H., M.Sc., et al., Psychiatric Services, July 9

Dental Pain and Opioid Use: Latest Findings, Jane Koppelman, Pew Charitable Trusts, July 6

Characteristics of the Remaining Uninsured: An Update, Urban Institute and Robert Wood Johnson, July 2018