

# National Association of State Mental Health Program Directors *Weekly Update*

## CDC Survey Finds 25.5 Percent of Millennials, 31 Percent of Unpaid Caregivers, and 22 Percent of “Essential Workers” Have Seriously Contemplated Suicide During the Pandemic

With conventional wisdom being that the COVID-19 pandemic and the activities implemented to mitigate the spread of the virus have increased the incidence of anxiety and depression in the general population, the Centers for Disease Control and Prevention (CDC) conducted the third of a series of representative panel surveys among adults 18 years of age and older across the United States from June 24 to June 30 to assess levels of mental health, substance use, and suicidal ideation in the U.S.

The CDC [reported August 14](#) in its *Morbidity and Mortality Weekly Report* that overall, 40.9 percent of respondents acknowledged at least one adverse mental or behavioral health condition related to the pandemic, including symptoms of anxiety disorder or depressive disorder (30.9 percent), symptoms of a trauma- and stressor-related disorder (TSRD) (26.3 percent), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3 percent).

The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7 percent) was significantly higher among respondents ages 18 to 24 years (25.5 percent), minority racial/ethnic groups (Hispanic respondents [18.6 percent], non-Hispanic black [black] respondents [15.1 percent], self-reported unpaid caregivers for adults (30.7 percent), and essential workers (21.7 percent).

A total of 5,412 (54.7 percent) of 9,896 eligible invited adults completed the web-based survey. Respondents were informed of the study's purposes and were asked to provide electronic consent before commencement, and investigators received anonymized responses. Participants included 3,683 (68.1 percent) first-time respondents and 1,729 (31.9 percent) respondents who had completed two earlier related surveys in April and May that found an increase in symptoms of anxiety disorder and depression disorder.

At least one adverse mental or behavioral health symptom was reported by more than one-half of respondents who were aged 18 to 24 years (74.9 percent) and 25 to 44 years (51.9 percent), of Hispanic ethnicity (52.1 percent), or who held less than a high school diploma (66.2 percent), as well as those who were essential workers (54 percent), unpaid caregivers for adults (66.6 percent), and those who reported treatment for diagnosed anxiety (72.7 percent), depression (68.8 percent), or PTSD (88 percent) at the time of the survey.

Analyses were stratified by gender, age, race/ethnicity, employment status, essential worker status, unpaid adult caregiver

status, rural-urban residence classification, whether the respondent knew someone who had positive test results for SARS-CoV-2, the virus that causes COVID-19 or who had died from COVID-19, and whether the respondent was receiving treatment for diagnosed anxiety, depression, or posttraumatic stress disorder (PTSD) at the time of the survey.

During the June survey, symptoms of anxiety disorder and depressive disorder were assessed using the four-item Patient Health Questionnaire, and symptoms of a COVID-19-related TSRD were assessed using the six-item Impact of Event Scale. Respondents also reported whether they had started or increased substance use to cope with stress or emotions related to COVID-19 or seriously considered suicide in the 30 days preceding the survey.

A longitudinal analysis of responses of 1,497 persons who completed all three surveys revealed that unpaid caregivers of adults had a significantly higher odds of incidence of adverse mental health conditions than others. Among those who did not report having started or increased substance use to cope with stress or emotions related to COVID-19 in May, unpaid caregivers for adults had 3.33 times the odds of reporting this behavior in June. Among those who did not report having seriously considered suicide in the previous 30 days in May, unpaid caregivers for adults had 3.03 times the odds of reporting suicidal ideation in June.

CDC says that markedly elevated prevalences of reported adverse mental and behavioral health conditions associated with the COVID-19 pandemic highlight the broad impact of the pandemic and the need to prevent and treat these conditions. Identification of populations at increased risk for psychological distress and unhealthy coping can inform policies to address health inequity, including increasing access to resources for clinical diagnoses and treatment options. Expanded use of telehealth, an effective means of delivering treatment for mental health conditions, including depression, substance use disorder, and suicidal ideation, might reduce COVID-19-related mental health consequences.

CDC adds that future studies should identify drivers of adverse mental and behavioral health during the COVID-19 pandemic and whether factors such as social isolation, absence of school structure, unemployment and other financial worries, and various forms of violence (e.g., physical, emotional, mental, or sexual abuse) serve as additional stressors. The CDC says that community-level intervention and prevention efforts, including health

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## Two Scandinavian Nationwide Register Studies Find Clozapine to be the Only Antipsychotic to Reduce Risk of Suicide in Patients With Schizophrenia

The authors of two separate Scandinavian nationwide studies undertaken in Sweden and Finland whose joint findings are published in the [August 15 Schizophrenia Bulletin](#) have found that Clozapine is the only antipsychotic associated with a decreased risk of attempted or completed suicide among patients with schizophrenia.

No antipsychotic other than Clozapine was found to be associated with a reduced risk of attempted and/or completed suicide. Benzodiazepines and Z-drugs were associated with an increased risk of attempted or completed suicide (hazard ratio, HR, 1.29–1.30 for benzodiazepines and 1.33–1.62 for Z-drugs). HR for risk of attempted or completed suicide was 0.64 in the Finnish cohort, and 0.66 in the Swedish cohort. When excluding the first 30 days from the beginning of use, clozapine was associated with a decreased risk of suicide attempt/death in the Finnish cohort (HR 0.74) but no level of statistical significance in the Swedish cohort (HR 0.67).

Risperidone LAI was the second best-performing antipsychotic, although not reaching statistical significance in any analyses.

Heidi Taipale, Ph.D., of the University of Eastern Finland and her colleagues had conducted two register-based cohort studies of 61,889 patients with schizophrenia who lived in Finland and 29,823 patients with schizophrenia who lived in Sweden. They utilized data from two countries to minimize the differences in risk arising from a variance in treatment practices and prescribing patterns in countries.

In Finland, the cohort was identified from the Hospital Discharge Register (HDR) maintained by the National Institute of Health and Welfare. Data from the HDR (all hospital care periods with diagnoses, 1972–2017), Prescription Register (reimbursed prescription drug purchases, 1995–2017), and causes of death from Statistics Finland (1972–2017).

In Sweden, Schizophrenia diagnoses were derived from the National Patient Register (NPR, maintained by the National Board of Health and Welfare, inpatient and specialized outpatient care), disability pensions and sickness absences from the MiDAS register (maintained by the Swedish Social

Insurance Agency). Data from NPR (all hospital care periods and specialized outpatient visits with diagnoses, July 2005–December 2016), the Prescribed Drug Register (PDR, maintained by the National Board of Health and Welfare, prescription drug purchases July 2005–December 2016), the Causes of Death Register (maintained by the National Board of Health and Welfare, causes of death 2005–2016), and the LISA register (maintained by Statistics Sweden, demographic characteristics).

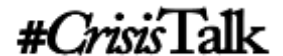
To keep the study cohorts homogenous, Dr. Taipale and her colleagues included in the definition of schizophrenia only schizophrenia and schizoaffective disorder, a definition often used in previous literature, and excluded delusional disorder and psychosis resulting from neuroactive steroids (NAS).

The researchers focused on patients who took the following 10 most commonly prescribed first- or second-generation antipsychotics: clozapine, olanzapine, quetiapine, risperidone, risperidone (long-acting injectable), aripiprazole, perphenazine, zuclopenthixol (long-acting injectable), haloperidol, and levomepromazine. The main outcome measure was attempted or completed suicide. Each patient served as his or her own control in the study, with the authors comparing suicide attempt/death during periods the patient was taking an antipsychotic with periods the patient was not taking antipsychotics.

Follow-up under the study started on July 1, 2006 for persons diagnosed before that and at the first recorded diagnoses for persons diagnosed between July 2006 and December 2013. The follow-up time ended at death or December 31, 2016, whichever occurred first. Patients committing suicides before receiving their schizophrenia diagnosis were not included in the studied cohorts.

The median follow-up time was 15.3 years in the Finnish cohort and 9.8 years in the Swedish cohort (corresponding to maximum follow-up times 22 and 11 years, respectively). Suicide attempt/death was recorded for 7.0 percent (4315) and 7.4 percent (2203) of the Finnish and Swedish cohorts, respectively. Compared to the entire cohorts, persons with suicide attempt/death were

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## #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: THE ARIZONA CRISIS SYSTEM IS THE EQUIVALENT OF EVEREST BASE CAMP... THE FINAL CLIMB IS STILL AHEAD

Imagine that 911 doesn't exist and a fire breaks out in your home. If you are able to find the number, you might call the fire department directly. But what if they're not equipped to come to your location and can only put out fires after you bring them to the fire station? What if you find out that the only people that will come to you during an emergency are the police? They are dedicated and hard-working, but they provide a very different type of public service.

Recently, the Federal Communications Commission (FCC) designated "988" as the future single number for mental health and suicide crises, to take effect by July 2022. This is a big step in the right direction. But who will RESPOND to these calls? The Bureau of Justice Assistance reported that 10% of police contacts are related to psychiatric emergencies; suggesting 24 million 911 calls per year could be appropriately served through 988 in the future (this is ten times the number of calls to the National Suicide Prevention Lifeline today). Currently, in most communities, 911 dispatches law enforcement in response to these calls. Even when officers are well-trained they have limited options if action is needed. They can arrest for a minor offense (leading to more misuse of jails for people with mental illness), transport to a hospital emergency room, or leave the individual in the community after their brief encounter without mental health or substance use treatment.

The demand is huge. And our lack of mental health crisis care is expensive as well as often inhumane. An estimated 20,000 to 25,000 people in crisis go to emergency departments every day in the U.S. Emergency departments are usually not equipped to provide psychiatric care, but their services are expensive. Neither emergency departments nor jails offer the specific services needed to resolve brain crises. We have a patchwork system relying on the wrong services that can't respond timely or appropriately, while at the same time hindering the normal work of police officers and medical urgent care personnel.

### [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](#)

## Two Scandinavian Nationwide Register Studies Find Clozapine to be the Only Antipsychotic to Reduce Risk of Suicide in Patients With Schizophrenia

(Continued from page 3) somewhat younger (5 years in the Swedish cohort and 9 years in the Finnish cohort), more likely to be women, and presented a higher prevalence of previous substance abuse and suicide attempts. During the follow-up, the persons with suicidality continued having more substance abuse and had more use of all medication classes as compared to the total cohorts. The use of benzodiazepines and related drugs and lithium was more frequent and other mood stabilizer use less frequent in Sweden than in Finland.

The main outcome measure was attempted or completed suicide, defined as inpatient care and causes of death diagnoses ICD-10 X60-84 and Y10-34. Diagnoses with undetermined intent (Y10-34) were included to compensate underreporting of suicides and regional differences in ascertainment practices. Secondary outcome measure was suicide attempt, defined as inpatient care diagnoses only. Both outcomes were treated as recurrent events.

While the rate for completed suicide among patients with schizophrenia appears to be dropping, according to the researchers, in Finland and Sweden, persons with schizophrenia are still 6 times to 14 times more likely to die due to suicide than individuals in the general population.

The researchers conducted their study because a third of the patients who report no suicidal ideation at the time of treatment initiation in first-episode psychosis develop suicidal ideation or engage in suicidal behaviors during the first year of treatment. They felt it is important for clinicians to be aware that transitions

between suicidal stages occur frequently, especially among first-episode patients and the risk of suicide is highest within the first year after discharge from the initial hospitalization in first-episode psychosis and shortly after discharge among general psychiatric inpatients.

In most observational studies, a decreased risk of suicide has been reported for clozapine. In one trial, clozapine was associated with a lower risk of suicidal behavior than olanzapine (hazard ratio 0.76) and showed superiority in all key measures of suicidality. But a previous Swedish case-control study had found that olanzapine (compared with haloperidol) showed lower risks of suicide and attempted suicide similar to clozapine.

The authors note that previous studies had mainly focused on suicidal death, and studies assessing the risk of attempted suicide are scarce. In addition, they suggest that previous observational studies had some selection bias (e.g., illness and symptom severity).

The authors note that a limitation of the study is that early discontinuation of medications and short periods of nonadherence could not be observed in register-based data. In addition, as there is generally a substantial lag in setting a diagnosis of schizophrenia after the first onset of prodromal symptoms, it is possible that setting the inclusion criteria at schizophrenia diagnosis rather than the onset of prodromal symptoms may have introduced some survival bias into the analysis.



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

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

After completing this course, attendees will be able to:

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

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

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

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

[ENROLL HERE](#)

## CDC Survey Finds 25.5 Percent of Millennials, 31 Percent of Unpaid Caregivers, and 22 Percent of “Essential Workers” Have Seriously Contemplated Suicide During the Pandemic

(Continued from page 1) communication strategies, designed to reach each of the groups surveyed could help address various mental health conditions associated with the COVID-19 pandemic. Those intervention and prevention efforts should include strengthening economic supports to reduce financial strain, addressing stress from experienced racial discrimination, promoting social connectedness, and supporting persons at risk for suicide. Communication strategies should focus on promotion of health services and culturally and linguistically tailored prevention messaging regarding practices to improve emotional well-being.

CDC also suggests that development and implementation of

COVID-19-specific screening instruments for early identification of COVID-19-related TSRD symptoms would allow for early clinical interventions that might prevent progression from acute to chronic TSRDs. To reduce potential harms of increased substance use related to COVID-19, resources, including social support, comprehensive treatment options, and harm reduction services, are essential and should remain accessible. Periodic assessment of mental health, substance use, and suicidal ideation should evaluate the prevalence of psychological distress over time.

The CDC says addressing mental health disparities and preparing support systems to mitigate mental health consequences as the pandemic evolves will continue to be needed urgently.



### COVID-19 Response and Recovery

September  
16-17



Join us for a virtual two-day Summit examining key issues surfaced by the COVID-19 pandemic and paths forward to more effective and equitable response and recovery efforts. Twenty concurrent sessions will cover critical issues including health equity for marginalized communities; drug and vaccine development and access; federal, state and local emergency measures; voter safety and participation; and more.

[See the full session list and descriptions here.](#)

[REGISTER HERE](#)



### Treating the Whole Person: Faith and Mental Health Professionals Partner to Address Mental Illness Tuesday, August 25, 12:00 p.m. to 1:00 p.m. E.T.

Principles 4 and 5 in the **Compassion in Action Guide** emphasize the importance of mental health professionals and faith leaders working together to provide support for the treatment of people with mental illness. We will discuss with our guest speakers how faith leaders can make effective referrals to mental health professionals. Furthermore, we will outline particular projects that are bringing together faith and mental health leaders to address clients' mental health and spiritual needs. You won't want to miss this episode!

- [David Eckert, Access Services](#)
- [Doug Moister, Renew Community](#)
- [Glen Milstein, Ph.D., The City College of New York](#)
- [Rabbi Tzvi Steinberg, Zera Abraham](#)

[REGISTER HERE](#)



And REGISTER for the final webinar in this series:

["A Proven Lifeline: Keeping Hope in Mind While Addressing the Complexities of Mental Illness"](#)

**Fridav. September. 15. 12:00 p.m. to 1:00 p.m.. E.T..**



BUILDING PARTNERSHIPS FOR  
OLDER ADULT BEHAVIORAL HEALTH

Tri-County Older Adult Behavioral Health  
Initiative would like to invite you to a webinar  
on Aging with Technology!

# AGING WITH TECHNOLOGY

Thu, August 27, 2020  
2:00 PM – 3:30 PM PDT

Learn from a panel of  
tech experts in  
Oregon and beyond  
on exciting new  
products and  
services that are  
helping to shape the  
future of aging.



This webinar will be held on a  
zoom platform. Register below.

[REGISTER HERE](#)



Multnomah  
County





## **Upcoming Webinar from the National Center for Complex Health and Social Needs:**

### **Increasing Inclusion of People with Lived Experiences**

***Wednesday, August 26, 2:00 p.m. to 3:00 p.m. E.T.***

Over the last several months, conversations about diversity and inclusion have become increasingly commonplace. No matter the issue at hand, people with lived experience understand the challenges and barriers experienced by their communities, and can provide insight into the opportunities to bring about lasting and positive change. While many healthcare and social service professionals support the inclusion of people with lived experience, there are often uncertainties about how to build and maintain authentic, mutually beneficial partnerships.

In this Office Hours session, we will discuss opportunities for organizations to increase inclusion of people with lived experiences. The speakers for this session are:

- Lee Harrison and John Butler of San Mateo County Health's Lived Experience Academy will speak about their work to support participants to use their lived experience with mental health and/or substance use challenges to empower themselves, to educate others, and to advocate for systems level changes.
- Danielle Hodges of the Camden Coalition and Stephanie Burdick of the National Center's National Consumer Scholar program will discuss a research survey project co-lead by a team of Consumer Scholars designed to illuminate opportunities for strengthening partnerships between organizations and people they serve.

#### **Presenters:**

- Lee Harrison, Behavioral Health Specialist, [San Mateo County Health's Lived Experience Academy \(LEA\)](#)
- John Butler, program graduate, [San Mateo County Health's Lived Experience Academy \(LEA\)](#)
- Danielle Hodges, Program Manager, Data and Quality Improvement, [Camden Coalition of Healthcare Providers](#)
- Stephanie Burdick, National Consumer Scholar, [National Center for Complex Health and Social Needs](#)

**[REGISTER HERE](#)**

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### **About the National Center for Complex Health and Social Needs**

The National Center is an initiative of the [Camden Coalition of Healthcare Providers](#) in Camden, New Jersey. The National Center works to engage a wide range of national stakeholders across the spectrum of health care and health policy around improving care for high-cost, high-need consumers. The founding sponsors of the National Center are the [Robert Wood Johnson Foundation](#), the [Atlantic Philanthropies](#), and [AARP](#).

Learn more about the National Center on our website: [www.nationalcomplex.care](http://www.nationalcomplex.care).

# National Institute of Drug Abuse Notice of Special Interest (NOSI)

## Utilizing Telemedicine or Other Remote-Based Platforms to Develop and Support Treatments for Substance Use Disorders (NOT-DA-20-058)

Release Date: June 29, 2020

First Available Due Date: October 5, 2020

Expiration Date: January 8, 2024

### Related Announcements:

**PA-20-185**– NIH Research Project Grant (Parent R01 Clinical Trial Not Allowed)

**PA-20-183**- Research Project Grant (Parent R01 Clinical Trial Required)

**PA-20-195** - NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Not Allowed)

**PA-20-194** - NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Required)

There is an urgent need for remotely delivered Substance Use Disorder (SUD) treatments to reduce patient burden and for methods to conduct clinical trials remotely. The purpose of this NOSI is to stimulate research to evaluate the safety and efficacy of telemedicine or remotely provided treatments for SUD, and to develop tools for remote collection of data in clinical trials of treatments for SUD.

### Background

Most mainstream treatments for SUD currently rely on in-person clinical visits as an essential setting for treatment delivery and outcomes monitoring. The advent of the COVID-19 pandemic has substantially disrupted in-person treatment delivery, demonstrating the limitations of relying on in-person approaches. Further, even during normal circumstances, in-person treatment delivery results in additional travel-related demands and schedule conflicts (e.g., work, childcare) that can be burdensome to patients. These issues may be addressed via remote treatment delivery and patient outcomes monitoring as exemplified by telemedicine. Few studies have demonstrated that remote delivery of SUD treatment is feasible, safe, and efficacious. These remote delivery methods are generally still in the early stages of development, and existing studies generally lack the scope required to inform dissemination into clinical practice. Therefore, there is a need to develop new remotely-delivered SUD treatments and expand the dissemination of those already evaluated.

Similarly, clinical trials of SUD interventions generally require frequent in-person contact to monitor tolerability, adherence, and efficacy outcomes. The COVID-19 pandemic halted most SUD clinical research, which is evidence that methods for conducting clinical trials remotely are needed to overcome these challenges when participants cannot attend in-person clinic visits. Thus, there is an urgent need of research to develop tools to reduce the frequency of in-person visits in SUD clinical trials.

We expect this NOSI to accelerate the development of (1) remotely-delivered SUD treatment interventions, and (2) remote methods for collecting outcome measures evaluating the safety or efficacy of SUD treatments. These advances will facilitate the delivery of effective treatments to those in need and permit the execution of clinical trials when physical access to clinical research sites is limited. Ultimately, both these advances will lead to improved treatment options for individuals with SUD.

### Research Objectives

NIDA encourages the submission of applications that will rapidly improve the ability to: (1) offer remotely-delivered SUD treatments to patients, including efforts to bring access to difficult to reach populations, and (2) conduct clinical trials of novel treatments using remote patient safety and clinical outcomes monitoring to reduce the need for in-person clinical visits.

This NOSI encourages research among subgroups that have been disproportionately impacted by COVID-19 or have difficulty accessing SUD treatment/research programs, including racial/ethnic minorities, socioeconomically disadvantaged individuals, and rural populations. This NOSI will also prioritize applications that have an impact beyond the circumstances created by the COVID-19 pandemic, for example, applications that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research.

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due diligence to ensure that the proposed technologies address an unmet need or substantially enhance existing capabilities.

Areas of interest include, but are not limited to:

- Development and evaluation of new or existing remote-delivery of treatments for SUD.
- Development and evaluation of new or existing remote-delivery interventions for SUD among patients with or at risk of limitations of mobility, such as:
  - Pregnant or recently postpartum women
  - Older adults
  - Low SES populations
  - Racial/Ethnic minority, or health disparity populations
  - Rural populations
  - Individuals living in Native-American nations
  - Comorbid medical or mental health conditions
- Development and evaluation of new or existing tools and methods for remote monitoring of SUD treatment recruitment, adherence, tolerability, and outcome measures.
- Development and evaluation of research designs that may enhance the implementation of clinical trials that can be conducted remotely, in full or partially, and reduce the number and frequency of in-person clinical visits. These may include recruitment from a larger geographical area, or of patients who live in more rural areas, have disabilities, or have other specific barriers/challenges regarding attending in-person clinical visits (e.g., work during clinic hours, lack childcare, etc.).

**Scientific/Research Contact:** Evan S. Hermann, PhD. National Institute on Drug Abuse (NIDA), Email: [evan.herrmann@nih.gov](mailto:evan.herrmann@nih.gov)



National Federation of Families  
for Children's Mental Health

## An Important Grant Award Announcement

### **SAMHSA's First National Family Support Technical Assistance Center (NFSTAC)**

A coalition led by the National Federation of Families for Children's Mental Health, in partnership with the Center on Addiction, C4 Innovations, SAFE Project, and Boston University has been awarded SAMHSA's first National Family Support Technical Assistance Center (NFSTAC). NFSTAC is committed to providing tiered training and technical assistance (TTA), using a lifespan approach, that focuses on supports for families caring for loved ones who experience serious emotional disturbances, serious mental illness, and substance use disorders. This approach is anchored by the underlying principles that families play a vital role in supporting their loved ones, are the experts regarding their family support needs, and can be productively engaged to play a central role in treatment and recovery services.

#### **NFSTAC will deliver comprehensive TTA that:**

- Advances partnerships between clinical and peer providers and family members of individuals experiencing SED/SMI/SUDs
- Promotes stronger and more sustainable recovery-oriented outcomes
- Focuses on adapting and implementing recovery-oriented services
- Targets emphasis on workforce capacity and competencies
- Trains and certifies family peer specialists
- Delivers field-requested and on-demand resources for families and the general public
- Offers a multimodal platform including virtual trainings, mobile apps and social media

The NFSTAC team is comprised primarily of family members with loved ones of varying ages who experience SED/SMI/SUDs as well as individuals in recovery. This lived experience, combined with collective decades of experience as researchers, practitioners, TTA providers, and leaders in family engagement, will inform every aspect of NFSTAC. The effect of entrusting this agenda to a family-run organization, in collaboration with local, state and national family-centered partners, and strong alignment with professionals who advance the importance of family engagement in their work, will be transformational in the delivery of TTA. It will also emphasize to all stakeholders that lived experience and authentic family voice are cornerstones of the NFSTAC approach.

For more information, please contact Lynda Gargan, Executive Director, at [lgargan@nffcmh.org](mailto:lgargan@nffcmh.org).



## OFFICE OF JUSTICE PROGRAMS SPONSORED WEBINARS

### Webinar Series: Implementing the Principles of a Trauma Responsive Service System

#### [REGISTER FOR SERIES HERE](#)

The SAMHSA Concept Paper on [Implementing a Trauma Informed Approach](#) will provide the basis for this four-part series designed to create a values-based framework for moving from theory to practice. The six principles for creating a trauma responsive service delivery will be presented. Organizations that serve victims of crime and those that have used their services will lend their voices and their experiences to share how they used the principles in creating trauma responsive services. Discussions on the importance of recognizing and addressing unconscious or implicit bias and its impact on services will also be discussed. The principles serve as a non-prescriptive road map to assist with the implementation of trauma responsive services and creating an atmosphere where all victims of crime want to come for help/services.

Sessions	Dates	Speakers
<i>Lessons Learned: Increasing Access to Mental Health Services to Traditionally Underserved Victims of Crime</i> through implementation of trauma-responsive services. The purpose of addressing the trauma experienced by victims of crime is not always understood by their providers. By understanding the impact of trauma on victim survivors, responding in ways that enhances the realization that behavior is frequently an adaptation to trauma and that healing must be the focus of service and support is key to ensuring organizations create an atmosphere where all victims of crime want to come to you for help/services. Grantees will discuss challenges and how they applied a trauma-informed lens to successfully overcome obstacles	September 10, 12:00 p.m. to 1:30 p.m. E.T.	OVC Purpose Area 3b Grantees from Los Angeles LGBT Center, Clinical and Support Options, Inc. (MA), and Center for Trauma & Resilience (CO)

#### [REGISTER HERE](#)

*This product was supported by grant number 2017-VF-GX-K142, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

## AHRQ Announces New Challenge Competition Focusing on Postpartum Mental Health Care for Rural Families

The Agency for Healthcare Research and Quality (AHRQ) has announced a challenge competition to highlight local innovations to improve postpartum mental health care for rural American families. The total prize pool for the competition is \$175,000.

The two-fold purpose of the challenge is to amplify innovative programs that rural communities already are implementing to address challenges to postpartum mental health diagnosis and treatment and elicit new solutions. AHRQ plans to share the information with rural communities, healthcare systems, healthcare professionals, local and state policy makers, federal partners, and the public. Rapid shifts in the healthcare landscape have highlighted the need to create solutions to support community-based, digital,

Through this new challenge, AHRQ is interested both in success stories that highlight community achievements and new program proposals that demonstrate innovative planning for community action to improve postpartum mental health. Organizations that serve rural communities, including health care providers, community-based organizations and clubs, faith-based groups, cooperative extension services, schools, hospitals, local health departments, and state, territorial, and tribal organizations are eligible to submit proposals that highlight successful or promising programmatic interventions to improve rural postpartum mental health.

AHRQ is hosting this challenge during Women's Health Month as a single-phase competition with two categories: success stories and proposals. Applicants may only submit proposals in one category. [Submissions are due in September](#), and AHRQ plans to announce challenge winners during Rural Health Month (November).

There will be five winners in the Success Story Category, with each receiving \$15,000.

There will be two winners in the Program Proposal Category, with each receiving \$50,000.

For more information, visit the [AHRQ Cross-Sectional Innovation to Improve Rural Postpartum Mental Health Challenge](#) website.

## NASMHPD Links of Interest on Coronavirus

[NEW YORK HAS TAMED THE VIRUS. CAN IT HOLD OFF A SECOND WAVE?](#), J. DAVID GOODMAN, *NEW YORK TIMES*, AUGUST 17

[NEW YORK CORRALLED CORONAVIRUS. WHAT'S CALIFORNIA'S EXCUSE FOR CASE SURGE?](#), JOHN WOOLFOLK & HARRIET BLAIR ROWAN, *MERCURY NEWS*, AUGUST 16

[THE PARTICULAR PAIN OF PANDEMIC GRIEF](#), SONJA MACKENZIE, *NEW YORK TIMES*, AUGUST 14

[PLANS OF US PARENTS REGARDING SCHOOL ATTENDANCE FOR THEIR CHILDREN IN THE FALL OF 2020: A NATIONAL SURVEY](#), KROSHUS E., .Sc.D., M.P.H., *ET AL.*, *JAMA PEDIATRICS*, AUGUST 14

[COVID-19 DEATHS SKEW YOUNGER AMONG MINORITIES](#), PAUL OVERBERG & JON CAMP, *WALL STREET JOURNAL*, AUGUST 17

[OPINION: DON'T JUST LOOK AT COVID-19 FATALITY RATES. LOOK AT PEOPLE WHO SURVIVE — BUT DON'T ENTIRELY RECOVER.](#), MEGAN McARDLE, AUGUST 16 & [OUTCOMES OF CARDIOVASCULAR MAGNETIC RESONANCE IMAGING IN PATIENTS RECENTLY RECOVERED FROM CORONAVIRUS DISEASE 2019 \(COVID-19\)](#), PUNTSMANN V.O., M.D., Ph.D., *JAMA CARDIOLOGY*, JULY 27

[HEALTH DEPARTMENT-REPORTED CASES OF MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN \(MIS-C\) IN THE UNITED STATES](#), CENTERS FOR DISEASE CONTROL AND PREVENTION, UPDATED AUGUST 6

[IT'S OK TO FEEL OK RIGHT NOW \(ON-LINE\)](#) / GUILT IS A NORMAL REACTION TO THRIVING IN BLEAK TIMES (IN PRINT), CHAR ADAMS, *NEW YORK TIMES*, AUGUST 17

[RACIAL AND ETHNIC DISPARITIES AMONG COVID-19 CASES IN WORKPLACE OUTBREAKS BY INDUSTRY SECTOR — UTAH, MARCH 6–JUNE 5, 2020](#), BUI D.P., Ph.D., *ET AL.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, *MORBIDITY AND MORTALITY WEEKLY REPORT*, AUGUST 17

[WHAT IF 'HERD IMMUNITY' IS CLOSER THAN SCIENTISTS THOUGHT?](#), APOORVA MANDAVILLI, *NEW YORK TIMES*, AUGUST 17

[COMMENTARY: COVID-19, MENTAL HEALTH, AND SUICIDE RISK AMONG HEALTH CARE WORKERS: LOOKING BEYOND THE CRISIS](#), REGER M.A., Ph.D., PICCIRILLO M.L., M.A. & BUCHMAN-SCHMITT J.M., Ph.D., *JOURNAL OF CLINICAL PSYCHIATRY*, AUGUST 4

[COVID-19 SYMPTOMS MAY RAISE RISK OF GENERAL PSYCHIATRIC DISORDERS](#), *PSYCHIATRY AND BEHAVIORAL HEALTH LEARNING NETWORK*, JULY 28 & [PREVALENCE AND PREDICTORS OF GENERAL PSYCHIATRIC DISORDERS AND LONELINESS DURING COVID-19 IN THE UNITED KINGDOM](#), LI L.Z. & WANG S., *PSYCHIATRY RESEARCH*, SEPTEMBER 2020

[HOW STATES COLLECT DATA, REPORT, AND ACT ON COVID-19 RACIAL AND ETHNIC DISPARITIES](#), NATIONAL ACADEMY FOR STATE HEALTH POLICY, UPDATED JULY 28

[STATE APPROACHES TO CONTACT TRACING DURING THE COVID-19 PANDEMIC](#), NATIONAL ACADEMY FOR STATE HEALTH POLICY, AUGUST 17

[ADDRESSING NATIVE AMERICAN FOOD INSECURITY DURING THE COVID-19 PANDEMIC: FOOD DISTRIBUTION PROGRAMS ON INDIAN RESERVATIONS](#), NETWORK FOR PUBLIC HEALTH LAW, MATTHEW R. SWINBURNE, AUGUST 12

[DISPARITIES IN INCIDENCE OF COVID-19 AMONG UNDERREPRESENTED RACIAL/ETHNIC GROUPS IN COUNTIES IDENTIFIED AS HOTSPOTS DURING JUNE 5–18, 2020 — 22 STATES, FEBRUARY–JUNE 2020](#), MOORE J.T., M.Sc., M.P.H., *ET AL.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, *MORBIDITY AND MORTALITY WEEKLY REPORT*, AUGUST 14

[TRUMP ADMINISTRATION STEPS IN AS ADVOCACY GROUPS WARN OF COVID 'DEATH PANELS'](#), SUSANNAH LUTHI, *POLITICO*, AUGUST 10

[RACIAL DISPROPORTIONALITY IN COVID CLINICAL TRIALS](#), CHASTAIN D.B., PHARM.D., *ET AL.*, *NEW ENGLAND JOURNAL OF MEDICINE*, AUGUST 11

[THE PROMISE OF TELEHEALTH BEYOND THE EMERGENCY](#), ARIELLE KANE & DEAN CLANCY, PROGRESSIVE POLICY INSTITUTE & AMERICANS FOR PROSPERITY, AUGUST 2020

[DIGITAL CONTACT TRACING TECHNOLOGIES IN EPIDEMICS: A RAPID REVIEW](#), ANDREW ANGLEMEYER, *ET AL.*, COCHRANE, UPDATED AUGUST 18

[COVID-19 AMONG AMERICAN INDIAN AND ALASKA NATIVE PERSONS — 23 STATES, JANUARY 31–JULY 3, 2020](#), HATCHER S.M., Ph.D. *ET AL.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, *MORBIDITY AND MORTALITY WEEKLY REPORT*, AUGUST 19

[HEALTH CARE ORGANIZATIONS SHOULD TAKE ACTION NOW TO PROMOTE RACIAL JUSTICE](#), CENTER FOR CONSUMER ENGAGEMENT IN HEALTH INNOVATION, AUGUST 2020

# Save the Date!

We Have Added a Virtual HCBS Conference Option  
Sign Up [Here](#) to be Notified When Registration Opens!



## HCBS CONFERENCE

Home & Community-Based Services

Marriott Wardman Park  
Washington, DC

[HCBSconference.org](https://hcbconference.org)

Early Bird rates for the 2020 HCBS Conference: \$625 for ADvancing States members, nonprofits, government attendees, and speakers; \$1050 for corporate attendees.

### NEW DATES

ADvancing States Fall Member Meeting: December 7, 2020  
HCBS Conference: December 8-11, 2020



**Announcement Type: Research Award**  
**Total Funds Available: \$30 Million**  
**Maximum Project Period: 5 years**  
**Applicant Town Hall Session: September 2020**

**Letter of Intent Deadline: September 29, 2020, 5 p.m. E.T.**  
**Total Direct Costs: \$10 million**  
**Earliest Start Date: November 2021**  
**Application Deadline: January 12, 2021, 5 p.m. E.T.**

Provides information about an upcoming Targeted Patient-Centered Outcomes Research Institute (PCORI) Funding Announcement (PFA), which will be released by PCORI on September 1, 2020. Through this initiative, PCORI seeks to fund large randomized controlled trials (RCTs) and/or observational studies that compare the effect of brief interventions on acute suicide risk in youth ages 15 to 24.

Suicide rates in the US have increased by over 35 percent from 1999 to 2018. Of notable concern is the 46 percent increase in rates for youth ages 15 to 24 during this same time period (from 9.9 to 14.5 per 100,000). While suicide rates have risen across race/ethnicity, gender, and geographical groups, rates remain highest in boys/males, LGBTQ, rural, and American Indian/Alaska Native populations. Additionally, recent trends indicate an increasing suicide rate for Black and Latina adolescents.

Brief interventions (e.g., Teachable Moment Brief Intervention, Motivational Interviewing, Safety Planning) are often the first intervention patients presenting with suicidality receive. These interventions are designed to reduce acute suicide risk and direct patients to appropriate treatment, and can be delivered in a variety of settings (e.g., emergency departments, primary care, schools, mobile crisis units, community-based settings, home, inpatient care, juvenile detention centers) and by a range of healthcare professionals. The evidence base of brief interventions for suicidality comes primarily from studies done with adults. There is some evidence for youth, but which interventions work best for which populations of youth is not clear.

This Targeted PCORI Funding Announcement will solicit applications that respond to the following question:

**What is the comparative effectiveness of different brief interventions to reduce suicidality and improve outcomes for youth ages 15 to 24?**

PCORI is particularly interested in the comparative effectiveness of tailored approaches to brief interventions. Tailoring may include involvement of people with lived experience, telehealth (e.g., apps, text-based, web-based, phone calls, video calls), cultural factors (e.g., language, family involvement, rituals), and specific settings (e.g., primary care, school, home, community) or other cultural adaptations.

Applicants should consider the following outcomes: suicidal ideation, self-harm, engagement in mental health care, functional measures, school participation, employment, skills to manage suicidality, connectedness, quality of life, and healthcare utilization (hospital or ED use). Applications should include follow-up for up to one year.

Interventions must be evidence-based **and/or** in widespread use and reproducible. This Targeted PFA preannouncement is provided to allow potential applicants additional time to identify collaborators, obtain stakeholder input on potential studies, and develop responsive, high-quality proposals.



The Department of Behavioral Health and Developmental Disabilities and the Department of Public Health invite you to participate in our **2x2 Series: Self-Care Tips and Support for Managing Life**. These engaging and interactive sessions may be just the break you need from a challenging workday. They are designed to promote wellness and provide self-care tips and support for managing life during these unprecedented times. Each session offers mental health tips and information about reducing/managing stress, working through grief, improving work/life balance, enhancing personal and professional relationships, having fun, and other hot topics.

**NOTE:** The sessions use the WebEx webinar online conferencing system. WebEx allows participants to log on to a website from their computer and view the facilitator's information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

The 2x2 Series is held LIVE twice weekly, on Tuesdays and Thursdays at 2:00 p.m. Below is the date, time, session title and registration link for this week's sessions (the password for each session is "2by2"):

*All participants must use the links above to register for the 2x2 sessions. Additionally, please note that it is strongly encouraged that you join the webinar 10-15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.*

**Want to be a 2x2 Presenter?** The 2x2 Planning Team is recruiting new presenters to share their knowledge and experience with our growing audience. If you are interested, please click on the following link, and complete the Speaker Application. A member of our team will contact you to begin the vetting process. [https://www.surveymonkey.com/r/2x2\\_Series\\_Speaker\\_Application](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application)

If you cannot attend the live sessions, each one will be recorded and available for review on the DBHDD website: <https://dbhdd.georgia.gov/2x2-series>.

**Questions?** Please email [DBHDDLearning@dbhdd.ga.gov](mailto:DBHDDLearning@dbhdd.ga.gov)



MHTTC

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

## The MHTTC Network – School Mental Health Initiative

[The Mental Health Technology Transfer Center \(MHTTC\) Network](#), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a collaborative Network that supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. The Network includes 10 Regional Centers, a National American Indian & Alaska Native Center, a National Hispanic & Latino Center, and a Network Coordinating Office.

The MHTTC Network has supplemental funding to focus on the need for further implementation of mental health services in school systems. The Regional and National Centers provide technical assistance and develop resources, trainings and events around various school mental health topic areas, including evidence-based identification, early intervention, and treatment practices, youth suicide prevention, school wellness, and trauma-informed practices in schools.

During the current COVID-19 public health crisis, the MHTTC Network remains open and available to assist the school mental health workforce. While in-person learning opportunities are postponed until further notice, the Network is working quickly to offer virtual learning opportunities in the interim.

To view a compilation of MHTTC resources specific to school mental health during the COVID-19 pandemic, please visit our [website](#). For access to *all* MHTTC trainings and resources, visit the Training and Events Calendar [here](#) and the Products and Resources Catalog [here](#).

**STAY INFORMED! SUBSCRIBE TO *MHTTC PATHWAYS* [HERE](#)**

*MHTTC Pathways* is a monthly eNewsletter that keeps you informed about what is happening within the MHTTC Network. It highlights events, training opportunities, resources, and the latest Network products. Special features help you stay updated on the latest on evidence-based practices, implementation science, and workforce development.



# Disaster Distress Helpline

PHONE: 1-800-985-5990  
TEXT: "TalkWithUs" to 66746



**Call us:**  
**1-800-985-5990**



**Text:**  
**'TalkWithUs' to 66746**



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**<http://twitter.com/distressline>**

## Disaster Distress Helpline

PHONE: 1-800-985-5990 TEXT: "TalkWithUs" to 66746

**Call 1-800-985-5990**  
**or text 'TalkWithUs' to 66746**  
to get help and support  
for any distress that you or someone  
you care about may be feeling  
related to any disaster.

The **Helpline** and **Text Service** are:

- Available 24 hours a day,  
7 days a week, year-round
- Free (standard data/text messaging  
rates may apply for the texting service)
- Answered by trained crisis counselors.

TTY for Deaf / Hearing Impaired:  
**1-800-846-8517**

Spanish-speakers:  
Text **"Hablanos"** to 66746



**SAMHSA**  
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4787)

Administered by the Substance Abuse and Mental Health  
Services Administration (SAMHSA) of the U.S. Dept. of Health  
and Human Services (HHS).

**Disasters have the potential to cause emotional distress. Some are more at risk than others:**

- Survivors living or working in the impacted areas (youth & adults)
- Loved ones of victims
- First Responders, Rescue & Recovery Workers.

**Stress, anxiety, and depression are common reactions after a disaster.**

Warning signs of distress may include:

- Sleeping too much or too little
- Stomachaches or headaches
- Anger, feeling edgy or lashing out at others
- Overwhelming sadness
- Worrying a lot of the time; feeling guilty but not sure why
- Drinking alcohol, smoking or using tobacco more than usual;
- Using illegal drugs
- Feeling like you have to keep busy
- Lack of energy or always feeling tired
- Eating too much or too little
- Not connecting with others
- Feeling like you won't ever be happy again

# Disaster Distress Helpline

PHONE: 1-800-985-5990 TEXT: "TalkWithUs" to 66746

## TIPS FOR COPING WITH STRESS AFTER A DISASTER:

**Take care of yourself.** Try to eat healthy, avoid using alcohol and drugs, and get some exercise when you can- even a walk around the block can make a difference.

**Reach out to friends and family.** Talk to someone you trust about how you are doing.

**Talk to your children.** They may feel scared, angry, sad, worried, and confused. Let them know it's okay to talk about what's on their mind. Limit their watching of TV news reports about the disaster. Help children and teens maintain normal routines to the extent possible. Role model healthy coping.

**Get enough 'good' sleep.** Some people have trouble falling asleep after a disaster, others keep waking up during the night.

If you have trouble sleeping:

- Only go to bed when you are ready to sleep
- Don't watch TV or use your cell phone or laptop computer while you're in bed
- Avoid eating (especially sugar) or drinking caffeine or alcohol at least one hour before going to bed
- If you wake up and can't fall back to sleep, try writing in a journal or on a sheet of paper what's on your mind.

**Take care of pets or get outside into nature when it's safe.** Nature and animals can help us to feel better when we are down. See if you can volunteer at a local animal shelter- they may need help after a disaster. Once it's safe to return to public parks or natural areas, find a quiet spot to sit in or go for a hike.



**Know when to ask for help.** Signs of stress can be normal, short-term reactions to any of life's unexpected events- not only after surviving a disaster, but also after a death in the family, the loss of a job, or a breakup.

It's important to pay attention to what's going on with you or with someone you care about, because what may seem like "everyday stress" can actually be:

- Depression (including having thoughts of suicide)
- Anxiety
- Alcohol or Drug Abuse.

**If you or someone you know may be depressed, suffering from overwhelming feelings of anxiety, or possibly abusing alcohol or drugs ...**

**Call 1-800-985-5990 or  
text 'TalkWithUs' to 66746.**

**You Are Not Alone.**

## Research on Co-Morbid Substance Use, Substance Use Disorders, and (C) Psychiatric Disorders



The purpose of this Notice is to encourage the submission of research project grant applications that address co-morbid substance use and/or substance use disorders, and other psychiatric disorders. Research in response to this NOSI may include etiologic investigations to inform prevention intervention, intervention development and testing, and research to address service delivery strategies to address co-morbid conditions. The intent is to encourage a broad portfolio of research, that enhances understanding of risk, etiology, prevention, treatment and service delivery related to co-occurring conditions.

### Background:

The association between substance use, substance use disorders, and psychiatric disorders, including depression, anxiety, bipolar disorder, ADHD and other externalizing disorders, has been well established through population based epidemiologic surveys. Numerous developmentally focused theory-based approaches have been proposed, including shared underlying vulnerabilities or risk factors. From a disorder perspective, prevalence can be expressed as either the prevalence of other psychiatric disorders among substance using populations or the prevalence of substance use among individuals with other psychiatric disorders, leading to variability in rates. Mental illness is often characterized as a risk factor for substance use initiation and for transition from use to misuse and disorder, though the exact sequence and relationship between substance use, substance use disorders and psychiatric co-morbidity is unclear and may vary by disorder. For some substances and disorders, it may be the substance use that precedes the onset of other psychiatric symptoms. Additional research is needed to determine the various trajectories of substance use and psychiatric symptoms, as well as strategies for intervention to change trajectories.

### Research Objectives:

The National Institute of Drug Abuse (NIDA) is interested in research project grant applications that would further our understanding of co-morbidity through studies that test etiological theories and interventions (treatment and prevention), across the lifespan.

NIDA interest includes, but is not limited to, applications in the following areas:

- Epidemiologic studies of the etiology of co-morbidity that directly lead to the development of targeted preventive intervention research projects; of priority are studies that include prevention scientists as part of the research team, to facilitate the application of findings into next phase prevention intervention development. These can include primary data collection or secondary data analyses.
- Studies of the trajectories of the development of co-morbid substance use, substance use disorders and psychiatric disorders and the ways in which their interactions influence the onset, course and recovery of both; of interest are studies which additionally identify potentially effective points and models of intervention.
- Intervention research to directly address common mechanisms/dimensions that may underlie both substance use disorders and other psychiatric disorders. Among treatment seeking populations, studies to determine whether or how the receipt of evidence-based treatments for psychiatric disorders impact substance use initiation/and or progression to misuse and disorder.
- Strategies for augmenting psychiatric care to prevent substance use initiation and/or progression from use to misuse or disorder. This could include research to test whether and how models of care delivery for mental illness (e.g., the collaborative care model, coordinated specialty care for first episode psychosis) could be leveraged for substance use prevention among at-risk individuals.
- Studies to further understand and prevent suicide and other adverse outcomes (morbidity and mortality) among individuals using illicit substances.
- Research that uses clinically validated digital therapeutics, including mobile applications and other platforms, virtual reality, wireless monitoring and biofeedback, imaging tools for biofeedback to develop, improve and systematically measure behavioral interventions for substance use and psychiatric conditions. Additionally, neuromodulation devices to augment behavior therapies.
- Studies to evaluate the use of medications to improve the efficacy of behavioral interventions for co-morbidities.
- Research to promote adherence to pharmacotherapies, such as buprenorphine, methadone, depot naltrexone, Lofexidine, naloxone, or HAART, in substance abuse treatment populations with comorbidities.
- Studies that develop safe and effective psychosocial interventions to improve the outcomes of pharmacotherapies for substance use disorders including opioid use disorder, overdose reversal, and preventive efforts for psychiatric and suicide risk.
- Research on tobacco harm reduction strategies such as switching from combustibles to e-cigarettes with special attention to individuals with severe mental illness (e.g., schizophrenia, bipolar depression).
- Services research to develop and test strategies to improve system- or provider- capacity for treating and managing co-occurring conditions.

*(More on following page)*

## National Institute on Drug Abuse Notice of Special Interest (NOSI)

### Research on Co-Morbid Substance Use, Substance Use Disorders, and Other Psychiatric Disorders

*(Continued from previous page)*

#### Application and Submission Information

This notice applies to due dates on or after October 05, 2020 and subsequent receipt dates through May 8, 2023

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

- [PA-20-185](#): NIH Research Project Grant (Parent R01 Clinical Trial Not Allowed)
- [PA-20-183](#): NIH Research Project Grant (Parent R01 Clinical Trial Required)
- [PA-20-184](#): Research Project Grant (Parent R01 Basic Experimental Studies with Humans Required) Research Project Grant (Parent R01 Clinical Trial Required)
- [PA-20-200](#): NIH Small Research Grant Program (Parent R03 Clinical Trial Not Allowed)
- [PA-20-196](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Basic Experimental Studies with Humans Required)
- [PA-20-195](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Not Allowed)
- [PA-20-194](#): NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Required)
- [PA-18-775](#): Pilot and Feasibility Studies in Preparation for Drug and Alcohol Abuse Prevention Trials (R34 Clinical Trial Optional) or any re-issuances

All instructions in the [SF424 \(R&R\) Application Guide](#) and the funding opportunity announcement used for submission must be followed, with the following additions:

- For funding consideration, applicants must include "NOT-DA-20-004" (without quotation marks) in the Agency Routing Identifier field (box 4B) of the SF424 R&R form. Applications without this information in box 4B will not be considered for this initiative.

Applications nonresponsive to terms of this NOSI will be not be considered for the NOSI initiative.

**Inquiries:** Please direct all inquiries to the contacts in Section VII of the listed funding opportunity announcements with the following additions/substitutions:

**Scientific/Research Contact:** Amy B. Goldstein, Ph.D., National Institute on Drug Abuse (NIDA), 301-827-4124, [amy.goldstein@nih.gov](mailto:amy.goldstein@nih.gov).



The Georgia COVID-19 Emotional Support Line provides free and confidential assistance to callers needing emotional support or resources information as a result of the COVID-19 pandemic. The Emotional Support Line is staffed by volunteers, including mental health professionals and others who have received training in crisis counseling. Hours of operation: 8 am - 11 pm. Call 866.399.8938

[GEORGIA EMOTIONAL SUPPORT RESOURCES](#)

**Now Virtual !!!**

**32<sup>nd</sup>**  
Annual

**Tuerk Conference**

on Mental Health & Addiction Treatment

**UPDATE**



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.

**SEPTEMBER 10, 2020**

8:00 am – 5:00 pm

**RECORDED PLENARIES AND WORKSHOPS:** Available to  
access online for two weeks after the conference, so you  
can attend all in one day or spread it out over two weeks.

Conference Sponsors

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Clinic Management and Development Services, Inc. (CMDS)  
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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

## **2019 NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS**

NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 and 2018 *Beyond Beds* series of papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

A 2019 multiple-paper follow-up to the *Beyond Beds* series is now up on the [NASMHPD website](#). The 2019 papers take the *Beyond Beds* theme to look at additional innovative approaches offered in the community and factors impacting those services, covering such topics as early antipsychotic prescribing practices in nursing homes, developing a behavioral health workforce, a public health approach to trauma and addiction, addressing behavioral health in traumatic brain injury treatment, recovery-oriented cognitive therapy, integration of mental health and substance use services for those with co-occurring conditions, schools as part of the continuum of care for children and adolescents, and addressing social and mental health needs in transition-age homeless youth.

One of those papers, [\*Lessons from the International Community to Improve Mental Health Outcomes\*](#), authored by Deborah Pinals, M.D., chair of the NASMHPD Medical Directors Division and Medical Director, Behavioral Health and Forensic Programs in the Michigan Department of Health and Human Services, pivots from NASMHPD's previous work in this series to look beyond the borders of the United States to other countries for examples of successful and promising strategies across nine areas of focus. The paper's highlighted examples from the international community aim to further illuminate strategies and inspire ongoing crucial dialogue in an effort to improve mental health in the United States.

**Following are links to the other reports in the 2019 Technical Assistance Coalition series.**

[\*\*Effects of CMS' Measure of Antipsychotic Prescribing Practices for Nursing Facilities on Utilization of Antipsychotic Medications and Changes in Diagnostic Patterns\*\*](#)

[\*\*Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders\*\*](#)

[\*\*A Public Health Approach to Trauma and Addiction\*\*](#)

[\*\*Traumatic Brain Injury and Behavioral Health Treatment\*\*](#)

[\*\*Recovery-Oriented Cognitive Therapy: a Theory-Driven, Evidence-Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems\*\*](#)

[\*\*Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?\*\*](#)

[\*\*Schools as a Vital Component of the Child and Adolescent Mental Health System\*\*](#)

[\*\*Addressing Intersecting Social and Mental Health Needs among Transition-Aged Homeless Youth\*\*](#)

**The NASMHPD Technical Assistance Coalition series will continue in 2020.**



## Student Mental Health: Responding to the Crisis

### *Mary Ward House Conference & Exhibition Centre, London*

### **Tuesday, October 6, 2020**

This conference will break-down the cultures, economic factors, social and institutional pressures contributing to dramatic rises in disclosures of mental health issues at universities and student suicides.

Delegates will explore why more students are turning to unconventional incomes like gambling and sex work during their studies, how the university experience can compound cultural and environmental conditions that lead students to access and supply drugs; and discussing how cross-institutional co-operation as well as legislative review of attitudes towards information sharing could prevent students reaching a point of crisis.

With just over two months to go to this expected sell out event places are now at a premium. However you can still...

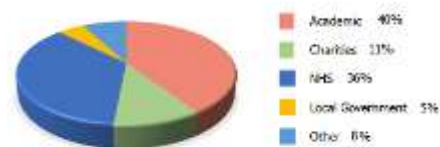
<a href="#">View Event</a>	<a href="#">View Programme</a>	<a href="#">Register Interest</a>	<a href="#">Book A Place</a>
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**Student Mental Health: Responding to the Crisis is our third national conference bringing together domestic and European HE institutes, students, academic/policy researchers, health, social care and counselling services to develop pragmatic approaches to:**

- Transitions of otherwise non-criminal student populations into drug use and supply created by financial instability, distance from guardians and the interconnected nature of student life.
- Preventing student suicides; developing best practices in data sharing between institutions and families – measuring the importance of student safety and public interest against data protection, as well as investing in welfare support services and advanced planning.
- Isolation and instability created by increases in students engaging with sex work and gambling as a means of meeting the cost of university life.
- Cultures of anxiety driven by transitions in curriculum and lifestyle, persecutory perfectionism, unrealistic expectations projected on new media platforms, institutional pressures and uncertainty around post-university employment opportunities.
- Normalization of competitive and insecure working cultures in the HE sector – how does this impact the human value of academic labor and the support available to young people struggling with their studies.

### **2020 Attendee Breakdown by Sector.**

Curious about who else will be in attendance on the day?



**WEBSITE FOR THE SAMHSA-SPONSORED**

**Center of Excellence for Protected Health Information**

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

**UPDATE**

# Altering Our Course: NASHIA's Virtual SOS Conference

**Feature Event : Sept. 22 and 23, 2020**  
**Workgroup Sessions : Sept. 24, 25, 28, & 29, 2020**  
**Podcasts Available : Beginning Sept. 22, 2020**  
**Post-Intensive Workshop : Sept. 29, 2020**

## **FORMAT**

THIS EVENT WILL INCLUDE A COMBINATION OF LIVE AND RECORDED SESSIONS IN A VARIETY OF FORMATS AND AN EXHIBIT HALL FOR EVENT SPONSORS AND ATTENDEES TO NETWORK AND COLLABORATE.

## **RATE (COVERS THE ENTIRE EVENT.)**

\$250 FOR MEMBERS

\$300 FOR NON MEMBERS

CEUs APPLIED FOR APA, SW, AND CRC.

## **LOCATION**

ALL EVENTS ARE VIRTUAL.

## **AGENDA**

## **SPONSORSHIP OPPORTUNITIES**

## **JOIN NASHIA FOR 2020**

## **CONTACT US**

FOR MORE INFORMATION,

CONTACT [INFO@NASHIA.ORG](mailto:INFO@NASHIA.ORG).

**Feature Sessions. Workshops.  
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for premier leaders  
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Reserve your seat today!**

**Register and Sponsor HERE**



## Multi-Part Virtual Learning Community Webinar Series

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation uses its Virtual Learning Community (VLC) model to deeply explore topics of interest to the field centered around a common theme. VLCs are composed of a series of webinars, small discussion groups, and webinar supporting materials. These communities are open to the field at no cost to the participant.

Each webinar provides an opportunity to hear from national experts and state representatives. The presenters offer guidance on best and promising practices as well as practical lessons learned from on-the-ground experience.

Selected webinars are followed by a small-group discussion, where audience members can engage directly with the presenters to learn more about the topics of discussion.

### **Implementing A Peer Mentor Program: Strategies for Engaging Peer Recovery Support Specialists in Adult Treatment Courts** *Monday, August 31, 12:30 p.m. to 2:00 p.m. E.T.*

Learn how to engage Peer Recovery Support Specialists (PRSSs) in adult treatment courts to support people with substance use disorders and co-occurring mental disorders.

Peer Recovery Support Specialists (PRSSs) working in treatment courts are people with lived experience of behavioral health disorders and criminal justice involvement who are key members of the clinical team serving those participating in drug court and mental health court programs.

This webinar covers strategies for how to engage PRSSs in adult treatment courts to support people with substance use disorders and co-occurring mental disorders. Topics covered will include training peers to work in treatment courts, identifying key community partners for an effective peer mentoring program, defining core activities of peers working in treatment courts, the peer certification process, and oversight and management of peer programs. Real-life examples of successful implementation in the state of Oklahoma will be shared.

[REGISTER HERE](#)

### **Understanding and Addressing Criminal Thinking** *Tuesday, September 1, 2:00 p.m. to 3:30 p.m. E.T.*

Learn about the concept of criminal thinking as a means of describing, understanding, assessing, and changing criminal behavior.

[REGISTER HERE](#)

### **Competence to Stand Trial/Competence Restoration** **Community of Practice Virtual Meeting** *Thursday, September 3, 1:00 p.m. to 4:00 p.m. E.T.*



As part of this Community of Practice (CoP), nine participating states have made remarkable progress over the last two years through a series of 32 interactive workshops and intensive technical assistance. It is particularly timely work, given Assistant Secretary Elinore McCance-Katz's letter to State Mental Health Commissioners allowing use of MHBG funds for Competency evaluations and restoration.

Some of the state accomplishments include:

- Legislation passed in three states related to Competence Evaluation/Restoration (CE/CR);
- Developed standards for competency restoration;
- Shortened waiting lists for CE/CR;
- Expanded/enhanced restoration services; and
- Development of early diversion programs.

Ongoing TA Topics from the GAINS Center include: community-based competency restoration; funding restoration services; clinical challenges; collaboration with justice partners; community readiness for diversion; building collaborations with leadership (legislative, judicial, mental health); data sharing; and data-informed decision-making. State teams on the CoP include judges, forensic directors, mental health commissioners, attorneys general, state health authorities, sheriffs, and other key stakeholders.

Please join us on September 3 to hear of the challenges in the competency system, state solutions, presentations from subject matter experts, forecasting future trends, and brief reports on lessons learned from the nine participating states. A link to this virtual meeting will be posted in late August.

## Training and Technical Assistance Related to COVID-19 Resources

<https://mhttcnetwork.org/centers/global-mhttc/responding-covid-19>

**Responding to COVID-19:** highlight products and resources that can be useful when coping with the effects of widespread public health crises such as::

- Psychosocial Impacts of Disasters: Assisting Community Leaders
- Supportive Practices for Mental Health Professionals During Pandemic-Related Social Distancing

**Recorded Webinars:** • [Substance Use Disorder Services in the Days of a Pandemic: You Need A Bigger Boat!](#)

### **ATTC Resources: OTP Questions Regarding Sustaining Operations During the Uncertain and Turbulent Times**

AATOD, ATTCs, and AAAP are collecting questions from OTPs related to sustaining care, providing support and maintaining a safe work environment for staff during these turbulent and uncertain times. We will compile all questions, work with field experts to determine responses, and develop and disseminate a "FAQ" document.

<https://attcnetwork.org/centers/global-attc/otp-questions-during-challenging-times-form>

**Compassion Fatigue and the Behavioral Health Workforce Curriculum Infusion Package** - This [5-part Curriculum Infusion Package \(CIP\)](#) on Compassion Fatigue and the Behavioral Health Workforce was developed in 2020 by the Pacific Southwest Addiction Technology Transfer Center (PSATTC). Part 1 provides a brief overview of the behavioral health workforce and associated shortages, and introduces the demands on the workforce. Part 2 focuses on compassion fatigue and secondary traumatic stress. Part 3 provides a brief overview of how organizations can help individuals avoid experiencing burnout. Part 4 focuses on actions that behavioral health professionals can take to prevent compassion fatigue. And Part 5 focuses on self-care as an ethical duty in order to manage compassion fatigue.

## Upcoming Webinars

**[Click here to view a full list of our MHTTC Training and Events Calendar and to Register](#)**

**Educator Wellness Webinars-** (The Educator Wellness Webinar Series is part of The Well-Being Series - Connections During COVID-19: Mental Wellness Webinars for Families and Educator) - Hosted by Northwest MHTTC

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



*Knowledge Informing Transformation*

## **National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit**

**[GET THE TOOLKIT HERE](#)**

[Mental Health in a Pandemic: Q&A](#) with Thomasine Heitkamp and Dennis Mohatt,  
Co-Project Directors of the [Mountain Plains Mental Health Technology Transfer Center](#) (MHTTC)

[Depression, Alcohol and Farm Stress: Addressing Co-Occurring Disorders in Rural America](#),  
a guide for screening alcohol and depression in farming populations

[Rural Healthcare Surge Readiness: Behavioral Health](#)

[SIGN UP](#) TO RECEIVE THE [RURAL MONITOR NEWSLETTER](#)



Student Training & Education  
in Public Service

## Mental Health & Wellness Guide for Public Service Professionals

Being able to make a positive impact is what makes working in a public service field so special. From the school social worker keeping a group of at-risk teens on track to graduate, to the rookie cop protecting the neighborhood she grew up in, to the critical care nurse pulling a double shift during a healthcare crisis, public service professionals represent the best in all of us. Yet this same capacity and desire to do good often comes at the cost of mental health and wellness. Being overworked, dealing with life-and-death situations, and concerns over funding are just a few of the triggers that can lead to serious issues like compassion fatigue, burnout, and traumatic stress. And when symptoms do arise, it can be hard to ask for help when you're the one who usually provides it.

This guide explores mental health issues that public service professionals are most at risk for, the common stressors that cause them, and solutions and resources to get well. While this guide is not meant to (and should not) replace professional medical advice, it can help serve as a starting point for understanding and dealing with the mental health challenges of being in a helping career.

[ACCESS THE GUIDE HERE](#)

## IIMHL and IIDL Leadership Exchange

*Valuing Inclusion, Resilience and Growth.*

*Kaingākauria te whakawhāiti tāngata, te ngākau  
manawaroa, te puāwaitanga o te tangata.*

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## 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

**Application Due Date:** August 25, 2020, 5:00 p.m. Local Time of Applying Entity

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.

#### Eligibility

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

### Effectiveness of Implementing Sustainable Evidence-Based Mental Health Practices in Low-Resource Settings to Achieve Mental Health Equity for Traditionally Underserved Populations (R01 Clinical Trial Optional)

**Application Due Date:** August 25, 2020, 5:00 p.m. Local Time of Applying Entity

This Funding Opportunity Announcement (FOA) encourages studies that develop and test the effectiveness of strategies for implementation and sustainable delivery of evidence-based mental health treatments and services to improve mental health outcomes for underserved populations in under-resourced settings in the United States. Studies should identify and use innovative approaches to remediate barriers to provision, receipt, and/or benefit from evidence-based practices (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 are strongly encouraged, including due consideration of the needs of individuals across the life span.

#### Background

Evidence-based mental health treatment and preventive interventions and services (EBPs) are effective in improving clinical and functional outcomes for a wide variety of people. Ample research suggests, however, that EBPs are often not delivered in low-resource settings and in settings where clients are predominantly from traditionally underserved populations. These populations are also more likely to have worse mental health outcomes, and more inpatient hospitalizations and emergency room use for psychiatric crises. While the prevalence of some mental disorders may be lower among racial and ethnic minorities, the course of illness is often more severe, persistent, and disabling. Recent research also suggests that disparities in receipt of mental health treatment and services may be increasing. Based on these findings, this announcement solicits research intended to improve access to evidence-based mental health care in low-resource areas and for underserved populations as a strategy for achieving greater equity in mental health and related functional outcomes and reducing disparities.

#### Research Objectives

This initiative is focused on developing and 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, 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 retention and integration in the community, treatment of comorbid 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. Studies should identify and use innovative approaches to remediate barriers to provision, receipt, or benefit from EBPs and generate new information about factors integral to achieving greater equity in mental health and related functional outcomes for underserved populations. Research generating new information about factors causing/reducing disparities is strongly encouraged.

The goal is to develop scalable implementation strategies that achieve delivery of EBPs with high fidelity in these settings and significantly improve clinical and functional outcomes toward greater equity with outcomes documented in non-disparity populations.

This FOA is published in parallel to a companion R34 [RFA-MH-20-401](#) that supports pilot studies in preparation for the larger-scale studies described here.

#### Eligibility

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

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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](#)



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.

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

[www.samhsa.gov/find-help](http://www.samhsa.gov/find-help)





## 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.

<b>August 2020</b>	Myths and Misperceptions about Financing Peer Support in Medicaid
<b>September 2020</b>	Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises
<b>October 2020</b>	Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice
<b>November 2020</b>	Person, Family, Clan, Community: Understanding Person-Centered Thinking, Planning, and Practice in Tribal Nations
<b>December 2020</b>	Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition

NCAPPS has posted on its website a **Health Care Person-Centered Profile** to assist people with disabilities, older adults, and others to communicate their needs and preferences with hospital and other health care staff. Depending on state and hospital policy, people with communication, comprehension, and behavioral challenges may face the possibility of a hospital visit without significant others or usual supporters present. To address the heightened challenges this poses, a group of experts in person-centered planning developed a tool that people and their families and caregivers can fill out and share with medical staff upon hospital intake or care site transfer.

The tool has two pages: a Health Care Information sheet for capturing brief and vital information about the person's health status and a Health Care Person-Centered Profile for describing who the person is, what is most important to the person, and how best to provide support—vital information that can help medical staff provide more tailored and person-centered care.

The Health Care Information Sheet also has a section for detailed contact information to help medical staff reach a person's emergency contact or legal representative. It contains a section for indicating whether advance directives are in place and where those documents can be found.

The Profile, instructions, and sample profiles are available at:  
<https://ncapps.acl.gov/covid-19-resources.html>



## Tips for Telehealth Billing During the COVID-19 Pandemic

Plan to get reimbursed for services you would typically provide in the office? Then use this primer to identify the various types of telehealth visits and associated billing codes.

Keep in mind that guidelines change often during the COVID-19 crisis.  
Please reference the links below for the most current details.

### 1 TELEHEALTH VISITS THAT REPLACE OFFICE VISITS

This is a real-time video visit and is the most common type of mental health digital visit.

It has the same standards as an in-person visit and should be paid at the same rate. However, it is a good idea to review the settings on your billing software to make sure it is accurate.

**+95** Real-time audio video modifier to add to the end of the billing code  
During the COVID-19 crisis, use this for visits that you would typically have in your office.

You can use the same CPT codes you already use with the addition of a modifier – modifier 95 in most cases – that tells the payer that the visit was a telehealth visit and a place of service code (POS) that tells the payer the location of the clinician. Coverage policies may vary across payers, especially during the public health emergency. Before you bill, make sure to check and confirm that you can provide and bill the service by telehealth.

*Information listed in italics are those services that can also be temporarily provided by telephone during the COVID-19 crisis.*

#### Initial Psychiatric Evaluation

90791+95  
90792+95

#### Evaluation and Management Outpatient

99204+95      99205+95      99212+95  
99213+95      99214+95      99215+95

#### Evaluation and Management Plus Psychotherapy

30 (16-37\*) minutes - E/M code [Audio only - use the appropriate 99441-99443 code] and 90833+95

45 (38-52\*) minutes - E/M code [Audio only - use the appropriate 99441-99443 code] and 90836+95

60 (53+\*) minutes - E/M code [Audio only - use the appropriate 99441-99443 code] and 90838+95

#### Psychotherapy Alone

90832+95      30 (16-37\*) minutes  
90834+95      45 (38-52\*) minutes  
90837+95      60 (53+\*) minutes

#### Family Therapy

90846+95      Patient not present  
90847+95      Patient present  
90849+95      Group

#### Group Therapy

90853+95 *(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)*

### 2 TELEPHONE VISITS

There are CPT codes that describe care provided via telephone alone. They are for medical discussions or assessment and management of a new (allowed during COVID-19 crisis) or established patient.



For physicians and others who can bill for E/M services:

99441      5-10 minutes  
99442      11-20 minutes

For psychologists, social workers, and others who can bill for E/M services:

98966      5-10 minutes  
98967      11-20 minutes  
98968      21-30 minutes



## Tips for Telehealth Billing During the COVID-19 Pandemic

### 3 VIRTUAL CHECK-IN (G2012)

Physicians and others who can bill E/M services can bill for time spent talking to a new or established patient on the telephone or via telephone and video. Generally, the physician is responding to a contact made by the patient. This code should not be billed if the patient has been seen in the 7 days prior to the call or within 24 hours or the soonest available appointment after the brief check-in. The goal of this visit is to see if a patient needs to be seen for further evaluation or if the problem can be resolved through this call.

### 4 E-VISIT

This type of visit is not real time or face-to-face. It is a digital communication that a patient must initiate. Often it is done through a portal or email. This visit requires a clinical decision that typically you would provide in an office. Time is cumulative during a 7-day period. You can use CPT codes for these visits based on time.



Those that bill evaluation and management services should use:

99421	5-10 minutes
99422	11-20 minutes
99423	21-30 minutes

Those that cannot bill evaluation and management services should use:

G2061	5-10 minutes
G2062	11-20 minutes
G2063	21-30 minutes



### REMOTE PATIENT MONITORING

This involves the collection and interpretation of data that is digitally stored and transmitted by a patient to a clinician. An example is sleep tracking data from a wearable device. There are no specific billing codes in mental health for this type of visit.

### STAY CURRENT

Guidelines for telehealth visits change fast. For up-to-date details on telehealth, you can use these resources.

[SMI Adviser](#)

[American Psychiatric Association](#)

[Center for Connected Health Policy](#)

[Centers for Medicare and Medicaid Services](#)

[Federation of State Medical Boards](#)



## SMI Adviser Coronavirus Resources

### Recorded Webinars

[Managing the Mental Health Effects of COVID-19](#)

[Telepsychiatry in the Era of COVID-19](#)

#### Physician Continuing Medical Education (CME) Credit

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 enduring activity for a maximum of 12.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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## 2020 ANNUAL CONFERENCE ON ADVANCING SCHOOL MENTAL HEALTH OCTOBER 29 TO 31



The Annual Conference on Advancing School Mental Health brings together a diverse group including educators, providers, researchers, administrators, advocates, youth, caregivers, and national/state/local leaders to share the latest research and best practices. The 2020 conference will take place Oct. 29-31 in Baltimore.

**REGISTER ON-SITE**

**FOR ADDITIONAL INFORMATION, CONTACT CHRISTINA WALKER, 443-790-4066**



The MHDD-NTC is a collaboration between the University Centers 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/>



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](#)

## **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

[ALCOHOL SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT \(SBIRT\) FOR GIRLS AND WOMEN](#), HAMMOCK K., VELASQUEZ M.M., ALWAN H. & VON STERNBERG K., *ALCOHOL RESEARCH CURRENT REVIEW*, AUGUST 13

[BREAKING BARRIERS TO QUALITY MENTAL HEALTH CARE FOR LGBTQ YOUTH](#), TREVOR PROJECT, AUGUST 18

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[THE MILLION DOLLAR \(HOMELESS\) PATIENT: CALCULATING THE HEALTH CARE COSTS OF CHRONIC HOMELESSNESS](#), SARAH ARNQUIST, CENTER FOR HEALTH JOURNALISM, AUGUST 19