L.A. County Supervisors Replace Plans for Central Jail with Plans for Inmate Mental Health Facility

Los Angeles County supervisors approved a plan February 12 to tear down the Men’s Central Jail downtown and build at least one mental health treatment facility in its place.

The new plan, approved by a narrow 3 to 2 vote, modifies a $2.2-billion plan to create a Consolidated Correctional Treatment Facility, which was slated to house 3,885 “inmate patients” in a rehabilitation-focused center in the footprint of the Central Jail, which was built in 1963.

The Department of Health Services would oversee the new facility, rather than the Sheriff’s Department which currently manages all jail operations. The new facility, called the Mental Health Treatment Center, would be staffed by the Department of Mental Health, with a limited number of deputies providing security. The county would also consider building a series of smaller mental health centers instead of a single, large hospital.

Inmates who are medically or mentally ill now make up an estimated 70 percent of people held in the county jail system.

“Sheriff’s deputies will never receive enough training to become mental health professionals, nor should they,” Supervisor Janice Hahn, who co-authored the motion outlining the plan with Supervisor Mark Ridley-Thomas, told the Los Angeles Times. Supervisor Hahn said the ultimate goal is to divert inmates to community-based care wherever possible.

Supervisors Hilda Solis and Sheila Kuehl opposed the move, arguing the plan might still allow for the construction of a massive building with thousands of beds, which they said would lead to poor outcomes for people suffering from mental illness. The revised plan would keep the underlying construction contract that was slated for the Consolidated Correctional Treatment Facility and instead use the $2.2 billion to build the mental health facility. If the county deviated dramatically from the existing plan, it would be required to restart the environmental review process, but opponents argued the existing contract may not allow enough flexibility to create a completely different project.

“It’s still a jail. It’s still walls. It’s still preventing people from having freedom, the possibility of even rehabilitation,” Supervisor Solis said. Supervisor Solis, whose district includes the downtown men’s jail, also worried about how the county would pay to operate the mental health center.

She warned colleagues about making promises they couldn’t keep, recalling the county’s healthcare crisis of the 1990s.

Supervisor Kuehl said the new project, if it contained close to the original number of beds provided under the old proposal, would house a larger number of people than all the county hospitals combined. California’s largest state-run mental health hospital operates about 1,500 beds. Supervisor Ridley-Thomas responded that the plan does not mandate a certain number of beds.

The Consolidated Correctional Treatment Facility, which will no longer be built, had been billed as representing a “paradigm shift” in the treatment of inmates. That plan called for inmates currently held at the Twin Towers Correctional Facility, the primary site for inmates with mental illness or drug addiction, to be moved to the new facility. Men’s Central Jail inmates would have been transferred to the Twin Towers in a kind of prisoner swap.

More than a hundred advocates for jail reform filled the meeting location Tuesday to argue the mental health treatment facility would become a dressed-up jail. They called for a decentralized, community-based clinical service model, with five separate treatment centers countywide and argued that the billions of dollars devoted to a new facility would be better spent on reentry programs, supportive housing, community-based services and other alternatives.

“You cannot provide good mental health care in a facility built for 4,000 people. It’s preposterous,” Peter Eliasberg of the American Civil Liberties Union of Southern California told the Board of Supervisors.

Eunisses Hernandez of JustLeadershipUSA, an organization dedicated to reducing the jail population, told the Los Angeles Times the supervisors had just approved a contract to create a mental health jail, a jail with a bow on it,” Hernandez said. Still, she said it was a partial victory that years of activism had pushed county officials to seek alternatives to incarceration.
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Altha J. Stewart, M.D., President of the American Psychiatric Association (2018-2019)

Altha J. Stewart, M.D. began her term as President of the American Psychiatric Association at the end of the APA Annual Meeting in May, 2018.

Dr. Stewart is an associate professor of Psychiatry and Director of the Center for Health in Justice Involved Youth at the University of Tennessee Health Science Center.

Dr. Stewart has held several leadership roles at APA, including secretary of APA, past president of the American Psychiatric Association Foundation, chair of the APA Conflict of Interest Committee, chair of the Minority Fellowship Selection Committee, member of APA Ad Hoc Workgroups on Real Estate and Strategic Planning, member of the Council on Advocacy and Government Relations and member of the APA Joint Reference Committee.

Dr. Stewart previously served as Executive Director for Just Care Family Network, Memphis' federally funded System of Care program for children with serious emotional disorders and their families. Additionally, Dr. Stewart was Director of Systems of Care for the Shelby County Office of the Public Defender. Prior to this she served as Executive Director of the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services funded National Leadership Council on African-American Behavioral Health. Earlier in her career, Dr. Stewart served as Executive Director of Detroit-Wayne County Community Mental Health Agency, one of the largest public mental health systems in the U.S. She worked for over a decade as CEO and Executive Director in large public mental health systems in Pennsylvania and New York, overseeing the management and development of programs for persons with mental illness and substance use disorders.

Dr. Stewart is active in several professional organizations having previously served as president of the Association of Women Psychiatrists and the Black Psychiatrists of America.

Dr. Stewart is the recipient of many awards and honors, including:

- 2006 Regis College, Weston, Massachusetts, Doctor of Laws degree (honorary)
- 2006 American Psychiatric Association Alexandra Symonds Award
- 2003 Wayne State University Pathfinders in Medicine Award
- 2002 NAMI Exemplary Psychiatrist Award
- 1999 White House Conference on Mental Health, Invited Participant
- 1999 University of Maryland, Dana African-American Visiting Professorship in Psychiatry

Education

- Doctor of Medicine, Temple University Medical School (Philadelphia, PA)
- Residency in General Psychiatry, Hahnemann Medical College & Hospital (Philadelphia, PA)
- Chief Resident (1981-1982)

Throughout February, we celebrate the considerable accomplishments of individuals of African descent to history. Did you know...

- In 1967, Thurgood Marshall became the first African American appointed to the U.S. Supreme Court.
- Madame C.J. Walker rose from a cotton plantation to became the first female self-made millionaire by inventing a line of hair products for African Americans.
- Canadian businesswoman, Viola Davis Desmond is now the first Black-Canadian on Canadian currency.
- In 2018, John Legend became the first African American to achieve an EGOT (Emmy, Grammy, Oscar, & Tony).
- In 1993, the Honorable Jean Augustine became the first Black-Canadian woman elected to Canada’s House of Commons. She negotiated unanimous support to pass a motion designating February as Black History Month in Canada.
- Mamie Phipps Clark was the first African American woman to earn a PhD in psychology.

Take time this month and throughout the year to honor and celebrate the contributions of these individuals and so many others to communities. Check out events in DC, Atlanta, Toronto, Montreal, or your local community.
Suicide rates have decreased globally by one third since 1990, according to research published online February 6 in The BMJ journal.


The 2016 Global Burden of Disease Study found that the total global number of suicides had increased by 6.7 percent over the study period from 762,000 in 1990 to 817,000 in 2017. However, when Dr. Naghavi adjusted for population growth, global suicides had decreased by 32.7 percent (16.6 deaths per 100,000 in 1990 to 11.2 deaths per 100,000 in 2016).

Although the suicide rate had decreased globally, several countries experienced a statistically significant increase including Zimbabwe, Jamaica, Paraguay, and Belize. Lesotho, Lithuania, Russia, and Zimbabwe had the highest suicide mortality rates among countries having populations greater than 1 million. China and India accounted for 44.2 percent of the global suicide deaths in 2016, but experienced significant decreases in rates of suicide (64.2 and 15.2 percent, respectively).

According to the report, suicide was the top ten leading causes of death in eastern Europe, central Europe, western Europe, central Asia, Australia, southern Latin America and high income North America. Suicide was also the leading cause of years of life lost in regions of high-income Asia Pacific. The investigator also found that the global suicide rate was higher for men than women (15.6 per 100,000 and 7.0 per 100,000, respectively) in all regions and age groups, except for 15 to 19 year olds. However, countries with low socio-demographic index, the study found that females had higher rates than males.

The author noted that suicide mortality has decreased since 1990 with variations across geographic location, gender, and age groups. The author further concludes, “Whether the decline in suicide mortality is due to suicide prevention activities, or whether it reflects general improvements in population health, warrants further research.”

Even with the one-third decrease, only three percent of 118 countries and territories would attain the Sustainable Development Goals target of reducing suicide mortality by one-third by 2030. Similar to the Sustainable Development Goals, the World Health Organization’s (WHO) aim is to reduce the global suicide rate by 10 percent by 2020. WHO recognizes suicide as a public health crisis with at least 800,000 people dying by suicide every year.

The University of Washington’s Institute for Health and Metrics Evaluation conducts the Global Burden of Disease annual analysis, which is partly funded by the Bill and Melinda Gates Foundation.

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**52nd Annual Conference**

**Converging Fields, Expanding Perspectives**

**AMERICAN ASSOCIATION OF SUICIDIOLOGY**

**Suicide Prevention is Everyone’s Business**

**AAS is a charitable, nonprofit membership organization**

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Continuing Education  

**Register HERE**

(you will have to create a website account)
The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of HH policy development, including major activities in policy coordination, legislative development, policy research, program evaluation, and economic analysis.

Within ASPE, the Office of Disability, Aging, and Long-Term Care Policy (DALTCP) focuses on policies and programs that support the independence, productivity, health and well-being of people with disabilities, people with behavioral health conditions, and older adults. DALTCP’s portfolio includes substance use disorder and mental health treatment and coverage policy, use of long-term services and supports, consumer-directed supportive services, Alzheimer’s disease and related dementias, and behavioral health and long-term care financing through Medicare, Medicaid, and private insurance.

Position: DALTCP is currently seeking Economists at the GS-11 and GS-12 level (see Announcement HHS-ASPE-DH-19-10412832 on USAJobs.gov) to engage in policy research and analysis related to the financing, delivery, and quality of services and supports for people with disabilities, serious mental illness, and/or substance use disorders. Specifically, we are seeking an Economist with expertise in either:

- **Behavioral Health Policy:** examples of relevant topics include efforts to combat the opioid epidemic, reducing the treatment gap/stigma, addressing SUD privacy complexities, behavioral health IT, and insurance reimbursement for substance use and mental health services; or
- **Disability and Aging Policy:** examples of relevant topics include improving disability measurement, approaches to long-term services and supports financing, and addressing the burden of Alzheimer’s disease and related dementias.

Responsibilities may include responding to requests for policy analysis and developing and/or managing policy research and evaluation.

Qualifications: Graduate degree in economics, public policy, public health, statistics, or demography, among others. Applicant must have at least 21 semester hours in economics and 3 semester hours in statistics, accounting, or calculus, and an appropriate combination of education and experience. This can include a combination of graduate and undergraduate coursework.

Don’t delay! Please apply to USA Jobs ASAP! Please contact Erin.Bagalman@hhs.gov or William.Marton@hhs.gov with necessary questions.
CMS FUNDING OPPORTUNITY ANNOUNCEMENT

Maternal Opioid Misuse (MOM) Model (CMS-2A2-20-001)

Funding Mechanism: Cooperative Agreement
Anticipated Number of Awards: 12
Anticipated Length of Project: 5 years

Anticipated Total Available Funding: $64,560,000
Anticipated Award Amount: Up to $5,380,000 per year
Cost Sharing/Match Required?: No

Applications Due: Monday, May 6

The Maternal Opioid Misuse (MOM) model provides funding opportunities for selected state Medicaid agencies to test whether payments that support evidence-based, coordinated care delivery for pregnant and postpartum women with opioid use disorder (OUD) and their infants can reduce Medicaid and Children’s Health Insurance Program (CHIP) expenditures and improve the quality of care for this population of Medicaid and CHIP beneficiaries.

Pregnancy, a time during which women may be more engaged in their own care due to more regular interactions with the healthcare system, provides a key opportunity for focused impact on health care outcomes for pregnant women and their infants within the context of the broader opioid crisis. The MOM model will test payment and care-delivery innovation to improve outcomes and reduce costs for pregnant and postpartum Medicaid beneficiaries with OUD and their infants.

The MOM model leverages Center for Medicare and Medicaid Innovation authorities and state flexibility to address the fragmented care that the Model’s focus population currently receives. The Centers for Medicare & Medicaid Services (CMS) will provide support for model awardees to design and implement state-specific interventions through funding for infrastructure and capacity development and, potentially, 1) a one-year, transitional period of care delivery, and 2) achievement of quality milestones. During the Model’s five-year performance period, responsibility for funding the care-delivery innovation will transition to each state, with the ultimate goal of sustaining successful payment and care-delivery strategies through incorporation into each state’s Medicaid programs.

Agency Contacts:

Administrative and Budgetary Requirements: Monica Anderson, Office of Acquisitions and Grants Management, MOMModel@cms.hhs.gov
Program Requirements or Technical Assistance: Geraldine Doetzer, Center for Medicare and Medicaid Centers (CMS), MOMModel@cms.hhs.gov

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

Suicide Prevention Lifeline Crisis Center Follow-Up Expansion Grant Program (SM-19-008)

Funding Mechanism: Grant
Anticipated Number of Awards: 2
Length of Project: Up to three years

Anticipated Total Available Funding: $672,383
Anticipated Award Amount: Up to $336,192 per year
Cost Sharing/Match Required?: No

Applications Due: Monday, March 11

The purpose of this program is to provide an integrated hub that: (1) ensures systematic follow-up of suicidal persons who contact a NSPL Crisis Center; (2) provides enhanced coordination of crisis stabilization, crisis respite, and hospital emergency department services; and (3) enhances coordination with mobile on-site crisis response. In effect, with the resources provided, the hub should not lose track of a person in a suicidal crisis as they interface with crisis systems. It is expected that this program will promote continuity of care to safeguard the well-being of individuals who are at risk of suicide.

Eligibility is limited to National Suicide Prevention Lifeline Crisis Centers because they have been specifically trained in NSPL procedures pertaining to follow-up of persons at imminent risk of suicide and risk assessment, and are the only entities that can obtain the required consents from NSPL Crisis Center callers for follow-up activities. This eligibility limitation ensures that the infrastructure is in place to serve high-risk, high priority, and/or underserved populations. Limiting eligibility also ensures that relationships with local and state mental health systems are in place for NSPL Crisis Center callers, and that individuals discharged from partnering agencies receive follow-up care and access to treatment.

Contact Information:

Program Issues: Portland Ridley, Division of Prevention, Traumatic Stress, and Special Programs, Center for Mental Health Services/SAMHSA via phone at (240) 276-1848 or by email.
The START Model: Mental Health Services for Children and Adults with IDD

Mental Health & Intellectual/Developmental Disability

Numerous studies have found that, compared to other vulnerable populations, individuals with Intellectual/Developmental Disabilities (including ID and ASD) experience high rates of psychiatric disorders, with roughly 40 percent meeting diagnostic criteria, as well as externalizing and internalizing symptoms. Addressing the mental health needs of individuals with IDD is critical because psychiatric symptoms are severely impairing, resulting in poorer long-term outcomes and functioning for the individual, and lower quality of life.

Despite the prevalence of mental health needs, access to outpatient psychiatric treatment for individuals with IDD is limited. Even when services are available, the Mental Health and IDD service systems are described as fragmented, unresponsive, and insufficient. With limited outpatient options and untrained/unsupported caregivers, there is a high use of local hospital emergency departments for psychiatric care, and IDDMH patients are more likely than others to have extended stays in emergency rooms and mental health inpatient units.

Some mental health providers report they are not adequately trained to treat people with IDD, and traditional mental health outpatient settings report they are not equipped to meet the needs of the population overall. Barriers between IDD support services and mental health treatment providers in the ability to collaborate has undermined the quality of care and access to services in both the IDD and mental health service systems. This longstanding problem has reached crisis proportions in many states struggling to improve care and treatment. In order to improve outcomes, the system of care must work collaboratively, and more research to establish best practices is needed.

The START Program

START (an acronym for Systemic, Therapeutic, Assessment, Resources, and Treatment) is a tertiary care research-based model of services and supports. While providing training, assessment and crisis intervention services, START services are implemented in the context of a comprehensive, systems linkage approach, to improve capacity in the system as a whole.

First established in 1988, START is designed as a lifespan service for individuals ages six and older who are diagnosed with IDDMH. The program aims to strengthen experiences and service outcomes. The goal is to improve diagnosis and treatment, support effective services, create service linkages, promote health and wellness for both the individual with IDD and the caregiver, and reduce the need for emergency services.

START was first cited as a national model program in the 2002 U.S. Surgeon General’s Report on mental health disparities for persons with IDD, Closing the Gap, and as a best practice in overcoming health disparities by the Roundtable on the Promotion of Health Equity and the Roundtable on Health Literacy in 2016 as reported by the National Academy of Sciences in People Living with Disabilities: Health Equity, Health Disparities, and Health Literacy: Proceedings of a Workshop in 2018.

The Center for START Services

The Center for START Services, developed in 2009, is a national initiative based at the University of New Hampshire that provides educational and capacity building services, promotes and evaluates evidence-informed practices and approaches, and facilitates START model program implementation across the United States with the aim of improving the lives of individuals with IDD and behavioral health needs. At the direction of the founder of the START model, Joan B Beasley, PhD, the Center for START Services has facilitated the implementation of the START model in 15 states and actively supports 25 regional START programs.

To improve the overall community of practice, all START programs are linked and evaluated through ongoing data collection via the START Information Reporting System (SIRS), the national START database housed at the Center for START Services at the UNH/IOD. All data entry into SIRS is closely monitored for quality and frequency by the CSS. Investigating service experiences and outcomes among START recipients is highly important to the mission of the program in order to improve mental health service outcomes.

Recent studies have shown promising outcomes for START including improvement in caregiver service experiences and mental health symptoms of START enrolled individuals as well as reduced emergency department and psychiatric inpatient hospitalization usage.

The START National Training Institute | May 6-8, 2019 in DC

The Center for START Services hosts an annual training institute (SNTI) each year on the mental health aspects of intellectual and developmental disabilities. The SNTI provides an avenue for state directors to learn about the approaches promoted by START, as well as funding mechanisms and service outcomes associated with current START programs in Arkansas, Colorado, Iowa, Maryland, New Hampshire, New York, North Carolina, Oklahoma, Texas, Virginia, and Washington.

Learn more and register at centerforstartservices.org.

Recent Publications


Contact Information: Joan B. Beasley, PhD, Director of the Center for START Services, by phone (603) 228-2085 ext. 42 or by email.
Two independent advisory panels to the Food and Drug Administration (FDA) on February 13 jointly endorsed an esketamine nasal spray for the treatment of adults with treatment-resistant depression. While the FDA is not required to follow the recommendation of the panels, the agency does take their advice into consideration.

In a 14-2 vote with one abstention, the Psychopharmacologic Drug Advisory Committee and Drug Safety and Risk Management Advisory Committee concluded the benefits of the esketamine spray Spravato outweigh the risks. But there was much discussion at the meeting regarding whether a proposed Risk Evaluation and Mitigation Strategy (REMS) designed to prevent patient abuse and diversion of the product might prevent some patients from getting access to the treatment.

The committees’ vote on the safety and effectiveness of esketamine was based in part on the results of five Phase 3 studies of esketamine in patients with treatment-resistant depression. As described in background materials made available on the FDA website ahead of the meeting, these studies included three short-term, double-blind, placebo-controlled studies, one randomized withdrawal maintenance-of-effect study, and one long-term, open-label safety study. To participate in these studies, patients were required to have failed at least two prior antidepressant trials at study entry. In each trial, patients were assigned to receive esketamine or a placebo in addition to a newly initiated oral antidepressant.

According to the FDA briefing document, the evidence in support of esketamine’s effectiveness derived primarily from two positive Phase 3 trials, which showed that treatment with esketamine nasal spray plus a newly initiated oral antidepressant was associated with rapid reduction of depressive symptoms and delayed time to relapse of symptoms of depression compared with a placebo nasal spray plus a newly initiated antidepressant.

The safety profile of esketamine was evaluated in both short- and long-term trials, which concluded that the medication was generally tolerable in patients with treatment-resistant depression. The most common adverse events reported by patients in the trials included sedation, dissociation, and increases in blood pressure, with the symptoms most commonly presenting in the two hours following drug administration.

Because esketamine is a similar compound to ketamine—a drug known to be popular for recreational use for its ability to produce “out-of-body” experiences and hallucinations—some experts have expressed concerns about the risks of misuse and abuse. In briefing materials submitted by manufacturer Janssen Pharmaceutical Companies of Johnson & Johnson ahead of yesterday’s meeting, the company stated, “While the potential for abuse, misuse, and diversion exists for esketamine due to its similar pharmacologic profile to ketamine, no evidence of abuse, misuse, or overdose was observed in the esketamine development program with a [treatment-resistant depression] population (note, patients with moderate to severe substance use disorder were excluded from the studies), and possible diversion was minimal (<0.1% clinical supply kits unaccounted for in the Phase 3 studies).”

The FDA is proposing a Risk Evaluation and Mitigation Strategy (REMS) to ensure safe use of esketamine. Among the key elements of the proposed REMS, esketamine patient self-administration would occur only in certain health care settings where the patient could be monitored for two hours after administration, the drug would not be dispensed directly to patients, and patients would be enrolled in a registry to better characterize the risks associated with esketamine administration.” Members of the panels asked the agency to clarify what health care settings would be eligible to dispense the medication and how providers would be trained.

Steven Meisel, system director of medication safety at Fairview Health Services/Healtheast Care System, predicted there would be an issue of access versus control and safety. He described situations in which a patient might want to go on vacation or might live in a rural area and not be able to access medication once a week. Due to such real-life situations, he said, there will be pressure to loosen up the REMS restrictions.

Neither ketamine nor esketamine has been approved for any psychiatric indication worldwide although ketamine is currently being prescribed and administered off-label for major depressive disorder and several other psychiatric indications.

Esketamine, an antagonist of the N-methyl-D-aspartate (NMDA) receptor, was first granted an FDA breakthrough therapy designation for treatment-resistant depression in 2013 and for major depressive disorder with risk of suicide in 2016. According to Janssen, the decision by the FDA on whether to approve the medication is expected by March 4. If approved, it would be the first major therapeutic advance for depression since the introduction of selective serotonin reuptake inhibitors (SSRIs) such as Prozac in 1987.

For related information, see the April 16, 2018 American Journal of Psychiatry article Efficacy and Safety of Intranasal Esketamine for the Rapid Reduction of Symptoms of Depression and Suicidality in Patients at Imminent Risk for Suicide: Results of a Double-Blind, Randomized, Placebo-Controlled Study.
Health Resources and Services Administration (HRSA)
Funding Opportunity Announcement

NHSC Substance Use Disorder Workforce Loan Repayment Program

The most effective treatment for opioid addiction is a comprehensive approach that incorporates medication and behavioral health counseling.

To combat the nation’s opioid crisis, HRSA launched the NHSC Substance Use Disorder Workforce Loan Repayment Program (SUD Workforce LRP). The program supports the recruitment and retention of health professionals needed in underserved areas to expand access to SUD treatment and prevent overdose deaths.

Eligible clinicians may receive up to $75,000 in student loan repayment in exchange for a three-year commitment to provide substance use disorder treatment services at NHSC-approved sites.

- **Service** - You have an opportunity to increase access to primary care services to communities in need.
- **Flexible Service Options** - You have a choice between three years of full-time or part-time service at an NHSC-approved SUD service site. *Note:* If you serve in a private practice, you are not eligible to practice half-time.
- **Loan Repayment** - You will receive funds to repay your outstanding, qualifying, educational loans.

**Eligibility** - To apply for this program, you must be working, or have accepted an offer of employment by the date you submit an application, at an NHSC SUD Workforce LRP-approved service site.

You qualify if you work at a SUD site with a Health Professional Shortage Areas (HPSA) score that would ordinarily be too low to qualify for NHSC funding, using either your NHSC-approved site’s Mental Health or Primary Care HPSA score.

You are eligible for an NHSC SUD Workforce LRP award as long as you are:

- A United States citizen (U.S. born or naturalized) or United States national;
- A provider (or be eligible to participate as a provider) in the Medicare, Medicaid and the State Children’s Health Insurance Program, as appropriate;
- Fully trained and licensed to practice in the NHSC-eligible primary care medical, dental or mental/behavioral health discipline and state in which you are applying to serve; and
- A health professional in an eligible discipline with qualified student loan debt for education that led to your degree.

NHSC SUD Workforce LRP offers awards to providers who use evidence-based treatment models to treat substance use disorders. Evidence-based SUD treatment contributes to combating this epidemic through specific eligibility.

Providers must be trained and licensed to provide SUD treatment at NHSC-approved evidenced-based SUD treatment facilities.

The following disciplines and specialties are eligible to apply to the NHSC SUD Workforce LRP:

- Physicians;
- Nurse practitioners;
- Certified nurse midwives;
- Physician assistants;
- Behavioral health professionals;
- Substance use disorder counselors;
- Registered nurses; and,
- Pharmacists

Find out about specific guidelines and requirements for military reservists.

NHSC SUD Workforce LRP applicants must be working or have accepted a position at an NHSC-approved service site. An NHSC-approved site is a health care facility providing comprehensive outpatient services to populations residing in HPSAs and determined by HRSA to meet the NHSC site eligibility requirements and qualifications.

To be an NHSC-approved SUD site, facilities must have demonstrated that they meet the requirements set forth in the [NHSC Site Agreement](#) and [NHSC Site Reference Guide](#), including submission of [SUD documentation](#).

- SAMHSA-certified opioid treatment programs (OTPs)
- Office-based opioid treatment facilities (OBOTs)
- Non-opioid substance use disorder treatment facilities (SUD treatment facilities)
- Federally Qualified Health Care Centers (FQHCs)
- Rural Health Clinics (RHCs)
- American Indian Health facilities
- FQHC Look-Alikes
- State or federal correctional facilities
- Critical Access Hospitals
- Community health centers
- State or local health departments
- Community outpatient facilities
- Private practices
- School-based clinics
- Mobile units and free clinic

CTRL-CLICK HERE for the Application Process, Requirements, and Guidance
The purpose of this program is to support states and tribes with implementing youth suicide prevention and early intervention strategies in schools, educational institutions, juvenile justice systems, substance use programs, mental health programs, foster care systems, and other child and youth-serving organizations. It is expected that this program will: (1) increase the number of youth-serving organizations who are able to identify and work with youth at risk of suicide; (2) increase the capacity of clinical service providers to assess, manage, and treat youth at risk of suicide; and (3) improve the continuity of care and follow-up of youth identified to be at risk for suicide, including those who have been discharged from emergency department and inpatient psychiatric units.

SAMHSA expects states and tribes to make suicide prevention a core priority in statewide or tribal youth-serving systems. Efforts must include a linkage with health care programs and systems committed to making suicide prevention a core priority through implementation of the National Strategy for Suicide Prevention Goal 8 (promote suicide prevention as a core component of health care services) and Goal 9 (promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors).

In this announcement, the following definitions apply:
- “Youth” means individuals who are between 10 and 24 years of age.
- “Prevention” means a strategy or approach that reduces the likelihood or risk of onset, or delays the onset, of adverse health problems that have been known to lead to suicide.
- “Early intervention” means a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.
- “Schools” means an elementary school or a secondary school as defined in section 8101 of the Elementary and Secondary Education Act of 1969 [20 U.S.C. 7801].

Eligibility: Eligible applicants are:
- States;
- A public organization or private non-profit organization designated by a State to develop or direct the state-sponsored statewide youth suicide early intervention and prevention strategies; or
- A federally recognized Indian Tribe or tribal organization (as defined in the Indian Self- Determination and Education Assistance Act: 25 U.S.C. 5301 et seq.) or an urban Indian organization (as defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) that is actively involved in the development and continuation of a tribal youth suicide early intervention and prevention strategy.

Current recipients who received funding under SM-15-004 GLS State/Tribal Youth Suicide Prevention and Early Intervention are not eligible to receive funding under this FOA.

States/tribes who have been recipients of prior GLS State/Tribal Youth Suicide Prevention funding must address how this funding under this FOA would build on and/or expand the work of the previous grant.

Eligibility is statutorily limited by § 9008 of the 21st Century Cures Act.

Contact Information:
Program Issues: Savannah Kalman, Suicide Prevention Branch, Division of Prevention, Traumatic Stress, and Special Programs, Center for Mental Health Services, SAMHSA via phone at (240) 276-1071 or by email.
Digital interoperability across clinicians, care units, facilities, and systems has become more essential because of increasing complexity in health care, the need for more seamless interfaces among doctors, patients, and families, and the growing number of clinicians across disparate specialties that a typical patient sees. A recent National Academy of Medicine special publication, *Procuring Interoperability: Achieving High-Quality, Connected, and Person-Centered Care*, says better procurement practices, supported by compatible interoperability platforms and architecture, will allow for better, safer patient care; reduced administrative workload for clinicians; protection from cybersecurity attacks; and significant financial savings across multiple markets.

Featuring keynote speaker Seema Verma, administrator of the Centers for Medicare and Medicaid Services, and Harvey Fineberg (by pre-recorded video), president of the Gordon and Betty Moore Foundation, this webinar will discuss the special publication’s roadmap for establishing procurement specifications and how all health care stakeholders can accelerate progress in achieving system-wide interoperability.

The following experts will participate in a panel discussion and Q&A session:
- Raquel Bono, director, Defense Health Agency
- Bill Gregg, chief clinical transformation officer and vice president of clinical informatics, Hospital Corporation of America
- Ben Hohmuth, chief medical informatics officer, Geisinger
- Cris Ross, chief information officer, Mayo Clinic
- Claire Wang, vice president for research, evaluation, and policy, New York Academy of Medicine

**Webinar Registration and Agenda**

**14th Annual Amygdala, Stress and PTSD Conference**
**Risk, Resilience, and Recovery**
**Tuesday, April 16, Uniformed Services University, Sanford Auditorium**

The Amygdala, Stress and PTSD Conference at the Uniformed Services University brings together scientists and clinicians working toward solving the biological basis of stress, fear, and posttraumatic stress disorder. Our speakers this year are again an outstanding group of scientists and clinicians:

- Dennis S. Charney, MD. Dean, Icahn School of Medicine at Mount Sinai | RESILIENCE: The Science of Mastering Life’s Greatest Challenges
- Anne Germain, PhD, University of Pittsburgh School of Medicine | Wake up to Sleep! A Translational Perspective of the Role of Sleep in Readiness and Resilience
- Jessica M. Gill, PhD, National Institutes of Health | Gene-Activity and Proteins That Relate to Chronic PTSD Symptoms
- James L. Griffith, MD, George Washington University School of Medicine and Health Sciences | Mobilizing Hope in the Face of Despair: Applying Social Neuroscience Research
- Irwin Lucki, PhD, Uniformed Services University of the Health Sciences | Preclinical Development of Ketamine and the Metabolite 2R,6R-Hydroxynorketamine For Depression and Other Disorders

The conference is sponsored by the Center for the Study of Traumatic Stress (CSTS) of the Uniformed Services University in collaboration with the USU Department of Psychiatry, USU Neuroscience Program, USU Department of Family Medicine, and the Walter Reed National Military Medical Center, Department of Psychiatry.

**Register HERE**

Registration will remain open through April 9.

Please join us for a reception the evening prior to the conference (Monday, 4/15) at USU from 1800-2000. Open to all. Cost: No charge. RSVP is available on the Registration page. Special thank you to the Henry M. Jackson Foundation for their kind support.
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

National Center of Excellence for Integrated Health Solutions (SM-19-012)

Funding Mechanism: Grant
Anticipated Total Available Funding: $2 million
Anticipated Number of Awards: 1
Anticipated Award Amount: Up to $2 million per year
Length of Project: Up to 5 years
Cost Sharing/Match Required: No
Application Due Date: Friday, March 29, 2019

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2019 National Center of Excellence for Integrated Health Solutions. The purpose of this program is to advance the implementation of high quality, evidence-based treatment for individuals with co-occurring physical and mental health conditions, including substance use disorders. Data demonstrate that individuals with mental health conditions are far more likely to also experience physical health conditions. The co-occurrence of these conditions necessitates the delivery of holistic, integrated care. The goal of this grant is to ensure that these services are provided in the most effective manner possible. The mission and work of the Center of Excellence aligns with SAMHSA’s Strategic Plan Priority 5. Strengthening Health Practitioner Training and Education.

The grantee is expected to:

- Provide training and technical assistance to communities, individual practitioners, providers, and states on evidence-based and effective strategies to address the integration of primary and mental health care for individuals with mental disorders or co-occurring mental and substance use disorders.
- Develop an inventory of resources to be available on-demand for practitioners and providers addressing this population.
- Provide training in a variety of formats including webinars, resource documents, toolkit development, fact sheets, and direct provision of specific technical assistance on implementation. Online modules must be developed that are available on-demand at the convenience of the user.
- Develop fact sheets and other resources geared to the public at large and which will inform caregivers/families of relevant information to provide integrated care.
- Provide direct consultation through an ECHO type model established for the provision of weekly training/consultation which utilizes qualified providers. These models should be used particularly to enhance access to care in rural and other underserved areas.
- Establish a marketing strategy to make known the availability of training and TA and make widely available the products/assistance developed.
- Coordinate with SAMHSA’s other TA Centers, including the Mental Health, Prevention, and Addiction Technology Transfer Centers, Privacy Center of Excellence and the Clinical Support System for Serious Mental Illness to expand the ease of access of healthcare practitioners to technical assistance and training on a wide array of pertinent topics in addressing mental and substance use disorders.

SAMHSA expects an expeditious start-up for this grant given the critical need to disseminate information and training on this topic and the availability of existing resources to do so. SAMHSA expects that by three months post award, resources will be available.

Eligibility: Eligible applicants are domestic public and private nonprofit entities. For example:

- Public or private universities and colleges.
- Behavioral health care organizations.
- National stakeholder organizations.

Contact Information:
Program Issues: Tenley Biggs, Center for Mental Health Services, SAMHSA via phone at (240) 276-2411 or by email.

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) is accepting applications for fiscal year (FY) 2019 Strategic Prevention Framework - Partnerships for Success grants. The purpose of this grant program is to prevent the onset and reduce the progression of substance abuse and its related problems while strengthening prevention capacity and infrastructure at the community level. The program is intended to address one of the nation’s top substance abuse prevention priorities - underage drinking among persons aged 9 to 20. At their discretion, recipients may also use grant funds to target up to two additional, data-driven substance abuse prevention priorities, such as the use of marijuana, cocaine, opioids, or methamphetamine, etc. by individuals ages 9 and above.

The grant program focuses on community-driven efforts to advance substance abuse prevention. By working collaboratively, communities of high need can more effectively begin to overcome the challenges underlying their substance abuse prevention priorities. Additionally, the SPF-PFS grant program seeks to address behavioral health disparities among racial and ethnic minorities and other populations by encouraging the implementation of strategies to decrease the differences in access, service use, and outcomes among the populations served. Recipients must utilize a data-driven approach to identify communities of high need and at-risk populations of focus.

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

- To identify and select comprehensive, data-driven substance abuse prevention strategies to continue to accomplish the following goals:
  1) preventing the onset and reducing the progression of substance abuse;
  2) reducing substance abuse-related problems;
  3) strengthening prevention capacity/infrastructure at the community level; and
  4) leveraging other funding streams and resources for prevention;
  5) implementing a comprehensive prevention approach, including a mix of evidence-based programs, policies, and/or practices that best address the selected prevention priority(ies); and
  6) identifying TA and training needs and the development of responsive activities.

- Build capacity to address underage drinking among persons aged 9 to 20 and up to two additional, data-driven substance abuse prevention priorities in the community.

- Collect and report community-level data to determine progress toward addressing SPF-PFS prevention priority(ies).

- Utilize community coalition building strategies to advance substance abuse prevention efforts across the community.

- Develop prevention messaging and other prevention strategies and ensure dissemination of these messages and strategies.

- Utilize and share effective resources with the Prevention Technology Transfer Centers (PTTCs) to enhance the wide dissemination and adoption of best practices in substance abuse prevention.

Eligibility: Eligibility is limited to 1) Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations, or consortia of tribes or tribal organizations and 2) domestic public or private non-profit entities. Recipients who have received funding under SP-16-003 and SP-18-008 are not eligible to apply for funding under this FOA.

Contact Information:

Program Issues: Tonia F. Gray, M.P.H., Division of State Programs, Center for Substance Abuse Prevention, SAMHSA via phone at (240) 276-2492 or by email & Kameisha Bennett, Division of State Programs, Center for Substance Abuse Prevention, SAMHSA via phone at (240) 276-2586 or by email.

Presented by the Centers for Disease Control and Prevention (CDC)

Hosted by the National Association of State Head Injury Administrators (NASHIA)

For State brain injury administrators, State health departments, and Injury Prevention professionals

Presentation to include the CDC's opioid past and present work in combatting the opioid overdose epidemic; a focus on the potential connections between opioid overdoses and TBI; and how State brain injury programs can collaborate with State health departments to raise awareness of TBI related opioid overdoses.

Questions?: training@nashia.org
Register Now

For the 10th Anniversary Global Mental Health Research without Borders

April 8 & 9

Natcher Conference Center, Bethesda, MD, USA

The NIMH Center for Global Mental Health Research and Grand Challenges Canada will co-convene the 10th anniversary global mental health conference in 2019, bringing together researchers, innovators, and other stakeholders around the theme of Global Mental Health Research without Borders. The conference will showcase findings from cutting-edge science and identify opportunities for groundbreaking research to address the Grand Challenges in Global Mental Health.

The Grand Challenges in Global Mental Health, identified in 2011, are research priorities for achieving mental health equity worldwide, with focused attention on low- and middle-income countries and other low-resource settings. The grand challenges span the research pipeline from preclinical questions about etiology, to translational questions about developing more effective preventive and treatment interventions, to service delivery and implementation questions. These challenges require global cooperation to share research expertise, facilitate data sharing and use of common measures, amplify research capacity-building opportunities, and involve the full range of the world’s researchers, populations, environments, and cultures.

Six research tracks for this year’s conference derive from the Grand Challenges:

- Root causes of mental illness and key targets and times for intervention
- Prevention of mental illness and the delivery of early interventions
- Improved treatment quality, value, and effectiveness
- Integration of mental health services into existing healthcare platforms (e.g., HIV/AIDS, primary care, etc.)
- Implementation of sustainable, evidence-based mental health care
- Sustainable research capacity where it is underdeveloped

Conference activities will include:

- Plenary sessions and keynote addresses
- Thematic panels with paper presentations
- Symposia
- Poster session
- Lunchtime roundtable discussions – Students, trainees, post-docs and early-stage investigators can join senior investigators for a lively discussion at semi-structured lunchtime roundtables

Register HERE for the April 10 Workshop on Writing a Grant Application

National Institute of Mental Health, Rooms A1/A2, Bethesda, MD

On April 10, 2019, the NIMH Center for Global Mental Health Research will hold a one-day workshop on how to write a grant application for submission to NIH, and what to expect from scientific peer review. We encourage participation from early-career and early-stage investigators including but not limited to graduate students, junior faculty, post-doctoral fellows, trainees and others (e.g., non-U.S. researchers having limited experience with NIH funding processes) who attend the 10th anniversary global mental health conference.

This workshop will provide a broad overview of topics that include:

- Identifying NIH funding opportunities
- Developing a study concept and communicating with NIH Program Officers
- Moving from concept to application
- Clinical research guidelines including those related to data and safety monitoring, good clinical practice, and human subjects’ protections
- Submitting an application to the NIH using the Application Submission System & Interface for Submission Tracking (ASSIST)
- Grant application scientific peer review
- Current funding opportunities for research and training in global mental health

There is no cost to attend but interested participants must register because of limited space. After capacity is reached, there will be a webinar platform available for remote participation.
Accreditation  This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of Maryland School of Medicine and the National Council on Alcoholism and Drug Dependence, Maryland. The University of Maryland School of Medicine is accredited by the ACCME to provide continuing medical education for physicians. This activity has been approved for AMA PRA Category 1 Credit.™

About Us  NCADD Maryland, formed in 1988, is a statewide organization that provides education, information, help and hope in the fight against chronic, often fatal diseases of alcoholism, drug addiction, and co-occurring mental health disorders. NCADD Maryland devotes its resources to promoting prevention, intervention, research, treatment and recovery of the disease of addiction and is respected as a leader in the field throughout the state. For more information about NCADD MD, please visit our website at www.ncaddmaryland.org
Alabama Department of Mental Health-Office of Deaf Services and ADARA PRESENTS

Language Deprivation: How Does – or Should – It Change What Professionals in Deafness Do?

Thursday, April 11, 9:30 a.m. to 4:00 p.m. (5.5 clock hours)

*Lunch on your own

$40 Registration fee prior to March 1, 2019; $50 if paid March 1 and after
$20 registration for full time ITP or Counseling Students (Non-certified, non-working) prior to March 1, 2019
$30 registration for full time ITP or Counseling Students (Non-certified, non-working) March 1 and after.

Registration fee waived for employees of ADMH, employees of CMHzCs, and contracted SA provider agencies.

Presenter
Melissa L. Anderson, Ph.D., MSCI

Location
Alabama Department of Transportation 1409 Coliseum Boulevard, Montgomery, AL

A person impacted by language deprivation may struggle with concepts of time, story sequencing/developing a coherent narrative, a sense of self, cause-and-effect/the concept of why?, experiences of powerlessness/confusion, rigid modes of behavior, ability to learn from mistakes (use of generalizations), lacks awareness of others’ need for context, lacks theory of mind (understanding others’ perspectives), lack of understanding of limits to others’ ability to figure out the message, abstract concepts, difficulty learning, emotional regulation, acting out of emotions/feelings, struggles in relationships, can lead to victimization or victimizing, competency to stand trial, reduced fund of information, etc.

This session is targeted at service providers who specialize in some aspect of deafness (therapists, rehabilitation counselors and specialists, direct care staff, substance abuse providers, teachers and education staff, and interpreters, etc.). The presenter will discuss various aspects of working with individuals who are deaf or hard of hearing impacted by language deprivation. This course will include a discussion of barriers that deaf/hard of hearing individuals face, unique characteristics of the population, best practice approaches, and cultural and linguistic differences that are part of the developmental process for deaf and hard of hearing individuals.

During this training, participants will gain a thorough understanding of the impact of language deprivation within the deaf community.
- Discussing the barriers that are present for the deaf population
- Developing population specific skills in recognizing thoughts, behaviors, cultural influences of language deprivation in the deaf population
- Discussing dilemmas that emerge from this field of work

After the training, participants will be able to:
- Identify challenges of work with individuals who are Deaf and have experienced language deprivation.
- Recognize culturally and linguistically appropriate approaches as they relate to deaf and hard of hearing communities;
- Identify strategies to engage deaf and hard of hearing consumers with language deprivation;
- Develop resource strategies for effective treatment and service options
- Discuss interpreting considerations related to communication approaches and alliances

APRIL 11 AUDIENCE: FOR DEAF AND/OR SIGNING PROVIDERS:
Certified Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH and SA Providers, Group Home Staff, Educators, Educational staff, Interpreters in Mental Health, Community Interpreters, Educational Interpreters, etc.

See Page 19 for Application Information
Alabama Department of Mental Health-Office of Deaf Services and ADARA PRESENTS

The Impact Language Deprivation Has On Our Work When Serving Deaf Individuals in Mental Health, Social Service, and Educational Settings

Friday, April 12, 9:00 a.m. to 3:00 p.m. (5.0 clock hours)
* Lunch on your own

$40 Registration fee prior to March 1, 2019; $50 if paid March 1 and after
$20 registration for full time ITP or Counseling Students (Non-certified, non-working) prior to March 1, 2019
$30 registration for full time ITP or Counseling Students (Non-certified, non-working) March 1 and after.

Registration fee waived for employees of ADMH, employees of CMHCs, and contracted SA provider agencies.

$20 registration for full time ITP or Counseling Students (Non-certified, non-working) prior to March 1, 2019
$30 registration for full time ITP or Counseling Students (Non-certified, non-working) March 1 and after.

Location
Alabama Department of Transportation
1409 Coliseum Boulevard, Montgomery, AL

A person impacted by language deprivation may struggle with concepts of time, story sequencing/developing a coherent narrative, a sense of self, cause-and-effect/the concept of why?, experiences of powerlessness/confusion, rigid modes of behavior, ability to learn from mistakes (use of generalizations), lacks awareness of others’ need for context, lacks theory of mind (understanding others’ perspectives), lack of understanding of limits to others’ ability to figure out the message, abstract concepts, difficulty learning, emotional regulation, acting out of emotions/feelings, struggles in relationships, can lead to victimization or victimizing, competency to stand trial, reduced fund of information, etc.

This session is targeted at service providers who do not specialize in deafness yet may work with individuals who are deaf. The presenter will discuss various aspects of deafness and the complications inherent in working with individuals who are deaf or hard of hearing impacted by language deprivation. This course will include a discussion of barriers that deaf/hard of hearing individuals face, unique characteristics of the population, best practice approaches, and cultural and linguistic differences that are part of the developmental process for deaf and hard of hearing individuals.

During this training, participants will have a thorough understanding of the impact of language deprivation within the deaf community.
- Discussing developmental and linguistic barriers that are present for the deaf population
- Developing population specific skills in recognizing thoughts, behaviors, cultural influences of language deprivation in the deaf population
- Discussing dilemmas that emerge from this field of work

After the training, participants will be able to:
- Identify challenges of work with individuals who are Deaf.
- Recognize culturally and linguistically appropriate influences as they relate to deaf and hard of hearing communities;
- Identify strategies to engage deaf and hard of hearing consumers with language deprivation;
- Develop resource strategies for effective treatment and service options
- Discuss considerations related to communication approaches and alliances

APRIL 12 AUDIENCE: (HEARING/NON-FLUENT SIGNING/NON-SIGNING PROVIDERS):
Certified Mental Health Professionals, Nurses, Social Workers, Counselors, Rehabilitation Counselors, Case Managers, Psychologists, MH and SA Providers, Group Home Staff, Educators, Educational staff, etc

Melissa L. Anderson, Ph.D., MSCI, is Assistant Professor, psychologist, and clinical researcher in the University of Massachusetts Medical

See Page 19 for Application Information
School Department of Psychiatry. She completed her graduate work at Gallaudet University, where she studied intimate partner violence and trauma in the Deaf community. At UMass, Melissa provides individual therapy to Deaf clients recovering from trauma and addiction and conducts research on best approaches for working with Deaf clients. She is the recipient of a Clinical Research Scholar Award (KL2) administered by the UMass Center for Clinical and Translational Science, with which she and a team of Deaf and Hearing clinicians and community members are developing and testing a digital American Sign Language therapy manual for treating trauma and addiction.

Eligible participants must be in attendance for the full program to receive credit for completing the course.

The Alabama Department of Mental Health
• is approved as a provider of continuing education in nursing by the Alabama Board of Nursing and approves this program for 6.6 contact hours. ABNP0150, Expiration Date: July 12, 2021.
• is an approved provider of continuing education in social work by the Alabama State Board of Social Work Examiners and approves this program for 5.5 contact hours. Provider #0125, Expiration Date: January 31, 2020.
  The Alabama Department of Mental Health Office of Deaf Services
• is an approved RID CMP Sponsor. This activity has been awarded 0.55 CEUs in the area of Professional Studies by The Registry of Interpreters for the Deaf at the “some” Content Knowledge Level for CMP and ACET participants. Activity # 0263.0419.01.
• Has been approved by NBCC as an Approved Continuing Education Provider, ACEP no. 6824. Programs that do not qualify for NBCC are clearly identified. The Alabama Department of Mental Health, Office of Deaf Services is solely responsible for all aspects of this program. Participants completing the program may earn up to a total of 5.5 CE Hours.

Pre-registration is strongly encouraged. Payment may be made by PayPal (CTRL+click on your selection below) or checks can be written to ADARA and mailed to address indicated below:
$40 Registration fee prior to March 1, 2019
$50 if paid March 1 and after
$30 registration for full time student prior to March 1, 2019
$20 registration for full time student March 1st and after.

FOR ADDITIONAL INFORMATION, REFUNDS, SPECIAL ACCOMMODATIONS OR TO SUBMIT YOUR REGISTRATION:
Office of Deaf Services
Alabama Department of Mental Health
PO Box 301410,
Montgomery, AL 36130
FAX: 334-242-0796
DACTS@mhit.org

In the event either workshop is cancelled, you will be notified by email. No refunds will be provided for participant cancellation.

Please print clearly.

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New Publication: TIP 61: Behavioral Health Services for American Indians and Alaska Natives

SAMHSA’s new Treatment Improvement Protocol (TIP), TIP 61: Behavioral Health Services for American Indians and Alaska Natives (TIP 61), provides practical and culturally relevant guidance on how best to provide effective behavioral health services to clients in this population. TIP 61 is divided into three parts:

- **Part 1** focuses on American Indian and Alaska Native history, historical trauma, and critical cultural perspectives. It discusses demographics, social challenges, and behavioral health, highlighting the importance of providers’ cultural awareness, competence, and culture-specific knowledge. It also describes specific treatment interventions, including traditional American Indian and Alaska Native interventions and cultural adaptations to standard behavioral health approaches.

- **Part 2** is intended for administrators, program managers, and clinical and other supervisors to help foster a culturally responsive environment for American Indian and Alaska Native clients. Specific topic areas include workforce development, considerations in program and professional development, and culturally responsive program policies and procedures.

- **Part 3** provides a literature review.

Download TIP 61
CALL FOR PROPOSALS
APHSA National Health and Human Services Summit

Submissions Due by February 19, 2019

The American Public Human Services Association (APHSA) is accepting proposals for the APHSA 2019 National Health and Human Services Summit, May 19-22 in Arlington, VA.

APHSA is elevating critical policy discussions and providing an opportunity for collective conversations with the Administration and Congress for a shared path forward for a modern, responsive and effective human service system.

We are seeking proposals that will create conversations, engage public and private partners from the health and human services sector and include thought leaders in the field.

The agenda will be organized in these four areas:
- Operational Optimization
- Healthier Communities Through Prevention
- Policy and Practice Solutions for Family and Community Well-being
- Equity

Submissions are due by Tuesday, February 19, 2019.

Submit Your Proposal >>

- To submit and access the Call for Papers, please click here.
- Download this guide to help craft your submission.

For questions regarding the submission process please contact Donna Jarvis-Miler, djarvis-miller@aphsa.org.
Office of Science Policy and Communications,
National Institute on Drug Abuse/National Institutes of Health

Applications Due March 14, 5 p.m. Local Time

HEAL Initiative: Coordinating Center to Support NIDA Preventing Opioid Use Disorder in Older Adolescents and Young Adults (ages 16–30) Initiative (U24 Clinical Trial Not Allowed) – RFA-DA-19-034

NIDA is seeking cooperative agreement applications to participate in the HEAL Preventing Opioid Misuse and Opioid Use Disorder in Older Adolescents and Young Adults (ages 16-30) initiative administered by NIDA. This initiative will consist of research grants and a Coordinating Center, focused on establishing the evidence base for interventions and strategies to prevent initiation of opioid misuse and development of Opioid Use Disorder (OUD) in at-risk older adolescents and young adults. Of priority are studies that target older adolescents and young adults in health care settings (including emergency departments, surgical, orthopedic and other specialty care, dental care, primary care, urgent care, HIV/STI and reproductive health clinics, prenatal clinics, federally qualified health centers, school-based health centers, military and veteran health care settings, behavioral health systems, and occupational health settings); justice settings (including criminal justice, juvenile justice, as well as child welfare and other systems that intersect with the justice system); and, other systems and settings opportune for accessing and engaging at-risk older adolescents and young adults. The purpose of this FOA is to fund a single Coordinating Center to centralize support for individual research projects supported through the HEAL Prevention initiative. The Coordinating Center will be responsible for an array of scientific and logistical support activities in the following four broad areas: coordination and communication, data collection and management, implementation design and methodology consultation and economic evaluation.

HEAL Initiative: Preventing Opioid Use Disorder in Older Adolescents and Young Adults (ages 16–30) (UG3/UH3 Clinical Trial Required) – RFA-DA-19-035

As part of the NIH Helping to End Addictions Long-term (HEAL) initiative to speed development and implementation of scientific solutions to the national public health opioid crisis, NIDA is seeking cooperative agreement applications to participate in the HEAL Preventing Opioid Misuse and Opioid Use Disorder in Older Adolescents and Young Adults (ages 16-30) initiative administered by NIDA. This initiative will consist of research grants and a coordinating center, focused on establishing the evidence base for interventions and strategies to prevent initiation of opioid misuse and development of Opioid Use Disorder (OUD) in at-risk older adolescents and young adults. Of priority are studies that target older adolescents and young adults in health care settings (including emergency departments, surgical, orthopedic and other specialty care, dental care, primary care, urgent care, HIV/STI and reproductive health clinics, prenatal clinics, federally qualified health centers, school-based health centers, military and veteran health care medicine settings, behavioral health systems, and occupational health settings); justice settings (including criminal justice, juvenile justice, as well as child welfare and other systems that intersect with the justice system); and other systems and settings opportune for accessing and engaging at-risk older adolescents and young adults.

SAMHSA’s new 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.
The Patient-Centered Outcomes Research Institute (PCORI) has had an ongoing interest in funding high-quality clinical studies that compare the effectiveness of evidence-based clinical strategies to treat anxiety disorders in children, adolescents, and/or young adults. PCORI intends to release a new funding announcement for this topic in January 2019. Clinical strategies to be studied may include pharmacological interventions, psychological interventions, or a combination of both. Each proposed comparator must be clearly defined, evidence-based, widely available, and appropriate for the age range and clinical severity of the study population.

The proposed study population should include patients with a confirmed clinical diagnosis of a primary anxiety disorder and who are between 7 and 25 years of age. Applicants must clearly define the specific age range to be studied and provide a scientific rationale for the proposed study population and interventions. Applicants should consider several factors when defining their study population, including but not limited to: anxiety severity, type(s) of anxiety disorder(s), exposure to previous treatment(s)/treatment failure, recurrent or relapsed illness, and/or subpopulations. Studies should be conducted in well-defined, primary, specialty and/or integrated clinical care settings where psychological services are consistent and well-characterized.

Randomized controlled trials that compare the effectiveness of treatments are encouraged. Prospective, observational cohort studies that focus on assessing the heterogeneity of treatment effects and/or the comparative tolerability and safety of drugs may also be proposed. All studies should include outcome measures to assess function, symptoms, acceptability of treatment, and the measurement of adverse effects. Studies with a minimum follow-up period of nine months from baseline are sought, with one year of follow-up preferred. In addition, all studies funded through this initiative must include robust sample sizes of at least 300 participants, with sufficient power demonstrated to conduct the proposed analyses.

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**2019 NACBHDD Legislative and Policy Conference**

**Taking Stock of Key Developments**

March 4 through 6

Cosmos Club, 2121 Massachusetts Avenue, N.W., Washington, DC 20008

SAMHSA Assistant Secretary Dr. Elinore McCance-Katz will be joining Conference attendees to provide the latest on SAMHSA and its programs.

**Early Bird Registration by February 1:** $550 for Members; $625 for Non-Members

**Regular Registration after February 1:** $600 for Members, $675 for Non-Members

NACBHDD has arranged a block of sleeping rooms at the Cosmos Club for the nights of March 3-5. Reservations can be made by calling 202-387-7783 and identifying the NACBHDD Room Block.

[Register HERE]
NASUAD’s 2019
Sponsorship and Exhibitor Prospectus

Download HERE

HCBS
NATIONAL HOME & COMMUNITY
BASED SERVICES CONFERENCE

August 26–29, 2019
Baltimore Marriott Waterfront | Baltimore, MD

NASUAD
National Association of States
United for Aging and Disabilities
SAMHSA Funding Opportunity Announcement

Cooperative Agreement to Support the Southeast Asia Regional Technology Transfer Center for HIV and Substance Use and Mental Health (TI-19-006)

Funding Mechanism: Grant
Anticipated Total Available Funding: $700,000
Anticipated Number of Awards: 1
Anticipated Award Amount: Up to $700,000 per year
Length of Project: Up to 3 years
Cost Sharing/Match Required?: No

Application Due Date: February 26, 2019

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2019 Cooperative Agreement to Support the Southeast (SE) Asia Regional Technology Transfer Center (TTC) (Short Title: SEA-TTC) for HIV and Substance Use and Mental Health. The purpose of this program is to strengthen the current work of the SEA-TTC that builds the regional capacity to address the intersection of HIV, substance use and mental health at the policy, systems, and provider level, and increases the skills and abilities of the President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners in the national HIV/AIDS programs of countries in SE Asia through training, technical assistance, technology transfer, and workforce development. Training and technical assistance by an internationally-based TTC in behavioral health service provision includes integrating screening for and treatment of substance use disorders (SUDs), co-occurring substance use and mental disorders, and recovery support services into HIV/AIDS prevention, care, and treatment programs, with the objective of improving patient outcomes. The SEA-TTC will work collaboratively with other SAMHSA-funded internationally-based TTCs and the domestic TTC network (https://attcnetwork.org (link is external)) in developing evidence-based technical assistance for information exchange and technology transfer.

Asia is home to the largest number of people living with HIV (PLHIV) outside of Sub-Saharan Africa. The HIV epidemic is concentrated among key populations (injecting drug users (IDU), commercial sex workers (CSW), men who have sex with men (MSM), and transgender individuals). Studies show that these key populations consume alcohol and drugs, such as methamphetamine and opioids, which can result in risk behaviors that are drivers of the HIV epidemic. Through the development and implementation of regional and local activities, the SE Asia Regional TTC will work collaboratively to strengthen regional capacity to address the intersection of HIV, Substance Use and Mental Health at the policy, systems, and provider level, and increase the skills and abilities of PEPFAR implementing partners in the area of SUD treatment, including co-occurring disorders, and recovery support services as part of the national HIV/AIDS programs in SE Asia supported by PEPFAR, including some or all of the following: Thailand, India, Indonesia, Cambodia, Laos, Papua New Guinea, Burma, and Nepal. Workforce development, training, and technical assistance activities must be conducted in a culturally competent and linguistically appropriate manner.

Eligibility
- Public or private universities and colleges that have a proven experience in leading and working with local institutions in SE Asia region and demonstrated history of working with PEPFAR partners and PEPFAR programs in SE Asia;
- Community- and faith-based organizations that have a proven experience in leading and working with local institutions in SE Asia region and demonstrated history of working with PEPFAR partners and PEPFAR programs in SE Asia; and
- Currently funded SAMHSA Technology Transfer Centers (TTCs), including Addiction TTCs, Mental Health TTCs and Substance Abuse Prevention TTCs.
- These entities are uniquely qualified to implement the program because of their knowledge of, and working experience with the PEPFAR country teams and regional PEPFAR programs in SE Asia.

Contact Information

Program Issues: Humberto Carvalho, Office of Management, Analysis, and Coordination, SAMHSA, by email or by phone at (240) 276-2974.


Application Materials
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for fiscal year (FY) 2019 Provider’s Clinical Support System - Medication Assisted Treatment (Short Title: PCSS-MAT) grant. The purpose of this program is to expand the number of Drug Addiction Treatment Act (DATA) 2000 waived providers, increase understanding of the importance of medication-assisted treatment and ultimately increase access to MAT through expanded prescribing of FDA-approved medications for the treatment of opioid use disorders. Although the current initiative has provided multiple trainings and mentoring support, there still remains a significant need to increase the number of healthcare providers to address the nation’s lack of adequate access to care and treatment for opioid and other substance use disorders. The PCSS-MAT program will continue to provide up-to-date and evidence-based information to support the training of health professionals and to address the complex issues of addiction.

Eligibility

Eligibility is limited to the national professional medical organizations authorized by the Drug Addiction Treatment Act of 2000 (DATA) to carry out the training of providers desiring to prescribe and/or dispense FDA-approved schedule III medications for addictive disorders. These organizations are the American Society of Addiction Medicine (ASAM), the American Academy of Addiction Psychiatry (AAAP), the American Medical Association (AMA), the American Osteopathic Academy of Addiction Medicine (AOAAM), and the American Psychiatric Association (APA). Any of these entities may apply individually; they may also apply as a consortium comprised of all or several of the eligible organizations. If a consortium is formed for this purpose, a single organization in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

If a consortium submits an application, a written agreement must be included outlining the roles and responsibilities of each participating national professional medical organization. This agreement must be signed by an authorized official of each member of the consortium and included in Attachment 3 of the application, “Roles and Responsibilities of Participating National Professional Medical Organizations.”

There is a serious public health issue involving the abuse, misuse, non-medical use and concomitant morbidity and mortality associated with the increased availability of opioids for the treatment of acute pain, chronic pain, and opioid-related addiction. While these medications are mainly obtained legally through prescriptions, SAMHSA surveys indicate significant amounts are obtained through theft and other forms of diversion.

In addition, SAMHSA recognizes the difficulty in assessing patients for appropriate opioid prescribing and the limited training that physicians, psychiatrists, and dentists may receive during their formal, specialized training. Moreover, licensed physicians who have completed their formal training may lack adequate mentoring, continuing medical education, and other resources to evaluate patients and prescribe opioid analgesics appropriately.

To address this public health problem in a timely manner, SAMHSA is limiting eligibility to these five organizations because they have extensive experience providing educational and other support services for addictive disorders to physicians and other substance abuse and healthcare professionals. As such, SAMHSA believes they are uniquely qualified to meet the requirements outlined in this announcement because they have the experience, infrastructure, and capacity in place to expeditiously begin program activities.

Contact Information

Program Issues: Anthony Campbell RPH, D.O., Division of Pharmacologic Therapy, CSAT, SAMHSA, by email of by phone at (240) 276-2702.


Application Materials
Operationalizing State-Community Partnerships for SOC Expansion

This webinar will focus on strategies states and communities can use to create effective partnerships to expand systems of care for children, youth, and young adults with behavioral health challenges and their families. A framework will be presented that outlines the roles of states and communities in SOC expansion and sustainability, along with ideas to enhance partnerships. This webinar is part of the SOC Expansion Leadership LC.

Register NOW

The AAKOMA Project: Engaging African-American Youth and Youth of Color in Addressing Depression and Other Mental Health Needs

Alfiee Breland-Noble, PhD, M.H.Sc, project director for AAKOMA (African American Knowledge Optimized for Mindfully Healthy Adolescents), will present this webinar on increasing access to mental health services through culturally appropriate engagement. The webinar is part of the Cultural and Linguistic Competence LC.

Register NOW

Tribal Policy Guide

The National Indian Child Welfare Association with the collaboration with the Northwest Portland Area Indian Health Board recently developed a Tribal Policy Guide that serves as a tool for tribes involved in the policy making process. The guide offers ideas, concepts, and a tribal framework that relates to how tribal communities may approach the policy process at the community level. This webinar is part of the Tribal System of Care LC.

Register NOW

Adolescent Health: Think, Act, Grow ®

Adolescence is an important developmental period where small interventions can have a significant impact. In 2016, the Lancet Commission on Adolescent Health described the “triple dividend,” in which investments in adolescent health result in benefits to young people now, into adult life, and for future generations. Families play an important role in helping to realize the triple dividend. Join the Family Run Executive Director Leadership Association (FREDLA) to learn about information and resources available from the Office of Adolescent Health.

Register NOW

Registration for the National Wraparound Implementation Academy Opens Soon!

Early bird registration for the National Wraparound Implementation Center’s 4th National Wraparound Implementation Academy (NWIA) opens next month. The NWIA, which will be held Sept. 9-11, 2019 in Baltimore, is a biennial event that provides the opportunity to learn from the field’s foremost experts in Wraparound and systems of care and connect with peers from across the country.

LEARN MORE
Department of Veterans Affairs Notice of Funding Availability
Supportive Services for Veteran Families Program

Application Due Date: February 22, 2019

The Department of Veterans Affairs (VA) is announcing the availability of funds for supportive services grants for new applicants and existing grantees under the Supportive Services for Veteran Families (SSVF) Program. Awards made for supportive services grants will fund operations beginning October 1, 2019.

The SSVF Program provides supportive services grants to private non-profit organizations and consumer cooperatives that coordinate or provide supportive services to very low-income veteran families who: (i) are residing in permanent housing and are at risk of becoming homeless; (ii) are homeless and scheduled to become residents of permanent housing within a specified time period; or (iii) after exiting permanent housing within a specified time period, are seeking other housing that is responsive to such very low-income veteran family's needs and preferences. SSVF prioritizes the delivery of rapid re-housing services to homeless veteran households.

Rapid re-housing is an intervention designed to help individuals and families quickly exit homelessness, return to housing in the community, and avoid homelessness again in the near term. The core components of a rapid re-housing program are: housing identification, financial assistance with move-in and rental expenses, and rapid re-housing case management and services. These core components represent the minimum that a program must be providing to households to be considered a rapid re-housing program, but do not provide guidance for what constitutes an effective rapid re-housing program.

The principle goal for this NOFA is to provide support to those applicants who demonstrate the greatest capacity to end homelessness among veterans or, in communities that have already met US Interagency Council on Homelessness (USICH) Federal Criteria and Benchmarks, or, alternatively, Community Solutions' Functional Zero (the latter can be found at https://cmtysolutions.org/sites/default/files/final_zero_2016_metrics.pdf ), a capacity to sustain these gains. Priority will be given to grantees who can demonstrate adoption of evidence-based practices in their application.

Under Priority 1, VA will provide funding to existing grantees with 3-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) in Employment and Community Services: Rapid Rehousing and Homeless Prevention standards, a 4-year accreditation from the Council on Accreditation’s (COA) accreditation in Housing Stabilization and Community Living Services standards, or a 3-year accreditation in The Joint Commission’s (JC) Behavioral Health Care: Housing Support Services Standards.

Priority 2 includes existing grantees seeking to renew their grants not included under Priority 1.

Under Priority 3, VA will provide non-renewable grants for a 2-year period to eligible entities providing services to very low-income veteran families who are occupying permanent housing in the areas of one of the Continuums of Care (CoC) listed in the Award Information section of this Notice. VA has designed this 2-year effort to provide a surge of resources in communities with high need. Only existing grantees currently providing services in an identified target community are eligible to apply for additional funds in that target community they currently serve under Priority 3.

A CoC plan is a community plan to organize and deliver housing and services to meet the needs of people who are homeless as they move to stable housing and maximize self-sufficiency. The community plan includes action steps to end homelessness and prevent a return to homelessness. Priority 4 is open to new applicants only, who are seeking to provide services in the areas of one of the CoCs listed in the Award Information section of this Notice. These locations have been selected based on the current unmet service needs and the levels of Veteran homelessness, and VA also seeks to ensure that supportive services grants are equitably distributed across geographic regions, including rural communities and tribal lands. Applications for Priority 3 and 4 awards must include a letter of support from the target CoC to be considered for funding. CoC letters of support must contain the information described in the Award Information section of this Notice. (CoC locations and contact information can be found at www.hudhre.nfo/index.cfm?do=viewCocMaps).

Note: VA is considering adding an additional rental subsidy option for Priority 3 awards. Should VA announce this new rental subsidy option it would be noticed through the publication of rulemaking that would amend 38 Code of Federal Regulations (CFR) Part 62.

Copies of the application can be downloaded from the SSVF website at www.va.gov/homeless/ssvf.asp. ..

Technical Assistance: Information regarding how to obtain technical assistance with the preparation of a supportive services grant application is available on the SSVF Program website at: www.va.gov/homeless/ssvf.asp.

FOR FURTHER INFORMATION CONTACT: Mr. John Kuhn, National Director, Supportive Services for Veteran Families at SSVF@va.gov.
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

HRSA Notice of Funding Opportunity

Rural Communities Opioid Response Program (RCORP) Initiative (HRSA 19-082)

The Health Resources and Services Administration’s (HRSA) Federal Office of Rural Health Policy (FORHP) will be releasing a Notice of Funding Opportunity (NOFO) for a new Rural Communities Opioid Response Program (RCORP) initiative called RCORP-Implementation (HRSA-19-082). HRSA plans to award approximately 75 grants to rural communities as part of this funding opportunity.

The funding opportunity will be posted at the following link in the next few weeks: https://www.grants.gov/web/grants/search-grants.html?keywords=hrsa-19-082.

Successful RCORP-Implementation award recipients will receive up to $1 million for a three-year period of performance to enhance and expand substance use disorder (SUD), including opioid use disorder (OUD), service delivery in high-risk rural communities. Award recipients will implement a set of core SUD/OUD prevention, treatment, and recovery activities that align with the U.S. Department of Health and Human Services’ (HHS) Five-Point Strategy to Combat the Opioid Crisis.

Award recipients are encouraged to leverage workforce recruitment and retention programs like the National Health Service Corps (NHSC). We encourage you to learn more about how to become an NHSC site and NHSC site benefits. NHSC-approved sites provide outpatient, primary healthcare services to people in health professional shortage areas.

All domestic public and private entities, nonprofit and for-profit, will be eligible to apply and all services must be provided in HRSA-designated rural areas (as defined by the Rural Health Grants Eligibility Analyzer). Applicants do not need to be current or former RCORP-Planning award recipients to apply for this funding opportunity.

The applicant organization must be part of an established network or consortium that includes at least three other separately-owned (i.e., different Employment Identification Numbers) entities. At least two of these entities must be located in a HRSA-designated rural area.

RCORP is a multi-year initiative by HRSA aimed at supporting treatment for and prevention of SUD/OUD. In FY18, HRSA awarded 95 grants to rural communities under the RCORP-Planning initiative and funded a technical assistance center to support RCORP award recipients. In FY19, in addition to the RCORP-Implementation awards, HRSA anticipates awarding a new round of RCORP-Planning grants and launching a pilot grant program aimed at expanding the number of small rural hospitals and clinics that provide medication-assisted treatment.

You can subscribe to receive updates on this and other funding opportunities through grants.gov: https://www.grants.gov/manage-subscriptions.html. Potential applicants are encouraged to register early with grants.gov, SAM, and DUNS, as the registration process can take up to a month to complete. For more information about RCORP, please contact Federal Office of Rural Health Policy. To learn more about how HRSA is addressing the opioid epidemic, visit https://www.hrsa.gov/opioids.
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 Beyond Beds series of 10 papers highlighting the importance of providing a continuum of care beyond institutional inpatient care. A 2018 10-paper follow-up to the Beyond Beds series is now up on the NASMHPD website. The 2018 papers take the 2017 theme one step further, to look at specific services offered in the community and factors impacting those services, covering such topics as early psychosis intervention, supportive housing and supported employment, suicide prevention for older persons, children’s crisis care coordination in the continuum of care, and trauma-informed interventions, as well as court-ordered referrals to determine competency to stand trial.

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

The NASMHPD Technical Assistance Coalition series will continue in 2019.

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

Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes

Weaving a Community Safety Net to Prevent Older Adult Suicide

Making the Case for a Comprehensive Children’s Crisis Continuum of Care

Achieving Recovery and Attaining Full Employment through the Evidence-Based IPS Supported Employment Approach

Changing the Trajectory of a New Generation: Universal Access to Early Psychosis Intervention

Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness

A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness

Medical Directors’ Recommendations on Trauma-informed Care for Persons with Serious Mental Illness

Speaking Different Languages- Breaking Through the Differences in the Perspectives of Criminal Justice and Mental Health Stakeholders on Competency to Stand Trial Services: Part 1
Visit the New Resources at NASMHPD's Early Intervention in Psychosis (EIP) Virtual Resource Center

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

Snapshot of State Plans for Using the Community Mental Health Block Grant 10 Percent Set-Aside to Address First Episode Psychosis (NASMHPD/NRI)


Training Guide
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
Final Day (September 14) Will Be a NASMHPD Commissioner- & Division-Only Annual Conference Meeting

Discounted Government Rate Room Block at the nearby Madison Hotel in D.C. (a 5-minute walk),
Exclusively for All NASMHPD Attendees

Contact Meighan Haupt, NASMHPD Chief of Staff, With Any Questions

Alzheimer's Disease-and Related Dementias (ADRD) Summit 2019
March 14 & 15, Natcher Conference Center, NIH, Bethesda, MD

The Alzheimer’s Disease-Related Dementias (ADRD) Summit 2019 will be held on March 14-15, 2019, at the NIH. The summit will update national research priorities for ADRDs including frontotemporal, Lewy body, mixed, and vascular dementias. Organized by the National Institute of Neurological Disorders and Stroke with collaboration across the NIH, the summit will be held in response to the National Plan To Address Alzheimer’s Disease.

The goal of the 2019 Summit is to review and assess the progress made for each of the research recommendations developed by previous summits, amend or add recommendations based on recent scientific discoveries, solicit input from diverse stakeholders, and update priorities and timelines for addressing the Alzheimer’s disease-related dementias.

Registration is open and trainees can also find information on the ADRD Summit 2019 Trainee Travel Scholarship.
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NASMHPD Links of Interest

Two Hundred Years of Health and Medical Care, Maryaline Catillon, David M. Cutler, Thomas E. Getzen, VOX CEPR Policy Portal, January 9
Deregulating Health Insurance Markets: Value to Market Participants, White House Council of Economic Advisors, February 2019
Creating the Conditions for Successful Integration of Peer Support Specialists Into Research Studies, Regina M. Hendrix-Brown, M.A. & Gary R. Bourdeau, Psychiatric Services, February 5
Systematic Review of Symptom Assessment Measures for Use in Measurement-Based Care of Bipolar Disorders, Cerimele J.M., M.D., M.P.H., et al., Psychiatric Services, February 5
Interpreters in Transcultural Psychiatry, Skammeritz S., M.D. et al., Psychiatric Services, February 5
Ready, Risk, Reward: Improving Care for Patients with Chronic Conditions, Premier, February 2019
States Use Policy Levers and Emerging Research to Address Antipsychotic Use in Children in Foster Care & Evidence-Based Policymaking Is an Iterative Process: A Case Study of Antipsychotic Use among Children in the Foster Care System, Johanna Butler, Jennifer Reck & Maureen Hensley-Quinn, National Academy for State Health Policy, February 11
Discovering a Source of Laughter in the Brain, Francis Collins, M.D., NIH Director’s Blog, February 11
State Survey: Medicaid Behavioral Health Services Database (as of July 1, 2018), Kaiser Family Foundation/Health Management Associates
Addressing Social Isolation To Improve the Health of Older Adults: A Rapid Review, Agency for Healthcare Research and Quality (AHRQ), February 11