House Passes Dozens of Opioid-Related Bills, with Renumbered 42 CFR Part 2 Measure, H.R. 6082, Scheduled for June 20 Floor Vote as Stand-Alone Bill

The House of Representatives continued to work this week on passage of legislation designed to combat the U.S. opioid epidemic, with three dozen bills having been passed by late Thursday.

The legislation passed impacts the Medicaid, CHIP, and Medicare programs, Housing and Urban Development Section 8 housing programs, and Food and Drug Administration and Customs and Border Protection enforcement activities and Centers for Drug Control and Prevention (CDC) disease surveillance. It includes grant programs for regional comprehensive opioid recovery centers and regional technical assistance centers of excellence, as well as authorization for incentive payments to behavioral health providers who adopt and use certified electronic health record technology. It also includes a mandate that the Secretary of Health and Human Services conduct a demonstration program to test alternative pain management protocols designed to limit the use of opioids in emergency departments. In addition, it directs the Department of Veterans Affairs to hire additional outreach specialists and peer counselors and creates numerous educational, training, and technical assistance programs, including a training program for pharmacists, health care providers, and patients on indicators that a prescription is fraudulent, forged, or otherwise indicative of abuse or diversion.

The work will continue next week, with the NASMHPD-supported measure aligning the statute underlying 42 CFR Part 2 with the patient information disclosure provisions of Health Insurance Portability and Accountability Act (HIPAA) regulations scheduled for a floor vote on the afternoon of Wednesday, June 20.

That bill was renumbered H.R. 6082 when Health and Human Services Department staff asked for a technical clarifying amendment to the bill and proponents decided the bill should proceed to a vote as a standalone bill, rather than as the amendment to a larger package. That clarifying change is the only difference between H.R. 6082 and the previous version of the Overdose Prevention and Patient Safety Act, H.R. 5795, which had gathered 31 co-sponsors.

The bill continues to align the 1970s statute underlying 42 CFR Part 2 with the more recent HIPAA regulations to allow disclosures without specific patient authorization of patient substance use treatment and referral information to other health care providers of the same patient (and their health information exchanges), while strengthening existing 42 CFR Part 2 penalties for unauthorized disclosures, creating an affirmative duty not currently provided under Part 2 to notify of unauthorized disclosures, continuing to prohibit the use of patient information in criminal proceedings, adding prohibitions against the use of patient information in civil proceedings, and doubling down on the ADA prohibition against discrimination against individuals under treatment for substance use disorders.

Energy and Commerce Committee Ranking Member Rep. Frank Pallone (D-NJ) is expected to take the floor in opposition to the legislation, which he believes threatens the privacy of individuals being treated for substance use disorders, while Committee chair Greg Walden (R-OR) and lead sponsor Markwayne Mullin (R-OK) will champion its passage, arguing that it would further the integration of care and avoid the risk of medication adverse reactions and interactions and opioid overdoses.

The more than 40 member organizations of the Partnership to Amend 42 CFR Part 2, of which NASMHPD is a member, continue to seek support from both Republican and Democratic members of the House in advance of the vote. Republican leadership supports the legislation, and SAMHSA Assistant Secretary Elinore McCance-Katz has communicated her support in testimony in both houses of Congress. Interested states should contact their House members to express their support before Wednesday at 1 p.m.

Meanwhile, the Senate Finance Committee on June 12 approved its Helping to End Addiction and Lessen (HEAL) Substance Use Disorders Act of 2018, legislation combining 22 separate bills that Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) had posted a week earlier that address the epidemic through the Medicaid and Medicare programs. During the markup of that legislation, Senator Rob Portman (R-OH) informally presented an amendment, co-sponsored by Senators Ben Cardin (D-MD) and Sherrod Brown (D-OH), that would have created an exception from the Medicaid Institutions for Mental Disease (IMD) reimbursement exclusion for treatment in residential addiction treatment facilities, but withdrew the amendment from the markup before formally offering the amendment for a vote.

The language of the Portman amendment, similar to the language that was eventually eliminated by the Energy and Commerce Committee staff in the House, would require a state electing to receive reimbursement under the exception through the adoption of a Medicaid state plan amendment to maintain the number of both psychiatric and substance use disorder IMD beds in existence at the time of passage, and...
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CDC: U.S. Suicide Rates Have Risen Almost 30 Percent in the 21st Century

Suicide rates in the United States rose nearly 30 percent from 1999 to 2016, according to research published June 8 by the Centers for Disease Control and Prevention (CDC).

The Morbidity and Mortality Weekly Report (MMWR) and the Vital Signs reports analyzed two data sources for persons 10 years and older: the National Vital Statistics System for 50 states and the District of Columbia; and the National Violent Death Reporting System (NVDRS) collected in 27 states to examine contributing circumstances among decedents with and without known mental health conditions. The MMWR reported that from 1999 to 2016, suicide rates increased in almost all states, ranging from a 6 percent increase in Delaware to a 57 percent increase in North Dakota as referenced in a supplemental table (CDC Stacks).

Twenty-five states had increases of more than 30 percent. Nevada had a one percent decrease, although the suicide rate was still high there with rates ranging between 21 and 23 suicides per 100,000 during the study period. The national average was 15 suicides for every 100,000 in 2016 with rates varying from 29 suicides per 100,000 in Montana to 7 per 100,000 in the District of Columbia.

More than half (54 percent) of decedents did not have a known mental health condition at the time of death, according to the CDC researchers. When examining the differentials in contributing circumstances between decedents without known mental health conditions and decedents with known mental health conditions, they found the following: relationship problems/loss (45.1 percent versus 39.6 percent, respectively); intimate partner problems (30.2 percent versus 24.1 percent, respectively); arguments/conflicts (17.5 percent versus 13.6 percent, respectively); interpersonal violence in the past month (3.0 percent versus 1.4 percent, respectively); life stressors such as criminal/legal problems and eviction/loss of home (50.5 percent versus 47.2 percent, respectively); and recent/impending crisis (32.9 percent versus 26.0 percent, respectively). Physical health problems (23.2 percent versus 21.4 percent, respectively) and employment problems (15.6 percent versus 16.8 percent, respectively) were also contributing factors for both groups.

Two-thirds of suicide decedents with known mental health conditions had a history of treatment for mental health or substance abuse treatment. Over half (54 percent) of the decedents with known mental health conditions were in mental health or substance use treatment at the time of death, signifying the need for additional support and safety planning. About a quarter (24.5 percent) of decedents with mental health conditions had disclosed suicide intent versus 22.4 percent without known mental health conditions.

Firearms accounted for 55 percent of the suicides in decedents without known mental health conditions versus 41 percent with known mental health conditions. Hanging/strangulation/suffocation and poisoning were the second and third most common methods used. Opioids were present in 31 percent of the decedents who died by poisoning.

The researchers conclude, “Comprehensive statewide suicide prevention activities are needed to address the full range of factors contributing to suicide.” They further suggest the need for upstream prevention strategies such as enhancing economic supports (e.g., housing support); teaching skills that promote problem-solving and positive coping of life stressors; increasing social and emotional support; strengthening access to behavioral health providers; and reducing access to lethal means.
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.

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.

June Trainings
California
June 21 - 22 - Southern California Alcohol and Drug Programs, Downey

Maryland
June 28 - Anne Arundel Health System, Annapolis

Tennessee
June 26 - 27 - Moccasin Bend Mental Health Institute, Chattanooga

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

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.

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.

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

Register HERE
House Passes Dozens of Opioid-Related Bills, with Renumbered 42 CFR Part 2 Measure, H.R. 6082, Scheduled for June 20 Floor Vote as a Stand-Alone Bill

(Continued from page 1) maintain spending levels for those services as they exist at the time of passage. NASMHPD and the National Association of Medicaid Directors (NAMD) argued against the language in the House as a limitation on state flexibility with regard to how states spend their resources on inpatient and community-based mental health services. Although Senator Portman withdrew the amendment in the Finance Committee markup, he said he might offer it again during floor debate on any Senate opioid package. NASMHPD and NAMD will attempt to convince the Senator not to do so.

One bill impacting IMDs did pass the House on June 12 and is now in the Senate. H.R. 5800 would require the Medicaid and CHIP Payment and Access Commission (MACPAC), not later than January 1, 2020, to conduct a study, using data from a representative sample of States, and submit to Congress a report with respect to services furnished to individuals enrolled under Medicaid State Plans or waivers, who are patients in IMDs for which payment is made through fee-for-service or managed care, on:

- the number of such institutions in the State;
- the facility type of such institutions in the State;
- any coverage limitations under each State plan (or waiver) on scope, duration, or frequency of services;
- the services provided at each institution;
- the process, including any timeframe, used by the institution to clinically assess and reassess such individuals; and
- the discharge process used by each institution, including any care continuum of relevant services or facilities provided or used in such process.

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

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

NOW AVAILABLE
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.
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

31st Annual State Health Policy Conference

NASHPCONF18 | August 15-17 | Jacksonville, FL |

Celebrate the National Association of State Health Policy's (NASHP’s) 31st Annual State Health Policy Conference. Planned by state health policymakers, for state health policy makers, NASHP’s annual event is a “must-attend” for the state health policy community. With a carefully crafted agenda focusing on emerging issues and current best practices within states, our conference brings together the nation’s leading experts to share, learn and discuss.

The Top Five Reasons to Attend #NASHPCONF18

1) Informative sessions cover the nation’s most crucial health policy issues. #NASHPCONF18 is designed by state health policy makers for state health policy makers to explore the most up-to-date health care developments and initiatives in the United States. With 25+ thoughtfully-crafted sessions addressing the issues most important to you, as well as full-day pre-conferences that offer a deep dive into targeted topics, you’ll gain critical insights into the latest advances, changes, programs, and innovations in state health policy.

2) Outstanding networking opportunities. Our conference offers non-stop opportunities to network with more than 800 state health policy leaders from across the country. Join conference roundtables to discuss best practices and solutions to pressing issues with a small group of your peers, attend the networking breakfast or Blueberry Break to socialize with colleagues, or mix business with pleasure at our two evening events!

3) They’re not just speakers… They’re industry thought leaders. Our #NASHPCONF18 speakers are among the most distinguished and respected thought leaders in state health policy. Conference speakers will address a host of topics covering current and important issues, including health care costs, workforce, chronic care, stabilizing the individual market, social determinants of health and much more!

4) Exclusive access to the newest technology and business intelligence. NASHP’s exclusive exhibit hall offers a diverse group of exhibitors who are all eager to present you with the latest and greatest innovative ideas and smart solutions to help you achieve your goals.

5) Discover Jacksonville, Florida. Named to Expedia’s list of 21 Super Cool Cities in the U.S., Jacksonville is the perfect destination for both relaxation and adventure. With 22 miles of beaches, dining options that range from elegant bistros to local seafood shacks, more than 20 craft breweries, a sprawling arts district, wildlife sanctuary, and so much more, there is always something to do no matter what your mood. Enjoy the beautiful views of the St. Johns River while attending #NASHPCONF18 and experience all that this super cool city has to offer!
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.

An informational call for interested applicants will be held on June 12, 2018 at 2:00 pm, ET. To register for this call, go to [https://www.mymeetings.com/emeet/rsvp/index.jsp?customHeader=mymeetings&Conference_ID=7527433&passcode=4010154](https://www.mymeetings.com/emeet/rsvp/index.jsp?customHeader=mymeetings&Conference_ID=7527433&passcode=4010154)

This Funding Opportunity closes on July 17, 2018.

VETERANS’ ADMINISTRATION-SUPPORTED MINDFULNESS MEDITATION

Mindfulness Meditation is an evidenced-based, VA-supported mind-body technique that helps you face the challenges and stressors of everyday life.

Research has shown a connection between your mind and your body that can be used to improve health. When your mind is relaxed and focused on healing, your body can relax and focus on healing too. Meditation can be safely used in conjunction with other medical treatments such as prescribed medication or exercise.

Mindfulness Meditation teaches acceptance and awareness of what’s going on around you as well as what’s going on inside of you. It has been effective in treating health conditions such as insomnia, anxiety, high blood pressure, chronic pain and PTSD.

Mindfulness Meditation can be practiced sitting down, lying down, stretching, eating, even while walking the dog!

TWO MINDFUL MEDITATION CLASSES will be offered monthly to Veterans with a break in July; one topic the first two Fridays of each month. Take any or all classes! We encourage you to take as many as you can!

**JUNE – OCTOBER 2018 DATES:**

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<tr>
<td>June 1 &amp; 8</td>
<td>Mindful Movement</td>
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<td>Mindful Body Scan</td>
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<td>October 5 &amp; 12</td>
<td>Mindful Movement</td>
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This class will be offered via telephone using a toll free number: **1-800-767-1750** with Access Code 54220#. No registration is required. **FOR MORE INFORMATION:** Call Debbie Skeete-Bernard, RN, MSN at 1-973-676-1000, extension 2714.
SAMHSA-Sponsored Webinar
Promoting Recovery through Self Direction:
Strategies and Lessons from New York State
Tuesday, June 26, 2:00 p.m. to 3:15 p.m. ET

Within the public mental health system, self-direction supports people in developing and directing their own services to help reach their own goals for recovery and independence. New York State’s Office of Mental Health has begun implementing a self-direction pilot that pairs each person’s own recovery plan with a flexible budget to purchase goods and services relevant to their goals. This webinar will: 1) Provide an overview of self-direction models and outcomes research to assist people with serious mental illnesses; 2) Describe how New York’s model was developed and adopted during a shifting Medicaid managed care environment, including successful advocacy strategies; 3) Discuss operational concerns such as provider training and outreach during New York’s first pilot year; and 4) Report on early participant outcomes related to the pilot.

Presenters:
- Bevin Croft, PhD., MPP, Research Associate, Human Services Research Institute (HSRI)
- Briana Gilmore, MSc., Director of Planning and Recovery Practice, Community Access
- Keith Aguiar, Self-Direction Pilot Program Manager, Community Access
- Oyeama (“Zisa”) Okpalor, NY Program Participant

Register HERE
The U.S. Department of Transportation (DOT or Department) is seeking comment on amending its Air Carrier Access Act (ACAA) regulation on transportation of service animals. The Department has heard from the transportation industry, as well as individuals with disabilities, that the current ACAA regulation could be improved to ensure nondiscriminatory access for individuals with disabilities, while simultaneously preventing instances of fraud and ensuring consistency with other Federal regulations. The Department recognizes the integral role that service animals play in the lives of many individuals with disabilities and wants to ensure that individuals with disabilities can continue using their service animals while also helping to ensure that the fraudulent use of other animals not qualified as service animals is deterred and that animals not trained to behave properly in public are not accepted for transport as service animals.

DOT considers a service animal to be any animal that is individually trained to assist to a qualified person with a disability or any animal necessary for the emotional well-being of a passenger. U.S. airlines must transport all service animals regardless of species with a few narrow exceptions, such as snakes, reptiles, ferrets, rodents, and spiders. Under DOT's current rule, airlines may also refuse to carry other animals if the airline determines:

1. there are factors precluding the animal from traveling in the cabin of the aircraft, such as the size or weight of the animal;
2. the animal would pose a direct threat to the health or safety of others; or
3. it would cause a significant disruption of cabin service; or
4. the law of a foreign country that is the destination of the flight would prohibit entry of the animal.

Under DOT rules, a U.S. carrier is held responsible if a passenger traveling under the U.S. carrier's code is not allowed to travel with another type of service animal (e.g., cat) on a flight operated by its foreign code share partner. Regarding emotional support animals (ESA) and psychiatric service animals (PSA), DOT requires airlines to recognize these animals as service animals, but allows airlines to require that ESA and PSA users provide a letter from a licensed mental health professional of the passenger's need for the animal. To enable airlines sufficient time to assess the passenger's documentation, DOT permits airlines to require 48 hours' advance notice. PSAs, like other traditional service animals, are trained to perform a specific task for a passenger with a disability. In contrast, ESAs provide emotional support for a passenger with a mental/emotional disability but are not trained to perform specific tasks. However, DOT expects that all service animals are trained to behave properly in a public setting.

Under the existing service animal regulations, it is generally not permissible to insist on written credentials or documentation for an animal as a condition for treating it as a service animal, except for an ESA or PSA. DOT requires airlines to accept animals as service animals based on the "credible verbal assurances" of the passengers. Airlines also may not charge for the transport of service animals.

DOT's disability rule permits airlines not to transport service animals that pose a direct threat to the health or safety of others or would cause a significant disruption of cabin service. In guidance, DOT has advised airlines to observe the behavior of the service animal to determine if it is a properly trained animal as such an animal will calmly remain by its owner.

The Psychiatric Service Dog Society (PSDS), an advocacy group representing users of psychiatric service dogs, petitioned the Department in 2009 to eliminate a provision in DOT’s Air Carrier Access Act regulation that permitted airlines to require documentation and 48 hours' advance notice for users of psychiatric service animals. PSDS emphasized that DOT should not equate psychiatric service animals to emotional support animals. It noted that PSAs differ significantly from ESAs in that PSAs are trained to behave properly in public settings and to mitigate the effects of a mental health-related disability. PSDS also asserted DOT is discriminating against and stigmatizing individuals with mental health-related disabilities who use PSAs by imposing additional procedural requirements on users of PSAs that are not imposed on service animals used by individuals with physical disabilities. PSDS further raised practical concerns with the current documentation requirement (e.g., financial hardship on PSA users without health insurance) and advance notice requirement). The Department is granting the petition by issuing this advance notice of proposed rulemaking.

DOT seeks comments on:

1. treating psychiatric service animals similar to other service animals;
2. distinguishing between emotional support animals and other service animals;
3. requiring emotional support animals to travel in pet carriers for the duration of the flight;
4. limiting the species of service animals and emotional support animals that airlines are required to transport;
5. limiting the number of service animals/emotional support animals required to be transported per passenger;
6. requiring service animal and emotional support animal users to confirm their animal has been trained to behave in a public setting;
7. requiring service animals and emotional support animals have a harness, leash, or other tether with narrow exceptions;
8. limiting the size of emotional support animals or other service animals that travel in the cabin and the potential impact of such a limitation;
9. prohibiting airlines from requiring a veterinary health form or immunization record from service animal users without an individualized assessment that the animal would pose a direct threat to the health or safety of others or would cause a significant disruption in the aircraft cabin; and
10. no longer holding U.S. airlines responsible if a passenger traveling under the U.S. carrier's code is only allowed to travel with a service dog on a flight operated by its foreign code share partner.
SAMHSA-Sponsored Webinar
Criminal Justice and Serious Mental Illness: Moving to Patient Centered Care
Thursday, June 28, 12:30 p.m. to 2:00 p.m. E.T.
Developed under contract by the National Council for Behavioral Health

A 2010 report from the Treatment Advocacy Center found that jails and prisons have more than three times the individuals living with serious mental illness than hospitals. Labeled as the “new mental hospitals or asylums,” at least 16 percent of inmates currently in jails and prisons have a serious mental illness compared to 6.4 percent in 1983. Unless gaps in care for these individuals are identified and effective patient-centered interventions are implemented, this problem will persist and potentially worsen.

Attendees of this webinar will learn about the factors contributing to the current situation, gaps in the systems, how to improve access to care in the community and the role of diversion programs such as Mental Health Courts and Drug Courts in decreasing criminalization of serious mental illness and substance use disorders.

Presenter: Angeline Stanislaus, MD, Chief Medical Director of Adult Services for the Missouri Department of 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

SAMHSA-Sponsored Webinar
Beating the Clock: Reducing the Duration of Untreated Psychosis
Tuesday, June 26, 2:00 p.m. to 3:30 p.m. ET
Developed under contract by the National Alliance on Mental Illness

The “duration of untreated psychosis” is the time between the onset of psychosis and accessing appropriate treatment. The shorter the period of untreated psychosis, the better the outcomes for people. Unfortunately, people with early psychosis typically experience significant delays in accessing treatment and services - an average of 74 weeks in the U.S. With stakeholder collaboration, communities, families and caregivers can help identify young adults with psychosis quicker – and get them into effective programs that support recovery and keep lives on track.

This webinar will discuss strategies for engaging people in evidence-based first episode psychosis programs, building awareness through targeted outreach, collaborating with systems partners, encouraging help-seeking, and how all of this can impact the trajectory their wellness.

Presenters:

• Marla Zometsky has been with the Fairfax-Falls Church Community Services Board (CSB) for over 10 years and is currently the Project Manager for the Turning Point program, a Coordinated Specialty Care program for individuals 16 to 25 years of age who have experienced the onset of psychosis. Ms. Zometsky previously served as a senior clinician with the CSB’s Intensive Case Management team, supporting homeless adults with serious mental illness. In addition, she has experience working in a residential substance abuse program for adolescent males, providing services through a school-based mental health program and facilitating cultural-adjustment workshops for immigrants and refugees. She is a CSB facilitator for Mental Health First Aid.

• Tom Schuplin had worked at PRS, Inc. a non-profit mental health agency headquartered in Oakton, Virginia for 35 years. He was the Director of Day Programs and guided the programs’ conversion from standard psychosocial programs to Recovery Academies. He then became the Director of Special Projects and designed, developed and currently assists in the operation of Coordinated Specialty Care Programs for individuals with first episode psychosis in Fairfax and Loudoun Counties in Virginia. He also designed, developed and currently assists in the operation of a Primary Care Behavioral Health Integration Program (PCBHI) in Fairfax Virginia. Additionally he oversees a substance abuse peer program in Loudoun County. Currently, Mr. Schuplin works as an independent consultant and resides in Richmond, Virginia.

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
Webinar: Clinical Strategies to Promote Medication Adherence  
*Tuesday, June 19, 2:00 p.m. to 3:30 p.m. E.T.*

The use of medications to treat mental illness and opioid and alcohol use disorders can produce life changing benefits. However, these medications also have significant side effects. Non-adherence to medications is generally more common among persons with mental disorders than individuals with physical health conditions and can negatively impact health outcomes and increase costs.

Interdisciplinary teams in integrated care settings have the opportunity to improve medication adherence among patients by incorporating shared decision making into the provider-patient relationship, using motivational interviewing to promote adherence, establishing pharmacies onsite to reduce barriers to accessing medications, and engaging family members in the treatment plan.

Join the SAMHSA-HRSA Center for Integrated Health Solutions for this webinar to review the importance of medication adherence and key recommendations for organizations to promote medication adherence.

**Presenter:** Joe Parks, MD, Medical Director, National Council for Behavioral Health

After this webinar, participants will:

- Better understand the impact of medication non-adherence on the individual, family, and community
  - Better understand consumers’ perspectives and concerns related to medication
  - Learn about several key recommendations to improve medication adherence
- Hear about how one integrated care setting is successful in promoting medication adherence
  - Identify tools and resources to promote medication adherence

Register [HERE](#)

Registration is free and closed captioning is available upon request.

The SAMHSA-HRSA Center for Integrated Health Solutions does not provide certificates of attendance or continuing education credits for webinar attendance.
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) to access the distribution of $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.

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**State/ Territory** | **Annual Award Amount** | **State/Territory** | **Annual Award Amount** | **State/Territory** | **Annual Award Amount** | **State/Territory** | **Annual Award Amount**
--- | --- | --- | --- | --- | --- | --- | ---
Alabama | $13,544,925 | Indiana | $17,884,203 | Nevada | $7,114,956 | South Dakota | $4,000,000
Alaska | $4,000,000 | Iowa | $4,353,990 | New Hampshire | $22,897,347 | Tennessee | $18,274,333
American Samoa | $250,000 | Kansas | $4,000,000 | New Jersey | $21,233,870 | Texas | $45,359,037
Arizona | $19,978,519 | Kentucky | $31,207,484 | New Mexico | $5,280,352 | Utah | $7,843,277
Arkansas | $5,096,423 | Louisiana | $11,569,750 | New York | $36,297,994 | Vermont | $4,000,000
California | $68,829,190 | Maine | $4,358,694 | North Carolina | $22,699,479 | Virginia | $15,580,846
Colorado | $14,874,393 | Marshall Islands | $250,000 | North Dakota | $4,000,000 | Virgin Islands | $250,000
Connecticut | $10,968,403 | Maryland | $32,874,550 | Ohio | $55,229,855 | Washington | $21,260,403
Delaware | $12,550,000 | Massachusetts | $35,549,545 | Oklahoma | $7,599,438 | West Virginia | $27,910,443
D.C. | $21,100,000 | Michigan | $27,510,035 | Oregon | $7,758,010 | Wisconsin | $11,305,710
Florida | $49,331,356 | Micronesia | $250,000 | Northern Mariana | $250,000 | Wisconsin | $4,000,000
Georgia | $19,593,569 | Minnesota | $8,742,332 | Palau | $250,000
Guam | $250,000 | Mississippi | $5,254,503 | Pennsylvania | $55,745,358
Hawaii | $4,000,000 | Missouri | $18,097,314 | Puerto Rico | $6,896,701
Idaho | $4,053,322 | Montana | $4,000,000 | Rhode Island | $12,550,000
Illinois | $28,569,209 | Nebraska | $4,000,000 | South Carolina | $14,047,719

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.
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2018 Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants (Short Title: CCBHC Expansion Grants). The purpose of this program is to increase access to and improve the quality of community behavioral health services through the expansion of CCBHCs. CCBHCs provide person- and family-centered services and are available in the 24 states that participated in the FY 2016 Planning Grants for Certified Community Behavioral Health Clinics (SM-16-001). The CCBHC Expansion grant program must provide access to services for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring disorders (COD). SAMHSA expects that this program will improve the behavioral health of individuals across the nation by providing comprehensive community-based mental and substance use disorder services; treatment of co-occurring disorders; advance the integration of behavioral health with physical health care; assimilate and utilize evidence-based practices on a more consistent basis, and promote improved access to high quality care.

CCBHCs provide a comprehensive collection of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. CCBHCs provide services to any individual, regardless of their ability to pay or their place of residence.

The 21st Century Cures Act established the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). In December 2017, the ISMICC issued a Report to Congress that outlined five major areas of focus and recommendations intended to support a mental health system that successfully addresses the needs of all individuals with SMI or SED and their families and caregivers. Certified Community Behavioral Health Clinics Expansion Grants align with the following recommendations:

2.1. Establish standardized assessments for level of care and monitoring of consumer progress.

2.7. Use telehealth and other technologies to increase access to care.

2.8. Maximize the capacity of the behavioral health workforce.

3.1. Provide a comprehensive continuum of care for people with SMI and SED.

3.9. Make integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders and other substance use disorders.

3.10. Develop national and state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI and SED.

5.2. Adequately fund the full range of services needed by people with SMI and SED.

5.8. Expand the Certified Community Behavioral Health Clinic (CCBHC) program.

States were funded to develop CCBHCs in FY2016 through Planning Grants for Certified Community Behavioral Health Clinics (SM-16-001) This CCBHC expansion announcement creates opportunities to support the expansion of the CCBHC model in those states which participated in the 2016 Planning Grant program.

ELIGIBILITY: Eligibility is limited to certified community behavioral health clinics or community-based behavioral health clinics who may not yet be certified but meet the certification criteria and can be certified within 4 months of award in the following states: AK, CA, CO, CT, IA, IL, IN, KY, MA, MD, MI, MN, MO, NC, NJ, NM, NV, NY, OK, OR, PA, RI, TX, and VA.

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT
Infant and Early Childhood Mental Health Grant Program
(FOA No. SM-18-018)

Funding Mechanism: Grant
Anticipated Number of Awards: Up to 9
Anticipated Award Amount: Up to $500,000/year
Anticipated Total Available Funding: $23.4 million
Length of Project: Up to 5 years
No Cost-Sharing/Match Required
Applications Due: June 29, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2018 Infant and Early Childhood Mental Health Grant Program. Eligible children for services include children from birth to not more than 12 years of age, who are at risk for, show early signs of, or have been diagnosed with a mental illness including a serious emotional disturbance. The purpose of this program is to improve outcomes for these children by developing, maintaining, or enhancing infant and early childhood mental health promotion, intervention, and treatment services, including: (1) programs for infants and children at significant risk of developing, showing early signs of, or having been diagnosed with a mental illness, including a serious emotional disturbance (SED) and/or symptoms that may be indicative of a developing SED in children with a history of in utero exposure to substances such as opioids, stimulants or other drugs that may impact development; and (2) multigenerational therapy and other services that strengthen positive caregiving relationships. Programs funded under this FOA must be evidence-informed or evidence-based, and culturally and linguistically appropriate. SAMHSA expects this program will increase access to a full range of infant and early childhood services and build workforce capacity for individuals serving children from birth to age 12. Programs must describe a pathway to sustainability and will be expected to develop a plan for the dissemination of the program to other sites and settings.

WHO CAN APPLY: Eligibility for this program is statutorily limited to a human services agency or non-profit institution that:

- Employs licensed mental health professionals who have specialized training and experience in infant and early childhood assessment, diagnosis, and treatment; OR is accredited or approved by the appropriate State agency, as applicable, to provide for children, from birth to 12 years of age, mental health promotion, intervention, and/or treatment services; and
- Provides infant and early childhood services or programs that are evidence-based or that have been scientifically demonstrated to show further promise but would benefit from further applied development.

CONTACTS: Program Issues: Jennifer Oppenheim, via email or at (240) 276-1862.
Grants Management and Budget Issues: Gwendolyn Simpson via email or at (240) 276-1408.

Public Comment on Draft Recommendation Statement and Draft Evidence Review: Screening and Behavioral Counseling Interventions in Primary Care to Reduce Unhealthy Alcohol Use in Adolescents and Adults

The U.S. Preventive Services Task Force seeks comments on a draft recommendation statement and draft evidence review on screening and behavioral counseling interventions in primary care to reduce unhealthy alcohol use in adolescents and adults. The Task Force found that clinicians should screen all adults for unhealthy alcohol use and offer brief counseling to those who drink above recommended limits. The Task Force also found that more research is needed to make a recommendation for adolescents. The draft recommendation statement and draft evidence review are available for review and public comment from June 5, 2018 to July 2, 2018 here. See the full draft recommendation statement

DRAFT RECOMMENDATION SUMMARY

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults age 18 years or older, including pregnant women</td>
<td>The USPSTF recommends that clinicians in primary care settings screen for unhealthy alcohol use in adults age 18 years or older, including pregnant women, and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.</td>
<td>B</td>
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<tr>
<td>Adolescents ages 12 to 17 years</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents ages 12 to 17 years.</td>
<td>I</td>
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Recovery to Practice (RTP) Initiative invites you to attend... 

**Recovery-Oriented Engagement Practices - Spring 2018 Series**

Engagement in treatment and services has often been seen as a success of the clinician or a failure of the person being served. As we have learned more about seeking recovery, we know that engagement is a joining together of the person, the provider, and, frequently, other important people in the person's life - with everyone contributing to and responsible for engagement and alliance.

In this series of one-hour webinars, we explore three distinct elements of engagement. The first webinar looks at therapeutic alliance and its impact on engagement and outcomes. The second webinar considers how Wellness Recovery Action Plan (WRAP) tools for crisis and pre-crisis planning can promote engagement and positive relationships between individuals and service providers. The final webinar discusses social media and other technology as emerging tools for outreach and engagement in behavioral healthcare.

**Archived: Therapeutic Alliance and its Impact on Engagement**

Forrest (Rusty) Foster, M.S.W., Senior Implementation Specialist at the Center for Practice Innovations, Columbia University and Regina Shoen, Advocacy Specialist with the New York State Office of Mental Health, Office of Consumer Affairs will present clinical frameworks for strengthening engagement and alliance in therapeutic relationships, based on recovery oriented principles and practices.

**Archived: Engagement via a Crisis or Pre-crisis Tool within a Wellness Recovery Action Plan (WRAP)**

Nev Jones, M.A., M.A., PhD, Assistant Professor, University of South Florida and Matthew R. Federici, M.S., C.P.R.P. Executive Director of The Copeland Center will draw from the tools and resources in peer provided practices to identify respectful and meaningful approaches to engagement.

**Archived: Social Media/Technology for Outreach and Engagement**

John Naslund, PhD, Harvard Medical School, Global Health and Social Medicine will share his research and experiences working alongside individuals living with serious mental illness and community mental health providers. He will discuss ways to use technology and social media to overcome engagement challenges in a 21st Century world through systemic large-scale implementation of CT-R sharing evidence of culture change.

**Click on the Name of Each Session Above to Register**

You may attend one or all 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 and brief quiz completed. 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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**29th Annual Federation of Families for Children's Mental Health Conference**

Houston, Texas

November 1st-3rd, 2018

**CALL FOR PRESENTATIONS**

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
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](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](mailto: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.)
TA Network Webinars and Activities

SOC Expansion Leadership Learning Community: Improving Outcomes for Youth Dually Involved in Juvenile Justice and Child Welfare Systems

*Wednesday, June 20, 2:30 p.m. to 4:00 p.m. ET*

This learning community will focus on youth who are involved in both the juvenile justice and child welfare systems, many of whom have serious behavioral health challenges. This session will provide an overview of the Crossover Youth Practice Model (CYPM), developed by Georgetown University’s Center for Juvenile Justice Reform as an evidenced-based system reform model to impact this population.

**Register HERE**

Creating High-Integrity Peer Support in Early Psychosis Programs

*Friday, June 22, 1:00 p.m. to 2:30 p.m. ET*

This webinar will explore peer support as a critical discipline within early psychosis teams. Presenters will review the unique history and role of the peer support profession and how it differs from clinical perspectives. The webinar will discuss how agencies and early psychosis programs can most effectively integrate and support peer support specialists. There will be a discussion of common questions and challenges as well as resources for continuing education.

**Register HERE**

SAMHSA-SPONSORED WEBINAR

New Jersey’s Children’s System of Care: Peer Support in an Integrated System of Care

*Thursday, June 21, 3 p.m. to 4:30 p.m. E.T.*

Developed under contract by the National Federation of Families for Children’s Mental Health

In this presentation participants will learn about the integration of New Jersey’s Children's System of Care (SOC) for children and youth with serious emotional disturbances. The webinar will provide an overview of the history, structure, values, principles, objectives, integration planning process, and key system partners. Participants will learn about the role of assessment and what key components contribute to the ability to provide effective services across populations.

The webinar will explore how expanding their array of services and integrating those services through a single entry point has helped reduce high-intensity and out of home treatments. The presenters will describe the process for accessing services in New Jersey's SOC including who is eligible and how participants connect to services through multiple partnering agencies and child-serving systems. Additionally, the presentation will identify specific approaches, strategies and curriculums used in the New Jersey SOC.

Presenters:

- **James Sawyer** is an independent consultant, helping child, youth and family serving systems improve their effectiveness by strategic consultation. James is a Licensed Professional Counselor, with specialized training in infant mental health, achieving his master’s degree in community counseling while working as a system of care Youth Coordinator.

- **Wyndee Davis** is a Master’s level, licensed clinician with a degree in counseling from Villanova University and a bachelor’s degree in psychology and mathematics from Guildford College. She currently serves as a liaison and practice representative for the Children’s System of Care (CSOC) within the New Jersey Department of Children and Families.

**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**
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NASMHPD Links of Interest

WHY DIDN’T MY DRUG-ADDICTED FAMILY GET ANY SYMPATHY?, Issac J. Baily, Politico Magazine, June 10
NEONATAL ABSTINENCE SYNDROME: A CRITICAL ROLE FOR MEDICAID IN THE CARE OF INFANTS, Timothy B. Hill, Acting Director, Center for Medicaid and CHIP Services, June 11
LEVERAGING MEDICAID TECHNOLOGY TO ADDRESS THE OPIOID CRISIS, State Medicaid Director Letter 18-006, June 11
HOW TO CALCULATE WHAT OPIOID OVERDOSES COST GOVERNMENT, Governing Magazine, June 4
BEING BLACK IN AMERICA CAN BE HAZARDOUS TO YOUR HEALTH, Olga Khazan, The Atlantic, July-August 2018
MISSION POSSIBLE: TOO HEAVY A BURDEN: THOUGHTS ON THE IMPACT OF VIOLENCE DISPARITIES EXPERIENCED BY AFRICAN AMERICANS, Kameron J. Sheats, Ph.D., Centers for Disease Control and Prevention, June 11
FIVE FIRST RESPONDERS TO THE PULSE MASSACRE: ONE DIAGNOSIS: PTSD, Abe Aboraya, WMFE & Pro Publica Reporting Network, June 11
OVERCOMING CHALLENGES TO MEDICAID INVESTMENTS IN SOCIAL DETERMINANTS OF HEALTH, Enrique Martinez-Vidal, Debbie I. Chang & Tricia McGinnis, Health Affairs Blog, June 13
THE INFLUENCE OF TEAM FUNCTIONING AND WORKLOAD ON SUSTAINABILITY OF TRAUMA-FOCUSED EVIDENCE-BASED PSYCHOTHERAPIES, Mohr D.C., Ph.D. et al., Psychiatric Services, May 25
BEHAVORIAL HEALTH DIAGNOSES AMONG CHILDREN AND ADOLESCENTS HOSPITALIZED IN THE UNITED STATES: OBSERVATIONS AND IMPLICATIONS, Egorova M.N., Ph.D., M.P.H. et al., Psychiatric Services, June 1
PRESVALENCE OF PRESCRIPTION MEDICATIONS WITH DEPRESSION AS A POTENTIAL ADVERSE EFFECT AMONG ADULTS IN THE UNITED STATES, Qato, D.M., PharmD, M.P.H., Ph.D., Ozenberger K., M.S. & Olfson M., M.D., M.P.H., Journal of the American Medical Association, June 12
REMOVING ANTICOMPETITIVE BARRIERS FOR ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS, E. Kathleen Adams & Sara Markowitz, The Hamilton Project, June 13
NONINVASIVE NONPHARMACOLOGICAL TREATMENT FOR CHRONIC PAIN: A SYSTEMATIC REVIEW, Comparative Effectiveness Review #209, Agency for Healthcare Research and Quality, June 2018