

National Association of State Mental Health Program Directors Weekly Update

Study Finds One-Third of Recently Separated Veterans Report Chronic Mental Health Issues

The results of a survey of nearly 10,000 recently separated veterans reported in the [January 2020 issue of the American Journal of Preventive Medicine](#) reveal that one-third of veterans report having chronic mental health conditions within the first nine months of leaving the service.

The survey of 9,566 veterans leaving service in Fall 2016, was conducted at three months and nine months after leaving service by Dr. Dawn S. Vogt at the Women's Health Services Division of the National Center for PTSD at the Veterans Affairs Boston Healthcare System and her co-authors. The study tested several hypotheses regarding differences in veterans' well-being over time, across life domains, and based on sex, military rank, and deployment history. Veterans' status, functioning, and satisfaction with regard to their health, work, and social relationships were assessed within 3 months of separation and then 6 months later.

Health concerns were most salient for newly separated veterans, with many veterans reporting that they had chronic physical health (53 percent) or mental health (33 percent) conditions and were less satisfied with their health than either their work or social relationships. Enlisted personnel reported consistently poorer health, vocational, and social outcomes compared with their officer counterparts, whereas war zone-deployed veterans reported more health concerns and women reported more mental health concerns than their non-deployed and male peers.

At the same time, most veterans reported relatively high vocational and social well-being and only work functioning demonstrated a notable decline in the first year following separation.

The authors of the study explain the reason for their research:

Although some research has examined the health and well-being of this cohort, most studies include veterans with widely varying separation dates. Given that the concerns of newly separated veterans are likely to differ from veterans who left military service many years ago, the applicability of those findings to newly separated veterans remains unknown. In addition, most research has focused on Veterans Administration (VA) healthcare users and war zone-exposed veterans. Though these studies have produced important scientific findings, they may not reflect the experiences of the larger veteran population, as many veterans do not seek assistance for health problems, and almost half never experience a war zone deployment during service. Finally, most research has focused on documenting health conditions known to be of concern for warfare-exposed veterans, giving less attention to other important aspects of veterans' lives, including their experiences in the workplace and their social relationships.

This prospective cohort drew from a roster of all separating U.S. service members identified from the VA/Department of Defense Identity Repository. The sampling frame was limited to veterans who lived in the continental U.S. and had separated from active component service or activated reservist status within the previous 90 days. All 46,965 veterans who met inclusion criteria were invited to complete the study in Fall 2016. All potential participants received an incentive of \$5 cash, and those who completed the Month 3 survey received an electronic gift card valued at \$20. Those completing the Month 9 survey received a \$25 gift card incentive. The Surveys took about 37 minutes to complete.

Twenty-three percent of the prospective cohort responded to the survey. Of those who responded to the Month 3 survey, 79 percent responded to the Month 9 survey. Most respondents were male (82 percent) and white (66 percent), with an average age of 34.47. Veterans were from all branches of service, with 75 percent self-identifying as enlisted (versus officers), and 23 percent reporting that they served in combat. They reported 1.83 combat deployments and 10.71 years of military service, on average.

At three months, 53.2 percent reported physical health conditions, while 54.57 reported physical health conditions at nine months, while 32.22 percent reported mental health conditions at three months and 34.87 percent so reported at nine months. Of women, 40.48 percent reported a mental health condition at three months, and 46.11 percent reported a mental health condition at nine months, compared to 31.32 percent and 32.74 percent, respectively, for men.

Almost twice as many enlisted men (35 percent) as officers (19.73 percent) reported mental health conditions at three months, with the percentage difference remaining almost constant at nine months (37.11 percent to 21.69 percent), but rising for both categories.

Issues with anxiety plagued 22.47 percent at three months and 23.9 percent at nine months. Depression was a factor for 19.84 percent at three months and 22.04 percent at nine months. Post-traumatic stress disorder (PTSD) was reported by 12.32 percent at three months, while 13.71 percent reported PTSD issues at nine months. Issues with sleep were reported by 31.22 percent at three months, and 31.54 at nine months.

When asked whether they were satisfied with their overall health, 47.4 percent indicated they were at three months, with a minor drop to 47.01 percent indicating in the affirmative at nine months. However, chronic pain afflicted 40.44 percent of respondents at three months, 41.52 percent at nine months.



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Happy New Year!

Sending you our warmest thoughts and
best wishes for a wonderful New Year
ahead!

Looking forward to working together to
advance crisis services and the full
continuum of care to divert people from
jail and emergency rooms.

From,
All of us here at NASMHPD

New Action Alliance for Suicide Prevention Paper Highlights Evidence-Based Practices to Improve Suicide Care Transitions

Research demonstrates that individuals discharged from inpatient psychiatric care and transitioned to outpatient services have suicide rates 200 times (one week after being discharged) to 300 times (30 days post-discharge) higher than the general population. To address this critical time of care, the National Action Alliance for Suicide Prevention (Action Alliance) has published [Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care](#).

The report provides evidence-based practices to ensure care coordination and patient safety by outlining guidelines for inpatient care and outpatient care settings.

Recommendations for Inpatient Care

Prior to Discharge

1. Develop collaborative relationships and procedures with outpatient provider organizations to ensure post-discharge planning and to expedite the first outpatient intake appointment. Examples include developing memorandum of understanding or memorandum of agreement that detail care coordination expectations, and ensuring that outpatient provider receive all necessary documents.
2. Involve family members and other natural supports, such as peer specialists and community support systems (ex. school counselors, coaches) to increase the likelihood of participating in ongoing outpatient care.
3. Work collaboratively with patient, family and support system to develop a safety plan as part of pre-discharge planning. Coping strategies for the patient and family members are identified, as well as discussing lethal means restrictions.
4. Initiate connection between the outpatient provider and patient to bridge coordination between inpatient and outpatient care. Schedule an outpatient intake appointment within 24 to 72 hours of discharge and resolve any barriers (ex. transportation, childcare) to attending the appointment prior to discharge.

After Discharge

5. Maintain telephone contact with the patient until the first appointment by calling the patient or family member within

24 hours of discharge to provide support during this transition. Providing ongoing and multiple caring contacts (ex. postcards, texts, emails) for several months post discharge.

Recommendations for Outpatient Care

Prior to Discharge from Inpatient Setting

1. Work with inpatient care team to ensure a seamless transition, such as exchange of documentations, strategies to address barriers for attending outpatient care, and procedures for following up with the patient during the transitional phase and if initial appointment is missed.
2. Connect with patient and care team before inpatient discharge to build relationship and increase engagement with outpatient services through peer specialists. Telephone or video conference can be used if in-person meeting is not possible.

After Discharge from Inpatient Setting

3. Narrow the transition gap by working with the patient to schedule a clinical intake appointment with a provider trained in suicide care, ideally within 24 hours of hospital discharge. Establish a triage system by analyzing data on referral patterns outcome review of outpatient treatment referrals.
4. Maintain good communication with the inpatient provider conveying that the initial appointment was attended. If the intake appointment was missed, work with the inpatient provider to contact the patient. Train staff on protocols when a patient is unresponsive to outreach efforts and policies for initiating emergency welfare checks.

To encourage adoption of the recommendations, the Action Alliance developed a short [video](#) that highlights some of the care transition strategies and an [executive summary](#) that provides an overview of the report. These resources can be downloaded on the [Suicide Care Transitions website](#). The Best Practices report builds on the Action Alliance's [Recommended Standard Care for People with Suicide Risk](#) and [The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experiences](#).



Study Finds Medicaid Expansion Improved Health of Low-Income Adults in Southern States

A study published in the [January 2020 Health Affairs](#) of the self-reported health of nonelderly, low-income adults in four Southern expansion states and eight southern non-expansion states before and after expansion has found that a higher proportion of Medicaid enrollees in expansion states reported increases in Medicaid coverage, a lower proportion of Medicaid enrollees in expansion states reported health status decline, and a higher proportion of Medicaid enrollees in expansion states maintained their baseline health status after expansion.

The study by Dr. John A. Graves and his associates at the Vanderbilt University School of Medicine and Harvard Medical School Department of Health Care Policy found that Medicaid coverage of the low-income enrollees in the southern expansion states increased by 7.6 percentage points, with 1.8 percent fewer enrollees than in non-expansion states reporting a decline in health status and 1.4 percent more in expansion states reporting that health status had been maintained.

The researchers used longitudinal data from the Southern Community Cohort Study (SCCS), the largest epidemiologic cohort of low-income adults in the U.S., who were served community health centers in 12 southern states. SCCS participants have particularly low incomes and are older and have considerably higher mortality, morbidity, and uninsured rates than the low-income population in general. The expansion states included were Kentucky, West Virginia, Arkansas, and Louisiana. The non-expansion states studied were Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia (which expanded, in 2019, after the study was completed). The researchers included in the sample respondents who reported incomes below 400 percent of the Federal Poverty Level, but not those with incomes below a lower poverty level qualifying for Medicaid eligibility, in order to capture adults who were intermittently eligible for Medicaid or who may have gained subsidized coverage as a result of Medicaid expansion outreach.

Baseline (pre-expansion) sociodemographic and health characteristics did not differ substantially between the SCCS expansion- and non-expansion state samples, with one exception: African Americans were more prominently represented in those non-expansion states located in the Deep South than in expansion states (73 percent versus 44 percent).

How #CrisisTalk is Transforming Dialogue in Behavioral Health

The National Association of State Mental Health Program Directors (NASMHPD) and its [Crisis Now](#) partners—the [National Suicide Prevention Lifeline and Vibrant Emotional Health](#), the [National Action Alliance for Suicide Prevention](#), the [National Council for Behavioral Health](#), and [R.I. International](#)—have launched the #CrisisTalk website, sparking much-needed dialogue on behavioral health crises. The new publication provides a platform for diverse experts and people with Lived Experience to exchange thoughts, knowledge, and innovations. Each article shares a person's perspective, whether that's an emergency department doctor who tells her story, revealing the challenges emergency physicians experience when faced with a patient in crisis, or a student with suicidal ideation and his university choosing legal self-protection over doing what was best for him.

The objective is to facilitate conversations about mental health crises, including missed opportunities, gaps, tools, and best practices. #CrisisTalk is sharing the diverse stories of people affected by behavioral health crises, including those who have experienced one, loved ones, and stakeholders who need to be part of the conversation, swinging the pendulum worldwide toward awareness and change.

#CrisisTalk interviews reflect the perspectives of mental health experts and first responders. They point out common misconceptions and challenges in their fields and the communities they serve. This includes why some locations do not develop a full continuum of crisis care services. The discussions transcend geography and illustrate ways to make positive changes in the crisis space. Simply having a conversation with a person in crisis, a non-judgmental, empathic approach, along with a willingness to listen and sit with someone, can go a long way.

#CrisisTalk is part of [CrisisNow.com](#), a roadmap to safe, effective crisis care that diverts people in distress from the emergency department and jail by developing a continuum of crisis care services that match clinical needs to care. To learn more, visit [www.CrisisNow.com/talk](#).

THIS WEEK: Kevin and Margaret Hines on Changing the Narrative of Recovery

Kevin Hines altered the field of mental health by shattering the misconception that people intent on dying by suicide don't experience ambivalence. He and Margaret Hines say it's time for the field to change yet again: this time over the narrative of recovery and ensuring that people with lived experience are in leadership positions.

Not long ago, most mental health experts believed that people intent on dying by suicide didn't experience ambivalence. Today, the thinking in suicide prevention has shifted dramatically, and it is in large part because of people like Kevin Hines. In 2000, at the age of 19, he attempted to take his life by jumping off the Golden Gate Bridge. He survived, becoming the 26th person ever known to survive the 220-foot fall. Hines says that, during the four seconds it took to hit the water, freefalling at 75 miles per hour, he realized he did not want to die. Hines' revelation, and that of other attempt survivors, sent shockwaves throughout the mental health field. It turns out that just because a person is intent on dying does not mean he does not experience doubt. A leading expert on suicide, Thomas Joiner, Ph.D., defines ambivalence in this case as forces for and against life "contending with one another contemporaneously." This has profoundly influenced the trajectory of suicide prevention research and outreach and has helped to shatter the myth experts once believed: that attempt survivors were not in the same group as those who died by suicide, and thereby nothing could be gained from learning about them. Hines says it is time that the suicide and mental health field shift once again: this time over the narrative of recovery and ensuring that people with lived experience are in leadership positions.

[LEARN MORE](#)

Crisis Now Partners:

The National Association of State Mental Health Program Directors (NASMHPD), founded in 1959 and based in Alexandria, VA, represents the \$41 billion public mental health service delivery system serving 7.5 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD (pronounced "NASH-bid") is the only national association to represent state mental health commissioners/directors and their agencies, and serves as the lead for [www.CrisisNow.com](#).

The National Suicide Prevention Lifeline and Vibrant Emotional Health provides free and confidential emotional support and crisis counselling to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. Funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health, the Lifeline engages in innovative public messaging, development of best practices in mental health, creative partnerships, and more to improve crisis services and advance suicide prevention for all. [www.suicidepreventionlifeline.org](#) | [www.vibrant.org](#) | [www.twitter.com/800273TALK](#)

The National Action Alliance for Suicide Prevention is the public-private partnership working with more than 250 national partners advancing the National Strategy for Suicide Prevention with the vision of a nation free from the tragic experience of suicide and a goal of reducing the annual suicide rate 20 percent by 2025. Administered by EDC, Inc., the Action Alliance was the catalyst for the Zero Suicide Healthcare and Crisis w: Transforming Services innovations. [www.theactionalliance.org](#) | [www.edc.org](#) | [www.twitter.com/Action_Alliance](#)

The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with their 3,000 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council introduced Mental Health First Aid USA and have trained more than 1.5 million Americans. [www.thenationalcouncil.org](#) | [www.mentalhealthfirstaid.org](#) | [www.twitter.com/NationalCouncil](#)

RI International (d/b/a for Recovery Innovations, Inc.) is a global organization that offers more than 50 programs throughout the United States and abroad, characterized by recovery and a focus on what's strong, not what's wrong. More than 50% of employees report a lived experience with mental health, and the "Fusion Model" crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. [www.riinternational.com](#) | [www.zerosuicide.org](#) | [www.twitter.com/RI_International](#)

ACA Plan Enrollment for 2020 Benefit Year Increases in 11 Mostly Republican States

Final enrollment figures released by the Centers for Medicare and Medicaid Services on January 8 indicate that 8,286,871 people signed up for 2020 Affordable Care Act insurance coverage through HealthCare.gov by the extended December 18 deadline, putting sign-ups on the Federal enrollment website serving 38 states at about 124,743 or 1.5 percent behind last year's 8,411,614 million.

Of that total 2020 enrollment, 2,086,338 were new enrollees and 6,200,533 were consumers renewing coverage. Enrollment was up in 11 states, 9 of which had Republican governors.

On December 16, CMS extended open enrollment until December 18 because of glitches in Healthcare.gov on December 15.

HealthCare.gov State-by-State Snapshot - Cumulative Plan Selections November 1 – December 17, 2019 & [2018] Bold-Figure Numbers Indicate 2020 Enrollment Increases					
Alaska	17696 [17,805]	Louisiana	87,748 [92,948]	Oklahoma	158,642 [150,759]
Alabama	160,429 [166,1285]	Maine	62,031 [70,987]	Oregon	145,264 [148,180]
Arkansas	64,360 [67,413]	Michigan	262,919 [274,058]	Pennsylvania	331,825 [365,888]
Arizona	153,020 [160,456]	Missouri	202,750 [220,461]	South Carolina	214,030 [214,956]
Delaware	23,961 [22,562]	Mississippi	98,892 [88,542]	South Dakota	29,331 [29,069]
Florida	1,913,975 [1,783,304]	Montana	43,882 [45,374]	Tennessee	200,445 [221,533]
Georgia	463,910 [458,437]	North Carolina	505,275 [501,271]	Texas	1,116,293 [1,087,240]
Hawaii	20,073 [20,193]	North Dakota	21,666 [21,820]	Utah	200,261 [194,570]
Iowa	54,586 [49,210]	Nebraska	90,845 [87,416]	Virginia	269,474 [328,020]
Illinois	292,945 [312,280]	New Hampshire	44,412 [44,581]	Wisconsin	195,498 [205,118]
Indiana	140,931 [148,404]	New Jersey	246,426 [255,246]	West Virginia	20,066 [25,599]
Kansas	85,837 [89,993]	New Mexico	42,714 [45,001]	Wyoming	24,574 [24,852]
Kentucky	83,139 [84,620]	Ohio	196,806 [206,871]		



Suicide Prevention Resource Center

On-Line Course: Locating and Understanding Data for Suicide Prevention

Course Description: Effectively preventing suicide requires an understanding of who is attempting and dying by suicide, where the problem is most severe, and under what circumstances attempts and suicide deaths occur. But how do you find the data you need to answer these questions and others? *Locating and Understanding Data for Suicide Prevention* presents a variety of data sources that are useful for finding information about suicide deaths, suicide attempts, and suicidal ideation. This course also explains key concepts that will help you better understand the data you find.

After completing this course, you will be able to:

- Define and understand the difference between suicide deaths, suicide attempts, suicide ideation, and risk and protective factors for suicide.
- Explain key terms essential to accurately interpreting data and making meaningful comparisons; this includes counts, rates, and trends.
- Identify some commonly used and readily accessible online national data sources, and the type of data that is available from each source.
- Identify some alternative data sources that may be available in states and communities, the type of data available from these sources, and considerations when approaching organizations and agencies for these data.
- Think critically about the strengths and limitations of a given data source.

This course is open to anyone. We highly recommend it for any professional involved in national, state or community suicide prevention.

Course Length: This course can be completed in approximately two hours. You do not have to complete the course in one session. You can exit the course at any time and return later to the place where you left off.

Certificate of Completion: To receive a certificate of completion, you must do the following online: complete each lesson, pass the posttest (passing score is 80% or higher), and answer the feedback survey questions. You can earn a certificate of completion once per year for each course. We do not offer continuing education credits for any of our courses.

[ENROLL HERE](#)

Online registration starts January 15th

NEW!



32nd
Annual

Tuerk Conference

on Mental Health & Addiction Treatment



Kevin Lindamood



Beth Macy



Ashish Alfred



Carlo C. DiClemente

2020 Vision Working Together

Super Saver

\$165 includes
Lunch and
6 CEUs

Thursday, April 23, 2020

[Click here to download full program brochure](#)

Using Data Analytics to Better Understand State Medicaid Beneficiaries with Serious Mental Illness - Technical Assistance for Medicaid Agencies - Extension of Time for Application to January 15

The Medicaid Innovation Accelerator Program (IAP) is a collaboration between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI) designed to build state capacity and support ongoing innovation in Medicaid. IAP provides targeted technical assistance to states' ongoing delivery system reform efforts across four priority program areas: (1) substance use disorders; (2) Medicaid beneficiaries with complex care needs; (3) community integration through long-term services and supports; and (4) physical/mental health integration. IAP also provides assistance to states in four functional areas, which IAP sees as the building blocks to delivery system reform: (1) data analytics; (2) quality measurement; (3) value-based payment and financial simulations; and (4) performance improvement.

IAP's Beneficiaries with Complex Care Needs and High Costs (BCN) program area offers technical assistance and resources to Medicaid agencies seeking to design, plan, and implement strategies to improve care coordination for Medicaid BCN populations. As part of this program area, over the last year, IAP focused on adult Medicaid beneficiaries with Serious Mental Illness (SMI) and posted two technical resources for Medicaid agencies focused on data analytics.

Components of Technical Assistance for Medicaid Agencies

This year, starting in January 2020, the IAP is offering up to eight months of technical assistance for up to 10 Medicaid agencies that aim to utilize data analytics to gain a better understanding of their adult population with SMI and to help inform related programmatic decisions. This technical assistance opportunity is open to Medicaid agencies at all stages of development, from those just beginning this work to those building on existing initiatives.

This technical assistance includes interactive webinars and coaching assistance. The technical assistance is provided through three inter-related components which will run sequentially. Participating Medicaid agencies can select one or all three to join.

- **Component 1: Build an SMI Population Profile (January – March 2020)**

- o Conduct analyses to further understand state populations with SMI using Medicaid claims and encounters data (demographic, cost, and utilization information)
- o Develop or start developing state Medicaid SMI population profiles

- **Component 2: Leverage External Data Sources (April – May 2020)**

- o Augment state SMI population profiles with external data sources (e.g. corrections, housing data)
- o Navigate challenges in data matching and other SMI data sharing barriers
- o Develop data sharing and use strategies with other state or external data partners

- **Component 3: Consider SMI Data-Informed Delivery System Reform (June – August 2020)**

- o Exchange lessons learned
- o Apply SMI data in the design if a consider delivery system reform initiative

States have the option to participate in one or more of the components depending on their existing SMI analyses to date. Since the three components in this cohort are meant to build on one another, states are encouraged to participate in all three components of the work. However, it is understood that some states may, for example, already have a SMI state-specific population profile, and therefore may only want to participate in components 2 and/or 3.

States are encouraged to complete each components' activities during the component's timeframe. Nevertheless, the coach team is available to support each states' activities throughout the eight months. For example, the SMI population profile is not complete in the first three months, states can use the coaching team and the time during component 2 or 3 to complete the profile.

Expressions of interest (EOI) forms for the SMI technical assistance opportunity will be accepted on or before January 15, 2020. States will be selected for participation in early January 2020. The eight-month technical assistance activities will occur between late January and August of 2020.

- January 15, 2020: Expression of Interest form due
- January 2020: One-on-one conference calls with individual states to review their EOI forms and discuss their state goals
- Mid-January: States selected
- January 27, 2020: SMI technical assistance kick-off webinar
- January 2020-August 2020: Technical assistance activities, webinars, and coaching
- August 2020: Technical assistance ends

How Do Interested States Apply for Technical Assistance?

Review the [Technical Assistance Program Overview](#) and [Information Session Slides](#). Interested states are asked to submit the [Expression of Interest \(EOI\) form](#) by midnight (E.T.) on January 15, 2020 with the subject line "SMI data analytics" to cms.iap.smi@healthmanagement.com. Please direct questions to Katherine.Vedete@cms.hhs.gov, using the subject line "SMI data analytic opportunity questions."



Webinar: Innovative Approaches to Housing for People with Opioid Use Disorder **Thursday, January 30, 2020, 12:00 p.m. to 1:00 p.m. E.T.**

Housing is critical to health and well-being, which makes addressing the link between substance use disorders and housing instability all the more important as communities seek to address the opioid epidemic.

[In a recent ASPE report](#), Abt identified several promising housing models that support recovery from opioid use disorder (OUD), including HomeSafe (FAMILYConnections NJ) and HousingNow (Pathways to Housing PA). Join Abt experts and representatives of these two programs during this free webinar to learn about challenges and solutions to providing housing for individuals with OUD, including how these models can be replicated in other communities.

Speakers:

- Emily Rosenoff, Acting Director, Division of Long-Term Care Policy, ASPE
- Meghan Henry, Housing Expert, Abt Associates
- Sarah Steverman, Behavioral Health Expert, Abt Associates
- Alexandra Riley, Director of Programs, FAMILYConnections NJ
- Christine Simiriglia, President & CEO, Pathways to Housing PA

[**REGISTER HERE**](#)



MHTTC

Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

[Sign Up for the SAMHSA Mental Health Technology Transfer Center Network Pathways Newsletter](#)



GAINS Webinar: Screening and Assessment Across the Sequential Intercept Model, Part II **Tuesday, January 21, 2 p.m. to 3:00 p.m. E.T.**



Across the U.S., many individuals with mental and/or substance use disorders interface with the criminal justice system due to a lack of access to community-based resources. During their involvement with the justice system, it is important that people receive appropriate screenings and assessments to enable linkage to critical resources, services, treatment, and diversion programs. SAMHSA's GAINS Center is proud to present two webinars to support the use of screening and assessment across the Sequential Intercept Model.

This second webinar will walk participants through various real-life scenarios to learn how to apply screening and assessments at various points across the intercepts. Guidance will be provided on how to use the valuable data gathered to best support individuals with behavioral health disorders who are interfacing with the criminal justice system, as well as, to improve the effectiveness of local criminal justice and behavioral health systems.

[**REGISTER HERE**](#)

WEBSITE FOR THE SAMHSA-SPONSORED

Center of Excellence for Protected Health Information
Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)



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Years

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Check out the latest event and agenda information below.

Thursday, March 19, 2020

[Keynote Address](#): Resilience in Science and Practice: Pathways to the Future, Ann S. Masten, Ph.D.

[Trending Topics](#): Cannabis, Anxiety, and Depression: Cause for Pause or Peace of Mind? Staci Gruber, Ph.D.

[12 Master Clinician Sessions](#) which will inspire, educate, and challenge you to solve problems and achieve breakthroughs

[Timely Topics](#): Experts provide clinicians and other attendees with accessible evidence-based information on timely topics encountered in the practice setting.

Friday, March 20, 2020

[Jerilyn Ross Lecture](#): The State of the Art of Toxic Stress and Resilience Research: Implications for Best Practices with Vulnerable Populations, Joan Kaufman, Ph.D.

[Clinical Practice Symposium](#): The Nuts and Bolts of Working With PTSD, Depression, and Micro-Aggressions with Minority Clients Through the Lenses of CBT, ACT, and FAP

[Scientific Research Symposium](#): Resilience From Research to Practice

Saturday, March 21, 2020

[Science Spotlights](#): Targeting Biological Mechanisms of Resilience to Identify New Therapeutics for Depression and PTSD and A Walk Through the Lifecycle of the Memory Engram

Plan now to stay through Saturday night for ADAA's 40th Anniversary Celebration, featuring live entertainment, award recognitions, tributes to our longtime ADAA members, a memorable culinary experience, opportunities to meet and network with ADAA members and peers, and more.

The San Antonio Marriott Rivercenter - #ADAA2020 Conference Hotel

The 2020 ADAA Annual Conference (March 19-22) will be held at the San Antonio Marriott Rivercenter (101 Bowie Street, San Antonio, TX 78205) on the San Antonio River. Conference activities including all sessions, exhibits, and receptions take place at the San Antonio Marriott Rivercenter, which will be newly renovated in February. Plan to be there Saturday night (March 21) to help ADAA celebrate our 40th Anniversary! Rooms sell out quickly in San Antonio – so don't delay! Special ADAA Rate: \$229 Single/Double

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La Quinta San Antonio Riverwalk -

La Quinta is located directly across the street from the headquarters hotel and a 1-minute walk to the conference rooms at the Marriott Rivercenter. A complimentary breakfast is provided for overnight guests. Rooms sell out quickly in San Antonio – so don't delay! Special ADAA Rate: \$199 Single/Double

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Please reserve your room prior to February 24, 2020.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) ON-DEMAND WEBINAR:

PCORI Research Documents the Impact of Peer Navigators in Enhancing Health Goals of People with Serious Mental Illness

People with serious mental illness (SMI) get sick and die from 10 to 20 years younger than same-age peers. Morbidity and mortality are even worse when the person is of color or from low socioeconomic status. Fragmented health care systems are one of the major reasons why people with SMI suffer health challenges. These systems often lack primary and integrated care clinics, and those clinics that do exist are often not readily available given existing public transportation. Entitlement programs are minimal or inaccessible. Service teams fail to master cultural competence.

Patient navigators are one way to deal with fragmented health care. Patient navigators are paraprofessionals who offer practical, in-the-field support to assist people with SMI to engage in healthcare. Their service is hands-on, including assisting the person to make appointments, accompanying them to the clinic, entering the exam room, waiting for labs, and managing prescriptions; the person with SMI is in charge of all elements of this process. Patient navigators use counseling skills to provide a supportive relationship and join the person with SMI in ongoing health decisions and action.

Peer navigators are people in recovery from SMI who provide the same navigator services. They share lived experience in mental illness and, through strategic interactions, can use common history to engage the person with SMI in navigation. They are also peers because they are often drawn from the same ethnic group, SES, and community. Cultural competence is enhanced as a result.

As part of a PCORI-dissemination award, Patrick Corrigan from the Chicago Health Disparities Center (www.Chicagohealthdisparities.org) has worked with a team of peer service providers to develop a webinar summarizing research and practice findings. Corrigan's group is providing the webinar for free in real-time or as an online archived resource to any interested group. Corrigan's team is also able to attend conferences to present the information face-to-face; all costs will be covered by his center. Corrigan can be reached at corrigan@iit.edu.



SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Assisted Outpatient Treatment Program for Individuals with Serious Mental Illness (SM-20-006)

Funding Mechanism: Grant

Anticipated Total Available Funding: \$13,398,000

Anticipated Number of Awards: 14

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

Length of Project: 4 years

Cost Sharing/Match Required?: No

Application Due Date: Friday, January 24, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness (Short title: Assisted Outpatient Treatment [AOT]). This four-year 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 courts to allow these individuals to obtain treatment while continuing to live in the community and their homes.

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 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 individuals with serious mental illness (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.

Contacts:

Program Issues: David Barry, Center for Mental Health Services (CMHS) Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-0116, david.barry@samhsa.hhs.gov.

Grants Management and Budget Issues: Corey Sullivan, Office of Financial Resources, Division of Grants Management, SAMHSA, (240) 276-1213, FOACMHS@samhsa.hhs.gov.

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Family Support Technical Assistance Center (FG-20-002)



Funding Mechanism: Grant

Anticipated Total Available Funding: \$800,000

Anticipated Number of Awards: 1

Anticipated Award Amount: \$800,000 per year

Length of Project: Up to 5 years

Cost Sharing/Match Required?: No

Application Due Date: Friday, February 28, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2020 Family Support Technical Assistance Center (Fam-CoE). SAMHSA recognizes both the critical role families play in addressing mental and substance use disorders and the toll such disorders take on families across the country. The Fam-CoE will focus on training and education of the general public and healthcare practitioners on the importance of family supports and services and the integration of these services into mental and substance use disorder treatment programs. The Fam-CoE will also provide much needed resources and education directly for families.

The recipient is expected to implement the following activities.

- Provide up-to-date information and education related to the inclusion of family support services in the treatment of individuals with mental disorders, including serious mental illness (SMI) and serious emotional disturbance (SED), substance use disorders (SUDs), or co-occurring mental and SUDs. Training and education should be provided on support services such as family counseling; family group sessions; family peer support; parenting services; and services for children of individuals with mental or substance use disorders.
- Information and education must be offered to the public with a focus on reaching families of those affected by mental and substance use disorders. It must address the epidemiology, genetics, manifestation(s) of illness, course of illness, treatment and recovery services for major mental and substance use disorders in adolescents and adults, and serious emotional disturbance in children.
- Provide specialized training to provider organizations, practitioners, and the public, on communication during times of medical or psychiatric emergency and other critical situations with families. Privacy rules are often misunderstood to mean that no communication is permitted with families. A major role of the FamCoE will be to assist in clarifying these privacy regulations, including HIPAA and 42 CFR Part 2, which do permit communication by healthcare providers with family during times of medical or mental health emergency. It will be expected that the Fam-CoE will collaborate closely with the SAMHSA-sponsored Protected Health Information Center of Excellence to develop and disseminate this information.
- Provide publically available training, which includes providing Continuing Education Units (CEUs) for various healthcare professionals/Continuing Medical Education (CME) credit for physicians who participate in training activities, including, but not limited to, webinars, online distance education, and classroom-style trainings. There must be systematic and ongoing outreach to healthcare professionals/healthcare professional organizations to make providers aware of training opportunities offered by FAM-CoE.
- Provide comprehensive resources and training modules for family members to assist families with recognizing signs and symptoms of mental/substance use disorders and steps to take if such symptoms are identified. Resources should be provided to assist family members in identifying treatment resources for loved ones, as well as identifying supports for the family.
- Training and technical assistance (TTA) should be delivered in a variety of modalities including self-paced online learning modules; webinars; products/materials; and in-person intensive training on implementation strategies that will directly enhance family support services across the nation.
- Coordinate with other SAMHSA TTA providers, including the *SMI Advisor*, SAMHSA-sponsored regional Substance Abuse Prevention, Addiction and Mental Health Technology Transfer Centers; Opioid Response Network; Providers' Clinical Support System for Medication Assisted Treatment; the Addiction Peer Recovery Technical Assistance Center; and the Service Members, Veterans, and Families TA Center.
- Develop a system of ongoing environmental scans to assure that best practices/evidence-based practices are consistently being presented and updated as information becomes available. This includes working with SAMHSA to address new topic areas/evidence-based practices that require a focus by this resource center and dissemination of those practices.

Eligibility: Domestic public and private non-profit entities.

Contacts:

Program Issues: Humberto Carvalho, Office of Financial Resources, Substance Abuse and Mental Health Services Administration (SAMHSA), (240) 276-2974, Humberto.carvalho@samhsa.hhs.gov.

Grants Management and Budget Issues: Corey Sullivan, Office of Financial Resources, Division of Grants Management, SAMHSA, (240) 276-1213, FOACMHS@samhsa.hhs.gov.

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Planning and Developing Infrastructure to Promote the Mental Health of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Circles of Care) (SM-20-10)



Funding Mechanism: Grant

Anticipated Number of Awards: 17

Length of Project: Up to 3 years

Anticipated Total Available Funding: \$5,492,314

Anticipated Award Amount: Up to \$310,000 per year

Cost Sharing/Match Required?: No

Application Due Date: Monday, March 9, 2020

Anticipated Project Start Date: August 30, 2020

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Planning and Developing Infrastructure to Promote the Mental Health of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Circles of Care) grants. The purpose of this program is to provide tribal and urban Indian communities with tools and resources to plan and design a holistic, evidence and community-based, coordinated system of care to support mental health for children, youth, and families. These grants are intended to increase the capacity and effectiveness of mental health systems serving AI/AN communities. Circles of Care grant recipients will focus on the need to reduce the gap between the need for mental health services and the availability of such services for the target population. The program has a strong emphasis on cross-system collaboration, inclusion of family, youth and community resources, and cultural approaches.

Circles of Care grant funds must be used primarily to support infrastructure development, including the following types of activities:

- Identify a structure (i.e. advisory boards, workgroups, task force) and process that will provide ongoing guidance to project staff and promote the sense of community ownership. The identified structure may be a new or existing group, but must include representation from partner agencies, elected tribal officials and other decision makers, in addition to a variety of community members including youth and families as equal partners.
- Assure that orientation and ongoing training on the systems of care approach is provided to a wide audience for the purpose of workforce development through the life of the grant and beyond.
- Use a community-based process that is culturally appropriate and actively engages community members, key stakeholders, youth, elders, spiritual advisors, and tribal leaders throughout the life of the grant.
- Engage various sectors of the community to participate in the systems of care approach through outreach and educational strategies to sectors such as schools, the faith community, the housing community, and the justice system, in addition to healthcare systems.
- Conduct network development and collaboration activities, including ongoing training, for child and youth service providers, paraprofessionals and other informal support providers such as traditional healers, community natural helpers, youth peer leaders, and family members.
- Implement a community-based system of care model, or "blueprint", for how child/youth mental health and wellness services and supports will be provided in the community. Use a variety of ongoing consensus-building activities with continuous feedback from the community to develop the model, which should be holistic, community-based, culturally competent, family-driven, and youth-guided across multiple agencies.
- Formalize interagency commitments for collaboration and coordination of services and develop policies, corresponding funding streams, and other strategies for how the system of care model, or "blueprint", can be put into action.
- Identify an area in which services can be piloted to ensure that the infrastructure being created under this program is useful for its intended purpose. Services such as school-based mental health, educational, vocational, or family support services for children, youth, and families should be piloted. Recipients have the flexibility to choose the pilot location and service delivery type.

Eligibility:

- Federally recognized American Indian/Alaska Native (AI/AN) tribes;
- Urban Indian Organizations;
- Consortia of tribes or tribal organizations; and
- Tribal colleges and universities (as identified by the American Indian Education Consortium).

Prior Circles of Care recipients are ineligible to apply.

Program Issues: Amy Andre, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), (240) 276-1132, amy.andre@samhsa.hhs.gov.

Grants Management and Budget Issues: Corey Sullivan, Office of Financial Resources, Division of Grants Management, SAMHSA, (240) 276-1213, FOACMHS@samhsa.hhs.gov.



Department of Veterans Affairs Notice of Funding Availability: Homeless Providers Grant and Per Diem Program



***Application Date Deadline: March 2, 2020. 4:00 p.m. E.T.
Awards are for services to begin October 1, 2020.***

The Department of Veterans Affairs (VA) is announcing the availability of per diem funds to eligible entities to provide transitional housing beds or service centers for Veterans who are homeless or at risk for becoming homeless under VA's Homeless Providers GPD Program models. VA expects to fund approximately 11,500 beds and approximately 20 service center applications with this Notice of Funding Availability (NOFA) for applicants who will offer one or a combination of the transitional housing bed models (i.e., Bridge Housing, Low Demand, Hospital-to-Housing, Clinical Treatment and Service-Intensive Transitional Housing) and for applicants who will offer service centers. Funding is based on a variety of factors including the quantity and quality of applications as well as the availability of funding.

Each application must request either transitional housing bed model(s) or service center(s). Although transitional housing applications and service center applications are standalone applications, they will be reviewed, scored and selected for funding together. They will be selected based on their ranked order among all the applications submitted in response to this NOFA.

Grants: Limit is 65 percent of the costs of construction, renovation, or acquisition of a building for use as service centers or transitional housing for homeless Veterans. Renovation of VA properties is allowed, acquiring VA properties is not. Recipients must obtain the matching 35 percent share from other sources. Grants may not be used for operational costs, including salaries.

Per Diem: Priority in awarding the Per Diem funds goes to the recipients of Grants. Non-Grant programs may apply for Per Diem under a separate announcement, when published in the Federal Register, announcing the funding for "Per Diem Only."

Operational costs, including salaries, may be funded by the Per Diem Component. For supportive housing, the maximum amount payable under the per diem is \$48.50 per day per Veteran housed. Veterans in supportive housing may be asked to pay rent if it does not exceed 30 percent of the Veteran's monthly-adjusted income. In addition, "reasonable" fees may be charged for services not paid with Per Diem funds. The maximum hourly per diem rate for a service center not connected with supportive housing is 1/8 of the daily cost of care, not to exceed the current VA State Home rate for domiciliary care. Payment for a Veteran in a service center will not exceed 8 hours in any day.

Transitional Housing Applications: Applications are limited to up to one (1) transitional housing application per VA Medical Center (VAMC) catchment area per applicant's Employer Identification Number (EIN). Applications must include a minimum of five (5) transitional housing beds per model. Applications may include any combination of one, some or all transitional housing bed models. Choice of a model or combination of models is at the applicant's discretion. Applicants are encouraged to tailor the proposed model(s) to factors such as their own ability and the particular needs of the community. All housing model(s), site(s) and beds being proposed by the applicant for the VAMC catchment area must be included within a single application. If more than one (1) application per VAMC catchment area per applicant's EIN is received by the due date and time, VA will consider only one (1) application. VA reserves the right to select which application to consider based on the submission dates and times or based on other factors.

Applicants are encouraged to consider the need in their community for transitional housing models that are more focused (i.e., Bridge, Low Demand, Hospital-to-Housing and/or Clinical Treatment) over the transitional housing model that is more general (i.e., Service-Intensive). To that end, applicants may request up to 15 Service-Intensive beds per application. If more than 15 Service-Intensive beds are requested within the same application, then at least 60 percent of the additional beds beyond 15 must be for a transitional housing bed model(s) other than Service-Intensive. For example, an applicant applying for 50 total beds must allocate at least 21 of those beds to a housing model(s) that is not Service-Intensive (i.e., 50 total beds requested minus 15 Service-Intensive beds = 35 beds times 60 percent = 21 non-Service-Intensive beds, leaving 14 beds out of the total 50 beds for additional Service-Intensive beds and/or other beds at the applicant's discretion).

Service Center(s) Applications: Applications are limited to up to one (1) service center application per VAMC catchment area per applicant's EIN. Choice of site(s) and service(s) is at the applicant's discretion. Applicants are encouraged to tailor their proposed site(s) and service(s) to factors such as their own ability and the particular needs of the community. All service center(s) being proposed by the applicant for the VAMC catchment area must be included within a single application. If more than one (1) application per VAMC catchment area per applicant's EIN is received by the due date and time, VA will consider only one (1) application. VA reserves the right to select which application to consider based on the submission dates and times or based on other factors.

Note: Applications for transitional housing beds and applications for service center(s) do not have to include coverage for the entire VAMC catchment area in the application. The coverage area; however, must not exceed the VAMC catchment area identified in the application. If an applicant does not know their VAMC catchment area, they can contact the local medical facility: <https://www.va.gov/directory/guide/allstate.asp> and ask to speak with the Homeless Program.

Eligibility: To be eligible, an applicant must be a 501(c)(3) or 501(c)(19) non-profit organization, state or local government, or recognized Indian Tribal government that meets the requirements in 38 CFR 61.1. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling, services targeted towards specialized populations including homeless women Veterans, etc.) are eligible for these funds. The program has two levels of funding: the Grant Component and the Per Diem Component.

Questions: Questions may be sent to Jeff Quarles at [VA Grant and Per Diem Program](#).

NIMH Funding Opportunity Announcement

Implementing and Sustaining Evidence-Based Mental Health Practices in Low-Resource Settings to Achieve Equity in Outcomes (R34 Clinical Trial Required) – RFA- MH-20-401

Open Date (Earliest Submission Date) / Letter of Intent Date: January 24, 2020

Application Due Dates: February 24, 2020 & August 25, 2020, both , 5:00 p.m. Local Time of Applying Entity

Earliest Start Date: September 2020 & April 2021, respectively

This Funding Opportunity Announcement (FOA) supports pilot work for subsequent studies testing the effectiveness of strategies to deliver evidence-based mental health services, treatment interventions, and/or preventive interventions (EBPs) in low-resource mental health specialty and non-specialty settings within the United States. The FOA targets settings where EBPs are not currently delivered or delivered with fidelity, such that there are disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing, integration in the community, treatment of comorbid substance use disorders, etc.) for the population(s) served. Implementation strategies should identify and use innovative approaches to remediate barriers to provision, receipt, and/or benefit from EBPs and generate new information about factors integral to achieving equity in mental health outcomes for underserved populations. Research generating new information about factors causing/reducing disparities is strongly encouraged, including due consideration for the needs of individuals across the life span. Applications proposing definitive tests of an implementation strategy should respond to the companion R01 announcement RFA-MH-20-400.

This initiative supports pilot work in support of subsequent studies testing the effectiveness of strategies to deliver EBPs in low-resource settings in the United States, in order to reduce disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing, integration in the community, treatment of co-morbid substance use disorders, etc.) for the population(s) served. Of interest are settings where a significant number of children, youth, adults, or older adults with or at risk for mental illnesses can be found and evidence-based mental health treatments or services are not currently delivered. Applications focused on developmental work that would enhance the probability of success in subsequent larger scale projects are also encouraged.

Developmental work might include: refining details of the implementation approach; examining the feasibility of novel approaches and technologies; examining the feasibility of data collection including administration of instruments, obtaining administrative or other types of data, etc.; enhancing the protocol for the comparison group and randomization procedures (if appropriate); examining the feasibility of recruiting and retaining participants into the study condition(s); and developing and testing supportive materials such as training curricula. Therefore, collection of preliminary data regarding feasibility, acceptability and engagement of intervention targets is appropriate. However, given the intended pilot nature of the R34 activity code, conducting fully powered tests of outcomes or attempting to obtain an estimate of an effect size may not be feasible.

The goal of this FOA is to conduct pilot work in support of subsequent studies that develop test the effectiveness of scalable implementation strategies to achieve delivery of EBPs with high fidelity in low-resource settings and significantly improve clinical and functional outcomes toward greater equity with outcomes documented the general population studies.

Eligible Applicants

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

The following types of Higher Education Institutions are always encouraged to apply for NIH support as Public or Private Institutions of Higher Education:

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)

Nonprofits with and without 501(c)(3) IRS Status (Other than Institutions of Higher Education)

Small Businesses For-Profit Organizations Other Than Small Businesses

State Governments County Governments City or Township Governments Special District Governments

Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)

U.S. Territories or Possessions Independent School Districts Public Housing Authorities Indian Housing Authorities

Native American Tribal Organizations (other than Federally recognized tribal governments)

Faith-Based or Community-Based Organizations Regional Organizations

NOT Eligible to Apply: Non-domestic (non-U.S.) Entities (Foreign Institutions). . Non-domestic (non-U.S.) components of U.S. Organizations. Foreign components, as defined in the NIH Grants Policy Statement.



NIMH Funding Opportunity Announcement

Clinical High Risk for Psychosis Research Network (U01) - RFA-MH-20-340

Open Date (Earliest Submission Date) / Letter of Intent Date: December 31, 2019

Application Due Date: January 31, 2020, 5:00 p.m. Local Time of Applying Entity

Earliest Start Date: September 2020

Approximately 100,000 young persons in the United States experience a first episode of psychosis every year. During the same interval, it is estimated that over one million children and adolescents experience problems in perception, thinking, mood, and social functioning suggestive of a pre-psychosis risk state. Given the highly disruptive and disabling nature of psychotic disorders, early intervention has been recommended as a means of preventing psychosis onset among at-risk individuals, as well as averting other adverse outcomes such as mood syndromes, substance abuse disorders, and functional decline in social, academic, and vocational domains.

Researchers have noted that clinical heterogeneity within the CHR population presents a substantial challenge for intervention development. Approaches for addressing this heterogeneity to enable future intervention trials require the development of tools to address: (a) defining a core set of clinical and functional outcomes beyond onset of psychosis to include affective, cognitive, and negative symptom domains and functional outcomes; (b) prospective stratification of CHR individuals into more homogeneous risk subtypes to predict the likelihood of clinical outcomes; and (c) testing of interventions that target hypothesized underlying mechanisms for emerging psychosis, mood syndromes, and functional disability.

This FOA invites applications to establish a collaborative multi-site network(s) to rapidly recruit and characterize a sufficient number of CHR participants to dissect the heterogeneity of the CHR syndrome and predict differential outcomes. The tools and results generated from these studies are anticipated to advance intervention development and treatment for the CHR syndrome.

The ultimate outcome of project(s) funded under this FOA and companion RFA-MH-20-341 will be a set of validated tools - biomarkers, biomarker algorithms, and outcome measures - for selection of help-seeking/CHR subjects for enrollment in future clinical trials, to serve as readouts of early treatment effects, and/or to monitor disease progression and clinical and functional outcomes.

Eligible Applicants

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

The following types of Higher Education Institutions are always encouraged to apply for NIH support as Public or Private Institutions of Higher Education:

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)

Nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education)

Nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education)

Small Businesses

For-Profit Organizations Other Than Small Businesses

State Governments

County Governments

City or Township Governments

Special District Governments

Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)

U.S. Territories or Possessions

Independent School Districts

Public Housing Authorities

Indian Housing Authorities

Native American Tribal Organizations (other than Federally recognized tribal governments)

Faith-Based or Community-Based Organizations

Regional Organizations

Non-domestic (non-U.S.) Entities (Foreign Institutions) **are** eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations **are not** eligible to apply. Foreign components, as defined in the NIH Grants Policy Statement, **are allowed**.

NIMH Funding Opportunity Announcement

Clinical High Risk for Psychosis: Data Processing, Analysis, and Coordination Center (U24) - RFA - MH -20 - 341

Open Date (Earliest Submission Date) / Letter of Intent Date: December 31, 2019

Application Due Date: January 31, 2020, 5:00 p.m. Local Time of Applying Entity

Earliest Start Date: September 2020

This Funding Opportunity Announcement (FOA) invites applications for a CHR Data Processing, Analysis and Coordination Center (DPACC) to support and extend the work of the proposed Clinical High Risk for Psychosis Research Network to be funded under RFA-MH-20-340 . The DPACC will provide oversight and coordination of two parallel lines of inquiry: 1) The aggregation of extant CHR-related data sets and subsequent secondary analyses for refinement of multi-modal biomarkers and development of biomarker algorithms that predict individual clinical trajectory and outcomes and 2) the management, direction, and overall coordination, including data processing and analysis, for a new multi-site network(s) focused on dissecting the heterogeneity of the CHR syndrome. Toward achieving the first goal, the DPACC – in conjunction with NIMH and external working groups - will identify appropriate extant CHR data sets, aggregate and harmonize the data through development of a standardized processing and analysis pipeline for each data type, upload the data to the NIMH Data Archive (NDA), use computational techniques to identify and validate biomarker algorithms and/or risk calculators that predict the clinical trajectories and outcomes for individual patients, and establish a curated public data set that will serve as a resource for the research community.

Toward achieving the second goal of acquisition of new data via establishment of multi-site CHR cohort(s), the DPACC will provide the organizational framework for the management, direction, and overall coordination of a multi-site network(s) and will lead efforts, in conjunction with NIMH and external working groups to: (a) harmonize common data elements, standard measures, and uniform data collection procedures across multiple CHR/early psychosis research sites within the network; (b) assume responsibility for quality assurance and reliability assessments; (c) insure uniform standards for adverse event reporting, safety and protocol deviation monitoring; (d) build informatics infrastructure and pipelines necessary to gather, process and upload de-identified, patient-level data collected across all research sites to NDA; (e) develop data analysis, presentation, and reporting tools to facilitate analyses of clinical and biomarker data generated by the CHR networks described in RFA-MH-20-340 ; and (f) coordinate analyses of the newly acquired data for the identification of biomarkers or biomarker algorithms that are predictive of clinical trajectories and outcomes.

Eligible Applicants

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

The following types of Higher Education Institutions are always encouraged to apply for NIH support as Public or Private Institutions of Higher Education:

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)

Nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education)

Nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education)

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Faith-Based or Community-Based Organizations Regional Organizations

Non-domestic (non-U.S.) Entities (Foreign Institutions) **are not** eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations **are not** eligible to apply. Foreign components, as defined in the NIH Grants Policy Statement, **are allowed**.



National Institute on Drug Abuse Notice of Special Interest (NOSI):
Modeling Social Contagion of Substance Use Epidemics (NOT-DA-20-009)

Release Date: January 2, 2020

First Available Due Date: February 5, 2020

Expiration Date: January 8, 2023

The purpose of this Notice is to inform potential applicants to the National Institute on Drug Abuse (NIDA) of special interest in research projects involving the application of social network theory to study the social contagion of behaviors associated with substance use disorders that can provide insight into the prediction and prevention of the contagion of substance use epidemics. Applications should make use of large data sets and data science approaches to develop computational models of social networks to examine the association between social influence and substance use/misuse among individuals and their peers.

Background: Social contagion is the spread of affect or behavior from person to person and among larger groups. Social network theory (the study of how people, organizations, or groups interact with others inside their network) and its analysis have been a recent focus for public health issues. Although it has been primarily used to analyze and predict the transmission of infectious diseases, social network theory can also be applied to chronic behavioral conditions, including substance use disorders, as social factors and their interactions with age and sex are important determinants of substance use.

Research Objectives: NIDA is interested in projects that leverage big data sets and utilize machine learning algorithms to gain new knowledge related to the behaviors associated with substance use disorders and that will facilitate the prediction, prevention and response to epidemics of substance use disorders. Analyses should involve large datasets and data science approaches to develop computational models of social networks to examine how substance use/misuse and peer use/misuse is propagated among social networks.

Areas of programmatic interest to NIDA include, but are not limited to:

- Whether the next epidemic of substance use disorders/secular trends in substance use behaviors can be predicted with social network analysis (e.g., the crack epidemic of the 1990s and the current opioid epidemic)
- How social networks can be used to prevent epidemics related to or caused by substance use behaviors
- How social networks impact substance use, misuse, and recovery processes
- New or adapted interventions that leverage social networks to prevent substance use, misuse or support recovery processes
- Relationships between “in real life” and virtual social networks in influencing substance use behaviors and recovery
- Examination of multigenerational social network models that incorporate families and family structures as vectors of social influence, including effects of familial substance use behaviors
- The effects of peer substance use/misuse on individuals within their social network
- The influences of interpersonal networks and mass media on substance use, misuse, and recovery
- How network structures (e.g., the strength of ties) influence substance use, misuse, and recovery
- The role that social media plays in influencing substance use, misuse, and recovery
- How changes in social network composition and structure influence recovery processes
- Examination of how social network structure and composition among service providers (e.g., behavioral health providers, police, physicians) influence substance use behavior and recovery outcomes for people receiving services

Application and Submission Information: Submit applications for this initiative using one of the following funding opportunity announcements (FOAs) or any reissues of these announcements through the expiration date of this notice.

- [PA-19-056](#): NIH Research Project Grant (Parent R01 Clinical Trial Not Allowed)
- [PA-19-055](#): NIH Research Project Grant (Parent R01 Clinical Trial Required)
- [PA-19-091](#): NIH Research Project Grant (Parent R01 Basic Experimental Studies with Humans Required)
- [PA-19-052](#): NIH Small Research Grant Program (Parent R03 Clinical Trial Not Allowed)
- [PA-19-092](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Basic Experimental Studies with Humans Required)
- [PA-19-053](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Not Allowed)
- [PA-19-054](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Required)

Scientific/Research Contacts

Susan Wright, Ph.D., National Institute on Drug Abuse (NIDA), (301) 402-6683, susan.wright@nih.gov
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Financial/Grants Management Contact

Pamela G. Fleming, NIDA, (301) 480-1159, pfleming@nida.nih.gov

The Centers for Medicare & Medicaid Services (CMS) Seeks Members for Two Technical Expert Panels (TEPs):

- 1. Home and Community-Based Services (HCBS) Measures TEP; and**
- 2. Medicaid and Children's Health Insurance Program (CHIP) Scorecard Measures Gap Development TEP.**

CMS has contracted with The Lewin Group (Lewin) to work on a variety of measure development activities through a large project entitled Home and Community-Based Services Measure Development, Endorsement, Maintenance, and Alignment Contract. As part of its measure development process, Lewin will convene groups of stakeholders and experts for two distinct, unrelated TEPs that contribute direction and input during the development and maintenance lifecycle of measures covered under this scope of work. One TEP is focused on HCBS measurement development and the other TEP is focused on addressing gaps in the Medicaid and CHIP Scorecard across a variety of topics.

Each TEP will seat approximately 15 individuals, including HCBS providers, individuals or family members, representatives from stakeholder groups impacted by the measure(s), clinicians, state Medicaid and CHIP administrators, researchers, health information technology (IT) experts, and others with differing perspectives and areas of subject matter expertise.

- Subject matter expertise valuable to the **HCBS Measures TEP** includes: HCBS delivery and functional assessment items/data collection instruments used in HCBS settings (e.g., familiarity with the Functional Assessment and Standardized Items (FASI) or similar instruments, familiarity with eligibility determinations and reassessments); HCBS programs, person-centered planning, long-term services and supports (LTSS), systems, best-practice models, and assessment methods/tools, as well as knowledge of cross-walking efforts related to current health care assessment instruments; Experience of care within HCBS (e.g., familiarity with the Consumer Assessment of Healthcare Providers and Systems [CAHPS®] Home and Community Based Services Survey [HCBS CAHPS®] and similar instruments); Individual, family member, and caregiver perspective; Health IT and interoperability experience; Managed Long Term Services and Supports (MLTSS); Outcome measurement; and Quality improvement.
- Subject matter expertise valuable to the **Medicaid and CHIP Scorecard Measures Gap Development TEP** includes: Medicaid and/or CHIP quality and data reporting; Medicaid and/or CHIP adult healthcare quality issues; Individual beneficiary/family member (caregiver) perspective; Behavioral health; HCBS care and delivery; Outcome measurement; and Quality improvement

Both TEP nomination periods open on Thursday, December 12, 2019 and close on Thursday, January 16, 2020. Please submit all nomination materials by close of business (8:00 pm EST) on the closing date. [Additional information about the TEP and nomination requirements.](#)

Zero Suicide International 5

May 10 to 12, 2020, Anfield Stadium, Liverpool, UK
in Partnership with Mersey Care NHS Foundation Trust



Registration for the Zero Suicide International 5 Summit will open in November 2019!

Leaders from countries around the world came together in Rotterdam, the Netherlands in September 2018 for **Zero Suicide International 4**. As a result, the [2018 International Declaration](#) was produced with a video complement, [The Zero Suicide Healthcare Call to Action](#).

During the fifth international summit, our goal is to identify the three next key steps through inspiration, ideation, and implementation.

Please note a key change for 2020: Prior ZSI events have been invitation only. Our first three events in 2014, 2015, and 2017 were all part of the International Initiative for Mental Health Leadership (IIMHL) events and followed their small match meeting format (with 40 to 70 participants only), with Rotterdam in 2018 being the first ZSI event to stand on its own (over 100 leaders joined). For Liverpool 2020, we will partner with Joe Rafferty and, together with the Zero Suicide Alliance hosting up to 500 or more in the Liverpool Football Club. For the first time, no invitation will be required and all interested in advancing safer healthcare are welcome to join.

In order to ensure the Liverpool summit maintains the strong focus on networking and action steps of our prior more intimate convenings, we are working with the Flourishing Leadership Institute and their amazing team experienced in whole-system transformation. We'll be harnessing the complete power of the group's collective experience and imagination to drive forward the next successes in Zero Suicide Healthcare, and everyone who participates will be engaged.

Interested in becoming a sponsor? Contact karen.jones@riinternational.com at RI International or justine.maher@merseycare.nhs.uk at Mersey Care for details on available sponsorship packages. We're excited the American Foundation for Suicide Prevention has again committed their support and look forward to connecting with many others who will help us make this event and its outcomes a success.

David W. Covington, LPC, MBA
CEO & President

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CRA for Recovery Innovations, Inc.
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Get information on mental health services and resources near you, searchable by state or zip code:

www.samhsa.gov/find-help





The Holiday 2019 Issue of Signs of Mental Health Is Out

Vol 16, Number 4



In This Issue:

- Farewell to Associate Commissioner Baugher.
- Editor's Notes
- Dr. McCurry Tapped as New Associate Commissioner
- Brian A. Moss Joins ODS as New Visual Gestural Specialist
- An Open Letter to Fairview Health Services
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- LGBTQ Workshop Great Turnout
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- ODS Communication Skills Assessment Training 2019
- Notes and Notables
- Farewell Miranda Nichols
- ODS Winter Staff Meeting
- On the ODS Bookshelf
- ODS Directory
- Current Qualified Mental Health Interpreters
- Upcoming Workshops
- Help Wanted

FIND OUT MORE



NOW RECRUITING

CSC OnDemand: An Innovative Online Learning Platform for Implementing Coordinated Specialty Care

Combining the strongest components of OnTrack and the evidence-based Individual Resilience Training (IRT) of NAVIGATE, C4 Innovations is offering a new training in coordinated specialty care.

This is an ideal opportunity for teams to receive new or refresher training in CSC.

The tool will offer scalable, efficient professional development for CSC teams.

Now recruiting both new and already-established CSC teams interested in participating in a research study. Our goal is to **test our new training tool** with practitioners in the field. Your feedback will help us refine the tool, share what we learn, and **improve services for people experiencing first episode psychosis.**

What can teams EXPECT?

- Comprehensive, role-specific training for all team members, including peers, offered at no charge to teams
- Courses, consultation calls, and a community of practice led by experts in the field. See reverse for full list of expert trainers.
- Opportunity for refresher training for existing teams and teams with new members.
- Trainings will start in March of 2020
- Opportunity to provide critical feedback on a new CSC training tool

HOW CAN MY AGENCY TAKE PART?



Call our Research Coordinator, Effy: 347-762-9086
Or email: cscstudy@center4si.com





SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SM-20-07)

Funding Mechanism: Grant

Anticipated Number of Awards: 6 to 24

Length of Project: Up to 4 Years

Anticipated Total Available Funding: \$24,708,000

Anticipated Award Amount: \$1M to \$3M per year

Cost Sharing/Match Required?: Yes

Application Due Date: Monday, February 3, 2020

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (Short title: System of Care (SOC) Expansion and Sustainability Grants). The purpose of this program is to improve the mental health outcomes for children and youth, birth through age 21, with serious emotional disturbance (SED), and their families. This program will support the implementation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI).

Eligibility: Eligibility is limited to public entities, which refers to the following:

- State governments and territories (i.e., the District of Columbia; the Commonwealth of Puerto Rico; the Northern Mariana Islands; the Virgin Islands; Guam; American Samoa; the Republic of Palau; the Federated States of Micronesia; and the Republic of the Marshall Islands);
- Governmental units within political subdivisions of a state (e.g., county, city, town);
- Federally recognized American Indian/Alaska Native (AI/AN) tribal organizations, as defined in Section 5304(b) and Section 5304(c) of the Indian Self-Determination and Education Assistance Act.

Recipients that are currently funded under SM-17-001 or SM-19-009 are not eligible to apply for funding under this FOA.

Contacts:

Program Issues: Diane Sondheimer, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1922, diane.sondheimer@samhsa.hhs.gov.

Tanvi Ajmera, Center for Mental Health Services, SAMHSA, (240) 276-0307, tanvi.ajmera@samhsa.hhs.gov.

Grants Management and Budget Issues: Corey Sullivan, Office of Financial Resources, Division of Grants Management, SAMHSA, (240) 276-1213, FOACSAT@samhsa.hhs.gov.

Additional NASMHPD Links of Interest

[OPINION: WHY IS AMERICA SO DEPRESSED?](#), LEE SIEGEL, *NEW YORK TIMES*, JANUARY 2

[THE BURDEN OF MENTAL DISORDERS ACROSS THE STATES OF INDIA: THE GLOBAL BURDEN OF DISEASE STUDY 1990–2017](#), DANDONA R., PH.D., DANDONA L., M.D., M.P.H., & Vos T., M.D., M.Sc., PH.D., INSTITUTE FOR HEALTH METRICS AND EVALUATION, DECEMBER 20

[PTSD ASSOCIATED WITH BINGE EATING SYMPTOMS IN MEN AND WOMEN](#), PSYCHIATRY AND BEHAVIORAL HEALTH LEARNING NETWORK, DECEMBER 17 & [TRAUMA EXPOSURE, DSM-5 POSTTRAUMATIC STRESS, AND BINGE EATING SYMPTOMS: RESULTS FROM A NATIONALLY REPRESENTATIVE SAMPLE](#), BRAUN J., M.D., B.Sc., ET AL., *JOURNAL OF CLINICAL PSYCHIATRY*, DECEMBER 2019

[RESEARCHERS FIND NEURAL TARGET AREA FOR CBT IN PANIC DISORDER](#), *HEALIO PSYCHIATRY*, JANUARY 2 & [EFFECT OF CBT ON BIASED SEMANTIC NETWORK IN PANIC DISORDER: A MULTICENTER fMRI STUDY USING SEMANTIC PRIMING](#), YANG Y., PH.D., ET AL., *AMERICAN JOURNAL OF PSYCHIATRY*, DECEMBER 16

[DO SUBTLE COGNITIVE DEFICITS PRECEDE AMYLOID ACCUMULATION?](#), BETH E. SNITZ & ADAM M. BRICKMAN, *NEUROLOGY*, DECEMBER 30 & [OBJECTIVE SUBTLE COGNITIVE DIFFICULTIES PREDICT FUTURE AMYLOID ACCUMULATION AND NEURODEGENERATION](#), THOMAS K.R., PH.D., ET AL., *NEUROLOGY*, DECEMBER 30

[TRUMP TOUTED A NEW ANTIDEPRESSANT \[ESKETAMINE\] AS A SOLUTION FOR VETERANS. ONLY 15 HAVE BEEN TREATED](#), MEGAN THIELKING, *STAT*, JANUARY 6

[UPMC HEALTH PLAN LAUNCHES NEW DATA-BACKED SDOH INITIATIVE](#), DIANA MANOS, *HEALTH DATA MANAGEMENT*, JANUARY 6

[HEALTH INSURERS GET CREATIVE TO TACKLE BEHAVIORAL HEALTH CONDITIONS](#), BAILEY BRYANT, *BEHAVIORAL HEALTH BUSINESS*, JANUARY 3

[ONE-ON-ONE WITH TRUMP'S MEDICARE AND MEDICAID CHIEF: SEEMA VERMA](#), SARAH VARNEY, *KAISER HEALTH NEWS*, JANUARY 3



Agency for Healthcare
Research and Quality

Agency for Healthcare Research and Quality Funding Opportunity Announcement

Improving Management of Opioids and Opioid Use Disorder (OUD) in Older Adults (R18)



Letter of Intent Due: January 21, 2020

Application Due Date: February 20, 2020 by 5:00 p.m. Local Time of Applicant Organization

Earliest Start Date: Four (4) Months After Peer Review Date

The purpose of this FOA is to request applications to develop, implement, evaluate, and disseminate strategies to improve the management of opioid use and opioid use disorder (OUD) in older adults in primary care settings., *i.e* processes or activities to support the spectrum of care needed to: prevent potentially inappropriate prescribing and opioid misuse while ensuring the need for effective pain management is addressed; appropriately prescribe opioids when indicated; manage the care of opioid users to prevent adverse events and misuse; treat OUD when present..

AHRQ anticipates investing up to \$7.5 million over 3 years to support up to 3 awards.

The number of awards is contingent upon the submission of a sufficient number of meritorious applications and the availability of funds. Future year funding will depend on funding availability.

While older adults are typically defined to be persons aged 65 or older, AHRQ recognizes the potential limitations with this arbitrary definition and invites applicants to define the term "older adults" as they see appropriate for meeting the objectives of this FOA, if they provide a clear and convincing reason for why the different definition is will be more effective for meeting the objectives of the FOA.

Older adults are especially vulnerable to developing adverse events from opioids use, making safe prescribing more challenging even when opioids are an appropriate therapeutic choice. Biological changes associated with aging complicate management of opioids. Changes in metabolism in older adults enhance their risk of serious side effects such as overdose, dizziness, and/or delirium. Older adults often have multiple chronic conditions and take multiple medications that increase risk of side effects due to drug-disease and drug-drug interactions. For example, older adults are at higher risk for falls when opioids are co-administered with other medications that affect the central nervous system or when the person is frail and has had previous episodes of delirium

Identifying adverse effects due to opioid use, misuse or abuse is complicated further by factors such as co-occurring disorders that can mimic the effects of opioid use. There is also a risk of attributing clinical findings in older adults (e.g., personality changes, dementia, falls/balance problems, difficulty sleeping, and heart problems) to other conditions that are also common with age. If adverse events due to opioid prescriptions are identified, finding appropriate alternatives for pain management can be challenging if other pharmacologic options (e.g. NSAIDS, gabapentin) are contraindicated or mobility issues limit access to other therapeutic options. It can also be difficult to treat pain in persons with cognitive disorders (e.g. dementia, delirium, intellectual disabilities) where communication challenges exist.

Diagnosis of substance use disorders is also more complicated in older adults. Historically older adults have not experienced high rates of substance use disorders (SUDs); but there is some evidence these conditions have been under-diagnosed in older adults for many years. Clinicians may not associate substance use disorders with older adults or they may be inadequately trained in the identification and treatment of opioid misuse and OUD among older adults, and hence may not monitor for the signs of OUD or co-occurring SUDs in this population. Symptoms of OUD may be masked as part of the "aging" process or confused with other common diseases such as depression or dementia. Similarly, older persons may not seek help because they may not be aware that prescribed drugs can create dependence, or that treatment is available for OUD. Stigma is also an issue. Older patients may not report their concerns about their opioid use for fear of being labeled a "drug seeker" or "addicted. Substance use disorder treatment centers or programs are often designed to engage younger adults, which may present additional barriers.

Specific activities or tools utilized under this FOA might include, but would not be limited to, strategies to address needs and challenges associated with the following types of activities:

For patients for whom prescription of opioids may be considered (e.g., for pain management):

- Use of shared decision-making to support patient involvement in assessment of risk and benefits of treatment options (allow the physician and patient to jointly decide how the risks/benefits of opioids and other pain treatments align with their goals of care, and set realistic pain management expectations);
- Use of multi-modal pain management approaches;
- Use of risk mitigation strategies (e.g., time limited prescribing; developing plan for tapering and discontinuation of prescription at the time of initial prescribing as appropriate; naloxone distribution; prescribing medication for OUD if appropriate); and
- Use of other strategies to guide prescribing that mitigate risk for misuse or development of OUD.

For patients who are currently prescribed opioids for acute or chronic pain:

- Assessing whether opioid treatment is effective and whether the dose and duration is optimal;
- Use of shared decision-making to support patient involvement in assessment of risk and benefits of other available treatment options;
- Monitoring opioid use and identifying risk factors to prevent adverse events, misuse, diversion, or OUD;
- Determining whether tapering is appropriate and, if so, tapering and ensuring effective multimodal pain management; and
- Identification of the presence of opioid misuse or OUD in older adults, whether on prescription opioid therapy or not, and providing effective treatment. Identification of OUD should be based on careful assessment of validated criteria (i.e. using a Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (SCID) or Mini International Neuropsychiatric Interview (MINI) or other instrument to assess all symptoms).

(Continued on Next Page)



Agency for Healthcare Research and Quality Funding
Opportunity Announcement
**Improving Management of Opioids and Opioid Use
Disorder (OUD) in Older Adults (R18)**

(Continued from previous page) Applicants must:

1. Convene a team with: the expertise and experience to achieve the goals of this FOA; existing strong relationships with primary care practices; expertise in pain management, OUD, and geriatrics; experience with implementing quality improvement in primary care practices; and experience in disseminating and implementing findings from patient centered outcome research (PCOR).
2. Identify either a health system which provides primary care, or a network of primary care practices which care for older adults, and provide preliminary data to suggest that pain and opioid management in this population is suboptimal. Data might include, for example, hospitalizations rates related to opioids, lack of systems for assessing or monitoring opioid use, lack of procedures for multimodal pain or OUD management, etc. Applications are encouraged to consider including other settings...as long as the intervention is centered in primary care. Applications should include the influence of social risk and organizational factors in the development, implementation, and dissemination of strategies to improve the management of opioid use and OUD in older adults. Applications are also encouraged to select practices that include diverse populations in terms of socio-economic status, gender, race/ethnicity, and geography (including rurality). Descriptions of proposed implementation sites must include:
 - estimates of the number and percentage of older adults cared for;
 - opioid-related harm and adverse events resulting from opioid-misuse by older adults;and
 - current treatment of Opioid Use Disorder (OUD) among older adults.

If the cohort of practices to be recruited does not meet the above criteria (e.g., data demonstrating suboptimal pain and opioid management), the applicant must explain how the proposed intervention would lead to additional improvements.

3. Provide a preliminary assessment of the extent to which current efforts to improve pain management and optimize opioid use in the study practices specifically address older adults. Applicants should provide a description of any federal or state (SUD/OUD) funding that they currently receive and a description of how they will avoid duplication/overlapping of effort, science, and/or budgetary items and costs across awards.
4. Develop a comprehensive model or models for improving the management of pain, opioid use, and OUD for older adults in those primary care practices, in the context of person-centered management that acknowledges multiple chronic conditions as well as social risk factors. "Management" includes the entire continuum of care.... Proposed projects should consider all stages of management, although the intensity of intervention may vary by management stage, and should plan for sustainability. The project should integrate Department of Health and Human Services guideline recommendations (e.g., Centers for Disease Control and Prevention, National Institutes of Health), and findings from other relevant AHRQ projects related to opioids and pain management (<https://www.ahrq.gov/opioids/index.html>), and use evidence-based approaches where possible. AHRQ is interested in approaches that include Learning Health System models, shared decision-making (SDM), safe prescribing and risk mitigation practices, multimodal pain therapy for patients, leveraging existing health information technology or electronic health record systems, and adapting to meet the needs of specific populations of older adults. Models that engage relevant community-based organization(s) who serve older adults are also of interest.

We encourage use of innovative methods and study Mixed methods designs that include integrative approaches to examine qualitative and quantitative results together are encouraged. Innovative study designs such as agile and adaptive designs that address complexity are also encouraged.

5. Plan to recruit and engage at least 25 primary care practices, and provide necessary training and support to clinicians and practices in implementing the model.
6. Plan for a robust, multi-level intervention evaluation that will examine the effectiveness of the implemented model to improve opioid-related outcomes and pain outcomes among older adults while maintaining or improving other important measures of health and well-being. The evaluation should also describe the experience of primary care physicians and staff members in implementing the model, and lessons learned
7. Propose a dissemination plan (including a notification to AHRQ) of any related publications or events.
8. Provide a project timeline showing the major scheduled activities and milestones for the project, including:

Start-up activities (e.g., hiring and training staff)	Recruitment of primary care practices
Implementation initiation and completion	Evaluation plan Dissemination and Sustainability Plan

Eligibility: Eligible applicants include:

Public/State Controlled Institutions of Higher Education Private Institutions of Higher Education

The following types of Higher Education Institutions are always encouraged to apply for AHRQ support as Public or Private Institutions of Higher Education:

Hispanic-serving Institutions	Historically Black Colleges and Universities (HBCUs)
Tribally Controlled Colleges and Universities (TCCUs)	Alaska Native and Native Hawaiian Serving Institutions
Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)	

Nonprofits with and without § 501(c)(3) IRS Status (Other than Institutions of Higher Education)

State Governments County Governments City or Township Governments Special District Governments

Indian/Native American Tribal Governments (Federally and non-Federally Recognized)

Native American Tribal Organizations (other than Federally recognized tribal governments)

Eligible Agencies of the Federal Government U.S. Territories or Possessions

Faith-based or Community-based Organizations Regional Organizations

AHRQ's authorizing legislation does not allow for-profit organizations to be eligible to lead applications under this research mechanism. For-profit organizations may participate in projects as members of consortia or as subcontractors only. Because the purpose of this program is to improve healthcare in the United States, foreign institutions may participate in projects as members of consortia or as subcontractors only. Applications submitted by for-profit organizations or foreign institutions will not be reviewed. Organizations described in § 501(c) 4 of the Internal Revenue Code that engage in lobbying are not eligible.

Non-domestic (non-U.S.) Entities (Foreign Institutions) and non-domestic (non-U.S.) components of U.S. Organizations **are not** eligible to apply.

AHRQ Funding Opportunity Announcement Improving Quality of Care and Patient Outcomes During Care Transitions (R01)

Open Date (Earliest Submission Date): December 6, 2019

Application Due Date: February 5, 2020, 5:00 p.m. Local Time of Applying Entity

Earliest Start Date: October 2020

Transitions of care are the movements of patients between providers or clinical settings which typically occur when primary care providers refer patients to specialty care, or when patients are discharged from the hospital to subsequent care settings. During care transitions, critical information aimed to improve the patient's condition and health outcomes needs to be accurately communicated and coordinated between health professionals, the patient, and the family to ensure that safe, high-quality care is provided and care continuity is maintained.

This Funding Opportunity Announcement (FOA) invites R01 grant applications for funding health services research that improves the quality of care and patient outcomes during transitions of care. The purpose of this FOA is to support large-scale research projects that rigorously test promising interventions aimed at improving communication and coordination during care transitions.

The overarching objective for this FOA is to improve the quality of care and patient outcomes during care transitions. This FOA aims to support large-scale health services research projects that seek to test promising health information technology solutions to facilitate communication and care coordination as patients transition between providers, health care settings, and their communities.

Research should be designed to rigorously test solutions that enable or facilitate care transitions between providers, health care settings, and the community. A theoretical framework should inform the research study and incorporate the use of a [Care Transitions Model](#) (e.g., Chronic Care Model (CCM), Project Re-engineered Discharge (RED), Care Transitions Intervention (CTI), and INTERACT) when appropriate.

This FOA is focused on **three research areas of interest**. Examples of research projects responsive to this FOA include but are not limited to those expressed within the following research areas of interest:

Care transitions between primary care, acute care, and specialty providers - Finding required patient data at the point of care is too often an issue when multiple providers maintain different pieces of a patient's health data. When patients navigate between primary care and specialty care providers, data sharing and coordination of care are key ingredients to ensure that the care is value-based. Ineffective data sharing and care coordination can result in delayed diagnosis, medication errors, and even mortality. There is a need to (1) understand the types of information exchange that will optimize patient care during these transitions and (2) provide evidence-based, solutions to enable the exchange. AHRQ is interested in receiving applications that will rigorously test innovative solutions that facilitate data sharing and care coordination activities (i.e., care planning, medication reconciliation, referral tracking, and follow up appointment tracking) during care transitions between primary care, acute care, and specialty providers. AHRQ is also interested in understanding if the utilization of telehealth modalities requires different types of exchange and would welcome applications that conduct the care transition research when specialty care is provided via telehealth.

Care transitions between different institutional care settings - Information exchange is critical to high-quality care transitions between institutional care settings particularly between acute and post-acute care settings. Too often, patients are readmitted to acute care facilities just a few days after their admission to the post-acute setting. Additionally, patients often have hospital readmissions upon discharge from post-acute settings to home, which could be prevented with better information sharing and coordination. Employing better, evidenced-based solutions to facilitate information exchange between these care settings is required. AHRQ is interested in receiving applications that will rigorously test innovative solutions that facilitate communication and coordination for patients that are transferred between institutional care settings during care transitions and from these settings to home. AHRQ has a particular interest in improving care for MCC patients and would welcome applications that will rigorously test innovative solutions that facilitate the sharing of information about treatment decisions, care coordination, and care integration for MCC patients during various institutional care transitions.

Care transitions with a focus on patients, their families and communities - Patients, family care givers, and community resources including home care, long-term care services and supports are critical to maintaining optimum health during care transitions. There is a need to understand how new approaches can improve health outcomes by engaging patients and family caregivers and facilitating communication and coordination with needed community resources. AHRQ is interested in receiving applications that will rigorously test innovative solutions that support patient self-management activities during care transitions back home. AHRQ is also interested in applications that rigorously test innovative solutions that automatically link patient and family caregivers to community resources.

AHRQ recognizes there may be cases where grant applicants will propose research that crosses the research categories of interest mentioned above. The agency welcomes these research proposals for funding consideration.

Eligible Applicants

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

The following types of Higher Education Institutions are encouraged to apply for NIH support as Public or Private Institutions of Higher Education:

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)

Nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education)

State Governments County Governments City or Township Governments Special District Governments

Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)

U.S. Territories or Possessions Native American Tribal Organizations (other than Federally recognized tribal governments)

Faith-Based or Community-Based Organizations Regional Organizations



Department of Justice Funding Opportunity Announcements

Housing Assistance Grants for Victims of Human Trafficking (CFDA-16.320)

Funding Mechanism: Grant
Anticipated Number of Awards: 27
Length of Project: 36 Months
Application Due Date: Monday, February 3, 2020

Anticipated Total Available Funding: \$13,500,000
Anticipated Award Amount: \$500,000
Cost Match: 25 percent cash or in-kind match
Estimated Start Date: May 1, 2020

The U.S. Department of Justice (DOJ), Office of Justice Programs (OJP), Office for Victims of Crime (OVC) is seeking applications to support housing assistance for victims of all forms of human trafficking throughout the United States. This program furthers the Department's mission by enhancing the field's response to victims of human trafficking.

Eligibility

Pursuant to 22 U.S.C. § 7105(b)(2) the following entities are eligible to apply:

- 1) States and territories
- 2) Units of local government
- 3) Indian tribes
- 4) Nonprofit, nongovernmental victims' service organizations with the capacity to serve human trafficking victims (defined as an organization that is described in §501(c)(3) of Title 26 and is exempt from taxation under §501(a) of that title).

Nonprofit organizations holding money in offshore accounts to avoid paying the tax described in 26 U.S.C. § 511(a) are not eligible to apply.

OVC may make more than one award to a single organization if proposed projects are in distinct geographic areas. OVC will consider applications under which two or more entities would carry out the federal award; however, only one entity may be the applicant. Any others must be proposed as subrecipients ("subgrantees"). The applicant must be the entity that would have primary responsibility for carrying out the award, including administering the funding and managing the entire program.

Grants for Outreach and Services to Underserved Populations (CFDA-16.889)

Funding Mechanism: Grant
Anticipated Number of Awards: 10
Length of Project: 36 Months
Application Due Date: Monday, February 12, 2020

Anticipated Total Available Funding: \$4,500,000
Anticipated Award Amount: \$450,000
Registration & Letter of Intent Due: January 23, 2020
Estimated Start Date: October 1, 2020

Grants for Outreach and Services to Underserved Populations (Underserved Program) was authorized to develop and implement outreach strategies targeted at adult or youth victims of domestic violence, dating violence, sexual assault, or stalking in underserved populations and to provide victim services to those victims. Survivors from underserved populations face challenges in accessing comprehensive and effective victim services that fully meet their needs. As a result, survivors of these crimes from underserved communities often do not receive appropriate services. The Underserved Program supports projects to bridge these gaps. The purpose of all grants made by the Underserved Program is to provide or enhance population specific outreach and services to adult and youth victims in one or more underserved populations, including:

1. Working with federal, state, tribal, territorial and local governments, agencies, and organizations to develop or enhance population specific services.
2. Strengthening the capacity of underserved populations to provide population specific services.
3. Strengthening the capacity of traditional victim service providers to provide population specific services.
4. Strengthening the effectiveness of criminal and civil justice interventions by providing training for law enforcement, prosecutors, judges and other court personnel on domestic violence, dating violence, sexual assault, or stalking in underserved populations.
5. Working in cooperation with an underserved population to develop and implement outreach, education, prevention, and intervention strategies that highlight available resources and the specific issues faced by victims of domestic violence, dating violence, sexual assault, or stalking from underserved populations.

The term "population specific services" means victim-centered services that address the safety, health, economic, legal, housing, workplace, immigration, confidentiality, or other needs of victims of domestic violence, dating violence, sexual assault, or stalking, and that are designed primarily for and are targeted to a specific underserved population.

Eligible Applicants

1. Population specific organizations that have demonstrated experience and expertise in providing population specific services in the relevant underserved communities, or population specific organizations working in partnership with a victim service provider or domestic violence or sexual assault coalition.
2. Victim service providers offering population specific services for a specific underserved population.
3. Victim service providers working in partnership with a national, State, tribal, or local organization that has demonstrated experience and expertise in providing population specific services in the relevant underserved population.

Pre-Application Webinar: OVW will conduct an optional web-based pre-application information session for entities interested in submitting an application for this program. During this session, OVW staff will review this program's requirements, review the solicitation, and allow for a brief question and answer period. **The session is tentatively scheduled for Wednesday, January 15, 2020 from 2:00 p.m. to 4:00 p.m. E.T.**

Contact information: For technical assistance with submitting an application for either of these grants, contact the Grants.gov Customer Support Hotline at 800-518-4726, 606-545-5035, at <https://www.grants.gov/web/grants/support.html>, or at support@grants.gov. The Grants.gov Support Hotline operates 24 hours a day, 7 days a week, except on federal holidays.

New Training Offering

Group Training Course on the Mental Health Aspects of IDD for Mobile Crisis Responders

The Center for START Services (CSS) is pleased to announce a new 6-week web-based training course designed for mobile crisis responders who support individuals with IDD and mental health needs. The course will teach best practices in crisis assessment, response, and disposition and is highly recommended for the following providers:

- Mobile Crisis Responders, Clinicians & Supervisors
- Mental Health and/or IDD Case Managers /Service Coordinators
- Emergency Services Clinicians

The MHIDD Crisis Response course will be offered quarterly with the first **starting on January 14, 2020.**

Sessions are 75 minutes long and will take place each week on Tuesdays from 3:00 p.m. to 4:15 p.m. EST. The registration fee for this training course is \$149 per person and space is limited.

Course Learning Objectives:

- Identify how common mental health conditions may present in persons with IDD
- Identify the most common mental health conditions within the IDD population
- Clarify difference between presentation and conceptualization
- Apply skills and approaches learned within sessions to crisis assessments of individuals with MH/IDD
- Integrate information learned into disposition recommendations

Certificate of Completion Requirements: In order to receive a CSS Certificate of Completion for Training in Mobile Crisis Response for Persons with MH/IDD and 0.75 University of New Hampshire CEUs (7.5 contact hours), participants must:

- Attend each session via Zoom videoconferencing
- View/read weekly assigned materials before session date
- Complete weekly case vignette assignments
- Actively participate in each session
- Communicate with facilitator about any questions or feedback
- Complete pre-survey, evaluation & post-survey

[REGISTER HERE FOR THE MHIDD MOBILE CRISIS RESPONSE COURSE](#)

Please share this training announcement with partners in your community, outside your direct service area, as well as anyone that you think might benefit from this training. This is not a required training for any START teams but one that may enhance the capacity of mobile crisis providers in and around communities with START programs.



The National Center of Excellence for Eating Disorders (NCEED) was created to serve as *the* centralized hub dedicated to eating disorders education and training for both healthcare providers and the general public. NCEED is partnering with the 3C Institute to develop and launch an interactive, web-based, educational, training platform to ensure that high-quality trainings are provided to health professionals across multiple disciplines.

Visit NCEED's Website at <https://www.nceedus.org/>

NCEED is the nation's first center of excellence dedicated to eating disorders. It was founded in 2018 by the Substance Abuse and Mental Health Services Administration (SAMHSA), with the mission to advance education and training of healthcare providers and to promote public awareness of eating disorders and eating disorder treatment. Based at the University of North Carolina at Chapel Hill, NCEED includes clinicians, researchers, and advocates who specialize in eating disorders care and are committed to providing up-to-date, reliable, and evidence-based information.



The goal of NCEED is to ensure that all individuals with eating disorders are identified, treated, and supported in recovery. Though eating disorders are serious conditions, they can be identified and treated effectively—particularly when providers and the public have the knowledge and skills necessary to make a difference.

Information, Training, and Technical Assistance

The NCEED website (<https://www.nceedus.org/>) is designed to be user-friendly and easy to navigate for all users. The center's web platform is divided into four content areas based on the user's role. These content areas tailor the user's experience in searching for up-to-date, evidence-based trainings and resources.

We want to hear from you!

We are looking for individuals with lived experience related to **mental health conditions and developmental disabilities** to share their stories!



Your story is **important, valued, and respected**. We'd love to highlight your experience in video, podcast, or written format to bring about positive change.

If you are interested in being a part of this effort or have additional questions please contact Danielle Augustin deau222@uky.edu (859) 257-6086.

The Mental Health and Developmental Disabilities National Training Center (MHDD-NTC)



is pleased to announce the launch of their website! The MHDD-NTC is a collaboration between the University Centers for Excellence in Developmental Disabilities at the University of Kentucky, University of Alaska Anchorage, and Utah State University. Established in 2018 through funding provided by the Administration for Community Living, the training center aims to improve mental health services and supports for people with developmental disabilities. By serving not only as a training center, but also as a national clearinghouse, the training center helps provide access to the most current evidence-based, trauma-informed, culturally responsive practices that address the mental health needs of individuals with developmental disabilities. Please visit their website at <https://mhddcenter.org/>.

For more information on their upcoming trainings and efforts or contact them directly at info@mhddcenter.org.



National Center on Advancing Person-Centered Practices and Systems

NCAPPS assists states, tribes, and territories to transform their long-term care service and support systems to implement U.S.

Department of Health and Human Services policy on person-centered thinking, planning, and practices. It supports a range of person-centered thinking, planning, and practices, regardless of funding source. Activities include providing technical assistance to states, tribes, and territories; establishing communities of practice to promote best practices; hosting educational webinars; and creating a national clearinghouse of resources to support person-centered practice. [Visit the new NCAPPS website for more information.](#)

Each month, NCAPPS will host monthly informational webinars on a range of topics that relate to person-centered thinking, planning, and practice. NCAPPS webinars are open to the public, and are geared toward human services administrators, providers, and people who use long-term services and supports. Webinars will be recorded and archived on the NCAPPS website. All webinars will include a panelist who represents the perspective of service users, including our Person-Centered Advisory and Leadership Group members, self-advocates, or other stakeholders with lived experience with the topic.

January 2020	Linguistic Competence (includes Communication and Health Literacy) and Implications for Person-Centered Thinking, Planning, and Practice
February 2020	Person-Centered Practice in Managed Care: Roles and Developments (Part 1 of 2)
March 2020	Person-Centered Practice in Managed Care: Roles and Developments (Part 2 of 2)
April 2020	Inclusion & Belonging and Implications for Person-Centered Thinking, Planning, & Practice
May 2020	Person-Centered Thinking, Planning, and Practice in the No Wrong Door System (e.g., Aging and Disability Resource Centers, Centers for Independent Living, and Area Agencies on Aging)
June 2020	Can Measures of Person-Centered Thinking, Planning, and Practice Be Used to Nudge Providers and Systems to Be More Person-Centered?
July 2020	Applying Person-Centered Thinking, Planning, and Practice in Long-Term Care Settings
August 2020	Myths and Misperceptions about Financing Peer Support in Medicaid
September 2020	Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises
October 2020	Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice
November 2020	Person, Family, Clan, Community: Understanding Person-Centered Thinking, Planning, and Practice in Tribal Nations
December 2020	Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition



Target Audiences: Counselors, Nurses/Nurse Practitioners, Psychiatrists, Physicians (Non-Psychiatrists), Psychologists, Social Workers, and Peer Specialists/Peer Support

IMPROVING LIVES THROUGH EMPLOYMENT AND EDUCATION *FRIDAY, JANUARY 10, 12:00 P.M. TO 1:00 P.M. E.T.*

Over 60 percent of people with serious mental illness express an interest in employment yet less than 20% are employed, and only 2 percent have access to effective employment services. The evidence-based approach to supported employment, also known as Individual Placement and Support (IPS), includes 27 randomized controlled trials demonstrating that two to three times more people gain employment with IPS support when compared to usual stepwise employment services. In addition, many people and especially young adults want further education or training to advance their work lives. This webinar includes a description of supported employment and supported education principles and practices, a brief overview of the research, and identification of the roles of mental health practitioners, employment and education specialists, Vocational Rehabilitation counselors, family members, employers and educators to support people's work and school efforts **Presenter:** Deborah Becker, M.Ed., Westat

[**REGISTER HERE**](#)

SHARING CLINICAL NOTES WITH PATIENTS: BENEFITS, RISKS & CHALLENGES *THURSDAY, JANUARY 16, 3:00 P.M. TO 4:00 P.M.*

OpenNotes is an international effort where patients are given access to their medical records and clinical notes. Benefits of OpenNotes include increased patient engagement with care, adherence with medications, and satisfaction with care among many others. OpenNotes has been utilized in primary care, specialty care, and even mental health settings. Yet there is often more resistance in using OpenNotes for people with serious mental illness despite a lack of evidence for withholding it. This webinar will introduce the concept of OpenNotes, explore the evidence in mental health and SMI, review how OpenNotes can be trialed today often using patient portals, and suggest tips for how to use sharing of electronic medical records to improve overall care. **Presenter:** Charlotte Blease, Ph.D., Beth Israel Deaconess Medical Center/Harvard Medical School

[**REGISTER HERE**](#)

VIRTUAL LEARNING COLLABORATIVE : GETTING STARTED WITH TELEMENTAL HEALTH FOR SMI *COURSE SCHEDULE: JANUARY 6 TO MARCH 29*

This Virtual Learning Collaborative is ideal for all mental health clinicians across various practice settings.

Telehealth makes mental health care more accessible to individuals who have serious mental illness (SMI) and may otherwise not receive care. Learn how using telehealth services can create access to care, provide support in between visits, and improve outcomes for individuals who have SMI. Earn up to 12.0 AMA PRA Category 1 Credits™.

This 12-week, interactive learning experience gives you knowledge and skills to feel confident and ready to offer virtual care. You do not need experience or history with telehealth technology to take this course. Learn and apply new skills in important areas such as how to:

- Identify key factors that constitute a safe and effective telehealth service
- Ask the right questions if you want to convert your practice or organization to telehealth
- Understand what tools to consider when looking at telehealth systems
- Approach important topics that surround telehealth - professional ethics, cultural considerations, legal issues, billing practices and more
- Apply best practices from organizations who successfully use telehealth to provide care to individuals who have SMI

Participate in group calls, ask questions during virtual office hours, and share ideas on interactive discussion boards. Gain new skills to improve your clinical practice while you get real-time feedback and support from national experts. The time you invest in this learning collaborative helps you translate skills directly from concept into actionable care for individuals who have SMI.

[**REGISTER NOW**](#)

Accreditation - The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurse/Nurse Practitioner Accreditation - The American Psychiatric Nurses Association is accredited with distinction as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Funded by **SAMHSA**
Substance Abuse and Mental Health
Services Administration

Administered by **AMERICAN
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Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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A Free, New Resource for All Mental Health Professionals Who Treat Serious Mental Illness

SMI Adviser helps you provide better care and support to people who have serious mental illness (SMI). Connect with clinical experts and find evidence-based answers that support your clinical decisions for bipolar disorder, major depression, and schizophrenia. We invite you to access our free services right now!

FREE Education

SMI Adviser offers live webinars and dozens of on-demand courses on topics related to SMI. Hear evidence-based insights, participate in live Q&A with faculty, earn CME/NCPD/CE credits, and enhance your clinical practice with guidance from experts.



FREE Consultations

All mental health professionals can submit questions to our national experts on bipolar disorder, major depression, and schizophrenia. Receive guidance within one business day. It only takes two minutes to submit a question and it is completely confidential and free to use.

Ask us about psychopharmacology, therapies, recovery supports, patient and family engagement, comorbidities, and more.

FREE Resources and Guidance

Find answers to hundreds of clinical questions in SMI Adviser's Knowledge Base. All content is reviewed by our team of national experts from APA, Harvard, UCLA, Mental Health America, and more. Browse any subject area, ask a question to our interactive chatbot, or search for a specific topic.



Visit [SMIadviser.org](https://www.smiadviser.org)

**Let SMI Adviser help you provide evidence-based, person-centered care
to individuals who have SMI.**

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The Clozapine Center of Excellence

After 30 years, clozapine is still the best medication for treatment-resistant patients. Yet, it's often underutilized because clinicians, patients and families lack access to evidence-based practices around its use.

The Clozapine COE provides FREE resources, education, consultation, tools and more on the use of clozapine.



Sign up for the Clozapine COE listserv. Share best practices with other clinicians. Join the conversation.

FREE CME/CNE-certified online courses. Direct access to clozapine activities and upcoming events.



Visit SMIadviser.org/clozapine

Check Out the *SMI Adviser's* Clozapine Center of Excellence



Find answers. Access clinical tips that provide information on prescribing clozapine, managing side effects, coordinating blood testing, and more. Quick links to tips, tools and evidence-based data.

Request a FREE confidential consultation. Ask us about starting clozapine, adjusting clozapine dosage, blood testing requirements, management of side effects, and other issues.



Let SMI Adviser help you increase and improve the use of clozapine in individuals with treatment-resistant schizophrenia.

Visit SMIadviser.org/clozapine and join the conversation.



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Monday, January 13
2:00 p.m. to 3:00 p.m. E.T.

UNDERSTANDING THE FAMILY FIRST PREVENTION SERVICE ACT: IMPLICATIONS FOR TRIBAL PROGRAMS

The Family First Prevention Services Act was enacted into law in 2018, providing tribes and states with opportunities to receive funds for preventative services for eligible children and their caregivers. This law has established new opportunities to address trauma within Native children and families, but also contains new restrictions on how tribes and states can seek funding under the Title IV-E. Join us in the conversation with David Simmons, M.S.W., Government Affairs and Advocacy Director, National Indian Child Welfare Association.

[REGISTER HERE](#)

Thursday, January 23
1:30 p.m. to 3:00 p.m. E.T.

FAMILY ENGAGEMENT AND LEADERSHIP: STRENGTHENING SYSTEMS, SERVICES AND COMMUNITIES

Family engagement requires a top-down, bottom-up approach where their input permeates the culture of systems, organizations, and programs. Positive outcomes are more likely to be achieved when family engagement is systemic, integrated and comprehensive. Being strategic in how families interact can improve the effectiveness of service delivery in the mental health system. Join Presenter Pat Hunt, executive director of FREDLA, the national Family Run Executive Director Leadership Association, a non-profit union of leaders of grassroots family-run organizations across the nation, for this discussion

[REGISTER HERE](#)

MOVING UP THE LADDER: AUTHENTIC YOUTH ENGAGEMENT FOR POLICY AND SYSTEMS CHANGE

Centering the experiences and voices of youth and young adults is critical to transforming systems, dismantling harmful policies, and designing new ones that more effectively address their needs. How can systems addressing mental health and substance use move up the engagement ladder from consultation with youth to true partnership, shared decision making, and youth-led policy improvement? This webinar will share examples of youth engagement at different points on this continuum and push system leaders to move their organizations up the engagement ladder to achieve lasting system transformation.

[REGISTER HERE](#)

Tuesday, January 28
2:00 p.m. to 3:30 p.m.



2020 TRAINING INSTITUTES, JULY 1 TO 3, 2020 EARLY BIRD SAVINGS!

For more than 30 years, the Training Institutes, a biennial event, have been the premier convening of leaders in Children's Services. The 2020 Training Institutes, *What Could Be: Bolder Systems and Brighter Futures for Children, Youth, Young Adults, and their Families*, challenge us to build on existing delivery systems for Children's Services with new ideas to meet the future. Rescheduled from November 21.

[REGISTER HERE](#)



33RD ANNUAL RESEARCH AND POLICY CONFERENCE ON CHILD, ADOLESCENT, AND YOUNG ADULT BEHAVIORAL HEALTH

Since 1988, this annual conference has been a leader in promoting the development of the research base essential to improved service systems for children and youth with mental health challenges and their families. Known widely as "The Tampa Conference," this annual gathering of more than 700 researchers, evaluators, policymakers, administrators, parents, and advocates is sponsored by Child & Family Studies at the University of South Florida, in partnership with the Children's Mental Health Network, Morehouse School of Medicine, the National Wraparound Initiative, Casey Family Programs, Florida Institute for Child Welfare, Institute for Translational Research Education in Adolescent Drug Abuse, Transitions to Adulthood Center for Research, Pathways to Positive Futures, Child & Family Evidence Based Practice Consortium, Family-Run Executive Director Leadership Association, the National Technical Assistance Network for Children's Behavioral Health, and the Movember Foundation.

[REGISTER HERE](#)





SAMHSA's Early Serious Mental Illness Treatment Locator is a confidential and anonymous source of information for persons and their family members who are seeking treatment facilities in the United States or U.S. Territories for a recent onset of serious mental illnesses such as psychosis, schizophrenia, bi-polar disorder, or other conditions. These evidence-based programs provide medication therapy, family and peer support, assistance with education and employment and other services.

Individuals who experience a first onset of serious mental illness - which can include a first episode of psychosis - may experience symptoms that include problems in perception (such as seeing, hearing, smelling, tasting or feeling something that is not real), thinking (such as believing in something that is not real even when presented with facts), mood, and social functioning. There are effective treatments available and the earlier that an individual receives treatment, the greater likelihood that these treatments can lead to better outcomes and enable people to live full and productive lives with their family and friends.

SAMHSA has integrated data on first episode psychosis programs that was provided by NASMHPD and the NASMHPD Research Institute (NRI) into its existing treatment locator. Users receive information on Coordinated Specialty Care and other first episode psychosis programs operating in their state. This tool is designed to help quickly connect individuals with effective care in order to reduce the risk of disability.

YOU CAN ACCESS THE SMI TREATMENT LOCATOR [HERE](#)

Social Marketing Assistance Available

Social marketing resources for system of care communities were developed by the SAMHSA-funded Caring for Every Child's Mental Health Campaign team, which was a collaboration between NASMHPD, [Vanguard Communications](#) (link is external), [Youth MOVE National](#) (link is external), and the [Federation of Families for Children's Mental Health](#) (link is external). The Campaign was funded through Fiscal Year 2018. Below are a sampling of commonly-requested social marketing resources developed by the Campaign.

System of Care Cooperative Agreements that are currently funded by SAMHSA should seek social marketing technical assistance through the [University of Maryland's TA Network](#).

Other organizations or entities seeking social marketing technical assistance, including State Behavioral Health Agencies, are welcome to contact NASMHPD. Additional social marketing instructional materials, training, and consultation may be available. If you'd like to discuss your needs and/or have questions about how we can help, please contact [Leah Holmes-Bonilla](#). If you would like to submit a request for social marketing technical assistance or training from NASMHPD, please fill out [this application form](#).

Tip Sheets and Workbooks

Getting Started

- [Brand Development Worksheet](#)
- [Creating Your Social Marketing Plan](#)
- [Developing a Social Marketing Committee](#)
- [Social Marketing Needs Assessment](#)

Social Marketing Planning

- [Social Marketing Planning Workbook](#)
- [Social Marketing Sustainability Reflection](#)

Hiring a Social Marketer

- [Sample Social Marketer Job Description](#)
- [Sample Social Marketer Interview Questions](#)

Engaging Stakeholders

- [Involving Families in Social Marketing](#)
- [Social Marketing in Rural and Frontier Communities](#)
- [The Power of Partners](#)
- [Involving Youth in Social Marketing: Tips for System of Care Communities](#)
- [The Power of Telling Your Story](#)

NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS—2018

NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 *Beyond Beds* series of 10 papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

A 2018 10-paper follow-up to the *Beyond Beds* series is now up on the [NASMHPD website](#). The 2018 papers take the 2017 theme one step further, to look at specific services offered in the community and factors impacting those services,, covering such topics as early psychosis intervention, supportive housing and supported employment, suicide prevention for older persons, children’s crisis care coordination in the continuum of care, and trauma-informed interventions, as well as court-ordered referrals to determine competency to stand trial.

One of those papers, [*Experiences and Lessons Learned in States with On-Line Databases \(Registries\) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements*](#), authored by Robert Shaw of the NASMHPD Research Institute (NRI), reviews a 2017 NRI survey of the extent to which psychiatric bed registries-- a “centralized system that uses real-time tracking to monitor the availability of psychiatric beds” are being implemented in the United States. The study found that 16 states had bed registries and that an additional 8 states were in the process of planning or developing a bed registry. In just over one-half the states with bed registries (9 states), participation in the registry was voluntary and very few states reported having registries that were updated 24/7 with real-time information. The types of beds covered by the registries generally included beds in state and private hospitals, and general hospital psychiatric beds, but only a few covered crisis beds, either for mental illness or substance use disorders, or Veterans Administration beds.

The NASMHPD Technical Assistance Coalition series will continue in 2019.

Following are links to the other nine reports (in final draft) in the 2018 Technical Assistance Coalition series.

[**Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes**](#)

[**Weaving a Community Safety Net to Prevent Older Adult Suicide**](#)

[**Making the Case for a Comprehensive Children’s Crisis Continuum of Care**](#)

[**Achieving Recovery and Attaining Full Employment through the Evidence-Based IPS Supported Employment Approach**](#)

[**Changing the Trajectory of a New Generation: Universal Access to Early Psychosis Intervention**](#)

[**Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness**](#)

[**A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness**](#)

[**Medical Directors' Recommendations on Trauma-informed Care for Persons with Serious Mental Illness**](#)

[**Speaking Different Languages- Breaking Through the Differences in the Perspectives of Criminal Justice and Mental Health Stakeholders on Competency to Stand Trial Services: Part 1**](#)

Visit the Resources at NASMHPD's Early Intervention in Psychosis (EIP) Virtual Resource Center

These TA resources, developed with support from the U.S. Substance Abuse and Mental Health Services Administration, are now available for download!

[Windows of Opportunity in Early Psychosis Care: Navigating Cultural Dilemmas](#) (Oscar Jimenez-Soloman, M.P.H., Ryan Primrose, B.A., Hong Ngo, Ph.D., Ilana Nossel, M.D., Iruma Bello, Ph.D., Amanda G. Cruz, B.S., Lisa Dixon, M.D. & Roberto Lewis-Fernandez, M.D.)

Training Guides

Training Videos: Navigating Cultural Dilemmas About –

- 1. *Religion and Spirituality***
- 2. *Family Relationships***
- 3. *Masculinity and Gender Constructs***

[Transitioning Clients from Coordinated Specialty Care: A Guide for Clinicians](#) (Jessica Pollard, Ph.D. and Michael Hoge, Ph.D.)

[Best Practices in Continuing Care after Early Intervention for Psychosis](#) (Jessica Pollard, Ph.D. and Michael Hoge, Ph.D.)

Training Webinars for Receiving Clinicians in Community Mental Health Programs:

- 1. *Overview of Psychosis***
- 2. *Early Intervention and Transition***
- 3. *Recommendations for Continuing Care***

Addressing the Recognition and Treatment of Trauma in First Episode Programs (Andrea Blanch, Ph.D., Kate Hardy, Clin. Psych.D., Rachel Loewy, Ph.D. & Tara Neindam, Ph.D.)

[Trauma, PTSD and First Episode Psychosis](#)

[Addressing Trauma and PTSD in First Episode Psychosis Programs](#)

Supporting Students Experiencing Early Psychosis in Schools (Jason Schiffman, Ph.D., Sharon A. Hoover, Ph.D., Samantha Redman, M.A., Caroline Roemer, M.Sc., and Jeff Q. Bostic, M.D., Ed.D.)

[Engaging with Schools to Support Your Child with Psychosis](#)

[Supporting Students Experiencing Early Psychosis in Middle School and High School](#)

Addressing Family Involvement in CSC Services (Laurie Flynn and David Shern, Ph.D.)

[Helping Families Understand Services for Persons with Early Serious Mental Illness: A Tip Sheet for Families](#)
[Family Involvement in Programming for Early Serious Mental Illness: A Tip Sheet for Clinicians](#)

[Early Serious Mental Illness: Guide for Faith Communities](#) (Mihran Kazandjian, M.A.)

[Coordinated Specialty Care for People with First Episode Psychosis: Assessing Fidelity to the Model](#) (Susan Essock, Ph.D. and Donald Addington, M.D.)

***For more information about early intervention in psychosis, please visit
<https://www.nasmhpd.org/content/early-intervention-psychosis-eip>***

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