

National Association of State Mental Health Program Directors Weekly Update

Finnish Study Finds No Association Between Long-Term Antipsychotic Use and the Likelihood That a Patient Will Experience Severe Somatic Illness Leading to Hospitalization

A study published [January 10 in the journal World Psychiatry](#) reveals that long-term antipsychotic use does not increase the likelihood that a patient will experience severe illness leading to hospitalization.

The study led by Heidi Taipale, Ph.D., of the Karolinska Institute in Sweden sought to determine whether the shorter life expectancy of individuals with schizophrenia is partly due to the adverse effects associated with antipsychotics, such as weight gain, dyslipidemias, glucose metabolism dysregulation, and tardive dyskinesia. The researchers used data from a Finnish national hospital discharge registry on 62,250 patients treated for schizophrenia between 1972 and 2014, with up to 20 years of follow-up. The follow-up started on January 1, 1996. The follow-up time ended at death or on December 31, 2015, whichever occurred first. The median follow-up time was 14.1 years.

Mortality outcomes were adjusted for gender, age at cohort entry, year of cohort entry, time since diagnosis, number of prior psychiatric hospitalizations, temporal order of exposure to antipsychotics, other medication use, non-adherence, prior use of long-acting injectable (LAI) antipsychotics, prior suicide attempt, substance abuse, and physical comorbidities.

Dr. Taipale and her colleagues analyzed the association between periods of antipsychotic use and no antipsychotic use with hospitalization and/or death. Hospitalization was classified as either somatic hospitalization (all hospitalizations except psychiatric and cardiovascular hospitalizations) or “cardiovascular” hospitalization. Three causes of death were analyzed—all-cause mortality, cardiovascular mortality, and suicide death. During the follow-up, 13,889 (22.3 percent) persons in the cohort died, and 42,271 persons (67.9 percent) experienced somatic hospitalization.

At the start of follow-up, the median age was 45.6 years in the cohort. The proportion of males was 50.2 percent in the cohort. The prevalence of comorbid conditions at baseline in the cohort was 4 percent for alcohol or substance abuse, 4.8 percent for cardiovascular disease, 5.1 percent for diabetes, 0.2 percent for liver disease, and 0.8 percent for renal disease.

The authors of the study found no risk of somatic or cardiovascular hospitalization associated with periods of antipsychotic use in monotherapy that was greater than the risk during periods of non-use. Cardiovascular deaths, suicide deaths, and all-cause deaths were significantly lower in patients using any antipsychotics compared with those using no antipsychotics. Most of the specific antipsychotics in monotherapy were associated with a lower risk of death.

Cardiovascular mortality was significantly lower with any antipsychotic use than with non-use. No specific antipsychotic was associated with an increased risk of cardiovascular mortality.

Deaths were lowest for those individuals treated with clozapine. The cumulative mortality rates during 20-year follow-up were 46.2 percent for non-use, 25.7 percent for any antipsychotic use, and 15.6 percent for clozapine use, according to the reported study. The most beneficial mortality outcome was associated with use of clozapine in terms of all-cause, cardiovascular, and suicide mortality. The weakest mortality outcome— all-cause, cardiovascular, and suicide—was associated with levomepromazine.

Suicide mortality was significantly lower during antipsychotic use than with non-use. Several antipsychotics were associated with a reduced suicide mortality.

The researchers conclude:

Regarding physical morbidity, periods of antipsychotic use were not associated with an increased risk of somatic or cardiovascular hospitalizations. These findings on long-term outcomes may appear inconsistent with the adverse effects of short-term antipsychotic use. ... An explanation for this disconnect is likely to be the improved control of psychiatric symptoms associated with antipsychotic use, which in turn may lead to improved adherence to healthy lifestyle behaviors and utilization of health care services for physical illnesses.

Persons with schizophrenia have a greater prevalence of sedentary lifestyle, obesity and smoking, are less likely to receive adequate pharmacotherapy for hypertension and dyslipidemias, and are seldom tested for glucose and lipid alterations. This problematic general reduction in adequate secondary prevention of cardiovascular morbidity and mortality is likely aggravated in individuals with schizophrenia not taking antipsychotics.

There are several other possible mechanisms explaining the decreased mortality in patients receiving antipsychotic treatment. Antipsychotics reduce symptoms of schizophrenia, and this may be a major factor for decreased suicide mortality. Relief of stress may also have a beneficial effect on cardiovascular mortality. Smoking and high blood pressure are among the most important risk factors for cardiovascular death, and antipsychotics, especially clozapine, decrease blood pressure and possibly also the rate of smoking.



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[NASMHPD Board & Staff](#)



NEW!

NO PLACE LIKE HOME?

Critical Considerations in Residential Crisis Settings

THURSDAY
FEB. 27
12PM ET

Register at
CrisisResidentialNetwork.com

REGISTER HERE

Nearly 50 years ago, residential crisis treatment emerged as a psychiatric hospital alternative in a vastly different setting--in homes with features much like the neighboring houses occupied by people who are not in crisis. While the model has since been expanded and experimented with, the homelike environment remained constant up until recently as communities have begun building multi-function crisis centers in the same buildings.

In this webinar we gather national experts in residential crisis treatment to explore the extent to which residential crisis services should be provided in a home or homelike setting, and the implications of providing them anywhere else.

Moderator:

Travis Atkinson, Consultant, TBD Solutions

Panelists:

Steve Fields, Executive Director, The Progress Foundation, CA

Steve Miccio, Executive Director, People, USA, NY

Jaime Brewer, Director of Programs, Community Reach Center, CO



1 in 5 Adults with Major Depression Experience Suicidal Ideation Despite Treatment with SSRI and Tricyclic Antidepressants

One in five people with major depressive disorder (MDD) experience high or fluctuating suicidal ideation even after receiving 12 weeks of antidepressant treatment, according to a recent study published in the July 2019 Journal of Clinical Psychiatry.

The objective of the study, entitled *Trajectories of Suicidal Ideation During 12 Weeks of Escitalopram or Nortriptyline Antidepressant Treatment Among 811 Patients With Major Depressive Disorder*, was to identify trajectories of suicidal ideation among adults with major depressive disorder weekly during a 12-week treatment. Of the study's 811 participants, 458 were treated with the selective serotonin reuptake inhibitor (SSRI) escitalopram (trade name *Lexapro*) and 353 were treated with the tricyclic antidepressant (TAC) nortriptyline.

Dr. Trine Madsen, Ph.D., with Copenhagen University Hospital's Mental Health Center at the Capital Region of Denmark, lead author of the study and her colleagues identified five different classes of suicidal ideation during the twelve weeks of antidepressant treatment. Over one-half (53.7 percent) experienced no or low—categorized as persistent-low—levels of suicidal thoughts over the 12 weeks. The persistent-high class (9.8 percent) showed high suicidal ideation throughout the study period. About one-quarter (26.5 percent) of the participants—categorized as the fast-response class—reported high levels of suicidal ideation, similar to the persistent-high class, at the start of the study, but responded well to the antidepressants within a few weeks of treatment. This fast-

response class stayed at a low level of suicidal ideation throughout the course of treatment. However, two classes showed a fluctuating pattern: the fluctuating class (5.2 percent) ended at a low level of suicidal ideation and the slow-response-relapse class (4.8 percent) slowly started responding, but showed a high level of suicidal ideation after the 12 weeks.

The researchers found that past suicide attempts and higher severity of mood symptoms were strongly associated with poorer suicidal ideation trajectories. The authors noted, "The poor reduction in suicidal ideation in our study was related to worse antidepressant treatment responses in general, indicating that worse response on suicidal ideation might represent a more general treatment-resistant depression." However, patients living with a partner tended to respond better to treatment and show a reduced response to suicidal ideation.

Madsen and her colleagues conclude that the vast majority of patients showed an improvement in suicidal ideation during the course of antidepressant treatment, but that 20 percent of patients showed high or fluctuating suicidal ideation regardless of treatment. The authors recommend that future studies should explore more targeted pharmacological and/or psychological treatment options for patients with treatment-resistant depression and that future studies investigate whether such patients experience suicidal ideation for longer than 12 weeks.



NRI is Creating a 2020 State Mental Health Profile System - SMHA Information Sought



The NRI Board of Directors, primarily comprised of State Mental Health Agency (SMHA) Commissioners and their senior staff, has initiated a new State Profiles System (SPS) to provide SMHAs with up-to-date information about the financing and organization of state mental health systems. For over 20 years, NRI has been providing SMHAs information about the organization, funding, operation, services, policies, statutes, staffing, and clients of all SMHAs across the U.S. States, NASMHPD, and advocates use this information in budgeting, planning, and evaluating state mental health systems and in responding to requests from Governor's, Legislators, media, and advocates. The 2020 SPS Components were sent to all SMHAs on January 14, 2020 and responses are due from states by March 20, 2020. NRI will begin producing topical reports utilizing the Profiles data soon after state response are finalized.

The SPS components for 2020 were developed with guidance from an advisory group comprised of SMHA Commissioners, Planners, and program staff, as well as staff from NASMHPD and NRI. The 2020 SPS components build on prior years' components, but have been tailored to address new issues facing the states, and edited to ensure that only relevant information is included. Based on major policy topics raised by SMHA Commissioners and their senior staff, the 2020 SPS includes expanded components addressing Forensic Mental Health Services (including a focus on competency assessment and restoration activities in hospital and community settings), and a new Residential Continuum of Care component addressing housing options and supports provided by the SMHA for individuals with mental illness.

The updated 2020 SPS is a self-funded effort by the SMHAs that recognize the value in having access to an up-to-date, comprehensive database of comparable information about all SMHAs that states can use for budgeting, planning, and policymaking at the local, state, and national levels. Having access to this information will provide critical information to SMHA leadership and will reduce the burden on SMHAs of compiling information for decision makers, planners, researchers, and others through the availability of a centralized, standard compilation of information about the financing of SMHAs. To date, over half of the states have committed to helping fund this initiative.

Every state that completes the 2020 SPS Components will receive general reports showing state and national trends. However, states that financially support this initiative will also receive more expansive, customized state reports with additional details and trends. For more information about supporting this important initiative, please contact NRI's Executive Director/CEO, Tim Knettler at tknettler@nri-inc.org or 703-738-8160.

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: How New Jersey Is Using a PADs Registry to Give People Real-time Access

On June 27, 2019, the state of New Jersey launched a Psychiatric Advance Directives (PADs) Registry, giving anytime access to people in the state who want to participate. In the United States and internationally, mental health advance directives are back in the spotlight since the first came to be in the late 1990s and early 2000s. Partly, this is because acts passed at that time, like that which launched New Jersey's PADs Registry into existence, are beginning to come to fruition. It's also because of a great deal of back and forth over how to make PADs the most impactful. In our interview with Jeffrey Swanson, Ph.D., a psychiatry and behavioral sciences professor at Duke University, he shared that PADs must be both legally sufficient and available. He said for notable change to happen in the mental health field, there must be enough people with advance directives to reach critical mass so that the healthcare system has to deal with them. Otherwise, he said, "You might as well roll it up, put it into a bottle, and throw it into an ocean and hope someone finds it."

[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](#)

HHS Assistant Secretary for Planning and Evaluation Completes Environmental Scan of State Regulations Governing Residential Treatment for Behavioral Health Conditions

A [new report](#) by the Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE) on state regulation of Residential Treatment programs, prepared for ASPE by Truven/IBM, provides an environmental scan summarizing the oversight of adult residential care for mental health and substance use care in the United States.

Information for the report is obtained from national surveys (e.g., National Mental Health Services Survey [N-MHSS], National Survey of Substance Abuse Treatment Services [N-SSATS]), English-language peer-reviewed and grey literature, and subject matter experts. The literature search focused on the past five years, 2014-2018, but also included seminal papers and reports that were published prior to 2014 if subject matter experts identified them as key.

The NASMHPD Research Institute and the National Association of State Alcohol and Drug Abuse Directors helped to identify state regulations and facilitated state review and verification of the information summarized for the ASPE report.

The report excludes inpatient hospital care, facilities for those under age 18 years or over age 64 years, criminal justice facilities, and facilities specific to intellectual or developmental disabilities, except to the extent that they are combined with facilities providing residential care for persons with a mental health or substance use disorder (SUD).

The report reveals that, there were approximately 856 organizations in 2017 providing residential mental health treatment for adults in the United States and approximately 3,125 organizations providing residential substance use treatment in the U.S.

The range of conditions addressed in residential mental health facilities is broad, with most offering services for individuals with serious mental illness and many for co-occurring conditions. In the 2017 N-MHSS, 80 percent of adult residential treatment facilities offered psychotropic medications, 65 percent offered group psychotherapy, 60 percent offered individual psychotherapy, and 58 percent offered cognitive behavioral therapy.

Most of the mental health facilities are licensed by state departments of health or departments of mental health. Some also are licensed by state substance use agencies. The mental health field does not have a universally accepted assessment tool; instead, payers may use purchased or self-developed tools.

Most residential substance use facilities are licensed by their state substance use agency. Unlike mental health services, substance use treatment has a commonly used set of assessment and placement criteria. The American Society of Addiction Medicine (ASAM) has established criteria for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions, including levels of care that encompass residential treatment.

Pennsylvania High Court Hears Duty to Protect Case Where Treating Physicians Abandoned Involuntary Commitment

A plaintiff is [asking the Pennsylvania Supreme Court](#) to interpret a commonwealth law in a way that would ultimately force physicians who feared being sued to err on the side of providing involuntarily treatments for patients to whom they otherwise would have provided voluntarily outpatient care.

The original lawsuit, [rejected by the states' lower courts](#), stems from a 2012 mass shooting in the outpatient lobby of the Western Psychiatric Institute and Clinic (WPIC) in Pittsburgh. WPIC receptionist Kathryn Leight sued after outpatient John Shick shot her and several other people.

She and her husband are seeking damages from the University of Pittsburgh Physicians and University of Pittsburgh of the Commonwealth System of Higher Education and their primary care physicians who decided against involuntarily committing Mr. Shick after treating him. Testimony in the lower court revealed that the physicians began the involuntary commitment process for Mr. Shick—who had been walking around with a baseball bat and threatening people—but never completed it. Plaintiffs contend they showed gross negligence by failing to follow through on his involuntary commitment.

The Leights are seeking damages under the state Mental Health Procedures Act (MHPA), which provides physicians who treat mentally ill patients with limited immunity in cases of involuntary treatments. The law does not extend the protections to physicians who act with “willful misconduct or gross negligence.” The Leights contend the physicians acted with gross negligence

The physicians treating Mr. Shick considered whether he was a candidate for involuntary commitment, but after a clinical examination never found that he met that criteria. Mr. Shick never expressed suicidal or homicidal ideations and denied having them during examinations, court documents show. Physicians never found he presented an immediate threat, or that Leight was an identified or readily identified target.

The physicians, an American Medical Association (AMA) Litigation Center brief says, are not liable under traditional liability law. The brief says the court should not allow the lawsuit to go forward because the physicians only provided voluntary outpatient care, which means the MHPA does not apply. The Leights, the brief says, are attempting to trigger a statute that provides defendants with immunity in order to sue them, “turn[ing] the MHPA on its head.”

Beyond that, the brief concludes, “creating liability may result in compensation to Ms. Leight and her family, but it will not lead to a safer community or better mental health care. It could very easily have the opposite effect [of] putting more patients and others at greater risk.”



Scholarships for Disadvantaged Students Program – Technical Assistance

Apply Now

Apply for the [2020 Scholarship for Disadvantaged Students](#) – through March 3, 2020

Technical Assistance

Technical assistance helps you understand Scholarships for Disadvantaged Students (SDS) Program requirements.

Thursday, February 6, 2:00 p.m. - 3:30 p.m. E.T.

Thursday, February 20, 2:00 – 3:00 p.m. E.T.

Call (toll-free): 888-455-2923 | **Passcode:** 8103807

[Join the webinars](#)

Where does SDS funding go?

The SDS program funds academic institutions that are training health profession students. They then make the scholarship awards available to students.

Do you qualify for the SDS program?

Contact your financial aid office. You can find out if they participate and get more details.

What guidance helps SDS program applicants?

- [HRSA-16-069 Funding Opportunity Announcement: Scholarships for Disadvantaged Students](#) (PDF - 4.4 MB)
- [Poverty Guidelines](#) (U.S. Department of Health and Human Services)

NASMHPD Additional Links of Interest (Special Edition)

[SAMSHA GRANT AWARDS BY STATE FOR 2019 \(BY MAP\)](#)

[2019 NEW AND CONTINUATION GRANT AWARDS](#)

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT



Grants to Implement the National Strategy for Suicide Prevention (SM-20-014)

Funding Mechanism: Grant

Anticipated Total Available Funding: \$2 M

Anticipated Number of Awards: 5

Anticipated Award Amount: Up to \$400,000 per year

Length of Project: Up to 3 years

Cost Sharing/Match Required?: No

Application Due Date: Monday, March 23, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Grants to Implement the National Strategy for Suicide Prevention (Short Title: NSSP) grants. The purpose of this program is to support states and communities in advancing efforts to prevent suicide and suicide attempts among adults age 25 and older in order to reduce the overall suicide rate and number of suicides in the U.S. nationally. Addressing suicide prevention among adults is imperative to decreasing the nation's suicide rate.

Grantees must use SAMHSA's services grant funds primarily to support direct services. This includes the following activities:

- Implement initiatives to ensure greatest reach and system change.
- Develop and implement a plan for rapid follow-up of adults who have attempted suicide or experienced a suicidal crisis after discharge from emergency departments and inpatient psychiatric facilities. This must include directly linking up with selected emergency departments and inpatient psychiatric facilities to ensure care transition and care coordination services.
- Establish follow-up and care transition protocols to help ensure patient safety, especially among high risk adults in health or behavioral health care settings who have attempted suicide or experienced a suicidal crisis, including those with serious mental illnesses.
- Provide, or assure provision of, suicide prevention training to community and clinical service providers and systems serving adults at risk. Clinical training conducted should include assessment of suicide risk and protective factors, use of best practice interventions to ensure safety (including lethal means safety), treatment of suicide risk, and follow-up to ensure continuity of care. Applicants must measure changes in provider's competence/confidence in each of the clinical training areas.
- Incorporate efforts to reduce access to lethal means among individuals with identified suicide risk. This effort will be done consistent with all applicable federal, state, and local laws.
- Work across state and/or community departments and systems in order to implement comprehensive suicide prevention. Relevant state agencies should include, but are not limited to, agencies responsible for Medicaid; health, mental health, and substance abuse; justice; corrections; labor; veterans affairs; and the National Guard.
- Work with VHA Medical Centers and Community-Based Outpatient Clinics (CBOCs), state department of veteran affairs and national SAMHSA and VA suicide prevention resources to engage and intervene with veterans at risk for suicide but not currently receiving VHA services.

If your application is funded, you will be expected to develop a behavioral health disparities impact statement no later than 60 days after your award. SAMHSA also strongly encourages all recipients to adopt a tobacco/nicotine inhalation (vaping) product-free facility/grounds policy and to promote abstinence from all tobacco products (except in regard to accepted tribal traditions and practices).

Eligibility:

- State government agencies, including the District of Columbia and U.S. Territories. The State mental health agency or the State health agency with mental or behavioral health functions should be the lead for the NSSP grant.
- Community-based primary care or behavioral healthcare organizations
- Public health agencies
- Emergency departments
- Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations, and consortia of tribes or tribal organizations. (At least one award will be made to a tribe/tribal organization pending adequate application volume).

NSSP recipients funded under SM-17-007 are not eligible to apply for funding under this FOA

Contacts:

Program Issues: Michelle Cornette, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1213, michelle.cornette@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.

32nd Annual Tuerk Conference
on Mental Health & Addiction Treatment



Kevin Lindamood



Beth Macy



Ashish Alfred



Carlo C. DiClemente

2020 Vision Working Together

Sponsored by

The National Council on Alcoholism and Drug Dependence, Maryland
University of Maryland, School of Medicine, Department of Psychiatry
Division of Addiction Research and Treatment

Super Saver

\$165 includes
Lunch and
6 CEUs

We strongly encourage you to register online at our
[website](#) for the fastest and most efficient process.

Thursday, April 23, 2020

8:00 am – 5:00 pm

The Baltimore Convention Center
Pratt and Sharp Streets

Conference Sponsors

Premier

Ammon Analytical Laboratory

Platinum

Ashley Treatment Centers • Behavioral Health System Baltimore
Clinic Management and Development Services, Inc. (CMDS)
Delphi Behavioral Health Group • Gaudenzia, Inc.
Kolmac Outpatient Recovery Centers • Maryland Addiction Recovery Center
Maryland Center of Excellence on Problem Gambling • Medmark Treatment Centers
Mountain Manor Treatment Centers • Pathways / Anne Arundel Medical Center
Powell Recovery Center • Project Chesapeake • Recovery Centers of America
Recovery Network • Total Health Care • Tuerk House • Turning Point Clinic
University of Maryland, Drug Treatment Centers
University of Maryland Medical System, EAP
University of Maryland, Psychiatry, Division of Addiction Research and Treatment
Warwick Manor Behavioral Health

PSYCHIATRIC PHARMACISTS

Improving access, outcomes and cost



25%
shortage of
psychiatrists
by 2025

HRSA, 2017



44.7
million adults
experience
mental illness
in a given year

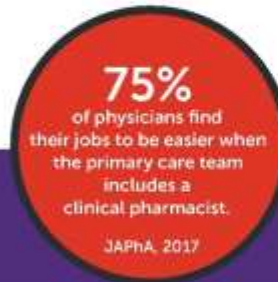
NIMH, 2018



\$225
billion are
spent on
mental health
annually

SAMHSA, 2014

Psychiatric pharmacists are advanced practice clinical pharmacists who specialize in mental health care. With an extensive knowledge of medication management, they are skilled at treating the whole patient. They strengthen the mental health team by working directly with patients, improving outcomes and saving lives.



PSYCHIATRIC PHARMACISTS ADD UNIQUE VALUE

Part of the team, part of the treatment.

In collaboration with the health care team, patients, and caregivers, psychiatric pharmacists:



PRESCRIBE* or recommend
appropriate medications



RESOLVE drug interactions



EVALUATE responses and
modify treatment



SUPPORT medication adherence



MANAGE medication
adverse reactions



PROVIDE medication education

*Prescriptive and practice authority varies by state and practice setting.



EXPANDED PHARMACY EDUCATION

- **6-8 YEARS** Undergraduate and Doctor of Pharmacy Degrees
- **1 YEAR** General Pharmacy Residency
- **1 YEAR** Psychiatric Residency
- **CERTIFY** by examination

☆ **Board Certified
Psychiatric Pharmacist (BCPP)**
(+ recertification every 7 years)

COMMON PLACES OF PRACTICE



Government supported hospitals or clinics (VA, Dept. of Defense, state)



Public, private, and academic hospitals



Outpatient mental health clinics



Outpatient primary care clinics



Prisons and correctional facilities

TYPES OF MEDICATION-RELATED PROBLEMS RESOLVED BY PHARMACISTS

Medication Management Systems, 2010



- **30.9%** Untreated condition
- **22.8%** Inadequate dose
- **13.5%** Poor adherence
- **12.6%** Adverse reaction
- **8.8%** Ineffective medication
- **5.8%** Unnecessary medication

38%

improvement in patient
depression response rates
when working with a
psychiatric pharmacist.
JPP, 2016

This information brought to you by the College of Psychiatric and Neurologic Pharmacists (CPNP), a professional association representing psychiatric pharmacists nationwide. Our members integrate into teams of health care professionals, making a difference in overall costs, treatment efficiencies, patient recovery and quality of life.

More information and references available at CPNP.org/392646.

cpnp

Agency for Healthcare Research and Quality (AHRQ) is Seeking Nominations for New Members of the U.S. Preventive Services Task Force (USPSTF)

The Agency for Healthcare Research and Quality (AHRQ) seeks nominations for new members to the U.S. Preventive Services Task Force (USPSTF). Since 1998, the Agency for Healthcare Research and Quality (AHRQ) has been authorized by Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support to the Task Force.

The USPSTF is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. The Task Force assigns each of its recommendations a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service. Section 2713 of the Affordable Care Act requires private insurers to cover preventive services recommended by the USPSTF with a grade of A or B, at no cost to the insured.

The Task Force does not consider the costs of a preventive service when determining a recommendation grade. The recommendations apply only to people who have no signs or symptoms of the specific disease or condition under evaluation, and the recommendations address only services offered in the primary care setting or services referred by a primary care clinician.

Each year, new members are appointed to replace those who will be completing their service. To learn more about the nomination process, how to nominate an individual for consideration, or how to self-nominate, go [here](#).

Nominations must be received by March 15, 2020 to be considered for appointment with an anticipated start date of January 2021.

Qualified candidates must demonstrate expertise and national leadership in:

- Clinical preventive services
- Critical evaluation of research
- Implementation of evidence-based recommendations in clinical practice

In addition, AHRQ seeks diverse candidates who have experience in public health; the reduction of health disparities; the application of science to health policy; and the communication of findings to various audiences.

**SAMHSA'S GAINS Center Seeks Experienced Trainers
to Participate in Trauma - Informed Responses
Train-The-Trainer (TTT) Event**
Applications Due Friday, February 21



SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA), is known nationally for its work regarding people with behavioral health needs involved in the criminal justice system. Each year, the GAINS Center provides its trauma-informed responses training, *How Being Trauma-Informed Improves Criminal Justice System Responses*, to the field via direct deliveries and Train-The-Trainer (TTT) events. The target audiences for the training program are primarily community-based criminal justice system professionals, including law enforcement, community corrections (probation, parole, and pre-trial services), court personnel, as well as human service providers that serve adult justice-involved populations.

To find out more about *How Being Trauma-Informed Improves Criminal Justice System Responses* training program, please visit the GAINS Center website here: <https://www.samhsa.gov/gains-center>

The GAINS Center is now soliciting applications from experienced trainers (individuals) who are interested in developing their capacity to provide trauma-informed training in their local agencies/communities via the GAINS Center's *How Being Trauma-Informed Improves Criminal Justice System Responses* training program. Selected applicants will learn to facilitate the training via a centralized Train-The-Trainer (TTT) event and subsequently deliver the training program in their local communities across the country. While not a requirement to apply to this opportunity, this year's training events will place special emphasis during the selection process on applicants who provide training to drug courts and/or re-entry programs.

The GAINS Center is offering this event to experienced trainers who successfully complete the application process at no cost to the participant. **While participants must cover their own travel expenses, there are no fees for registration, tuition, materials, or follow-up technical assistance and support associated with the event.** If this TTT event for individuals is of interest to you, please review the solicitation and submit your completed application form to the GAINS Center no later than **February 21, 2020**.

Don't miss this exciting opportunity to become the local "expert" in this training program for your agency or community!

To download the solicitation for the *How Being Trauma-Informed Improves Criminal Justice System Responses* TTT Event for Individual Trainers, [click here](#)

There are three TTT events scheduled for **June 10-11, July 22-23 & August 12-13, 2020** at the Sage Colleges in Albany, NY, so please note the dates before applying. You will be expected to attend one of these full two-day trainings.

We thank you in advance for your interest, and look forward to reviewing your application.

*SAMHSA's GAINS Center for Behavioral Health and Justice Transformation Funded by the
Substance Abuse and Mental Health Services Administration.*

**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](#)



Don't miss out on all #ADAA2020 has to offer! The conference includes 150+ sessions highlighting cutting-edge research and clinical practice treatment concepts centered around anxiety, depression, and co-occurring disorders. With a wide offering of innovative presentations and workshops eligible for CE or CME credits or hours, the 2020 annual conference is the place to be March 19-20, 2020 in San Antonio, Texas. [Register today](#) to gain access to great learning and networking opportunities and to benefit from the lowest rate available.

Not a member? [Join now](#) to take advantage of these low registration rates and receive a year of [ADAA member benefits](#).

Is your practice or institution planning to send more than 4 attendees to #ADAA2020? Click [here](#) to learn how you can qualify for additional savings through Group Registration. (Group registration is only available to current ADAA members.)

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



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



Please reserve your room prior to February 24, 2020.

Scaife Medical Student Fellowship in Substance Use Disorders

2020 APPLICATIONS NOW OPEN!

Scaife Medical Student Fellowship in Substance Use Disorders

An intensive learning experience about addiction and its treatment far beyond anything students may have encountered in their prior medical school education or clinical rotations.

Two available sessions:

- SESSION 1: JUNE 8 - 26, 2020
- SESSION 2: JULY 6 - 24, 2020

Program consists of:

- Lectures
- A variety of site visits
- Patient contact
- Group sessions with clients
- Training with standardized patients
- Shadowing with residents and physicians
- Opportunities to present what students have learned



We are now accepting for the 2020 Scaife Fellowship! The application period closes February 28.

We are excited to announce that the application period for the 2020 Scaife Medical Student Fellowship in Substance Use Disorders is now open! The specialized program offers medical students an intensive learning experience about addiction and its treatment. Medical students interested in all specialties, not only addiction medicine, are encouraged to apply! Please share with any colleagues, friends, or anyone else you know who may be interested.

LEARN MORE & APPLY

January 27 Webinar || #SDOH || @NIHCMfoundation
1:00 p.m. to 2:30 p.m. E.T.

SOCIAL DETERMINANTS OF HEALTH **Technology and Workforce Approaches**



The social determinants of health - defined as the conditions in which people are born, grow, live, work and age - influence 50% of health outcomes. Recognizing that addressing unmet social needs can have an outsized impact in improving health, leaders are leveraging technology and nonmedical professionals to meet people where they are.

This webinar will explore:

- A national initiative bringing together public health stakeholders to systematically implement and sustain social determinants of health efforts
- An innovative federal model testing whether addressing health-related social needs of Medicare and Medicaid beneficiaries improves outcomes
- How a health plan is partnering with social workers to help patients with housing, transportation, utilities and more

REGISTER HERE

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Comprehensive Opioid Recovery Center (TI-20-006)



Funding Mechanism: Grant

Anticipated Total Available Funding: \$1,900,000

Anticipated Number of Awards: 2

Anticipated Award Amount: Up to \$850,000 per year

Length of Project: Up to 4 years

Cost Sharing/Match Required?: No

Application Due Date: Tuesday, March 17, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2020 Comprehensive Opioid Recovery Centers Program. The CORC Program is authorized under § 7121 of the SUPPORT Act for Patients and Communities. The purpose of the program is the operation of comprehensive centers which provide a full spectrum of treatment and recovery support services to address the opioid epidemic.

Activities required in the CORC program are clearly identified in § 7121 of the SUPPORT Act. The following activities are required by recipients:

- Treatment and recovery services. Each Center shall:
 - Ensure that intake, evaluations, and periodic patient assessments meet the individualized clinical needs of patients, including by reviewing patient placement in treatment settings to support meaningful recovery.
 - Provide the full continuum of treatment services, including:
 - a. all drugs and devices approved or cleared under the Federal Food, Drug, and Cosmetic Act and all biological products licensed under § 351 of this Act to treat substance use disorders or reverse overdoses, pursuant to Federal and State law;
 - b. medically supervised withdrawal management, that includes patient evaluation, stabilization, and readiness for and entry into treatment;
 - c. counseling provided by a program counselor or other certified professional who is licensed and qualified by education, training, or experience to assess the psychological and sociological background of patients, to contribute to the appropriate treatment plan for the patient, and to monitor patient progress;
 - d. treatment, as appropriate, for patients with co-occurring substance use and mental disorders;
 - e. testing, as appropriate, for infections commonly associated with illicit drug use;
 - f. residential rehabilitation, and outpatient and intensive outpatient programs;
 - g. recovery housing;
 - h. community-based and peer recovery support services;
 - i. job training, job placement assistance, and continuing education assistance to support reintegration into the workforce; and
 - j. other best practices to provide the full continuum of treatment and services, as determined by the Secretary.
 - Ensure that all programs covered by the Center include medication-assisted treatment, as appropriate, and do not exclude individuals receiving medication-assisted treatment from any service;
 - Periodically conduct patient assessments to support sustained and clinically significant recovery, as defined under Data Collection Requirements;
 - Provide onsite access to medication, as appropriate, and toxicology services;
 - Operate a secure, confidential, and interoperable electronic health information system; and
 - Offer family support services such as child care, family counseling, and parenting interventions to help stabilize families impacted by substance use disorder, as appropriate.
- Outreach - Each Center shall carry out outreach activities regarding the services offered through the Centers which may include:
 - training and supervising outreach staff, as appropriate, to work with State and local health departments, health care providers, the Indian Health Service, State and local educational agencies, schools funded by the Indian Bureau of Education, institutions of higher education, State and local workforce development boards, State and local community action agencies, public safety officials, first responders, Indian Tribes, child welfare agencies, as appropriate, and other community partners and the public, including patients, to identify and respond to community needs;
 - ensuring that the entities described above are aware of the services of the Center; and
 - disseminating and making publicly available, including through the internet, evidence-based resources that educate professionals and the public on opioid use disorder and other substance use disorders, including co-occurring substance use and mental disorders.

Eligibility: Eligibility is statutorily limited to domestic nonprofit organizations which provide substance use disorder treatment.

Contacts:

Program Issues: Tracy Weymouth, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-0142, tracy.weymouth@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

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

Funding Mechanism: Grant

Anticipated Number of Awards: 14

Length of Project: 4 years

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

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

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.



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](#)



WEBSITE FOR THE SAMHSA-SPONSORED

Center of Excellence for Protected Health Information

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENTS

Disaster Response Grant Program – School-Based Services (SG-20-003)

Funding Mechanism: Grant

Anticipated Number of Awards: 70

Length of Project: 18 months

Anticipated Total Available Funding: \$70 million

Anticipated Award Amount: From \$1M for 18 months

Cost Sharing/Match Required?: No

Application Due Date: Wednesday, February 12, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for Fiscal Year (FY) 2020 Disaster Response Grant Program – School-Based Services. The purpose of this program is to provide mental and substance use disorder treatment, crisis counseling, and other related supports to children in school-based settings impacted by Hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, and wildfires and earthquakes occurring in Calendar Year 2018 and tornadoes and floods occurring in Calendar Year 2019 in those areas for which a major disaster or emergency was declared under § 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5170 and § 5191) (referred to under this heading as “covered disaster or emergency”), including activities authorized under § 319(a) of the Public Health Service Act. SAMHSA recognizes the impact natural disasters can have, particularly on youth, and is providing funding to mitigate this impact.

Eligibility: Eligible applicants are domestic public and private nonprofit entities in affected areas. Affected Areas include those impacted by: Hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, and wildfires and earthquakes occurring in Calendar Year 2018 and tornadoes and floods occurring in Calendar Year 2019 in those areas for which a major disaster or emergency was declared under § 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170 and 5191) (referred to under this heading as “covered disaster or emergency”), including activities authorized under section 319(a) of the Public Health Service Act.

Contact: Program & Grant Management and Budget Issues:

Odessa Crocker, Office of Financial Resources, Division of Grants Management, Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1078, odessa.crocker@samhsa.hhs.gov.

Disaster Response Grant Program – Services for Adults (SG-20-004)

Funding Mechanism: Grant

Anticipated Number of Awards: 30

Length of Project: 18 months

Anticipated Total Available Funding: \$30 million

Anticipated Award Amount: From \$1M for 18 months

Cost Sharing/Match Required?: No

Application Due Date: Wednesday, February 12, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for Fiscal Year (FY) 2020 Disaster Response Grant Program – School-Based Services. The purpose of this program is to provide mental and substance use disorder treatment, crisis counseling, and other related supports to adults impacted by Hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, and wildfires and earthquakes occurring in Calendar Year 2018 and tornadoes and floods occurring in Calendar Year 2019 in those areas for which a major disaster or emergency was declared under § 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5170 and § 5191) (referred to under this heading as “covered disaster or emergency”), including activities authorized under § 319(a) of the Public Health Service Act. SAMHSA recognizes the impact natural disasters can have and is providing funding to mitigate this impact.

Eligibility: Eligible applicants are domestic public and private nonprofit entities in affected areas. Affected Areas include those impacted by: Hurricanes Florence and Michael, Typhoon Mangkhut, Super Typhoon Yutu, and wildfires and earthquakes occurring in Calendar Year 2018 and tornadoes and floods occurring in Calendar Year 2019 in those areas for which a major disaster or emergency was declared under § 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. § 5170 and § 5191) (referred to under this heading as “covered disaster or emergency”), including activities authorized under § 319(a) of the Public Health Service Act.

Contact: Program & Grant Management and Budget Issues:

Odessa Crocker, Office of Financial Resources, Division of Grants Management, Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1078, odessa.crocker@samhsa.hhs.gov.



SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

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

Funding Mechanism: Grant

Anticipated Number of Awards: 1

Length of Project: Up to 5 years

Anticipated Total Available Funding: \$800,000

Anticipated Award Amount: \$800,000 per year

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)

Small Businesses For-Profit Organizations Other Than Small Businesses

State Governments County Governments City or Township Governments Special District Governments

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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
Peter Hartsock, Ph.D., NIDA, (301) 402-1964, peter.hartsock@nih.gov

Financial/Grants Management Contact

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

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 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.

Nominate a Dr. Jan Mokkenstorm International Zero Suicide Visionary Award Winner

This year's International Zero Suicide Summit will be bittersweet as our first without our beloved colleague Jan Mokkenstorm. During the Summit in Liverpool, the first annual Jan Mokkenstorm Zero Suicide Visionary Award will be presented in his honor. Below is information on the award and instructions for nominating someone. We look forward to seeing everyone in Liverpool and remembering Jan's contributions to making sure no one dies alone and in despair.

Dr. Jan Mokkenstorm played an integral part of the inaugural International Zero Suicide Summit with the International Initiative for Mental Health Leadership match in Oxford in 2014. In subsequent years, Dr. Mokkenstorm attended the International Zero Suicide Summits in Atlanta (2015), and Sydney (2017) in his continued commitment to the global Zero Suicide Movement. He provided vital participation in the collaborative development of the "International Declaration for Better Healthcare: Zero Suicide" in 2015. He also continued the push for the initiative to "move beyond the tipping point" by hosting the 4th international Zero Suicide Summit in Rotterdam in 2018.

Jan demonstrated his passionate commitment to reducing suicides through his tireless efforts to promote the belief that suicides should never be an event that occurs. Through visionary leadership he inspired countless others to join this cause themselves on an individual, organizational, and community level. He was instrumental in spreading the global adoption of the Zero Suicide mission as well as set the pace for innovation and substantial change in many countries across the globe. Simply put, Jan demonstrated exceptional service to the betterment of society through his work with Zero Suicide and suicide prevention.

Nomination Requirements

1. Must have shown national/international leadership in the area of suicide prevention
2. Must have participated in fostering substantial change and innovation in the area of suicide prevention
3. Must have challenged/helped shape government policies and supported a wider awareness and discussion around suicide prevention
4. Must be in attendance at the International Zero Suicide Summit when the award will be presented
5. Must have two (2) letters of recommendation from recognized suicide prevention leaders in one's home country

Judging

1. The announcement of nominations will be handled by the host nation in conjunction with other communications about the Zero Suicide Summit
2. The host nation will convene a Nomination Committee of three individuals who will review the nominations and award one winner

If you have nominations or would like to participate, please contact Becky Stoll, Vice President, Crisis and Disaster Management at becky.stoll@centerstone.org.

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Centers for Medicare & Medicaid Services
Request for Information
[CMS-2324-NC] RIN: 0938-ZB57

Coordinating Care from Out-of-State Providers for Medicaid-Eligible Children with Medically Complex Conditions

This is a request for information (RFI) to seek public comments regarding the coordination of care from out-of-state providers for Medicaid-eligible children with medically complex conditions. We wish to identify best practices for using out-of-state providers to provide care to children with medically complex conditions; determine how care is coordinated for such children when that care is provided by out-of-state providers, including when care is provided in emergency and non-emergency situations; reduce barriers that prevent such children from receiving care from out-of-state providers in a timely fashion; and identify processes for screening and enrolling out-of-state providers in Medicaid, including efforts to streamline such processes for out-of-state providers or to reduce the burden of such processes on them. We intend to use the information received in response to this RFI to issue guidance to state Medicaid directors on the coordination of care from out-of-state providers for children with medically complex conditions.

DATES: Comments: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [insert date 60 days after date of publication. This document is scheduled to be published in the *Federal Register* on 01/21/2020 and is available online at <https://federalregister.gov/d/2020-00796>, and on www.govinfo.gov the *Federal Register*].

ADDRESSES: In commenting, refer to file code CMS-2324-NC..

The Medicaid Services Investment and Accountability Act of 2019 (MSIA) (Pub. L. 116-16, enacted April 18, 2019), added § 1945A to the Act, which authorizes a new optional Medicaid health home benefit. Under § 1945A of the Act, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions who choose to enroll in a health home. States will submit State Plan Amendments (SPAs) to exercise this option, which permits them to specifically target children with medically complex conditions as defined in § 1945A(i) of the Act. States will receive a 15 percent increase in the federal match for their expenditures on § 1945A health home services during the first two fiscal year quarters that the approved health home SPA is in effect, but under no circumstances may the federal matching percentage for these services exceed 90 percent. Among other required information, states must include in their § 1945A SPAs a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

To qualify for health home services under § 1945A of the Act, children with medically complex conditions must be under 21 years of age and eligible for Medicaid. Additionally, they must either: (1) have at least one or more chronic conditions that cumulatively affect three or more organ systems and that severely reduce cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also require the use of medication, durable medical equipment, therapy, surgery, or other treatments; or (2) have at least one life-limiting illness or rare pediatric disease as defined in § 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

§ 1945A(i)(2) of the Act defines a chronic condition as a serious, long-term physical, mental, or developmental disability or disease. Qualifying chronic conditions listed in the statute include cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, and serious emotional disturbance or serious mental health illness. The Secretary may establish higher levels as to the number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for health home services under § 1945A of the Act.

Under § 1945A(i)(4) of the Act, health home services for children with medically complex conditions must include the following list of comprehensive and timely high-quality services:

- Comprehensive care management;
- Care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- Patient and family support, including authorized representatives;
- Referrals to community and social support services, if relevant; and
- Use of health information technology (HIT) to link services, as feasible and appropriate.

These services are very similar to the health home services described in § 1945 of the Act, with some variations to reflect the targeted population for § 1945A health homes.

Section 1945A of the Act does not limit the ability of a child (or a child's family) to select any qualified health home provider as the child's health home. Per § 1945A(i)(5) of the Act, designated providers may be:

- A physician (including a pediatrician or a pediatric specialty or subspecialty provider), children's hospital, clinical practice or clinical group practice, prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) (as those terms are defined in 42 CFR 438.2);
- A rural clinic;
- A community health center;
- A community mental health center;
- A home health agency; or

(Continued on Next Page)

[THE FOLLOWING NOTICE IS ABBREVIATED FOR YOUR CONVENIENCE]



Centers for Medicare & Medicaid Services Request for Information [CMS-2324-NC] RIN: 0938-ZB57

Coordinating Care from Out-of-State Providers for Medicaid-Eligible Children with Medically Complex Conditions

(Continued from Previous Page)

- Any other entity or provider that is determined by the state and approved by the Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation that the entity has the systems, expertise, and infrastructure in place to provide health home services. Designated providers may include providers who are employed by, or affiliated with, a children's hospital.

B. Guidance on Coordinating Care from Out-of-State Providers.

Under § 1945A(e) of the Act, the Secretary must issue guidance to state Medicaid directors by October 1, 2020 on:

- Best practices for using out-of-state providers to provide care to children with medically complex conditions;
- Coordinating care provided by out-of-state providers to children with medically complex conditions, including when provided in emergency and non-emergency situations;
- Reducing barriers that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion; and
- Processes for screening and enrolling out-of-state providers, including efforts to streamline these processes or reduce the burden of these processes on out-of-state providers.

Under § 1945A(g)(2)(B) of the Act, states with an approved § 1945A State Plan Amendment must submit to the Secretary, and make publicly available on the appropriate state website, a report on how the state is implementing the guidance issued under § 1945A(e) of the Act, including through any best practices adopted by the state. The required report must be submitted no later than 90 days after the state's § 1945A SPA is approved. § 1945A(e)(2) of the Act directs the Secretary to issue this request for information (RFI) as part of the process of developing the required guidance, to seek input from children with medically complex conditions and their families, states, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care provided by out-of-state providers to children with medically complex conditions.

We are soliciting general comments on the coordination of care provided by out-of-state providers including but not limited to primary care providers, pediatricians, hospitals, specialists, and other health care providers or entities who may provide care for Medicaid-eligible children with medically complex conditions. We are specifically seeking input on these topics as they relate to urban, rural, Tribal, and medically underserved populations, as barriers and successful strategies may vary by geography. We also seek input on these topics with respect to both Medicaid fee-for-service and Medicaid managed care arrangements. Therefore, in responding to these comments, please differentiate between Medicaid fee-for-service and Medicaid managed care arrangements, as appropriate.

- We are seeking public comment on any best practices for using out-of-state providers to provide care to children with medically complex conditions, including specific examples of what has and has not worked in the commenter's experience.
- We are seeking public comment about coordinating care from out-of-state providers for children with medically complex conditions, including when care is provided in emergency and non-emergency situations. Discussion of specific examples of what has and has not worked, in the commenter's experience, is especially welcome.
- We are seeking information about any state initiatives that have promoted and/or improved the coordination of services and supports provided by out-of-state providers to children with medically complex conditions.
- We are seeking public comment related to administrative, fiscal, and regulatory barriers that states, providers, beneficiaries, and their families experience that prevent children with medically complex conditions from receiving care, including community and social support services, from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.
- We are seeking public comment related to barriers that prevent caregivers from accessing or navigating care from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.
- We are seeking public comment related to individual financial barriers (for example, costs of travel, lodging, and work hours lost) that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.
- We are seeking public comment on successful methods to inform caregivers of children with medically complex conditions about ways to access care from out-of-state providers.
- We are seeking public comment on any measures that have been, or could be employed by states, providers, health systems and hospitals to reduce barriers to coordinating care for children with medically complex conditions when receiving care from out-of-state providers.
- We are seeking public comment related to processes that states could employ for screening and enrolling out-of-state Medicaid providers, in both emergent and non-emergent situations, including efforts to streamline these processes or reduce the administrative and fiscal burden of these processes on out-of-state providers and states.
- We are seeking public comment on challenges with referrals to out-of-state providers for specialty services, including community and social supports, for children with medically complex conditions and the impact of these challenges on access to qualified providers.
- We are seeking public comment on best practices for developing appropriate and reasonable terms of contracts and payment rates for out-of-state providers, for both Medicaid fee-for-service and Medicaid managed care.



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

Certified Community Behavioral Health Clinic Expansion Grants (SM-20-12)

Funding Mechanism: Grant

Anticipated Number of Awards: 98

Length of Project: Up to 2 Years

Anticipated Total Available Funding: \$197 million

Anticipated Award Amount: Up to \$2M per year

Cost Sharing/Match Required?: No

Application Due Date: Tuesday, March 10, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2020 Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants (Short Title: CCBHC Expansion Grants). The purpose of this program is to increase access to and improve the quality of community mental and substance use disorder treatment services through the expansion of CCBHCs. CCBHCs provide person- and family-centered integrated services. The CCBHC Expansion grant program must provide access to services including 24/7 crisis intervention services for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid use disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring mental and substance disorders (COD). SAMHSA expects that this program will provide comprehensive 24/7 access to community-based mental and substance use disorder services; treatment of co-occurring disorders; and physical healthcare in one single location.

Eligibility: Certified community behavioral health clinics or community-based behavioral health clinics who may not yet be certified but meet the certification criteria and can be certified within 4 months of award. Recipients funded under SM 18-19 in 2019 are not eligible to apply for this funding opportunity, since those organizations will be implementing a second year of grant funding at the time of award of this announcement. Those entities whose CCBHC-Expansion grant funding is ending by September 2020 are eligible to apply., ,

Contacts:

Program Issues: Nancy Kelly, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1839, nancy.kelly@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.



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.



Call for Conference Presentation Submissions

2020 Annual Conference on Advancing School Mental Health



Conference Theme: *Equitable and Effective School Mental Health*
October 29 to 31, 2020
Marriott Baltimore Waterfront Hotel, Baltimore, Maryland

Hosted by the [National Center for School Mental Health \(NCSMH\)](#)
at the University of Maryland School of Medicine
Division of Child and Adolescent Psychiatry

Submission Deadline: Midnight (PST), Monday, February 24, 2020
All proposals must be submitted online.

Download the [2020 Annual Conference Request for Proposals](#) for detailed instructions. Additionally, **we strongly recommend** downloading the [Word proposal template](#) to prepare your proposal for online submission: type your responses into the Word document and once fully completed, begin your online submission.

If you experience any difficulties, please contact the NCSMH:
Phone: 410-706-0980
Email: ncsmh@som.umaryland.edu

Web: [Annual Conference on Advancing School Mental Health](#)

Get information on mental health services and resources near you, searchable by state or zip code:

www.samhsa.gov/find-help



SAMHSA
Substance Abuse and Mental Health
Services Administration

Behavioral Health Treatment Services Locator

HHS.gov



**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
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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
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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
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Faith-based or Community-based Organizations	Regional Organizations
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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.



Training.
Educating.
Leading.



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.

February 26, 2020 3:00 to 4:30 p.m. E.T.	Building Capacity Using Family-Centered Approaches to Promote the Best Life for Young Children with Disabilities: An Innovative Family-to-Family Program REGISTER HERE
March 2020	Person-Centered Practice in Managed Care: Roles and Developments
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

TREATMENT CONSIDERATIONS FOR TRANSITIONAL-AGE YOUTH WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES AND CO-MORBID SMI

THURSDAY, JANUARY 30, 3:00 P.M. TO 4:00 P.M. E.T.

This webinar will discuss treatment considerations for transitional-age youth with intellectual/developmental disabilities and co-morbid SMI. It will review the common co-morbid medical conditions in this population that can influence the choice in therapeutic agent, as well as the current evidence and guidelines available to guide clinical decision-making.

Presenter: Rebecca McCloskey, PMHNP-BC, Boston Psychiatric Care.

[**REGISTER NOW**](#)

THE WORK IS ONLY AS GOOD AS THE TEAM: STRATEGIES FOR DEVELOPING A STRONG INTERPERSONAL TEAM COLLABORATION

FRIDAY, FEBRUARY 7, 12:00 P.M. TO 1:00 P.M. E.T.

Effective teamwork is the cornerstone of the development and promotion of interprofessional collaboration. When teams come together, their ability to work toward health and wellness for service participants, families, and communities are stronger than any individual efforts. In this webinar strategies to promote interprofessional collaboration and team work will be presented using lessons learned from Assertive Community Treatment in New York.

Presenter: Helle Thorning, Ph.D., Clinical Professor of Psychiatric Social Work (in Psychiatry) at Columbia University

[**REGISTER NOW**](#)

STRATEGIES FOR SUCCESS: USING LONG-ACTING INJECTABLE MEDICATIONS

THURSDAY, FEBRUARY 14, 3:00 P.M. TO 4:00 P.M. E.T.



Effective teamwork is the cornerstone of the development and promotion of interprofessional collaboration. When teams come together, their ability to work toward health and wellness for service participants, families, and communities are stronger than any individual efforts. In this webinar strategies to promote interprofessional collaboration and team work will be presented using lessons learned from Assertive Community Treatment in New York.

Presenter: Yvonne Yang, MD, PhD, UCLA Semel Institute for Neuroscience and Human Behavior

[**REGISTER NOW**](#)

PEER SUPPORT IN TRANSITIONING FROM CRISIS CARE: VARIATIONS ON THE NYAPRS PEER BRIDGER MODEL

THURSDAY, FEBRUARY 27, 3:00 P.M. TO 4:00 P.M. E.T.



Transitioning from a short-term crisis stay or a longer-term hospitalization for psychiatric problems is a difficult time. In 1994 the New York Association for Psychiatric Rehabilitation Services (NYAPRS) developed a peer support program to assist people experiencing long term or frequent hospitalizations in transitioning back to life in the community. The program was designed to have peer support workers build positive and trusting relationships with individuals in hospital setting and then to follow the person back into the community, post discharge, providing support and connections to community resources. The Bridger program has continued to evolve over the years and can now be found around the country, serving people being discharged from hospitals, crisis stays, and emergency departments. This webinar will examine the core principles of the Bridger model and its use in transitioning levels of care and supporting people in their journeys to recovery.

Presenter: Patrick Hendry, Mental Health America

[**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.



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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.

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The Clozapine COE is a special community, made up of people who share a common goal: to improve the use of clozapine in the lives of patients. Join the community and share your experiences.

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

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- Clozapine blood levels
- Constipation side effect of clozapine
- Is weight gain a problem with clozapine, and what can be done?
- How does one dose or titrate clozapine dosage when starting on this medication?
- Medication interactions with clozapine

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

Request a Consultation

Get a FREE confidential consultation with an expert on starting clozapine, adjusting clozapine dosage, blood testing requirements, management of side effects, and other issues. Request your consultation today.

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

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](#)

Thursday, January 30
1:00 p.m. to 2:30 p.m. E.T.

LEARNING FROM THE STRIVE FOR WELLNESS PROGRAM: USING MODULAR APPROACHES TO CHR OUTREACH AND SERVICE DELIVERY

Dr. Jason Schiffman, Professor of Psychology and Director of Clinical Training at the University of Maryland, Baltimore County, will describe the Strive for Wellness (SFW) CHR-P clinic in Maryland, a state/university partnership embedded within the Maryland Early Intervention Program. Evolving from an outreach, assessment and research clinic, with the support of the SAMHSA CHRP grant, SFW has grown to include psychosocial and psychopharmacological care. Taking an evidence-based, youth/ family-driven, and flexible approach to care, the SFW model uses a strengths-based approach when partnering with clients to reach their stated goals in treatment.

This presentation will describe:

- 1) the clinic's research,
- 2) its recruitment strategies,
- 3) its staffing model, and
- 4) its modular treatment approach.

He will also describe and provide resources that may be useful for CHR and first episode programs, and discuss opportunities for the CHR team to collaborate with other CHRP sites.

[REGISTER HERE](#)



Thursday, February 6
1:30 p.m. to 3:00 p.m. E.T.

MOVING FORWARD: USING THE NATIONAL CLAS STANDARDS TO ADDRESS SOCIAL JUSTICE AND HEALTH EQUITY

The National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) were developed as a tool to enforce Title VI of the Civil Rights Act of 1964. This history positions the National CLAS Standards as an effective tool for advancing health equity and improving social justice. This webinar will focus on understanding the history of the CLAS Standards and learning how they can be used to advance health equity and social justice by improving access and effectiveness.

[REGISTER HERE](#)



2020 TRAINING INSTITUTES, JULY 1 TO 3, 2020

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. The "Tampa Conference gathers than 700 researchers, evaluators, policymakers, administrators, parents, and advocates. It 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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NASMHPD Links of Interest

[PANICKING ABOUT YOUR KIDS' PHONES? NEW RESEARCH SAYS DON'T](#), NATHANIEL POPPER, *NEW YORK TIMES*, JANUARY 18 & [ANNUAL RESEARCH REVIEW: ADOLESCENT MENTAL HEALTH IN THE DIGITAL AGE: FACTS, FEARS, AND FUTURE DIRECTIONS](#), ODGERS C.L & JENSEN M.R., *JOURNAL OF CHILD PSYCHOLOGY AND PSYCHIATRY*, JANUARY 17
[PSYCHIATRIC MEDS DURING PREGNANCY: HOW I NAVIGATED A MINEFIELD](#), JENNIFER POLLOCK, *WASHINGTON POST*, JANUARY 20
[COGNITIVE DECLINE MAY BE ACCELERATED IN ADULTS WITH PSYCHOTIC DISORDERS](#), *PSYCHIATRY AND BEHAVIORAL HEALTH LEARNING NETWORK*, JANUARY 13 & [LONG-TERM CHANGES IN COGNITIVE FUNCTIONING IN INDIVIDUALS WITH PSYCHOTIC DISORDERS: FINDINGS FROM THE SUFFOLK COUNTY MENTAL HEALTH PROJECT](#), FETT A-K.J., PH.D., ET AL., *JAMA PSYCHIATRY*, DECEMBER 11, 2019
[CANNABIS AND PSYCHOSIS THROUGH THE LENS OF DSM-5](#), PEARSON N.T. & BERRY J.H., *INTERNATIONAL JOURNAL OF ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH* VIA U.S. NATIONAL LIBRARY OF MEDICINE, NATIONAL INSTITUTES OF HEALTH, OCTOBER 28, 2019
[VOICE-ANALYSIS APPLICATION ASSESSES WELL-BEING OF PATIENTS WITH SERIOUS MENTAL ILLNESS](#), *HEALIO PSYCHIATRY*, JANUARY 20 & [CLINICAL STATE TRACKING IN SERIOUS MENTAL ILLNESS THROUGH COMPUTATIONAL ANALYSIS OF SPEECH](#), AREVIAN A.C., ET AL., *PLOS ONE*, JANUARY 15
[BLOG: NEW CLOUD LIBRARY OFFERS CURATED OPIOID USE RESOURCES](#), ALLISON LEOF, *THE MILBANK QUARTERLY*, JANUARY 21
[STATE TELEHEALTH MEDICAID FEE-FOR-SERVICE POLICY A HISTORICAL ANALYSIS OF TELEHEALTH: 2013 – 2019](#), CENTER FOR CONNECTED HEALTH POLICY, NATIONAL TELEHEALTH POLICY RESOURCE CENTER, JANUARY 2020
[PET DOGS IN CHILDHOOD MAY LOWER SCHIZOPHRENIA RISK](#), *PSYCHIATRY AND BEHAVIORAL HEALTH LEARNING NETWORK*, JANUARY 14 & [EXPOSURE TO HOUSEHOLD PET CATS AND DOGS IN CHILDHOOD AND RISK OF SUBSEQUENT DIAGNOSIS OF SCHIZOPHRENIA OR BIPOLAR DISORDER](#), YOLKEN R.H., M.D. ET AL., *PLOS ONE*, DECEMBER 2, 2019
[STUDY SHOWS BENEFITS OF LONG-TERM ANTIPSYCHOTIC USE FOR PATIENTS WITH SCHIZOPHRENIA](#), *PSYCHIATRIC NEWS ALERT*, JANUARY 16 & [20-YEAR FOLLOW-UP STUDY OF PHYSICAL MORBIDITY AND MORTALITY IN RELATIONSHIP TO ANTIPSYCHOTIC TREATMENT IN A NATIONWIDE COHORT OF 62,250 PATIENTS WITH SCHIZOPHRENIA \(FIN20\)](#), TAIPALE H., PH.D. (PHARM) ET AL., *WORLD PSYCHIATRY*, JANUARY 10
[ALCOHOL-RELATED DEATHS INCREASING IN THE UNITED STATES](#), NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM PRESS RELEASE, JANUARY 8 & [USING DEATH CERTIFICATES TO EXPLORE CHANGES IN ALCOHOL-RELATED MORTALITY IN THE UNITED STATES, 1999 TO 2017](#), WHITE A.M., PH.D. ET AL., *ALCOHOLISM: CLINICAL AND EXPERIMENTAL RESEARCH*, JANUARY 7
[ASSOCIATION OF SOCIAL MOBILITY WITH THE INCOME-RELATED LONGEVITY GAP IN THE UNITED STATES: A CROSS-SECTIONAL, COUNTY-LEVEL STUDY](#), VENKATARAMANI A., M.D., PH.D., DAZA S., M.A. & EMANUEL E., M.D., PH.D., *JAMA INTERNAL MEDICINE*, JANUARY 21