



National Association of State Mental Health Program Directors

Weekly Update

California Medicaid to Begin Covering Undocumented Children with State Monies

Approximately 170,000 undocumented children under the age of 19 in California will gain access to mental health services, emergency care, and other vital services on May 16 under a state-funded Medi-Cal expansion that will provide full coverage to all low-income children in the state, regardless of immigration status. Coverage will be retroactive to May 1.

Children in families earning up to 266 percent of the Federal poverty limit will be eligible for free or low-cost Medi-Cal; the income limit will be about \$64,000 a year for a family of four. About half of the state's undocumented immigrant families have incomes low enough to qualify.

California will be the first state to cover undocumented low-income children. The [expansion](#), approved by Governor Jerry Brown (D) in October 2015, is expected to cost the California Department of Health Care Services about \$40 million in the first year and \$132 million annually thereafter.

The state has more undocumented immigrants—2.4 million, about 6 percent of the California population and 10 percent of the workforce—than any other state. Those individuals are excluded from purchasing marketplace plans under the Affordable Care Act and have access only to state-funded Medi-Cal programs for limited populations, such as a program for minors seeking

substance use disorder treatment. Those who aren't otherwise insured by employers get their health care through county services, safety-net clinics, and hospital emergency rooms, or they go without necessary screenings and treatment due to the cost of premiums or fear of deportation.

At the same time, county health departments and Covered California are taking steps to cover the population, and local advocates and community clinic counselors are trying to match eligible families with affordable coverage options that will give them access to the same preventive services as their neighbors. Covered California announced April 7 it would seek a Federal waiver to allow undocumented residents of all ages to buy insurance, but without benefit of Federal or state subsidies or tax credits.

Forty-seven California counties are also currently offering, or planning to offer, undocumented families limited coverage paid for with taxpayer dollars, foundation grants, and other private funding. That's 40 more counties than at the beginning of 2015, according to a [January 24 California Healthline news report](#). The [California Coverage and Health Initiatives](#) helps organize many of those county programs.

Other Things You Should Know:

1. Senate Finance Committee Chairman Orrin Hatch (R-Utah) will convene a hearing on Thursday, April 28, to examine various options for how to address mental health issues in our health care system. The hearing, entitled *Mental Health in America: Where Are We Now*, will take place at 2:00 p.m. in Room 215 of the Dirksen Senate Office Building. Doug Thomas, the Director of Utah's Division of Substance Abuse and Mental Health, will testify. The hearing will not be webcast.

You may submit a written statement to the Committee, no longer than 10 pages in length, to the Senate Committee on Finance, Attn. Editorial and Document Section, SD-219 Dirksen Senate Office Bldg, Washington, DC 20510-6200. Statements must be received no later than two weeks following the conclusion of the hearing. Faxed statements will not be accepted.

2. The final [Medicaid and CHIP Managed Care rules](#) which, when proposed last June, included capitated reimbursement under managed care for IMD services lasting less than 15 days in a month, were released from Office of Management and Budget review on April 20 and will likely be posted and published by CMS by April 25.
3. HHS and the Departments of Labor and Treasury on April 20 released new [FAQs](#) for marketplace plans on preventive services, limits on cost-sharing, emergency services, and application of the Mental Health Parity and Addiction Equity Act.

CDC's National Center for Health Statistics: Suicide Rates Climb to a 30-Year High

The Centers for Disease Control and Prevention's National Center for Health Statistics [reported](#) April 22 that suicide rates in the United States have surged to the highest levels since 1986, with increases in every age group except older adults. The rise was particularly steep for women and middle-aged Americans, a group whose suicide rates had been stable or falling since the 1950s.

From 1999 to 2014, the age-adjusted suicide rate in the United States increased 24 percent, from 10.5 to 13 per 100,000 population, with the pace of increase doubling after 2006.

The average annual percent increase in the age-adjusted suicide rate was about 1 percent per year from 1999 through 2006, but increased to 2 percent per year from 2006 through 2014. In all, 42,773 people died from suicide in 2014, compared with 29,199 in 1999.

Suicide rates in the United States rose among most age groups. Among 35- to 64-year-olds, the rates have risen 7 percent since 2010. Men and women ages 45 to 64 had a sharp increase. Rates fell among those age 75 and older. The suicide rate for middle-aged women, ages 45 to 64, jumped by 63 percent over the period of the study, while it rose by 43 percent for men in that age range, the sharpest increase for males of any age.

The gap in suicide rates for men and women has narrowed because women's rates are increasing faster than men's, but in 2014, the age-adjusted rate for males (20.7) was more than three times that for females (5.8). Though suicide rates for older adults fell over the period of the study, men over 75 still have the highest suicide rate of any age group — 38.8 per 100,000 in 2014, compared with just 4 per 100,000 for women in the same age group.

Researchers also found an increase among girls 10 to 14, whose suicide rate, while still very low, had tripled. The number of girls who killed themselves rose to 150 in 2014 from 50 in 1999.

American Indians had the sharpest rise of all racial and ethnic groups, with rates rising by 89 percent for women and 38 percent for men. White middle-aged women had an increase of 80 percent. The rate declined for just one racial group: black men. And it declined for only one age group: men and women over 75.

The rise in suicide rates has happened slowly over many years. The [New York Times reported April 22](#) that Federal health researchers said they chose 1999 as the start of the period they studied because it was a low point in the national suicide rate, and they wanted to cover the full period of its recent sustained rise.

The NCHS analysis notes that methods of suicide are changing. About one in four suicides in 2014 involved

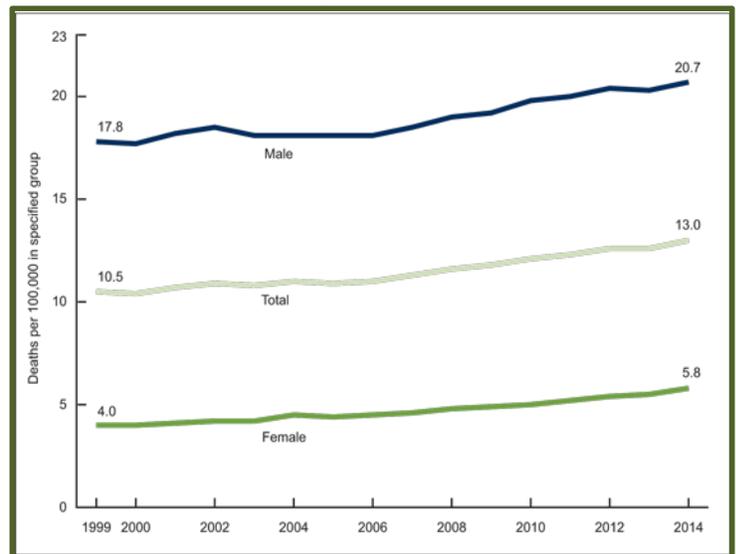
suffocation, which includes hanging and strangulation, compared with fewer than one in five in 1999. Death from guns fell for both men and women; guns went from being involved in 37 percent of female suicides to 31 percent, and from 62 percent to 55 percent for men, still more than half of all male suicides. Poisoning was the most common method of suicide for females in 2014, accounting for about one-third (34.1%) of all female suicides. This was a change from 1999, when firearms were the most common suicide method for women (36.9%), slightly more likely than poisoning (36.0%).

Policy makers say efforts to prevent suicide across the country are spotty. While N.I.H. funding for suicide prevention projects has been relatively flat — rising to \$25 million in 2016 from \$22 million in 2012 — it was a small fraction of funding for research of mental illnesses, including mood disorders like depression.

Experts interviewed in the [April 22 New York Times article](#) were uncertain what has driven the increases. Unmet expectations of social and economic well-being among less educated white men from the baby-boom generation may be playing a role. Another possible explanation: an economy that has eaten away at opportunities for families on the lower rungs of the income ladder.

Suicide has historically been highest when the economy was weak. One of the highest rates in the country's modern history was in 1932, during the Great Depression, when the rate was 22.1 per 100,000, 70 percent higher than in 2014.

Age-adjusted suicide rates by gender: United States, 1999–2014



The NASMHPD Weekly Update will take a break next week, but will return on May 6.

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

Funding Opportunity Announcement Number: SM-16-011

Posted on Grants.gov: Monday, April 18, 2016

Application Due Date: Thursday, June 16, 2016

Anticipated Total Available Funding: \$13,250,000

Anticipated Number of Awards: Up to 15 awards

Anticipated Award Amount: Up to \$1 million/year

Length of Project: Up to 4 years

Cost Sharing/Match: No

Description

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

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

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

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

Eligibility

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

Proposed budgets may not exceed the amount listed in the tier chart in the FOA in total costs (direct and indirect) in any year of the proposed project. The amount of each grant will be based on the population of the area, including the estimated number of individuals to be served under the grant. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

Contacts:

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

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

[FOA document Part I \(PDF | 515.5 KB\)](#)

[FOA document Part I \(DOC | 317 KB\)](#)

[FOA document Part II \(PDF | 433.03 KB\)](#)

[FOA document Part II \(DOC | 156.5 KB\)](#)

[Pre-Application Webinar Announcement \(PDF | 65.85 KB\)](#)

NIH Funding Opportunity: Development of Technology to Support Zero Suicide

Title: [Products to Support Applied Research Towards Zero Suicide Healthcare Systems](#)

Funding Opportunity Announcement PAR-16-185

Open Date (Earliest Submission Date): August 5, 2016.

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

Due Date: September 5 (Cycle I); January 5 (Cycle II); and April 5 (Cycle III).

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

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

On April 12, the National Institute of Health (NIH) announced a funding opportunity, Products to Support Applied Research Towards [Zero Suicide](#) Healthcare Systems, to advance the National Action Alliance for Suicide Prevention's goal of Zero Suicide. Zero Suicide is the belief that suicide attempts and deaths are preventable for individuals under the care of a health or behavioral health care system. It aims to improve the quality of care and outcomes for individuals at risk of suicide and to support the clinical staff who do the demanding work of treating and supporting patients at risk of suicide.

Further research is needed on how health information technology products play a role in advancing the goal of zero suicide. To explore this role, this funding opportunity supports small business innovation research (SBIR) to incorporate health technologies that improve, manage



NIMH Twitter Chat on Disruptive Mood Dysregulation Disorder/Severe Irritability

A child that displays extreme irritability, anger, and frequent, intense temper outbursts, may benefit from being screened for disruptive mood dysregulation disorder (DMDD), which is a fairly new diagnosis.

On National Children's Mental Health Awareness Day, May 5, NIMH will host a [Twitter chat on DMDD and severe irritability](#) from 12 to 1 p.m. EDT with expert [Dr. Ellen Leibenluft](#). Follow the tweets on [NIMH's Twitter page](#). To ask questions, you must have a Twitter account and include the hashtag [#NIMHchats](#) in every tweet. Those who cannot make the chat, can submit questions in advance via email to [NIMHpress@nih.gov](#), via Twitter using [#NIMHchats](#), or using [NIMH's Facebook page](#).

NIH will post a [transcript](#) of the chat within 24 hours.

and/or deliver services that promote the zero suicide movement. The FOA lists examples of technology capacity needs to advance the zero suicide initiative, such as the need to enhance suicide assessment and screenings, data-mine existing data resources, enable rapid identification of suicide prevention barriers, and establish a service delivery safety net.



The funding announcement strongly encourages SBIR applicants to collaborate with and reach out to local and state authorities that have a suicide prevention infrastructure in place, including: (1) states participating in the National Violent Death Reporting System ([NVDRS](#)) surveillance system (see next page for a related FOA); (2) local or state laws requiring suicide prevention training (ex. Washington State's [HB 2366—Chapter 181 of 2012](#)) that can be supported through technology); or (3) state agencies that have embraced the zero suicide framework in their systems of care. The application also strongly encourages SBIR applicants to consider proposing a technology that can be applied in various healthcare settings relevant to implementing zero suicide—including mental health and substance abuse outpatient clinics, emergency departments and crisis care programs, as well as integrated primary care programs.

Applicants are encouraged to contact [Adam Haim](#) by email or at 301-435-3593 for further guidance.

Center for Trauma-Informed Care: Upcoming Sessions

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

Below is an upcoming training.

[Tennessee](#)

Johnson City – April 25 & 26

Dept. of Psychology, East Tennessee State University

For more information on these trainings, please contact [jeremy.mcshan@nasmhpd.org](#).

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

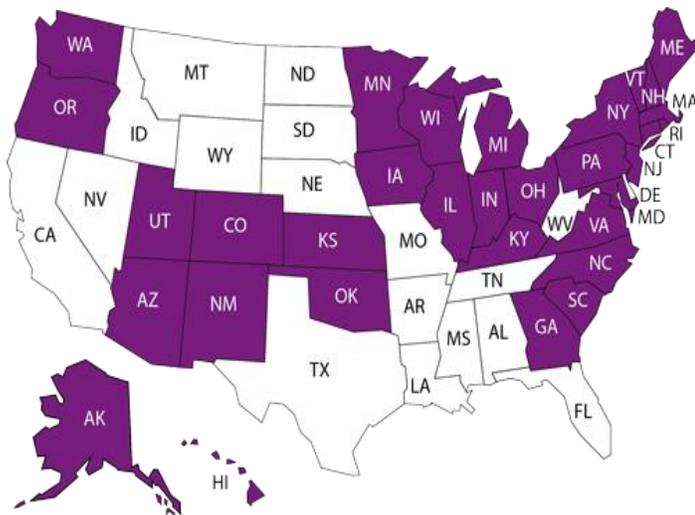
Due Date of Letter of Intent: April 26, 2016

Due Date for Applications: May 27, 2016

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

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

Created in 2002, NVDRS is an ongoing state-based surveillance system that collects comprehensive information on violent deaths—suicides, homicides, deaths from legal intervention, deaths of undetermined



intent, and unintentional firearm deaths—from various sources such as death certificates or reports from

coroners or medical examiners, law enforcement, crime labs, and hospitals. The NVDRS is the first system to: 1) provide detailed information on circumstances precipitating all types of violent deaths, including brief narratives that summarize what happened in the violent death incident, 2) combine information across multiple data sources, and 3) link multiple deaths that are related to one another (e.g., multiple victim homicides, suicide pacts, and cases of homicide followed by the suicide of the suspect).

Data elements include victim demographics, injury and death information, geographic information, toxicology, criminal activity, life stressors, mental health, weapon information, circumstances surrounding the death (ex. suicide, homicide, undetermined), and rich narratives from coroners, medical examiners, and law enforcement. The online data helps states and communities guide and target violence prevention programs, policies, and practices with the goal of reducing violence. States have used the data they have collected to examine suicide rates in their state.

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

For additional information on this grant opportunity, please visit grants.gov and search “CDC-RFA-CE16-1607,” or contact [Rebecca Wilson](#) at the CDC.



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

To Request On-site TA: States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals that the state is seeking to address via the support.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: <http://tatracker.treatment.org/login.aspx>. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tatracker@treatment.org.

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

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

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

FOA Number: SM-16-012

Posted on Grants.gov: Friday, April 8, 2016

Application Due: June 7, 2016

Description

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

Eligibility

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

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

Award Information

Funding Mechanism: Grant

Anticipated Number of Awards: Up to 11

Length of Project: 5 years

Anticipated Total Available Funding: \$10,000,000

Anticipated Award Amount: Up to \$1,000,000

Cost Sharing/Match Required? No

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

Contact Information

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Application Materials

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

[FOA document Part I \(PDF | 535.74 KB\)](#)

[FOA document Part I \(DOC | 297.5 KB\)](#)

[FOA document Part II \(PDF | 448.41 KB\)](#)

[FOA document Part II \(DOC | 167.5 KB\)](#)

[Pre-Application Webinar Announcement \(PDF | 248.43 KB\)](#)

May 5 is National Children’s Mental Health Awareness Day

National Children’s Mental Health Awareness Day (Awareness Day) 2016 is Thursday, May 5.

A national event will take place at 7 p.m. EST in Washington, DC, at The George Washington University School of Media & Public Affairs’ Jack Morton Auditorium, 805 21st Street, NW. The event—*Awareness Day 2016: “Finding Help, Finding Hope”*—will explore how communities can increase access to behavioral health services and supports for children, youth, and young adults who experience mental or substance use disorders and their families.

Admission is free, but registration is required to attend the event, due to limited seating. Attire will be business formal.

[REGISTER HERE TO ATTEND THE EVENT](#)

The interactive event, which will be webcast live as a special edition of [Knowledge Network for Systems of Care TV \(KSOC-TV\)](#), will feature youth and family leaders, educators, law enforcement officials, and behavioral health professionals discussing how communities can work together to improve access to behavioral health services and supports. Organizations and individuals from communities around the country also will share insights on strategies for overcoming barriers to behavioral health care access. Audience members will have the opportunity to ask questions and share their perspectives.

In addition, SAMHSA will present a Special Recognition Award to this year’s Honorary Chairperson, Reid Ewing—best known for his role as Dylan on *Modern Family*—for his efforts to promote openness and educate others about mental health.

Event panelists will include SAMHSA Acting Administrator Kana Enomoto and Center for Mental Health Services Director Paolo del Vecchio, MSW, along with Linda Rosenberg, MSW, the President and CEO of the National Council for Behavioral Health.

All panels will be moderated by NBC4 Washington Morning News Anchor Aaron Gilchrist.

Communities, collaborating organizations, and individuals around the country will participate in *Awareness Day Live!* activities, [viewing the live webcast](#) and interacting with the onstage discussion by sharing questions, ideas, or insights via email, Twitter, or text. Moderator Aaron Gilchrist will share questions and comments from viewers around the country onstage. Some *Awareness Day Live!* activities will include large, community-level gatherings hosted by systems of care or national collaborating organizations, while others will take place in smaller groups.

Viewers are encouraged to use the hashtag #HeroesofHope when participating in the national event discussion on social media.



Communities nationwide can participate in the national event by:

- **Organizing an [Awareness Day Live!](#) viewing event on May 5 at 7 p.m. EDT.** Gather a group to watch the live webcast and participate in the onstage discussion via digital or social media using the hashtag #HeroesofHope.
- **Hosting a viewing event of the on-demand version of *Awareness Day Live!*** The event might involve a viewing of all or part of the national webcast, along with a discussion of the unique challenges and opportunities related to behavioral health care access in your community.
- **Joining the social media conversation using the hashtag #HeroesofHope.** Use the hashtag to share your ideas and perspectives leading up to Awareness Day, during the national observance on May 5, and throughout the month of May.
- **Participating in the Awareness Day 2016 [Text, Talk, Act](#) conversation.** Through text messaging, small groups can receive discussion questions that lead them through a conversation about mental health.

The Awareness Day national event complements activities in more than 1,100 communities across the country and more than 145 federal programs and national organizations that observe Awareness Day every year.

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LINKS OF NOTE

Last fall, NRI, NASADAD, NASMHPD, and Truven completed a report on the organization and funding of SMHAs and SSAs in 2015 for SAMHSA. While the full report is still under review by SAMHSA, the agency has approved a publicly available poster summarizing the report's findings at [2015 State Mental Health and Substance Abuse Agency Profiles: Understanding the Organization, Financing, Services, and Policies of SMHAs and SSAs](#).

The new SAMHSA publication [Screening and Assessment of Co-Occurring Disorders in the Justice System](#) provides knowledge on a wide range of evidence-based practices for screening and assessment of adults in the justice system who have co-occurring mental and substance use disorders. The publication discusses the importance of instrument selection for screening and assessing patients.

On April 21, a bipartisan group of four members of the House Ways and Means Committee sent a [letter](#) to CMS Acting Administrator Andrew Slavitt seeking greater transparency of data on the behavioral health disorders of Medicare beneficiaries.