In a published Open Forum article currently posted on-line in *Psychiatric Services, current and former members of NASMHPD’s leadership reflect on the impact of the ongoing COVID-19 pandemic on the state of behavioral health in the U.S.

The article, *The Behavioral Health System and Its Response to COVID-19*, written in April by chair of the NASMHPD Medical Directors Council and Michigan Medical Director Deborah A. Pinals, M.D., NASMHPD C.E.O. Brian Hepburn, M.D., former Medical Directors Council chair and National Council on Behavioral Health Medical Director Joseph Parks, M.D., and former Maryland Acting Secretary of Health and Mental Hygiene Arlene H. Stephenson, M.A.S., reviews the adaptations made to the behavioral health system in response to COVID-19 and suggests needed future multidimensional policy and practice considerations.

The article is a snapshot of:

- changes to communication and coordination;
- the expansion of telehealth, telemedicine, and tele-psychiatry; and
- the impact on health care workers, first responders, racial-ethnic minority populations, and those who have experienced losses of family or supports due to the pandemic and measures implemented to address the pandemic.

The authors acknowledge the assistance provided in responding to the pandemic by local and Federal partners such as the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services. But they add that as the situation continues to unfold, additional solutions will be needed in the realms of policy, technical, and financial relief for populations of all types, ages, races, and ethnicity. They say those solutions will need to be developed for individuals with behavioral health needs who also disproportionally face unique challenges related to issues such as child welfare, forensic or justice involvement, and homelessness.

They add that while Disaster Preparedness for behavioral health has evolved to entail structure and planning, the pandemic has exceeded the capacity of many behavioral health and other systems. They say the pandemic has created an expanded imperative to be nimble and responsive to growing demands, increasing stress, and a rising incidence of illness and death.

**Study Finds Nearly 50 Percent of Medicaid-Enrolled Children, Teens Released from a Psychiatric Hospital Do Not Receive Follow-Up Care within a Week of Discharge, Raising Suicide Risk**

An Ohio State University Wexner Medical Center study has found that nearly 50 percent of Medicaid-enrolled children and adolescents released from a psychiatric hospital do not receive follow-up care within 7 days of discharge and that a lack of follow-up care results in a higher risk of suicide within the ensuing 180 days.

The study published in *JAMA Network Open* on August 11 by Cynthia A. Fontanella, Ph.D. and her colleagues, focused on 139,694 child and adolescent Medicaid enrollees in 33 states admitted for psychiatric hospital stays between January 1, 2009 and December 31, 2013.

The objective of the study was to evaluate whether receipt of outpatient care within 7 days of psychiatric hospital discharge is associated with a reduced risk of subsequent suicide among child and adolescent inpatients and to examine factors associated with timely follow-up care. The National Committee on Quality Assurance and the Centers for Medicare & Medicaid Services endorse follow-up within 7 and 30 days after psychiatric hospitalization as quality indicators, but the authors of the study note the rationale is based on clinical consensus rather than empirical evidence. They suggest that, although some studies have examined the association of timely outpatient follow-up with hospital readmission, the association of timely outpatient care with suicide risk after inpatient psychiatric discharge has not been adequately studied.

The 33 states studied were selected based on quality and completeness of managed care claims. The Medicaid claims data included demographic and clinical characteristics, program eligibility, and detailed services information. To identify date and cause of death information, the Medicaid data were linked with data from the National Death Index. (Continued on page 6)
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| Student Mental Health: Responding to the Crisis, October 6, London |
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Supported Employment Programs Push On Virtually, with Some Returning to In-Person Services

State mental health and vocational rehabilitation agencies utilizing the Individual Placement and Support (IPS) model to place individuals with mental illness in competitive employment have continued to operate, throughout the COVID-19 pandemic, through virtual means, but are beginning now to schedule face-to-face sessions with the mutual agreement of the employment specialist and the client.

The 24 states and 6 countries in the IPS Learning Community convened by Westat shared their experiences on a bimonthly call held on August 4. All of the states have been providing services virtually, but as many as 20 percent of services in one state are now being provided in person.

While states reported a reduction in job referrals ranging from 4 percent to 50 percent, they also reported that a greater number of those clients who have been placed are retaining their employment. Oklahoma reported a 200-person statewide wait list. Interviews for jobs in at least one state have been conducted by phone.

Training of IPS specialists has been ongoing virtually in many states. One state reported that the turnover in specialists has been higher than usual during the pandemic, while another reported that a number of employment agencies have been forced to close due to financial considerations.

A significant number of states have suspended fidelity reviews during the pandemic, substituting such protections as quality assurance measures, technical assistance and mentoring, and training on best practices.

The IPS Learning Center has developed a worksheet to help guide a conversation between IPS specialists or peer specialists with IPS participants about Covid-19. The goal is to provide information about going back to work during this pandemic, and to help individuals weigh the risks and benefits to employment.

The worksheet warns that talking about the pandemic can cause anxiety for some, but that not talking about what is going on can also be stressful. The worksheet suggests that some IPS specialists may prefer to discuss parts of the document on different days so that they do not feel overwhelmed.

The worksheet says discussions about personal safety should be ongoing and notes that clients may change their perspectives if a person in their life becomes infected, if their living situation changes, or if the numbers of new cases of COVID-19 increase in their area.

Tips for talking with IPS clients include:

- Listening;
- Avoiding language that could blame others or lead to stigma for those infected;
- Providing as accurate information on COVID-19 as is possible, double-checking information from the Center for Disease Control (CDC), World Health Organization (WHO), and local public health departments; and
- Keeping the information provided simple, focusing on health and safety and actions to take to reduce spread.
INDIVIDUAL PLACEMENT AND SUPPORT is an evidence-based practice for helping people with serious mental illness gain competitive employment.

People living with serious mental illness want to work. IPS helps them attain their goals.

Studies show 60% of people with SMI want to work, but only about 15% are employed.

Benefits of Work for People with Serious Mental Illness
- Increased self-esteem
- Better control of psychiatric symptoms
- Reduced psychiatric hospitalizations
- Reduced criminal justice involvement
- Increased self-sufficiency
- Decreased dependence on others

THE IPS MODEL IS COST-EFFECTIVE

EMPLOYMENT RATES: IPS VS. OTHER SERVICES
- 60% (IPS)
- 26% (Other Services)

For every 100 people who enroll in IPS in the US, 60 get a job, more than twice as many as those who enroll in any other employment program.

HAVING A JOB CAN REDUCE THE COSTS OF REHABILITATION AND MENTAL HEALTH SERVICES.

A 10-year follow-up study of people with co-occurring serious mental illness and substance use disorder found an average annual savings of more than $16,000 per person in treatment costs for steady workers, compared to clients who remained out of the labor force.

programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral recovery and a focus on what's strong, not what's wrong. More than 50% of employees report a lived experience with mental health, and the "Fusion Model" crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. www.rinternational.com www.zerosuicide.org www.twitter.com/RI_International.

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

The objective is to facilitate conversations about mental health crises, including missed opportunities, gaps, tools, and best practices. #CrisisTalk is sharing the diverse stories of people affected by behavioral health crises, including those who have experienced one, loved ones, and stakeholders who need to be part of the conversation, swinging the pendulum worldwide toward awareness and change. #CrisisTalk interviews reflect the perspectives of mental health experts and first responders. They point out common misconceptions and challenges in their fields and the communities they serve. This includes why some locations do not develop a full continuum of crisis care services. The discussions transcend geography and illustrate ways to make positive changes in the crisis space. Simply having a conversation with a person in crisis, a non-judgmental, empathic approach, along with a willingness to listen and sit with someone, can go a long way.

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

**THIS WEEK: A SOCIAL WORKER’S SUBSTANCE USE AND MENTAL HEALTH RECOVERY JOURNEY**

Wendy Linebrink Allison, MSW, MBA, program manager of the New Mexico Crisis and Access Line, has been in recovery for over 15 years. She says she was jolted into sobriety when she witnessed her husband having a seizure in their front yard. He was experiencing severe withdrawal symptoms from alcohol.

Linebrink Allison was familiar with alcohol use. She’d worked for years as a bartender and, at the time, thought she understood alcoholism and how it impacted people, observing customers become happy or woeful when they drank in excess. What she didn’t know, she says, was the rest of the story until she met her husband. When he didn’t have alcohol in his system, he’d experience convulsions and tremors, withdrawal symptoms she’d been unaware of. “I quickly realized I wasn’t far behind him, and I didn’t want my children to find me in the same condition.” Linebrink Allison decided to take control of her life and find better ways to manage her depression, anxiety, and post traumatic stress without the use of drugs and alcohol.

There were clear markers that it was time for her to make a change, she says. Over the years of substance use, Linebrink Allison lost a home to foreclosure, a car to repossession, and went from job to job. When my kids were born, I made a promise to give them a better childhood than I’d experienced. It was a wake up call that I wasn’t.” Seeing her husband have a seizure due to alcoholism was a turning point in both of their lives. Her husband said, “I don’t want to die but don’t know how to stop drinking.” He had just returned from a 72 hour detox program, and the waitlist at the longer term facilities was between 30 and 60 days. Linebrink Allison began making calls and found a place four hours away in southern New Mexico that could take him that day. “That was the beginning of our recovery journey. It was a crossroad where I either stepped into this new phase or continued to damage myself and others.”

Linebrink Allison decided to have a clean slate, not sharing her challenges with new colleagues and friends. It was isolating. When her colleagues invited her to Friday night happy hour, she would say she was busy, not wanting to explain why she wasn’t drinking. Looking back, she says there were missed opportunities to share her story with people on their way to recovery. “There are unintended consequences of staying in the closet about your experiences.”

**Learn More**

Crisis Now Partners:

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

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

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

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

RI International (d/b/a for Recovery Innovations, Inc.) is a global organization that offers more than 50 programs throughout the United States and abroad, characterized by recovery and a focus on what’s strong, not what’s wrong. More than 50% of employees report a lived experience with mental health, and the “Fusion Model” crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. www.rinternational.com www.zerosuicide.org www.twitter.com/RI_International.
Study Finds Nearly 50 Percent of Medicaid-Enrolled Children and Teens Released from a Psychiatric Hospital Do Not Receive Follow-Up Care within a Week of Discharge, Raising Suicide Risk

(Continued from page 1) The authors found receiving timely follow-up care was associated with a significantly lower adjusted relative risk of suicide (56 percent) during the 8 to 180 days post-discharge period.

Of the 22 youths in the cohort who died by suicide within 6 months of discharge, eight received a mental health service during the first 7 days after discharge. Among youths who died by suicide, most were male, white, and between the ages of 14 and 18 years. Most were diagnosed with a mood disorder. Of the 22 suicides, 23 percent occurred from 8 to 30 days after discharge, 36 percent occurred from 31 to 90 days after discharge, and 41 percent occurred from 91 to 180 days after discharge.

Youth between the ages of 10 and 18 who were admitted to psychiatric hospitals for up to a month, discharged home, and continuously enrolled in Medicaid throughout the next six months were included in the study. Individuals who were readmitted to psychiatric hospitals were excluded.

About one-third of the cohort were ages 10 to 13 (31.1 percent); the rest (68.9 percent) were older teens. Of the total in the cohort, 47.7 percent were male.

Two-thirds (66.7 percent) were enrolled in Medicaid due to poverty, while 19 percent were enrolled due to disability and 14.3 percent were enrolled through their state’s foster care program. About 77 percent stayed in the hospital for 1 to 7 days.

A single psychiatric diagnosis was recorded for most youths (62.5 percent), but 21.7 percent had two or more comorbid psychiatric conditions. Depression (36.4 percent) and bipolar or mood disorders (33.3 percent) were the most common diagnoses. In the six months before hospitalization, only 6.3 percent of youths had a psychiatric inpatient stay, 15.5 percent had a mental health emergency department visit, and 24.2 percent received outpatient mental health treatment.

Just over half of those in the sample attended a mental health follow-up visit within a week of being discharged (56.5 percent), with children of color less likely to receive follow-up care within 7 days of discharge compared with white children. Compared with white children, it was less likely for African American children, Hispanic children, and children of other racial/ethnic groups to receive follow-up care. Also less likely to receive follow-up care were: children with comorbid medical conditions, substance abuse, and recent self-harm. Youths with self-harm had 18 percent lower odds of receiving follow-up care within 7 days and youths with chronic medical conditions had nearly 23 percent lower odds. Youths discharged with a primary diagnosis of depression did not have statistically significant differences from those with schizophrenia or bipolar disorder and other mood disorders in receipt of mental health visits within 7 days.

Foster care youth were more likely to receive follow-up care than children enrolled in Medicaid due to poverty. Children with longer length of stays also tended to be more likely to go on and receive care after discharge.

Teens between 14 and 18 were found by the authors to be less likely to receive follow-up care within a week of discharge than pre-adolescents between the ages of 10 and 13, as were children enrolled in managed care versus fee-for-service care.

The authors of the study note that the findings might not be generalizable to non-Medicaid enrollees or patients with readmissions, and data on some factors like use of psychotropic medication or the nature of linkage services at discharge was not available. In addition, they note that the number of suicides in the cohort was small enough to raise doubts about its statistical relevance.

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

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

After completing this course, attendees will be able to:

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

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

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

Certificate of Completion: To receive a certificate of completion, you must do the following online: complete each lesson, pass the posttest (passing score is 80 percent or higher), and answer the feedback survey questions. You can earn a certificate of completion once per year for each course. We do not offer continuing education credits for any of our courses.
HHS Region III Virtual Adoption Initiative Roundtable
“Strengthening the Child Welfare System”

YOU ARE INVITED!
...to attend Region III’s Virtual Adoption Roundtable. During the Roundtable you will hear from experts in the field of Adoption and how to engage stakeholders in the vision of everyone partnering to help America’s children. Presenters will articulate specific ways each group, from non-profit, philanthropic, faith-based organizations, and businesses can contribute meaningful support to secure homes for children waiting to be adopted.

Featured Speakers:
Eric D. Hargan (invited), Deputy Secretary, U.S. Department of Health and Human Services (HHS)
Lynn Johnson, Assistant Secretary, Administration for Children and Families (ACF)
Matthew E. Baker, Regional Director, HHS Region III
Jerry Milner, Associate Commissioner, Children’s Bureau, ACF
Carlis Williams, Regional Administrator, Regions III & IV, ACF
Jon Rubin, Deputy Secretary, Pennsylvania Department of Human Services
Max Baer, Pennsylvania Supreme Court Justice
Shari Brown, Regional Program Manager, Child Welfare, ACF

Date: Tuesday, August 18, 2020
Time: 2:00 p.m. – 4:45 p.m.
Location: Virtual

Note: All Participants must REGISTER for this event by clicking the link below:

https://acf.adobeconnect.com/epv1luvr0zc6/event/registration.html
CMS Publishes Final Notice for State Basic Health Programs’ 2021 Federal Funding Methodology

Section 1331 of the Affordable Care Act gives states the option of creating a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. The Basic Health Program gives states the ability to provide a coverage option for low-income residents whose income fluctuates above and below Medicaid and Children’s Health Insurance Program (CHIP) levels.

On August 10, the Centers for Medicare & Medicaid Services (CMS) published the final notice for the Basic Health Program (BHP) federal funding methodology for program year 2021. This document provides the methodology and data sources necessary to determine federal payment amounts for program year 2021 to states that elect to establish a BHP.

Medicare Providers Given Second Opportunity to Access Provider Relief Fund

On July 31, 2020, the Department of Health and Human Services (HHS) announced that certain Medicare providers would be given another opportunity to receive additional Provider Relief Fund payments. These are providers who previously missed the June 3, 2020 deadline to apply for additional funding equal to 2 percent of their total patient care revenue from the $20 billion portion of the $50 billion Phase 1 General Distribution, including many Medicaid, Children’s Health Insurance Program (CHIP), and dental providers with low Medicare revenues. In addition, certain providers who experienced a change in ownership, making them previously ineligible for Phase 1 funding, will also be given an opportunity to apply for financial relief.

Starting August 10th, these eligible providers may now submit their application for possible funds by August 28. The deadline aligns with the extended deadline for Medicaid, Medicaid managed care, CHIP, and dental providers.

Latest Eligible Providers for Phase 2 General Distribution Funding

- Providers who were ineligible for the Phase 1 General Distribution because:
  - They underwent a change in ownership in calendar year 2019 or 2020 under Medicare Part A; and
  - Did not have Medicare Fee-For-Service revenue in 2019.
- Providers who received a payment under Phase 1 General Distribution but:
  - Missed the June 3 deadline to submit revenue information – including many Medicaid, CHIP, and dental providers with low Medicare revenues that assumed they were ineligible for additional distribution targeted at Medicare providers or had planned to apply for a Medicaid and CHIP specific distribution; or
  - Did not receive Phase 1 General Distribution payments totaling approximately 2 percent of their annual patient revenue.

- Providers who previously received Phase 1 General Distribution payment(s), but rejected and returned the funds and are now interested in reapplying.

Eligible providers will only receive funding of up to 2 percent of their reported total revenue from patient care. For providers who have already received a General Distribution payment from HHS, the previous amount received and kept will be taken into account when determining the eligible amount for Phase 2 General Distribution payment. All payment recipients must accept HHS’s terms and conditions and may be subject to auditing to ensure the data provided to HHS for payment calculation are accurate.

For the latest information on the Provider Relief Fund Program, visit: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html.

House Energy and Commerce Committee and Subcommittee Leaders Ask HHS Secretary Azar for Briefing on Overdoses During the COVID-19 Pandemic

The chair and ranking member of the House and Energy and Commerce Committee and the chairs and ranking members of the Committee’s subcommittees on Health and Oversight and Investigations on August 11 sent HHS Secretary Alex Azar a letter requesting he provide Committee staff an updated briefing on the latest trends in substance use and overdoses, how those trends are affected by the COVID-19 pandemic, and what more the federal government needs to do to address this growing crisis.

Jim Carroll, head of the White House Office of National Drug Control Policy (ONDCP), told Politico’s Brianna Ehley in late June that ONDCP analysis was showing an 11.4 percent year-over-year increase in overdose fatalities for the first four months of 2020. Many substance use disorder treatment facilities had to close in the early months of the pandemic and shift to telehealth services. It is believed that social isolation measures and economic uncertainties may be increasing the personal stresses leading to drug abuse.

The bipartisan letter was signed by Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR), and subcommittee chairs Anna G. Eshoo (D-CA) and Diana DeGette (D-CO) and ranking members Michael C. Burgess, M.D. (R-TX) and Brett Guthrie (R-GA).

Politico’s Ehley reports there are currently no plans to hold a public hearing on the issue.
The Trump Administration today announced it is further transforming the nation’s rural health care system by unleashing innovation through new funding opportunities that will increase access and improve quality. The Community Health Access and Rural Transformation (CHART) Model delivers on President Trump’s Executive Order from last week on Improving Rural Health and Telehealth Access as well as the President’s Medicare Executive Order and CMS’s Rethinking Rural Health initiative. Collectively, the Administration aims to ensure individuals in rural America have access to high quality, affordable health care.

Per the President’s Executive Order, the CHART Model also ties payment to value, increases choice and lowers costs for patients. CHART will empower rural communities to develop a system of care to deliver high quality care to their patients by providing support through new seed funding and payment structures, operational and regulatory flexibilities and technical and learning support.

Americans living in rural areas have worse health outcomes and higher rates of preventable diseases than the over 57 million Americans living in urban areas. Impediments such as transportation challenges disproportionately impact rural Americans and their access to care. Rural providers also experience challenges. For example, many rural healthcare facilities experience health care workforce shortages, and operate on thin margins and over 126 rural hospitals have closed since 2010. Many rural hospitals also have difficulty recruiting and retaining medical professionals to rural areas. Meanwhile, value-based payment models have accelerated nationally, though rural health care providers have been slow to adopt these models.

Providers interested in the CHART Model have two options for participation:

**Community Transformation Track**

The Trump Administration is investing up to $75 million in seed money to allow up to 15 rural communities to participate in the Community Transformation Track. The upfront investment empowers communities to implement care delivery reform, provide predictable capitated payments, and offer operational and regulatory flexibilities to build a sustainable system of care. Through these flexibilities, health care providers across the community will be able to pursue care transformation such as expanding telehealth to allow the beneficiary’s place of residence to be an originating site and waiving certain Medicare hospital conditions of participation to allow a rural outpatient department and emergency room to be paid as if they were classified as a hospital. The model also allows participant hospitals to waive cost-sharing for certain Part B services, provide transportation support, and gift cards for chronic disease management.

In September, CMS will select up to 15 rural communities to participate in this track, with the winners being announced in early 2021 and the model starting in Summer 2021.

**Accountable Care Organization (ACO) Transformation Track**

This track offers upfront investment to assist rural healthcare providers in improving outcomes and quality for rural beneficiaries. This track builds on the success of the ACO Investment Model (AIM), which has saved $382 million over three years. Providers participating in the ACO Transformation Track will enter into two-sided risk arrangements as part of the Medicare Shared Savings Program (MSSP) and may use all waivers available in the MSSP program. CMS anticipates releasing a Request for Applications in the Spring 2021 and selecting up to 20 rural ACOs to participate in this track starting in January 2022.

For more information, please visit: [https://innovation.cms.gov/initiatives/chart-model/](https://innovation.cms.gov/initiatives/chart-model/)

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

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

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

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

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

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

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

For more information, visit the [AHRQ Cross-Sectional Innovation to Improve Rural Postpartum Mental Health Challenge](https://innovation.cms.gov/initiatives/chart-model/) website.
Tri-County Older Adult Behavioral Health Initiative would like to invite you to a webinar on Aging with Technology!

AGING WITH TECHNOLOGY

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

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

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

Register Here
Final Research Plan: Screening for Depression, Anxiety, & Suicide Risk in Youth

The U.S. Preventive Services Task Force posted today a final research plan on screening for depression, anxiety, and suicide risk in children and adolescents. The draft research plan for this topic was posted for public comment from April 30, 2020 to May 27, 2020. The Task Force reviewed all of the comments that were submitted and took them into consideration as it finalized the research plan. To view the final research plan, please go [here](#).

FROM DRAFT TO FINAL

The Task Force posts its draft research plan and welcomes comments. Anyone can comment on the draft research plan for four weeks. All comments are reviewed and considered for use in writing the final research plan.
Areas of interest include, but are not limited to:

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

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

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

NFSTAC will deliver comprehensive TTA that:

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

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

For more information, please contact Lynda Gargan, Executive Director, at joan@nffcmh.org.

NFFCMH | 15800 Crabbs Branch Way Suite 300, Rockville, MD 20855
Establishing and Building Bed Registry Systems Highlighting the Success Outcomes of the 2019 Transformation Transfer Initiative (TTI) Projects

Wednesday, August 19, PART ONE – Understanding the Essential Elements of an Effective Statewide Bed Registry

Thursday, August 20, PART TWO – Establishing and Building Statewide Crisis Service/Bed Registries: Three Different Models for Success

In a continued effort to assist states in transforming their mental health systems of care, the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). The TTI provides competitive funding awards to States, the District of Columbia, and the Territories to identify, adopt, and strengthen innovative initiatives.

TTI 2019 recipients used the funds to establish and expand comprehensive crisis psychiatric bed registry programs by tracking and monitoring the availability of psychiatric beds. Efforts also included tracking other crisis service supports such as crisis assessment centers, crisis residential programs, respite, mobile crisis teams, and centralized crisis call centers. Recipients used TTI funds to identify, adopt, and strengthen bed registry systems through either a new initiative or expansion of an existing one.

These two webinars will provide insight into how recipients created or expanded their bed registry systems in the hope that their experiences will offer guidance for other states and communities undertaking similar projects.

PART ONE – Understanding the Essential Elements of an Effective Statewide Bed Registry

In this webinar, 2019 TTI states Georgia and Delaware will illustrate the key components of a successful Crisis Services/Psychiatric bed registry and its role in improving crisis services in their states.

Through their experiences, speakers will demonstrate that to develop a successful registry, it is critically important to establish early and ongoing communication with all internal and external organizations and partners, as well as incorporate their input and feedback throughout the process.

States will also share information regarding choosing and adapting technology to meet the needs of partners and end-users, creating training and implementation strategies, and collecting data. Finally, speakers will share lessons learned, successes in sustainability, and forecasts for the future. Each state will offer concrete examples, specific information on their methodologies and technological strategies, and important insights to their process.

Presenters:

Delaware
- Lisa Johnson, Informatics Consultant, HEALTHe Insights
- Kris Fraser, Manager, Research and Evaluation, Delaware Division of Substance Abuse and Mental Health

Georgia
- Debbie Atkins, LPC, Director, Office of Crisis Coordination, Georgia Department of Behavioral Health and Developmental Disabilities
- Jill Mays, LPC, Director, Office of Prevention & Federal Grants, Georgia Department of Behavioral Health and Developmental Disabilities

Register HERE for PART ONE

Closed-captioning is available for these webinars. We do not offer CEU credits. However letters of attendance are offered upon request. If you have any questions please contact Kelle Masten via email or at 703-682-5187.

(Continued on Next Page)
Establishing and Building Bed Registry Systems Highlighting the Success Outcomes of the 2019 Transformation Transfer Initiative (TTI) Projects

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**PART TWO – Establishing and Building Statewide Crisis Service/Bed Registries: Three Different Models for Success**

In this webinar, 2019 TTI states Rhode Island, North Carolina, and New Mexico will showcase their bed registry efforts, each using a different model for success. The three models for bed registries used by TTI 2019 recipients are: 1) search engine system, 2) referral system, and 3) referral network.

Rhode Island will explain its use of the search engine system, in which a platform refines searches by different terms relevant to patient placement, allowing providers to call the appropriate center. North Carolina will discuss the referral system, in which professionals make an assessment and then refer the patient to a hospital or crisis center. Finally, New Mexico will describe the referral network system. This model operates as a bi-directional referral system that refers patients to hospitals and allows hospitals to refer patients to other treatment centers. Each state will discuss how their model works and highlight unique and helpful features.

**Presenters:**

**Rhode Island**

- Olivia King, Behavioral Health IT Coordinator, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

**North Carolina**

- Krista Ragan, MA, BH-CRSys Program Manager, North Carolina Division of Mental Health, Developmental Disabilities & Substance Abuse Services/North Carolina Department of Health and Human Services

**New Mexico**

- Tiffany Wynn, MA, LPCC, Acting Deputy Director, Treatment & Programs Bureau, BHSA
- Hazel Mella, PhD, Staff Manager and Project Director, New Mexico BH Referral Network, BHSA

**Register HERE for PART TWO**

Closed-captioning is available for these webinars. We do not offer CEU credits. However letters of attendance are offered upon request. 
*If you have any questions please contact Kelle Masten via email or at 703-682-5187.*
The coronavirus pandemic has had a disproportionate impact on Native Americans and Tribal communities. Leading up to this current crisis, many state and federal policies undercut tribal sovereignty, leaving tribal healthcare systems underfunded and ill-equipped to respond to the spread of COVID-19 in their communities. In response, Tribes have exercised their inherent sovereignty to implement a range of infection control measures, with community-led initiatives providing creative and nimble solutions to the evolving crisis. This webinar will introduce participants to key principles in Indian law and Tribal public health law, discuss the impact of COVID-19 in Indian Country, and identify response strategies based upon practical experience.

This webinar will provide you with:

- An overview of Federal Indian law and the policies that have resulted in inequities that persist today
- A discussion of Tribal sovereignty and Tribal public health law, including recent Tribal actions to control COVID-19 within Indian Country
- Specific examples of how the pandemic has affected other public health issues in Tribal communities and solutions moving forward

Presenters:

- Ethel Branch, JD, MPP, Founder & Interim Director, Navajo & Hopi Families COVID-19 Relief Fund
- Aila Hoss, JD, Assistant Professor of Law, University of Tulsa College of Law
- Philomena Kebec, JD, Co-Coordinator, Gwayakobimaadiziwin Bad River Needle Exchange
- Heather Tanana, JD, MPH, Assistant Professor (Research), S.J. Quinney College of Law – University of Utah; Associate Faculty, Johns Hopkins University – Center for American Indian Health

The MHDD-NTC is a collaboration between the University Centers for Excellence in Developmental Disabilities at the University of Kentucky, University of Alaska Anchorage, and Utah State University.

Established in 2018 through funding provided by the Administration for Community Living, the training center aims to improve mental health services and supports for people with developmental disabilities. By serving not only as a training center, but also as a national clearinghouse, the training center helps provide access to the most current evidence-based, trauma-informed, culturally responsive practices that address the mental health needs of individuals with developmental disabilities.

Please visit their website at https://mhddcenter.org/
HHS Awards $101 million to Combat Substance Use Disorders to Organizations in 42 States, D.C.

(HRSA), awarded over $101 million to combat substance use disorders (SUD) and opioid use disorders (OUD). The awards support 116 organizations in 42 states and the District of Columbia, with many targeting high-risk rural communities.

Said HHS Secretary Alex Azar. "The pandemic has created particular stresses for many Americans struggling with substance use disorders, and these HRSA awards will help strengthen prevention, treatment, and recovery services, especially in rural America, at this difficult time."

HRSA's Federal Office of Rural Health Policy awarded $89 million to 89 rural organizations across 38 states as part of the Rural Communities Opioid Response Program-Implementation (RCORP-Implementation). Each RCORP-Implementation grant recipient will use the funding to enhance and expand service delivery for SUD and OUD in rural communities. Awardees will work with rural communities to implement a set of core SUD and OUD prevention, treatment and recovery activities grounded in evidence-based or promising practice models which can be tailored to communities’ unique needs. These awards are part of HHS’ broader focus on rural health and human service issues through the Secretary’s Rural Health Task Force and build on the Administration’s commitment to support rural communities under an Executive Order released August 3, 2020.

In addition to the RCORP-Implementation investments, HRSA’s Bureau of Health Workforce awarded nearly $12.5 million to 28 organizations to expand access to behavioral health services for families affected by opioids and other substance use disorders. The Opioid-Impacted Family Support Program (OIFSP) aims to increase the number of training opportunities for behavioral health paraprofessionals working with families, and provides tuition assistance for trainees. Today’s awardees will recruit and train paraprofessionals to work with youth, including in high-need rural areas across the United States.

“These RCORP-Implementation grants are an essential part of HRSA’s overall efforts in helping to combat the opioid epidemic in the rural areas of our country,” said HRSA Administrator Tom Engels. "In addition, behavioral health paraprofessionals play a critical role in taking care of youth and families struggling with substance use disorder and opioid use disorder. This HRSA funding gives trainees the chance to learn in the communities and with the families that most urgently need their services."

For a list of today's RCORP-Implementation award recipients, visit: https://www.hrsa.gov/rural-health/rcorp/implementation/fy20-awards

For a list of today's OIFSP award recipients, visit: https://bhw.hrsa.gov/grants/behavioral-health/opioid-impacted-family-support-fy20-awards

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**Office of Justice Programs Sponsored Webinars**

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

**REGISTER FOR SERIES HERE**

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

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

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

**The Intersection of Community Development and Mental Health: New Factsheet Series:** Build Health Places Network, July 23

**Legislative and Regulatory Steps for a National COVID-19 Testing Strategy,** Mark McClellan, Caitlin Rivers & Christina Silcox, Duke Margolis Center for Health Policy, August 5

**Indoor Air is the Next Coronavirus Frontline,** Bryan Walsh, *AXIOS*, August 8


**BLOG: Using Telemedicine To Make Accurate, Timely Diagnoses: What We Still Need To Learn,** Jeffrey Brady, M.D., M.P.H., Administration for Health Research and Quality (AHRQ), August 7

**CHILD and ADULT Core Set quality measure reporting dashboard,** Medicaid and CHIP Payment and Access Commission (MACPAC), August 2020

**Forty Percent of People with Coronavirus Infections Have No Symptoms, Might They Be the Key to Ending the Pandemic?** Ariana Eunjung Cha, *Washington Post*, August 8


**Providing Employment Services for Job Seekers Remotely,** Nicholas Holz, Andrea Cooper & David Hoff, Institute for Community Inclusion, *Tools for Inclusion*, 2020


**Wildfire Smoke and COVID-19,** Centers for Disease Control and Prevention, July 23

**When Things Aren’t Okay with a Child’s Mental Health,** Perri Klass, M.D., *New York Times*, August 10 (online & August 11 in print)


**Five-Minute Coronavirus Stress Resets: How to Get Unstuck From Your Anxiety,** Jenny Taitz, *New York Times*, August 6 (online & August 11 in print)

**The Coronavirus Is New, but Your Immune System Might Still Recognize It,** Katherine Wu, *New York Times*, August 6 (online & August 11 in print)

**Elevator Anxiety Will Stifle Re-openings,** Felix Salmon, *Axios*, August 9

**Americans Concerned About Schools Re-opening, Returning to ’Normal Life’,** Axios-Ipsos Coronavirus Index, August 11


**Healthcare Workers’ Mental Health and Quality of Life During COVID-19: Results From a Mid-Pandemic, National Survey,** Young K., Ph.D., *et al., Psychiatric Services In Advance*, July 21

**COVID-19 Could Change the Way We Respond to the Opioid Crisis—for the Better,** Bao Y., Ph.D., *et al., Psychiatric Services In Advance*, August 12

**Realizing the Promise of Learning Organizations to Transform Mental Health Care: Telepsychiatry Care As an Exemplar,** Beidas R.S. Ph.D.& Stirman, S.W., Ph.D., *Psychiatric Services In Advance*, August 12

**Psychiatric Training During a Global Pandemic: How COVID-19 Has Affected Clinical Care, Teaching, and Trainee Well-Being,** Richards M., M.D., M.S. & DeBonis K., M.D. *Psychiatric Services In Advance*, June 30

**Mental Health is Reaching a Breaking Point During COVID: How Employers Can Spot Suicide Warning Signs,** Alyssa Place, *Employee Benefit Advisor*, August 12
We Have Added a Virtual HCBS Conference Option
Sign Up Here to be Notified When Registration Opens!

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

Notice of Upcoming Targeted PCORI Funding Announcement
Suicide Prevention: Brief Interventions for Youth -- Cycle 3 2020

Notice of Upcoming Targeted PCORI Funding Announcement
Suicide Prevention: Brief Interventions for Youth -- Cycle 3 2020

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

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

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

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

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

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

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

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

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

Interventions must be evidence-based and/or in widespread use and reproducible. This Targeted PFA preannouncement is provided to allow potential applicants additional time to identify collaborators, obtain stakeholder input on potential studies, and develop responsive, high-quality proposals.
The Department of Behavioral Health and Developmental Disabilities and the Department of Public Health invite you to participate in our **2x2 Series: Self-Care Tips and Support for Managing Life**. These engaging and interactive sessions may be just the break you need from a challenging workday. They are designed to promote wellness and provide self-care tips and support for managing life during these unprecedented times. Each session offers mental health tips and information about reducing/managing stress, working through grief, improving work/life balance, enhancing personal and professional relationships, having fun, and other hot topics.

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

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

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

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

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

**Questions?** Please email DBHDDLearning@dbhdd.ga.gov

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**The MHTTC Network – School Mental Health Initiative**

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

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

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

To view a compilation of MHTTC resources specific to school mental health during the COVID-19 pandemic, please visit our website. For access to all MHTTC trainings and resources, visit the Training and Events Calendar [here](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application) and the Products and Resources Catalog [here](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application).

**Stay informed! Subscribe to MHTTC Pathways HERE**

**MHTTC Pathways** is a monthly eNewsletter that keeps you informed about what is happening within the MHTTC Network. It highlights events, training opportunities, resources, and the latest Network products. Special features help you stay updated on the latest on evidence-based practices, implementation science, and workforce development.
Disasters have the potential to cause emotional distress. Some are more at risk than others:
- Survivors living or working in the impacted areas (youth & adults)
- Loved ones of victims
- First Responders, Rescue & Recovery Workers.

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

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

Disasters Distress Helpline

Call us:
1-800-985-5990

Text:
‘TalkWithUs’ to 66746

Visit:
http://disasterdistress.samhsa.gov

Like us on Facebook:
http://facebook.com/distresshelpline

Follow us on Twitter (@distressline):
http://twitter.com/distressline

Disaster Distress Helpline
PHONE: 1-800-985-5990  TEXT: “TalkWithUs” to 66746

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

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

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

Spanish-speakers:
Text “Hablamos” to 66746

SAMHSA
Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Dept. of Health and Human Services (HHS).
TIPS FOR COPING WITH STRESS AFTER A DISASTER:

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

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

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

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

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

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

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

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

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

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

Call 1-800-985-5990 or text ‘TalkWithUs’ to 66746.

You Are Not Alone.
National Institute on Drug Abuse
Notice of Special Interest (NOSI)

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

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

Background:

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

Research Objectives:

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

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

- Epidemiologic studies of the etiology of co-morbidity that directly lead to the development of targeted preventive intervention research projects; of priority are studies that include prevention scientists as part of the research team, to facilitate the application of findings into next phase prevention intervention development. These can include primary data collection or secondary data analyses.

- Studies of the trajectories of the development of co-morbid substance use, substance use disorders and psychiatric disorders and the ways in which their interactions influence the onset, course and recovery of both; of interest are studies which additionally identify potentially effective points and models of intervention.

- Intervention research to directly address common mechanisms/dimensions that may underlie both substance use disorders and other psychiatric disorders. Among treatment seeking populations, studies to determine whether or how the receipt of evidence-based treatments for psychiatric disorders impact substance use initiation and/or progression to misuse and disorder.

- Strategies for augmenting psychiatric care to prevent substance use initiation and/or progression from use to misuse or disorder. This could include research to test whether and how models of care delivery for mental illness (e.g., the collaborative care model, coordinated specialty care for first episode psychosis) could be leveraged for substance use prevention among at-risk individuals.

- Studies to further understand and prevent suicide and other adverse outcomes (morbidity and mortality) among individuals using illicit substances.

- Research that uses clinically validated digital therapeutics, including mobile applications and other platforms, virtual reality, wireless monitoring and biofeedback, imaging tools for biofeedback to develop, improve and systematically measure behavioral interventions for substance use and psychiatric conditions. Additionally, neuromodulation devices to augment behavior therapies.

- Studies to evaluate the use of medications to improve the efficacy of behavioral interventions for co-morbidities.

- Research to promote adherence to pharmacotherapies, such as buprenorphine, methadone, depot naltrexone, Lofexidine, naloxone, or HAART, in substance abuse treatment populations with comorbidities.

- Studies that develop safe and effective psychosocial interventions to improve the outcomes of pharmacotherapies for substance use disorders including opioid use disorder, overdose reversal, and preventive efforts for psychiatric and suicide risk.

- Research on tobacco harm reduction strategies such as switching from combustibles to e-cigarettes with special attention to individuals with severe mental illness (e.g., schizophrenia, bipolar depression).

- Services research to develop and test strategies to improve system- or provider- capacity for treating and managing co-occurring conditions.

(More on following page)
National Institute on Drug Abuse
Notice of Special Interest (NOSI)

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

(Continued from previous page)

Application and Submission Information

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

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

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

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

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

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

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

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

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The Georgia COVID-19 Emotional Support Line provides free and confidential assistance to callers needing emotional support or resources information as a result of the COVID-19 pandemic. The Emotional Support Line is staffed by volunteers, including mental health professionals and others who have received training in crisis counseling. Hours of operation: 8 am - 11 pm. Call 866.399.8938
We strongly encourage you to register online at our website for the fastest and most efficient process.

SEPTEMBER 10, 2020
8:00 am – 5:00 pm

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

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

Super Saver
$165 includes Lunch and 6 CEUs

Conference Sponsors
Premier
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Platinum
Ashley Treatment Centers • Behavioral Health System Baltimore
Clinic Management and Development Services, Inc. (CMDS)
Delphi Behavioral Health Group • Gaudenzia, Inc.
Kolmac Outpatient Recovery Centers • Maryland Addiction Recovery Center
Maryland Center of Excellence on Problem Gambling • Medmark Treatment Centers
Mountain Manor Treatment Centers • Pathways / Anne Arundel Medical Center
Powell Recovery Center • Project Chesapeake • Recovery Centers of America
Recovery Network • Total Health Care • Tuerk House • Turning Point Clinic
University of Maryland, Drug Treatment Centers
University of Maryland, Medical System, EAP
University of Maryland, Psychiatry, Division of Addiction Research and Treatment
Warwick Manor Behavioral Health
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 and 2018 Beyond Beds series of papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

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

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

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

Effects of CMS’ Measure of Antipsychotic Prescribing Practices for Nursing Facilities on Utilization of Antipsychotic Medications and Changes in Diagnostic Patterns

Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders

A Public Health Approach to Trauma and Addiction

Traumatic Brain Injury and Behavioral Health Treatment

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

Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now?

Schools as a Vital Component of the Child and Adolescent Mental Health System

Addressing Intersecting Social and Mental Health Needs among Transition-Aged Homeless Youth

The NASMHPD Technical Assistance Coalition series will continue in 2020.
Student Mental Health: Responding to the Crisis

Mary Ward House Conference & Exhibition Centre, London
Tuesday, October 6, 2020

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

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

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

Student Mental Health: Responding to the Crisis is our third national conference bringing together domestic and European HE institutes, students, academic/policy researchers, health, social care and counselling services to develop pragmatic approaches to:

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

2020 Attendee Breakdown by Sector.

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

WEBSITE FOR THE SAMHSA-SPONSORED

Center of Excellence for Protected Health Information
Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)
Altering Our Course:
NASHIA's Virtual SOS Conference

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

Format
This event will include a combination of live and recorded sessions in a variety of formats and an exhibit hall for event sponsors and attendees to network and collaborate.

Rate (Covers the entire event.)
$250 for Members
$300 for Non Members
CEUs applied for APA, SW, and CRC.

Location
All events are virtual.

Agenda

Sponsorship Opportunities

Join NASHIA for 2020

Contact Us
For more information, contact INFO@NASHIA.ORG.


A premier event with premier presenters for premier leaders (that's you).
Reserve your seat today!

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

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

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

Part II - Tuesday, August 18, 1:00-2:30 p.m. E.T.

Several drug courts across the country have successfully leveraged teleservices in order to increase client access to medication-assisted treatment as well as a range of evidence-based psychosocial supports for the treatment of substance use disorders (SUD). Part II of this Virtual Learning Community webinar series will feature presentations from drug court practitioners and substance use treatment providers who will outline the various approaches they have taken to integrate teleservices in drug court. Case examples will illustrate several unique models of implementation, including:

- development of a comprehensive teleservices track in drug court,
- drug court partnerships with distance-based SUD telemedicine providers,
- drug court partnerships with community-based SUD treatment providers who offer remote services, and
- the integration of virtual counseling platforms.

Register HERE for PART II

Implementing A Peer Mentor Program: Strategies for Engaging Peer Recovery Support Specialists in Adult Treatment Courts

Monday, August 31, 12:30 p.m. to 2:00 p.m. E.T.

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

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

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

Register HERE

Understanding and Addressing Criminal Thinking

Tuesday, September 1, 2:00 p.m. to 3:30 p.m. E.T.

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

Register HERE
Training and Technical Assistance Related to COVID-19 Resources


Responding to COVID-19: highlight products and resources that can be useful when coping with the effects of widespread public health crises such as:
• Psychosocial Impacts of Disasters: Assisting Community Leaders
• Supportive Practices for Mental Health Professionals During Pandemic-Related Social Distancing

Recorded Webinars: • Substance Use Disorder Services in the Days of a Pandemic: You Need A Bigger Boat!

ATTC Resources: OTP Questions Regarding Sustaining Operations During the Uncertain and Turbulent Times
AATOD, ATTCs, and AAAP are collecting questions from OTPs related to sustaining care, providing support and maintaining a safe work environment for staff during these turbulent and uncertain times. We will compile all questions, work with field experts to determine responses, and develop and disseminate a “FAQ” document. https://attcnetwork.org/centers/global-attc/otp-questions-during-challenging-times-form

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

Upcoming Webinars
Click here to view a full list of our MHTTC Training and Events Calendar and to Register

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

Sign Up for the SAMHSA Mental Health Technology Transfer Center Network Pathways Newsletter

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

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

[Access the Guide HERE](#)
NIMH Funding Opportunity Announcement

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

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

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

This initiative supports pilot work in support of subsequent studies testing the effectiveness of strategies to deliver EBPs in low-resource settings in the United States, in order to reduce disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing, integration in the community, treatment of co-morbid substance use disorders, etc.) for the population(s) served. Of interest are settings where a significant number of children, youth, adults, or older adults with or at risk for mental illnesses can be found and evidence-based mental health treatments or services are not currently delivered. Applications focused on developmental work that would enhance the probability of success in subsequent larger scale projects are also encouraged. Developmental work might include: refining details of the implementation approach; examining the feasibility of novel approaches and technologies; examining the feasibility of data collection including administration of instruments, obtaining administrative or other types of data, etc.; enhancing the protocol for the comparison group and randomization procedures (if appropriate); examining the feasibility of recruiting and retaining participants into the study condition(s); and developing and testing supportive materials such as training curricula. Therefore, collection of preliminary data regarding feasibility, acceptability and engagement of intervention targets is appropriate. However, given the intended pilot nature of the R34 activity code, conducting fully powered tests of outcomes or attempting to obtain an estimate of an effect size may not be feasible.

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

Eligibility

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

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

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

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

Small Businesses For-Profit Organizations Other Than Small Businesses

State Governments County Governments City or Township Governments Special District Governments

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

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

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

Faith-Based or Community-Based Organizations Regional Organizations

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

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

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

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

Background

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

Research Objectives

This initiative is focused on developing and testing the effectiveness of strategies to deliver evidence-based mental health services, treatment interventions, and/or preventive interventions (EBPs) in low-resource mental health specialty and non specialty settings within the United States, where EBPs are not currently delivered or delivered with fidelity, such that there are disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing retention and integration in the community, treatment of comorbid substance use disorders, etc.) for the population(s) served. Of interest are settings where a significant number of children, youth, adults, or older adults with or at risk for mental illnesses can be found and evidence-based mental health treatments or services are not currently delivered. Studies should identify and use innovative approaches to remediate barriers to provision, receipt, or benefit from EBPs and generate new information about factors integral to achieving greater equity in mental health and related functional outcomes for underserved populations. Research generating new information about factors causing/reducing disparities is strongly encouraged.

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

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

Eligibility

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

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

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)
- Nonprofits with and without 501(c)(3) IRS Status (Other than Institutions of Higher Education)
- For-Profit Organizations Other Than Small Businesses
- Small Businesses
- State Governments
- County Governments
- City or Township Governments
- Special District Governments
- Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)
- U.S. Territories or Possessions
- Independent School Districts
- Public Housing Authorities
- Indian Housing Authorities
- Native American Tribal Organizations (other than Federally recognized tribal governments)
- Faith-Based or Community-Based Organizations
- Regional Organizations

NOT Eligible to Apply:

- Non-domestic (non-U.S.) Entities (Foreign Institutions)
- Non-domestic (non-U.S.) components of U.S. Organizations
- Foreign components, as defined in the NIH Grants Policy Statement
The National Center of Excellence for Eating Disorders (NCEED) was created to serve as the centralized hub dedicated to eating disorders education and training for both healthcare providers and the general public. NCEED is partnering with the 3C Institute to develop and launch an interactive, web-based, educational, training platform to ensure that high-quality trainings are provided to health professionals across multiple disciplines.

Visit NCEED’s Website at https://www.nceedus.org/

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

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

Information, Training, and Technical Assistance

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

Get information on mental health services and resources near you, searchable by state or zip code: www.samhsa.gov/find-help
National Center on Advancing Person-Centered Practices and Systems

NCAPPS assists states, tribes, and territories to transform their long-term care service and support systems to implement U.S. Department of Health and Human Services policy on person-centered thinking, planning, and practices. It supports a range of person-centered thinking, planning, and practices, regardless of funding source. Activities include providing technical assistance to states, tribes, and territories; establishing communities of practice to promote best practices; hosting educational webinars; and creating a national clearinghouse of resources to support person-centered practice. Visit the new NCAPPS website for more information.

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

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<th>Myths and Misperceptions about Financing Peer Support in Medicaid</th>
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<td>Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition</td>
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NCAPPS has posted on its website a Health Care Person-Centered Profile to assist people with disabilities, older adults, and others to communicate their needs and preferences with hospital and other health care staff. Depending on state and hospital policy, people with communication, comprehension, and behavioral challenges may face the possibility of a hospital visit without significant others or usual supporters present. To address the heightened challenges this poses, a group of experts in person-centered planning developed a tool that people and their families and caregivers can fill out and share with medical staff upon hospital intake or care site transfer.

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

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

The Profile, instructions, and sample profiles are available at: https://ncapps.acl.gov/covid-19-resources.html
Tips for Telehealth Billing During the COVID-19 Pandemic

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

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

1 TELEHEALTH VISITS THAT REPLACE OFFICE VISITS

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

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

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

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

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<thead>
<tr>
<th>Evaluation and Management Plus Psychotherapy</th>
<th>Family Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 (16-37*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90832+95</td>
<td>Patient not present</td>
</tr>
<tr>
<td>45 (38-52*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90836+95</td>
<td>Patient present</td>
</tr>
<tr>
<td>60 (53+*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90838+95</td>
<td>Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychotherapy Alone</th>
<th>Group Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832+95</td>
<td>90853+95</td>
</tr>
<tr>
<td>90834+95</td>
<td></td>
</tr>
<tr>
<td>90837+95</td>
<td>(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 (16-37*) minutes</th>
<th>45 (38-52*) minutes</th>
<th>60 (53+*) minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90842+95</td>
<td>90844+95</td>
<td>90847+95</td>
</tr>
<tr>
<td>90849+95</td>
<td>90850+95</td>
<td>90852+95</td>
</tr>
</tbody>
</table>

2 TELEPHONE VISITS

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

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

<table>
<thead>
<tr>
<th>5-10 minutes</th>
<th>11-20 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>99442</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>5-10 minutes</th>
<th>11-20 minutes</th>
<th>21-30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>98966</td>
<td>98967</td>
<td>98968</td>
</tr>
</tbody>
</table>
Tips for Telehealth Billing During the COVID-19 Pandemic

3 VIRTUAL CHECK-IN (G2012)
Physicians and others who can bill E/M services can bill for time spent talking to a new or established patient on the telephone or via telephone and video. Generally, the physician is responding to a contact made by the patient. This code should not be billed if the patient has been seen in the 7 days prior to the call or within 24 hours or the soonest available appointment after the brief check-in. The goal of this visit is to see if a patient needs to be seen for further evaluation or if the problem can be resolved through this call.

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

<table>
<thead>
<tr>
<th>Those that bill evaluation and management services should use:</th>
<th>Those that cannot bill evaluation and management services should use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99421 5-10 minutes</td>
<td>G2061 5-10 minutes</td>
</tr>
<tr>
<td>99422 11-20 minutes</td>
<td>G2062 11-20 minutes</td>
</tr>
<tr>
<td>99423 21-30 minutes</td>
<td>G2063 21-30 minutes</td>
</tr>
</tbody>
</table>

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

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

- SMI Adviser
- American Psychiatric Association
- Center for Connected Health Policy
- Centers for Medicare and Medicaid Services
- Federation of State Medical Boards
SMI, Psychotropics, and Sexuality

**Thursday, August 20, 3:00 p.m. to 4:00 p.m. E.T.**

Sex and sexuality are very sensitive and private issues for most people, and even more so for those with mental illnesses. Sexuality is often overlooked in the SMI population and many medications used to treat these disorders impact sexual performance and satisfaction. This presentation will discuss the effects of specific medications in this area and potential solutions, both pharmacological and non-pharmacological.

**Presenter:** Satarria Dilks, DNP, APRN, McNeese State University

**Register HERE**

SMI Adviser Coronavirus Resources

**Recorded Webinars**

- Managing the Mental Health Effects of COVID-19
- Telepsychiatry in the Era of COVID-19

**Physician Continuing Medical Education (CME) Credit**
The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The APA designates this enduring activity for a maximum of 12.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Psychologist Continuing Education (CE) Credit**
The American Psychiatric Association is approved by the American Psychological Association to sponsor continuing education for psychologists. American Psychiatric Association maintains responsibility for this program and its content.

**Nursing Continuing Professional Development (NCPD, formerly CNE) Credit**
The American Psychiatric Nurses Association is accredited with distinction as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

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**Grant Statement**

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**2020 Annual Conference on Advancing School Mental Health October 29 to 31**

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

**Register On-Site**

For Additional Information, Contact Christina Walker, 443-790-4066
SAMHSA’s Early Serious Mental Illness Treatment Locator is a confidential and anonymous source of information for persons and their family members who are seeking treatment facilities in the United States or U.S. Territories for a recent onset of serious mental illnesses such as psychosis, schizophrenia, bi-polar disorder, or other conditions. These evidence-based programs provide medication therapy, family and peer support, assistance with education and employment and other services.

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

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

You Can Access the SMI Treatment Locator HERE

Social Marketing Assistance Available

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

System of Care Cooperative Agreements that are currently funded by SAMHSA should seek social marketing technical assistance through the University of Maryland’s TA Network.

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

Tip Sheets and Workbooks

Getting Started
- Brand Development Worksheet
- Creating Your Social Marketing Plan
- Developing a Social Marketing Committee
- Social Marketing Needs Assessment

Social Marketing Planning
- Social Marketing Planning Workbook
- Social Marketing Sustainability Reflection

Hiring a Social Marketer
- Sample Social Marketer Job Description
- Sample Social Marketer Interview Questions

Engaging Stakeholders
- Involving Families in Social Marketing
- Social Marketing in Rural and Frontier Communities
- The Power of Partners
- Involving Youth in Social Marketing: Tips for System of Care Communities
- The Power of Telling Your Story
Visit the Resources at NASMHPD’s Early Intervention in Psychosis (EIP) Virtual Resource Center

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

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

**Training Guides**

Training Videos: Navigating Cultural Dilemmas About –
1. *Religion and Spirituality*
2. *Family Relationships*
3. *Masculinity and Gender Constructs*

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

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

**Training Webinars for Receiving Clinicians in Community Mental Health Programs:**
1. *Overview of Psychosis*
2. *Early Intervention and Transition*
3. *Recommendations for Continuing Care*

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

**Trauma, PTSD and First Episode Psychosis**

**Addressing Trauma and PTSD in First Episode Psychosis Programs**

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

**Engaging with Schools to Support Your Child with Psychosis**

**Supporting Students Experiencing Early Psychosis in Middle School and High School**

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

**Helping Families Understand Services for Persons with Early Serious Mental Illness: A Tip Sheet for Families**

**Family Involvement in Programming for Early Serious Mental Illness: A Tip Sheet for Clinicians**

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

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

*For more information about early intervention in psychosis, please visit [https://www.nasmhpd.org/content/early-intervention-psychosis-eip](https://www.nasmhpd.org/content/early-intervention-psychosis-eip)*
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NASMHPD Links of Interest


Clinical Course and Molecular Viral Shedding Among Asymptomatic and Symptomatic Patients With SARS-CoV-2 Infection in a Community Treatment Center in the Republic of Korea, Lee S., M.D., et al., JAMA Internal Medicine, August 6

What a Doctor Learns From Watching You on Video Chat, Marion Renault, The Atlantic, August 6

America’s Coronavirus Endurance Test, Howard Markel, The New Yorker, August 6

Health Care Workers of Color Nearly Twice as Likely as Whites to Get COVID-19, Christina Jewett, Kaiser Health News, August 7


Medicaid Funding for Family and Youth Peer Support Programs in the United States, Melissa Schober, M.P.M, & Kathryn Baxter, M.P.S, The Institute for Innovation and Implementation, University of Maryland School of Social Work, August 2020

Why the Coronavirus Is More Likely to ‘Superspread’ Than the Flu, Katherine J. Wu, New York Times, August 7

An Initial Guide to Leveraging the Power of Social Emotional Learning As You Prepare to Reopen and Renew Your School Community, CASEL, May 2020

Coronavirus Resources for 2020-21 Academic Year, National Center for School Mental Health