Congress Increases Suicide Lifeline Funding by 37 Percent, to $19 Million and Funding for Zero Suicide by 43 Percent, to $16.2 Million; CCBCH Grant Funding Increased 33 Percent

Congress remained focused on suicide prevention efforts in its final funding for Fiscal Year 2020, approved in the House December 17, 297-120, and scheduled to be voted in the Senate Thursday before funding for the Federal government runs out December 20.

Under the second of two FY 2020 funding measures devoted to non-defense agencies, $19 million is appropriated for the Suicide Lifeline, an increase of $7 million over FY 2019, and funding for Zero Suicide is increased $7 million, from $9.2 million to $16.2 million.

While the Mental Health Block Grant is funding for the second year at $701.5 million, funding for grants to Certified Community Behavioral Health Centers (CCBHC) within states is increased to $200 million from $150 million and funding for the CCBHC demonstration program under §223 of the Protecting Access to Medicare Act is temporarily extended to May 22, 2020.

Other Substance Abuse and Mental Health Services Administration mental health programs receiving increases include:

- The National Child Traumatic Stress Initiative, an increase of $5 million taking the program to $68,887,000;
- Project Aware, an increase of $31 million over FY 2019, taking the program to $102,001,000;
- Mental Health Awareness training, an increase of $2 million over FY 2019, taking the program to $22,963,000;
- Healthy Transitions, with a $3 million increase taking the program to $28,951,000; and
- Infant and Early Childhood Mental Health, with a $2 million increase taking the program to $7 million.

The Mental Health Block Grant 10 percent set-aside for treating First Episode Psychosis (FEP) and the 10 percent Children’s Mental Health Initiative set-aside for early interventions for individuals under the age of 25 at clinical high risk of developing an episode of FEP continue to be mandated, with funding for the CMHI remaining at the FY 2019 level of $125 million.

The Mental Health Block Grant set-aside for crisis services sought by NASMHPD and the American Psychiatric Association did not get funded, although SAMHSA is directed to provide a comprehensive plan to the Appropriations Committees no later than 60 days after enactment identifying current gaps in mental health care programs, highlighting how programs can help close those gaps, and providing recommendations to meet the needs of those experiencing mental illness.

The funding measure states that $13 million of the NCTSI appropriation is to be for a new competitive process to expand support for universities, hospitals, and community-based programs, and at least $4 million is to be prioritized for mental health services for unaccompanied alien children.

On the Substance Abuse Prevention and Treatment side, $1.5 billion is appropriated for State Opioid Response Grants for State Substance Abuse Agency activities, to be allocated according to a formula using national survey results that the Secretary determines are the most objective and reliable measure of drug use and drug-related deaths. Each state is to receive not less than $4 million, and $50 million is to be made available to Indian Tribes or tribal organizations; with 15 percent of the remaining amount is to go to the States with the highest mortality rate related to opioid use disorders.

In addition:

- funding for first responder training is increased by $5 million to $41 million;
- funding for pregnant and post-partum women is increased $2 million to $31,931,000;
- funding for Building Communities of Recovery is increased by $2 million to $8 million and Congress encourages the use of recovery coaches and ensuring that grants employing peers comply with the highest standards within their respective States; and
- $1 million in new funding is provided for the creation of a Peer Support Technical Assistance Center.

In addition to the temporary extension for the CCBHC demonstration, the Medicaid Money Follows the Person demonstration and the delay in the reduction in disproportionate share hospital payments mandated by the Affordable Care Act are both extended to May 22, 2020, as are the temporary increase in Federal payments to Medicaid programs in the territories and spousal impoverishment protections for individuals receiving home- and community-based services.

The taxes mandated under the Affordable Care Act to pay for private insurance premium subsidies—the health insurance tax, the medical device tax, and the “Cadillac tax” on high benefit policies are all repealed, at a cost of $377 billion in lost revenues.

Also included: a provision raising the minimum customer age for the sale of tobacco to 21.
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The Centers for Medicare & Medicaid Services (CMS) Seeks Nominees for Two Technical Expert Panels (TEPs):

SAVE THE DATE: May 10 to 12 Zero Suicide International 5 Conference in Liverpool, England

SAMHSA Behavioral Health Treatment Services Locator

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Center for Start Services Group Training Course in CIT International Releases Guide to Best Practices in Mental Health Crisis Response

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

SAMHSA Funding Opportunity Announcement: National Child Traumatic Stress Initiative (Category II)

SAMHSA Funding Opportunity Announcement: National Child Traumatic Stress Initiative (Category III)

SAMHSA Funding Opportunity Announcement: Recovery Community Services Program (TI-20-002)

Mental Health & Developmental Disabilities National Training Center: Recruitment for Digital Story-Telling of Lived Experiences

Link to Center of Excellence for Protected Health Information Website

Announcing the National Center of Excellence for Eating Disorders

Additional NASMHPD Links of Interest

Upcoming Webinars from the National Center on Advancing Person-Centered Practices and Systems (NCAPPS)

December 2019 SMI Adviser Webinars / Learning Collaboratives

Check Out the SMI Adviser’s Clozapine Center of Excellence TA Network Webinars and Opportunities

The Early Serious Mental Illness Treatment Locator Has Been Updated with NASMHPD/NRI Data

Social Marketing Assistance is Available 2018 NASMHPD Technical Assistance Coalition “BEYOND BEDS” Working Papers

Resources at NASMHPD's Early Intervention in Psychosis Resource Center

NASMHPD Links of Interest NASMHPD Board & Staff
Brain Connectivity Different for People with a Mood Disorder and History of Suicide Attempt

Brain images are a promising tool to predict individuals at risk for suicidal behaviors, according to a study published in Psychological Medicine. Subjects with a mood disorder and a history of suicide attempt appear to have distinct brain connectivity patterns in comparison to individuals with a mood disorder and a history of suicide ideation and those without a mood disorder.

Jonathan P. Stange, Ph.D., assistant professor of psychiatry at the University of Utah Health, and Scott Langenecker, Ph.D., professor of psychiatry at University of Illinois at Chicago (UIC) conducted a study to better understand brain mechanisms relevant to suicide risk. Currently suicide risk is gauged through self-report and clinical judgment. The researchers used resting-state functional MRI (fMRI) to analyze the connectivity of brain circuits. Langenecker stated in a UIC press release, “For risk factors involved in suicide, the tasks we have to measure are pretty nonspecific and inexact. If we go to the level of the resting-state networks, we’re actually asking the brain to tell us which brain networks and connections are most relevant.”

A total of 212 young adults participated in the study. Participants included: 18 individuals with mood disorders and a history of suicide attempt, 60 individuals with a mood disorder and a history of suicidal ideation, 52 individuals with a mood disorder and no history of suicidal behaviors, and 82 healthy individuals in the comparison group. Study participants with a mood disorder were in remission.

The authors studied the resting-state functional MRI (fMRI) connectivity within and between intrinsic and neural networks, including: (1) cognitive control network (CCN) that is associated with executive functioning skills, problem-solving, and impulsivity; (2) salience and emotional network (SEN) that involves emotional processing and regulation; and (3) default mode network (DMN), which is responsible for engaging in self-focused thought.

Stange and Langenecker found that individuals with a history of suicidal behaviors had distinct brain patterns of connectivity in the CCN and across CCN, SEN, and DMN. Subjects were also re-scanned after one to four months and brain connectivity states were distinguished for individuals with a history of suicidal behaviors. The authors concluded that the extracted data defined the suicidal behavior group with good accuracy, sensitivity and specificity, with ranges between 79 to 88 percent. Specifically, individuals with a mood disorder and a history of suicide attempt had less brain connectivity in the CCN and between the CCN and DMN, even when compared to subjects with a mood disorder and a history of suicidal thoughts. The findings indicate that these distinct brain patterns of neural connectivity are linked to cognitive control and impulsivity.

The researchers conclude that resting-state fMRI may be a promising tool for identifying a subgroup of patients with mood disorders who may be at risk for suicidal behavior and that neuromodulatory treatment approaches, such as improving brain circuit connectivity, may reduce suicide risk. However, the authors caution that future research is warranted to ensure their findings can be replicated because the study had a small cohort (18 individuals) with a mood disorder and a history of suicide attempts. In addition, they suggest a longitudinal design study to measure brain connectivity to provide a better understanding of neuromodulatory intervention.

Suicide Prevention Resource Center

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

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

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

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

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

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

ENROLL HERE
Federal Appeals Court Sends Challenge to Affordable Care Act Back to Texas Judge Who Ruled the Entire ACA Unconstitutional After Agreeing the Individual Insurance Mandate, Absent a Penalty, Lacks Constitutionality

The U.S. Fifth Circuit Court of Appeals has agreed with a lower federal court judge’s ruling that the Affordable Care Act’s mandate that individuals obtain health insurance became unconstitutional when Congress repealed the penalty underlying the mandate, but has asked District Court Judge Reed O’Connor to reconsider his December 14, 2018 ruling that the unconstitutionality of the mandate renders the entire ACA unconstitutional.

In its 2-1 ruling released December 18, the Fifth Circuit sent the case back to the Northern Texas U.S. District Court for additional analysis of remaining provisions of the Affordable Care Act (ACA) as they “currently exist.” The Appellate court directed the lower court to consider what provisions of the ACA are severable from the individual mandate. It also directed the court to consider a Federal government suggestion of enjoining only provisions that damage the plaintiffs in the case—officials from 18 Republican states and two private citizens—or only enjoining them in plaintiff states.

There were originally 19 plaintiff states, but Wisconsin sought and was granted dismissal from the appeal. The remaining plaintiff states are Texas, Alabama, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, West Virginia, and Arkansas.

The Appellate court agreed with Judge O’Connor that, absent a penalty, the individual mandate could no longer be read as a tax, as it was determined to be by the U.S. Supreme Court when it let the ACA stand in the 2012 NFIB decision, based on Congress’ authority to levy taxes. Congress repealed the penalty in December 2017 under the Tax Cuts and Jobs Act after failing to repeal the entire law in March 2017, July 2017, and September 2017.

In his lower court ruling, Judge O’Connor had insisted the law was not severable, saying:

*Congress stated many times unequivocally—through enacted text signed by the President—that the Individual Mandate is “essential” to the ACA. And this essentiality, the ACA’s text makes clear, means the mandate must work “together with the other provisions” for the Act to function as intended. All nine Justices to review the ACA acknowledged this text and Congress’s manifest intent to establish the Individual Mandate as the ACA’s “essential” provision.*

In fact, the individual mandate had been demanded by the insurance industry as the ACA worked its way through Congress in 2009 and 2010, in order to guarantee a risk pool of healthy insureds large enough to balance out the risk of sicker and older patients and those with pre-existing conditions.

But the two-judge majority noted in their opinion that the Federal defendants in the case, *i.e.*, the Justice Department and the Federal agencies charged with enforcing the law, had changed their original litigation position in the lower court that the ACA provision was severable to a position of non-severability, and that Judge O’Connor had been persuaded by that change. However, the defendants subsequently changed their litigation position on appeal—a fact they freely admitted—to argue that relief in the case should be tailored to enjoin enforcement of the ACA in only the plaintiff states—and that any declaratory judgment should only reach ACA provisions that injure the plaintiffs. The Federal defendants suggested that it “would be appropriate to remand to consider the scope of the judgment.”

The majority on the Appellate court agreed that remand would be appropriate for Judge O’Connor to consider those new arguments which he did not have the benefit of considering when he crafted his opinion striking down the entire law. The Appellate court said the District Court was in a far better position than itself to determine which ACA provisions actually injure the plaintiffs and whether the Federal defendants’ arguments have been timely raised. The Appellate court said:

*[W]e place no thumb on the scale as to the ultimate outcome; the district court is free to weigh the federal defendants’ changed arguments as it sees fit.*

The lone dissenter in the ruling and lone Democratic appointee, Judge Carolyn King, said because the mandate now carried no penalty and was unenforceable, nothing further need be said. King said the question of whether the rest of the law could remain once the mandate was severed was easily answered by the fact that Congress left the rest of the law in place when it repealed the penalty. She called the lower court ruling striking the entire ACA “textbook judicial overreach,” saying:

*Limits on judicial power demand special respect in a case like this. For one thing, careless judicial interference has the potential to be especially pernicious when it involves a complex statute like the ACA, which carries such significant implications for the welfare of the economy and the American populace at large. For another, the legitimacy of the judicial branch as a counter-majoritarian institution in an otherwise democratic system depends on its ability to operate with restraint—and especially so in a high-profile case such as the one at bar.*

Judge King said she failed to understand the logic behind “remanding the case for a do-over”.

*Severability is a question of law that this court can review de novo. And the answer here is quite simple—indeed, a severability analysis will rarely be easier. After all, “[o]ne determines what Congress would have done by examining what it did.” [quoting Justice Antonin Scalia in Legal Servs. Corp. v. Velasquez].*

At the time of the lower court ruling, legal experts on both sides of the ruling wrote that Judge O’Connor’s reasoning on severability was faulty and that it was unlikely to be sustained. The expectation is that the anticipated end result, in which the Supreme Court will render a final ruling on appeal, is unlikely to occur before the 2020 Presidential election. The Appellate court ruling came one year and four days after Judge O’Connor’s ruling.

California Attorney General Xavier Becerra, who has led the coalition of now 21 Democratic states defending the ACA since the Trump administration stopped defending the law, says he will petition the Supreme Court to immediately take up the Appellate court’s decision. Becerra says the appellate court’s decision leaves millions of people who are covered under the ACA in limbo and punts on the central question of the lawsuit.
NRI/SMI Adviser Survey on Technical Assistance Needed by State Mental Health Agency Medical Directors, State Psychiatric Hospitals, and Coordinated Specialty Care Providers

NRI and NASMHPD are again working with the American Psychiatric Association’s SMI Adviser, also referred to as the Clinical Support System for Serious Mental Illness (CSS-SMI). This SAMHSA-funded center supports mental health providers to promote person-centered treatment and recovery supports to individuals with SMI. A major task that we are working on with the APA to support this endeavor is an assessment of state mental health systems and their providers to understand their needs regarding how to improve clinical services for individuals with SMI.

As part of the CSS-SMI, APA has built a new website (www.smiadviser.org) designed to assist mental health clinicians and prescribers to find and use information about evidence-based clinical practices in order to aid in making treatment decisions for persons with bipolar disorder, major depressive disorder, and schizophrenia. We want to make sure that the information on SMI Adviser meets the needs of state behavioral health authorities, as well as the clinicians and prescribers that serve individuals with SMI.

To help us determine what types of assistance are most needed in the implementation of Evidence-Based Practices and Clinical Practice Guidelines, NRI is distributing a survey to State Medical Directors, State Hospital Administrators, and CSC Program Leads in each of the states. This 10- to-15-minute survey will help the APA and SAMHSA better understand what types of clinical consultations, training, and other TA would be especially helpful to these audiences. Information from these surveys will be used to help inform the TA activities provided under the CSS-SMI initiative to better meet the needs of behavioral health providers and clinicians. NRI is requesting that these surveys be completed by Friday, December 20th. If you feel you should have received an invitation to participate in this survey but did not, or if you have any questions related to this initiative, please contact Kristin Neylon (kneylon@nri-inc.org).

GAO Report Finds Limited Parity Compliance Monitoring by States, Federal Government

A report on Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance monitoring by the states and Federal government issued by the Government Accountability Office (GAO) on December 16 recommends that the Federal Department of Labor (DOL) and the Department of Health and Human Services (HHS) evaluate whether relying on targeted oversight is effective for ensuring compliance with parity requirements that coverage for mental health and substance use disorder (MH/SU) be no more restrictive than coverage for medical/surgical services or whether alternative approaches are needed.

State agencies, DOL, and HHS share responsibility for overseeing compliance with these MH/SU parity requirements among group and individual health plans.

The report, required under provisions of the 21st Century Cures Act, examines how DOL, HHS, and states oversee health plan compliance with MH/SU parity requirements and describes what is known about the extent to which health plans are complying with MH/SU parity requirements.

While nearly all of the state officials who responded to a GAO survey reported they perform some review of group and individual insurance plans for compliance with MH/SU parity requirements before they are approved to be sold to consumers, states vary in the frequency and type of reviews they conduct after consumers enroll in plans. Officials from 12 states reported that they conducted a targeted review of specific MH/SU parity concerns in 2017 and 2018, with the number of reviews ranging from one to 22 reviews per state.

GAO found that DOL and HHS conduct targeted reviews of certain employer-sponsored group plans when they receive information—such as consumer complaints—about possible noncompliance with MH/SU parity requirements or other federal health care requirements. Unlike states, these reviews only occur after consumers enroll in the plans.

In FYs 2017 and 2018, DOL completed 302 reviews of MH/SU parity compliance in its oversight of 2.2 million plans. Nearly all those reviews originated from complaints or other information about potential noncompliance with Federal health care laws unrelated to MH/SU parity. While states, DOL, and HHS have identified some instances of noncompliance with MH/SU parity requirements based on consumer complaints and other information about potential noncompliance, GAO found that the extent of compliance with parity requirements is unknown.

GAO recommends that DOL and HHS evaluate whether relying on targeted oversight is effective for ensuring compliance with MH/SU parity requirements or whether alternative approaches are needed. DOL and HHS concur with GAO’s recommendations.
The Consensus Workgroup on Behavioral Health Issues in the Criminal Justice System, of which NASMHPD is a member, has sent to Congress and the Trump Administration recommendations for addressing the growing need for mental health treatment in the criminal justice system.

In a December 2019 report, the Consensus Workgroup notes that

Increasingly, criminal justice systems are being called upon to manage individuals with mental illness and substance use disorders (SUD). Although many interactions between police and people with behavioral health disorders are not criminal in nature or are for low-level violations, alternatives to enforcement are lacking and many of these individuals end up in prisons and jails. Attempts to address the problem have resulted in a patchwork of federal, state, and local responses.

The Consensus Workgroup commends Congress for recognizing the problem and taking first steps toward a response, saying that

Recent investments in programs and practices strive to better meet justice-involved individuals’ behavioral health needs, make better use of public resources, protect public safety, and reduce the rate of reoffending and re-arrest. Pre- and post-booking diversion, such as Crisis Intervention Team models and problem-solving courts, help keep those who pose little risk to public safety out of formal criminal justice processes. Significant efforts also are underway to ensure that criminal justice and health agency partnerships, jails, and prisons work together to effectively meet the behavioral health needs of individuals who come into contact with the justice system.

However, the Consensus Workgroup goes on to say that addressing harmful fragmentation across systems requires additional coordination and resources at the Federal level, and that the time has come to achieve reduced recidivism by addressing behavioral health issues in criminal justice in a coordinated, comprehensive reform.

The Consensus Workgroup urges federal policymakers to take immediate action to:

- Establish a clearinghouse on best practices that lead to positive outcomes for people with mental health and SUD issues involved in the justice system;
- Help state and local systems expand efforts to universally screen and assess at arrest, sentencing, and all points across the criminal justice continuum for (1) mental health and substance use disorders to inform connections to appropriate treatment and services; and (2) criminogenic risk and need, to further inform recidivism reduction programming and release decisions;
- Connect justice-involved and at-risk individuals to health care coverage and services by (1) allowing Medicaid to cover services for individuals who are incarcerated but who have not been adjudicated or convicted of crimes; (2) supporting states in suspending, rather than terminating, Medicaid coverage during incarceration; (3) communicating the availability of services to Medicaid recipients, thereby also ensuring compliance with the Federal mental health and substance use disorder treatment parity mandate; (4) connecting individuals to health coverage and services during the re-entry process; and (5) building capacity of comprehensive, community-based mental health and addiction treatment services to meet the needs of justice-involved populations and those at risk of becoming justice-involved;
- Support the specific needs of justice-involved individuals in rural communities through telemedicine and other means of delivering services over longer distances;
- Address behavioral health disparities and the specific needs of populations involved in the justice system, including racial and ethnic minorities, women, individuals with disabilities, older adults, people experiencing homelessness, and sexual and gender minorities;
- Support the integrated treatment of co-occurring disorders; and
- Support the expansion of trauma-informed systems and care.

The Consensus Workgroup also makes recommendations to:

- ensure effective diversion practices at the pre-arrest, pre-trial, and post-adjudication stages; and
- implement effective practices during incarceration and re-entry.

Recommendations for juvenile justice include ensuring robust Federal funding for culturally and developmentally appropriate prevention programs that identify and target services to at-risk juveniles and their families at the first indication of problems, emphasizing diversion for justice-involved youths with behavioral health needs, and expanding and investing in evidence-based screening, assessment, and treatment of both criminogenic and behavioral health needs for youths held in secure detention or corrections.

The report also includes specific recommendations for Federal courts and prisons and behavioral health workforce development, as well as for Federal research, evaluation, and coordination.

The Consensus Workgroup includes, in addition to NASMHPD, The American Psychiatric Association, the American Psychological Association, the Campaign for Youth Justice, the National Alliance on Mental Illness, the National Association of Counties, the National Association of Social Workers, the National Council for Behavioral Health, the National Criminal Justice Association, the Police Foundation, the Treatment Advocacy Center, and the Vera Institute.
**Webinar: Innovative Approaches to Housing for People with Opioid Use Disorder**

*Thursday, January 30, 2020, 12:00 p.m. to 1:00 p.m. E.T.*

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

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

**Speakers:**

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

[Register HERE](#)

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**CMS Innovation Center Announces Awardees for the Maternal Opioid Misuse (MOM) and Integrated Care for Kids (InCK) Models to Combat Opioid Abuse by Pregnant and Post-Partum Moms**

The Centers for Medicare & Medicaid Services (CMS) on December 19 announced the agency had selected 10 states to receive funding under the Maternal Opioid Misuse (MOM) Model and that the agency had issued across seven states eight seven-year cooperative agreements to launch the Integrated Care for Kids (InCK) Model in January 2020.

CMS says the MOM Model has the potential to improve the quality of care and reduce expenditures for pregnant and postpartum women with opioid use disorders (OUD) as well as their infants, increase access to treatment, and create sustainable coverage and payment strategies that support ongoing coordination and integration of care. The InCK Model aims to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable payment models to coordinate physical and behavioral health care with services to address health-related needs.

The initiatives are the next steps in a CMS multi-pronged strategy to combat the nation’s opioid crisis and address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD.

The MOM Model will have a five-year period of performance, beginning in January 2020, with three different types of funding totaling approximately $50,000,000. Awardees will use the funds to transition into the new model of care, and then fully implement their plan. The 10 states awarded MOM Model funding are Colorado, Indiana, Louisiana, Maine, Maryland, Missouri, New Hampshire, Tennessee, Texas, and West Virginia.

The InCK Model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. By bringing together medical, behavioral, and community-based services, InCK will strive to reduce fragmentation in service delivery and expand access to care for children and youth.

InCK funding totaling $126 million will provide Connecticut, Illinois (two awards), New Jersey, New York, North Carolina, Ohio, and Oregon with the flexibility to design interventions for their local communities that align health care delivery with child welfare support, educational systems, housing and nutrition services, mobile crisis response services, maternal and child health systems, and other relevant service systems. Some programs will also include Children’s Health Insurance Program (CHIP) beneficiaries and pregnant woman over age 21 who are covered by Medicaid. Under this model, states and local providers will share accountability for cost and outcomes through the development of a state-specific alternative payment model (APM).
National Initiative Funded by the State Justice Institute is Launched to Improve the Court and Community Response to Mental Illness

The prevalence of mental illness and co-occurring disorders has greatly impacted the community and the justice system. State court leaders require resources, education and training, data, research, best practices and other tools to devise solutions to the growing number of ways state courts are impacted by cases involving individuals with mental and behavioral disorders.

BACKGROUND

In December 2017, the Conference of State Court Administrators (COSCA) adopted the policy paper, *Decriminalization of Mental Illness: Fixing a Broken System*, endorsed by the Conference of Chief Justices (CCJ) in February 2018. This work culminated in *Resolution 6, In Support of Improving the Justice System Response to Mental Illness*, adopted by CCJ/COSCA at the 2018 Annual Meeting. In early 2019, the State Justice Institute (SJI) awarded a three-year strategic initiative grant to the National Center for State Courts (NCSC) to support CCJ and COSCA in its commitment to improve the court and community response to those with mental illness and co-occurring disorders.

**NATIONAL PRIORITIES**

- Conduct Community Mapping Workshops
- Improve Case Flow Management and Address Competency Delays and Deficiencies
- Develop Model Civil Commitment and Assisted Outpatient Treatment Laws
- Promote Diversion and Deflection to Treatment
- Strengthen Partnerships with Other State and National Entities
- Share Practical Resources to Engage Community Stakeholders
- Strengthen Children and Families Through Access to Treatment
- Provide Education and Training Curriculum for Judges, Court Personnel and Others
National Initiative Funded by the State Justice Institute is Launched to Improve the Court and Community Response to Mental Illness (cont’d)

The CCJ/COSCA Advisory Committee, along with NCSC, are providing leadership to improve court and community responses to mental illness and co-occurring disorders. The Advisory Committee includes:

**Co-Chairs**
Hon. Paul Reiber, Chief Justice, Vermont Supreme Court (CCJ)
Hon. Milton Mack, Jr., State Court Administrator, Michigan State Court Administrative Office (COSCA)

**Members**
Hon. Mary Ellen Barbera, Chief Judge, Maryland Court of Appeals (CCJ)
Hon. Nathan Hecht, Chief Justice, Supreme Court of Texas (CCJ)
Nancy Cozine, State Court Administrator, Oregon Office of the State Court Administrator (COSCA)
Hon. Lawrence Marks, Chief Administrative Judge, New York Office of Court Administration (COSCA)
Hon. Steven Leifman, Judge, Miami Dade County, Florida
Hon. Paula Carey, Chief Justice, Massachusetts Trial Court (President, NAPCO)
Paul DeLosh, Department of Judicial Services, Supreme Court of Virginia (Past President, NACM)

**Ex Officio Member** – Hon. David Brewer, Retired Justice, Oregon Supreme Court
**Ex Officio Member** – Jonathan Mattiello, Executive Director, SJI

For additional information, please contact:

Patricia Tobias  
Principal Court Management Consultant  
National Center for State Courts  
707 Seventeenth Street, Suite 2900  
Denver, Colorado 80202  
(303) 308-4307  
ptobias@ncsc.org

Dr. Nicole Waters  
Director, Research Services  
National Center for State Courts  
300 Newport Avenue  
Williamsburg, Virginia 23185  
(757) 259-1574  
nwaters@ncsc.org
Don’t miss out on all #ADAA2020 has to offer! The conference includes 150+ sessions highlighting cutting-edge research and clinical practice treatment concepts centered around anxiety, depression, and co-occurring disorders. With a wide offering of innovative presentations and workshops eligible for CE or CME credits or hours, the 2020 annual conference is the place to be March 19-20, 2020 in San Antonio, Texas. Register today to gain access to great learning and networking opportunities and to benefit from the lowest rate available.

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

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

Check out the latest event and agenda information below.

**Thursday, March 19, 2020**
**Keynote Address:** Resilience in Science and Practice: Pathways to the Future, Ann S. Masten, Ph.D.

**Trending Topics:** Cannabis, Anxiety, and Depression: Cause for Pause or Peace of Mind? Staci Gruber, Ph.D.

**12 Master Clinician Sessions** which will inspire, educate, and challenge you to solve problems and achieve breakthroughs

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

**Friday, March 20, 2020**
**Jerilyn Ross Lecture:** The State of the Art of Toxic Stress and Resilience Research: Implications for Best Practices with Vulnerable Populations, Joan Kaufman, Ph.D.

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

**Scientific Research Symposium:** Resilience From Research to Practice

**Saturday, March 21, 2020**
**Science Spotlights:** Targeting Biological Mechanisms of Resilience to Identify New Therapeutics for Depression and PTSD and A Walk Through the Lifecycle of the Memory Engram

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

The San Antonio Marriott Rivercenter - #ADAA2020 Conference Hotel
The 2020 ADAA Annual Conference (March 19-22) will be held at the San Antonio Marriott Rivercenter (101 Bowie Street, San Antonio, TX 78205) on the San Antonio River. Conference activities including all sessions, exhibits, and receptions take place at the San Antonio Marriott Rivercenter, which will be newly renovated in February. Plan to be there Saturday night (March 21) to help ADAA celebrate our 40th Anniversary! Rooms sell out quickly in San Antonio – so don’t delay! Special ADAA Rate: $229 Single/Double

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

Please reserve your room prior to February 24, 2020.
We welcome your feedback to help guide the future of mental health research efforts and priorities at NIMH. Every five years, NIMH publishes a Strategic Plan for Research to accelerate progress in basic, translational, and clinical science. We have made huge strides in understanding and treating mental illnesses through basic and clinical research since the last Strategic Plan was published in 2015, and now we’re looking ahead to the next five years.

The 2020 Strategic Plan includes four goals that form a broad roadmap for the Institute’s priorities over the next five years, beginning with the fundamental science of the brain and behavior and continuing through to the public health impact of the research we support. Aimed at helping individuals living with mental illnesses and promoting both prevention and cure, NIMH’s high-level goals are as follows:

1. Define the Brain Mechanisms Underlying Complex Behaviors
2. Examine Mental Illness Trajectories Across the Lifespan
3. Strive for Prevention and Cures
4. Strengthen the Public Health Impact of NIMH-Supported Research

How to Submit Feedback

Members of the public are invited to provide comments through January 1, 2020.

- Review the draft Strategic Plan online
- Read the Guide Notice for more information on submitting your comments.
- Submit your feedback electronically via the Request for Information input page, or mail responses to:
  NIMH Strategic Planning Team
  6001 Executive Boulevard, Room 6200, MSC 9663
  Bethesda, MD 20892-9663

The submitted information will be reviewed by NIMH and used at its discretion. Respondents are advised that the government is under no obligation to acknowledge receipt of the information provided and will not provide feedback to respondents. This RFI is for planning purposes only and should not be construed as a solicitation for applications or proposals, or as an obligation in any way on the part of the U.S. government. The government will not pay for the preparation of any information submitted for the government’s use. Additionally, the government cannot guarantee the confidentiality of the information provided.
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) ON-DEMAND WEBINAR:
PCORI Research Documents the Impact of Peer Navigators in Enhancing Health Goals of People with Serious Mental Illness

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

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

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

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

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

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

Funding Mechanism: Grant
Anticipated Total Available Funding: $13,398,000
Anticipated Number of Awards: 14
Anticipated Award Amount: Up to $1,000,000 per year
Length of Project: 4 years
Cost Sharing/Match Required?: No
Application Due Date: Friday, January 24, 2020

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness (Short title: Assisted Outpatient Treatment [AOT]). This four-year program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI). This program is designed to work with courts to allow these individuals to obtain treatment while continuing to live in the community and their homes.

Eligibility: Eligible Applicants are: states, counties, cities, mental health systems (including state mental health authorities), mental health courts, or any other entity with authority under the law of the state in which the applicant is located to implement, monitor, and oversee AOT programs. Applicants must operate in jurisdictions that have in place an existing, sufficient array of services for individuals with serious mental illness (SMI), such as Assertive Community Treatment (ACT), mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma informed care.

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

NIMH Funding Opportunity Announcement

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

Open Date (Earliest Submission Date) / Letter of Intent Date: January 24, 2020
Application Due Dates: February 24, 2020 & August 25, 2020, both 5:00 p.m. Local Time of Applying Entity
Earliest Start Date: September 2020 & April 2021, respectively

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

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

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

The goal of this FOA is to conduct pilot work in support of subsequent studies that develop and 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 in the general population studies.

Eligible Applicants

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

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

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

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

Small Businesses For-Profit Organizations Other Than Small Businesses

State Governments County Governments City or Township Governments Special District Governments

Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)
U.S. Territories or Possessions Independent School Districts Public Housing Authorities Indian Housing Authorities

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

Faith-Based or Community-Based Organizations Regional Organizations

NOT Eligible to Apply: Non-domestic (non-U.S.) Entities (Foreign Institutions). Non-domestic (non-U.S.) components of U.S. Organizations. Foreign components, as defined in the NIH Grants Policy Statement.
Approximately 100,000 young persons in the United States experience a first episode of psychosis every year. During the same interval, it is estimated that over one million children and adolescents experience problems in perception, thinking, mood, and social functioning suggestive of a pre-psychosis risk state. Given the highly disruptive and disabling nature of psychotic disorders, early intervention has been recommended as a means of preventing psychosis onset among at-risk individuals, as well as averting other adverse outcomes such as mood syndromes, substance abuse disorders, and functional decline in social, academic, and vocational domains.

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

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

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

**Eligible Applicants**

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

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

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

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

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

Small Businesses 
For-Profit Organizations Other Than Small Businesses

State Governments 
County Governments 
City or Township Governments 
Special District Governments

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

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

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

Faith-Based or Community-Based Organizations 
Regional Organizations

Non-domestic (non-U.S.) Entities (Foreign Institutions) **are** eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations **are not** eligible to apply. Foreign components, as defined in the NIH Grants Policy Statement, **are allowed**.
This Funding Opportunity Announcement (FOA) invites applications for a CHR Data Processing, Analysis and Coordination Center (DPACC) to support and extend the work of the proposed Clinical High Risk for Psychosis Research Network to be funded under RFA-MH-20-340. The DPACC will provide oversight and coordination of two parallel lines of inquiry: 1) The aggregation of extant CHR-related data sets and subsequent secondary analyses for refinement of multi-modal biomarkers and development of biomarker algorithms that predict individual clinical trajectory and outcomes and 2) the management, direction, and overall coordination, including data processing and analysis, for a new multi-site network(s) focused on dissecting the heterogeneity of the CHR syndrome. Toward achieving the first goal, the DPACC – in conjunction with NIMH and external working groups - will identify appropriate extant CHR data sets, aggregate and harmonize the data through development of a standardized processing and analysis pipeline for each data type, upload the data to the NIMH Data Archive (NDA), use computational techniques to identify and validate biomarker algorithms and/or risk calculators that predict the clinical trajectories and outcomes for individual patients, and establish a curated public data set that will serve as a resource for the research community.

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

Eligible Applicants

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

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

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

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

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

Small Businesses

For-Profit Organizations Other Than Small Businesses

State Governments

County Governments

City or Township Governments

Special District Governments

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

U.S. Territories or Possessions

Independent School Districts

Public Housing Authorities

Indian Housing Authorities

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

Faith-Based or Community-Based Organizations

Regional Organizations

Non-domestic (non-U.S.) Entities (Foreign Institutions) are not eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations are not eligible to apply. Foreign components, as defined in the NIH Grants Policy Statement, are allowed.
The Centers for Medicare & Medicaid Services (CMS) Seeks Members for Two Technical Expert Panels (TEPs):

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

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

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

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

- Subject matter expertise valuable to the **Medicaid and CHIP Scorecard Measures Gap Development TEP** includes: Medicaid and/or CHIP quality and data reporting; Medicaid and/or CHIP adult healthcare quality issues; Individual beneficiary/family member (caregiver) perspective; Behavioral health; HCBS care and delivery; Outcome measurement; and Quality improvement

Both TEP nomination periods open on Thursday, December 12, 2019 and close on Thursday, January 16, 2020. Please submit all nomination materials by close of business (8:00 pm EST) on the closing date. Additional information about the TEP and nomination requirements.
Zero Suicide International 5  
**May 10 to 12, 2020, Anfield Stadium, Liverpool, UK**  
in Partnership with Mersey Care NHS Foundation Trust

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

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

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

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

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

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

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Get information on mental health services and resources near you, searchable by state or zip code:  
www.samhsa.gov/find-help
How #CrisisTalk is Transforming Dialogue in Behavioral Health

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

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

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

THIS WEEK: Washington State Senator Steve O’Ban Talks about Healthcare Integration, Diversion, and Expanding Crisis Care in Pierce County, Washington

Washington State Senator Steve O’Ban entered the Senate in 2013, inheriting committee roles from his predecessor, Senator Mike Carrell, who passed away unexpectedly. This included the chair position of the Human Services Committee, which focuses on mental health. Now he is the ranking member on the Senate Health and Long Term Care Committee and serves on the Behavioral Health Subcommittee. When O’Ban started, the learning curve was steep. “In 2013, I knew little about mental health policy but was thrust into these roles and needed to quickly get up to speed. I decided to learn all I could about mental health policy.” Since then, he has sponsored several vital bills enacted by the legislature to improve the delivery of mental health. By 2017, he had become a leading policymaker on mental health in the Senate, and when Bruce Dammeier became the Pierce County Executive in 2017, O’Ban joined his executive team as Senior Counsel for Behavioral Health. In that role, he has gained more and more practical knowledge and has headed up many key behavioral health initiatives for the county, including establishing a new crisis triage facility (think of it as an emergency room for mental health crises), expanding an innovative mobile mental health care team, launching a new regional system of care planning task force, spearheading an innovative “assisted outpatient treatment” program being piloted in Pierce County, and helping to oversee integrated healthcare for Pierce County, Washington. He continues to serve in the Senate.

Crisis Now Partners:

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

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

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

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

R.I. 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
NOW RECRUITING

CSC OnDemand: An Innovative Online Learning Platform forImplementing Coordinated Specialty Care

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

This is an ideal opportunity for teams to receive new or refresher training in CSC. The tool will offer scalable, efficient professional development for CSC teams.

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

What can teams EXPECT?

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

HOW CAN MY AGENCY TAKE PART?

Call our Research Coordinator, Effy: 347-762-9086
Or email: cscstudy@center4si.com
SAMHSA’s GAINS Center is soliciting applications from communities interested in Sequential Intercept Model (SIM) Mapping Workshops (SIM Workshops). SIM Workshops are designed to bring together a local, cross-system, multidisciplinary group of key stakeholders from a particular jurisdiction to facilitate collaboration and to identify and discuss ways in which barriers between the criminal justice and behavioral systems can be reduced through the development of integrated local strategic plans. SIM Workshop participants are expected to be drawn, in large part, from local criminal justice and behavioral health agencies and organizations.

The GAINS Center is accepting applications for two types of SIM Workshops:

**SIM Workshops to Develop Comprehensive, Community-wide Strategic Plans for Addressing Opioid Use:** These SIM Workshops will focus specifically on identifying and treating opioid use disorders across all the intercepts of the Sequential Intercept Model, including screening and assessment, diverting individuals out of the criminal justice system and into appropriate community-based treatment programs, implementing or expanding medication-assisted treatment (MAT), and maintaining continuity of care through transitions in and out of custody.

**Traditional SIM Workshops:** These SIM Workshops will focus on identifying and responding to the needs of adults with mental and substance use disorders who are involved or at risk for involvement in the criminal justice system.

Applications for both types of SIM Workshops are due by December 20, 2019.

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

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

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

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

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

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

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

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

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

**Eligible Applicants**

Public/State Controlled Institutions of Higher Education

Private Institutions of Higher Education

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

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

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

State Governments  County Governments  City or Township Governments  Special District Governments

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

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

Faith-Based or Community-Based Organizations  Regional Organizations
Pursuant to 22 U.S.C. § 7105(b)(2) the following entities are eligible to apply:

Eligibility

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

1. Working with federal, state, tribal, territorial and local governments, agencies, and organizations to develop or enhance population specific services.

2. Strengthening the capacity of underserved populations to provide population specific services.

3. Strengthening the capacity of traditional victim service providers to provide population specific services.

4. Strengthening the effectiveness of criminal and civil justice interventions by providing training for law enforcement, prosecutors, judges and other court personnel on domestic violence, dating violence, sexual assault, or stalking in underserved populations.

5. Working in cooperation with an underserved population to develop and implement outreach, education, prevention, and intervention strategies that highlight available resources and the specific issues faced by victims of domestic violence, dating violence, sexual assault, or stalking from underserved populations.

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

Eligible Applicants

1. Population specific organizations that have demonstrated experience and expertise in providing population specific services in the relevant underserved communities, or population specific organizations working in partnership with a victim service provider or domestic violence or sexual assault coalition.

2. Victim service providers offering population specific services for a specific underserved population.

3. Victim service providers working in partnership with a national, State, tribal, or local organization that has demonstrated experience and expertise in providing population specific services in the relevant underserved population.

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

Contact information: For technical assistance with submitting an application for either of these grants, contact the Grants.gov Customer Support Hotline at 800–518–4726, 606–545–5035, at https://www.grants.gov/web/grants/support.html, or at support@grants.gov. The Grants.gov Support Hotline operates 24 hours a day, 7 days a week, except on federal holidays.
CIT International Releases Guide to Best Practices in Mental Health Crisis Response
Now Available for Download or Purchase

CIT International has released *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises*, the first comprehensive guide for communities to best practices for starting and sustaining CIT programs.

A main focus of the guide is helping readers understand best practices for mental health crisis response systems, including the mental health services necessary for a quality crisis response and how to improve communication, reduce trauma, and keep people in crisis out of the justice system as much as possible. The guide highlights how communities can serve people in crisis through mental health services and peer support without the involvement of law enforcement.

In the Guide’s preface, Major Sam Cochran and Dr. Randolph Dupont, co-founders of the Memphis CIT program, say, “This guide will share with you the hard-won lessons we have learned from more than 30 years of practice…The hardest lesson we’ve learned is about the temptation of training.”

Throughout the guide, CIT leaders across the country echo this sentiment: officer training is one small piece of a puzzle that should include strong, sustained partnerships, program infrastructure, and systemic changes to law enforcement and mental health systems.

The guide takes a practical approach, providing examples and templates to inspire CIT programs, and worksheets to help facilitate difficult conversations among partners. Each chapter includes a case study from a CIT program, highlighting how communities are implementing CIT in different contexts. For example, Chapter 2: Make a Commitment, describes how rural Malheur County, Oregon, built a strong CIT steering committee, and Chapter 6: Sustain and Grow Your CIT Program, features Ohio’s statewide CIT network. In addition, more than 20 current and former board members of CIT International weighed in, along with dozens of advocates, mental health professionals and law enforcement from local programs—ensuring the guide reflects best practices from experienced CIT leaders and programs across the US.

Three leading national organizations that have partnered projects included in the guide—the National Alliance on Mental Illness (NAMI), the National Council for Behavioral Health, and Policy Research Associates, Inc., have offered their endorsement. Patrick J. Kennedy, a former U.S. Representative and founder of The Kennedy Forum, says “Widespread crisis intervention strategies and techniques are critical to addressing rising rates of overdoses and suicides that continue to devastate families nationwide. Now, more than ever, we have to break the all-too-common cycle of sending those with mental health and substance use disorders through the criminal justice system. This guidebook is an essential resource for communities to do their part.”

*Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises* includes seven chapters that guide local mental health advocates, mental health professionals, law enforcement and community leaders through the process of starting and sustaining their CIT programs.

- Chapter 1: Learn about Crisis Intervention Team (CIT) Programs and Find Allies
- Chapter 2: Make a Commitment
- Chapter 3: Understand Your Crisis Response System
- Chapter 4: Build the Infrastructure for CIT
- Chapter 5: Plan and Deliver Officer Training
- Chapter 6: Sustain and Grow Your CIT Program
- Resources and Examples

**Read the Guide Today!**

DOWNLOAD File for Desktop Printing  DOWNLOAD Interactive Web Version

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

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

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

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

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

The MHIDD Crisis Response course will be offered quarterly with the first starting on January 14, 2020. Sessions are 75 minutes long and will take place each week on Tuesdays from 3:00 p.m. to 4:15 p.m. EST. The registration fee for this training course is $149 per person and space is limited.

Course Learning Objectives:

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

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

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

Register Here for the MHIDD Mobile Crisis Response Course

Please share this training announcement with partners in your community, outside your direct service area, as well as anyone that you think might benefit from this training. This is not a required training for any START teams but one that may enhance the capacity of mobile crisis providers in and around communities with START programs.
The National Center of Excellence for Eating Disorders (NCEED) was created to serve as the centralized hub dedicated to eating disorders education and training for both healthcare providers and the general public. NCEED is partnering with the 3C Institute to develop and launch an interactive, web-based, educational, training platform to ensure that high-quality trainings are provided to health professionals across multiple disciplines.

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

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

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

Information, Training, and Technical Assistance

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

Additional NASMHPD Links of Interest


America’s Health Rankings Annual Report for 2019 & Executive Highlights. UnitedHealth Foundation, December 2019

MACStats: Medicaid and CHIP Data Book. Medicaid and CHIP Payment and Access Commission, December 2019


Effects of Individual Placement and Support Supplemented With Cognitive Remediation and Work-Focused Social Skills Training for People With Severe Mental Illness: A Randomized Clinical Trial. Christensen T.N., Ph.D., et al., JAMA Psychiatry, September 4


The Silent Cost of School Shootings. May Wong, Stanford Institute for Economic Policy Research, December 16
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 National Child Traumatic Stress Initiative (NCTSI) - Category II, Treatment and Service Adaptation (TSA) Centers grants (Short title: NCTSI II). The purpose of the TSA Centers is to provide national expertise for specific types of traumatic events, population groups, and service systems, and support the specialized adaptation of effective evidence-based treatment and service approaches for communities across the nation.

To date, the NCTSI has developed and implemented evidence-based interventions and promising practices to reduce immediate distress from exposure to traumatic events; developed and provided training in trauma-focused approaches and services for use in child mental health clinics, schools, child welfare, and juvenile justice settings, among other service areas; and developed widely used intervention protocols for disaster victims.

The TSA Centers develop activities that improve outcomes for traumatized children, adolescents, and their families. The centers are expected to provide training on best practices in child trauma to mental health, social service, and other child service system providers. The centers are expected to have national expertise in an area of child trauma, early intervention, and mental disorder treatment provision.

Note: Geographic distribution to ensure appropriate coverage across the nation will be considered when funding applications.

Eligibility: Domestic public and private non-profit entities. NCTSI II recipients funded under SM-16-008 are not eligible to apply for funding under this FOA.

Contacts:
Program Issues: Ken Curl, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration(SAMHSA). (240) 276-1779, kenneth.curl@samhsa.hhs.gov.

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 National Child Traumatic Stress Initiative (NCTSI) - Category III, Community Treatment and Service (CTS) Centers grants (Short title: NCTSI III). The purpose of this program is to provide and increase access to effective trauma-focused treatment and services systems in communities for children and adolescents, and their families who experience traumatic events throughout the nation.

Eligibility: Domestic public and private non-profit entities. NCTSI III recipients funded under SM-16-005 are not eligible to apply for funding under this FOA.

Contacts:
Program Issues: Ellen Dieujuste, Center for Mental Health Services (CMHS), SAMHSA, (240) 276-0734, Ellen.Dieujuste@samhsa.hhs.gov.
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT
Recovery Community Services Program (TI-20-002)

<table>
<thead>
<tr>
<th>Funding Mechanism: Grant</th>
<th>Anticipated Total Available Funding: $1,761,000</th>
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<tbody>
<tr>
<td>Anticipated Number of Awards: 6</td>
<td>Anticipated Award Amount: Up to $300,000 per year</td>
</tr>
<tr>
<td>Length of Project: 5 years</td>
<td>Cost Sharing/Match Required?: No</td>
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<tr>
<td>Application Due Date: Monday, December 23, 2019</td>
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The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for fiscal year (FY) 2020 Recovery Community Services Program (Short Title: RCSP). The purpose of this program is to provide peer recovery support services via recovery community organizations to individuals with substance use disorders or co-occurring substance use and mental disorders or those in recovery from these disorders. The program's foundation is the value of lived experience of peers to assist others in achieving and maintaining recovery. These services, in conjunction with clinical treatment services, are an integral component of the recovery process.

Eligibility: SAMHSA is limiting eligibility for this program to Recovery Community Organizations (RCOs) that are domestic private non-profit entities in states, territories, or tribes. RCOs are independent, non-profit organizations led and governed by representatives of local communities of recovery. To ensure that recovery communities are fully represented, only organizations controlled and managed by members of the addiction recovery community are eligible to apply. In order to strengthen and expand the impact of this program across the nation and ensure broad geographic distribution, SAMHSA will make only one award per state, territory, or tribe.

Contacts:
Program Issues: Matthew Clune, Center for Substance Abuse and Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1619, matthew.clune@samhsa.hhs.gov.

The Mental Health and Developmental Disabilities National Training Center (MHDD-NTC) is pleased to announce the launch of their website! The MHDD-NTC is a collaboration between the University Centers for Excellence in Developmental Disabilities at the University of Kentucky, University of Alaska Anchorage, and Utah State University. Established in 2018 through funding provided by the Administration for Community Living, the training center aims to improve mental health services and supports for people with developmental disabilities. By serving not only as a training center, but also as a national clearinghouse, the training center helps provide access to the most current evidence-based, trauma-informed, culturally responsive practices that address the mental health needs of individuals with developmental disabilities. Please visit their website at https://mhddcenter.org/ for more information on their upcoming trainings and efforts or contact them directly at info@mhddcenter.org.
**National Center on Advancing Person-Centered Practices and Systems**

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

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Topic</th>
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<tbody>
<tr>
<td>January 2020</td>
<td>Linguistic Competence (includes Communication and Health Literacy) and Implications for Person-Centered Thinking, Planning, and Practice</td>
</tr>
<tr>
<td>February 2020</td>
<td>Person-Centered Practice in Managed Care: Roles and Developments (Part 1 of 2)</td>
</tr>
<tr>
<td>March 2020</td>
<td>Person-Centered Practice in Managed Care: Roles and Developments (Part 2 of 2)</td>
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<tr>
<td>April 2020</td>
<td>Inclusion &amp; Belonging and Implications for Person-Centered Thinking, Planning, &amp; Practice</td>
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<tr>
<td>May 2020</td>
<td>Person-Centered Thinking, Planning, and Practice in the No Wrong Door System (e.g., Aging and Disability Resource Centers, Centers for Independent Living, and Area Agencies on Aging)</td>
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<tr>
<td>June 2020</td>
<td>Can Measures of Person-Centered Thinking, Planning, and Practice Be Used to Nudge Providers and Systems to Be More Person-Centered?</td>
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<td>July 2020</td>
<td>Applying Person-Centered Thinking, Planning, and Practice in Long-Term Care Settings</td>
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<td>August 2020</td>
<td>Myths and Misperceptions about Financing Peer Support in Medicaid</td>
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<td>September 2020</td>
<td>Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises</td>
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<tr>
<td>October 2020</td>
<td>Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice</td>
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<tr>
<td>November 2020</td>
<td>Person, Family, Clan, Community: Understanding Person-Centered Thinking, Planning, and Practice in Tribal Nations</td>
</tr>
<tr>
<td>December 2020</td>
<td>Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition</td>
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</table>
Supporting Clients Who Have Been Justice Involved  
Friday, December 20, 12:00 p.m. to 1:00 p.m. E.T.

Individuals with Serious Mental Illness who have been involved in the criminal justice system face numerous challenges including additional stigma. They may also exhibit behaviors that were adaptive in correctional settings, but become maladaptive in other settings. Many of these persons have histories of trauma and their exposure to criminal justice processes can be further traumatizing. Many will have antisocial personality features that the mental health treatment provider may feel ill-equipped to support and may even not enjoy the work of working with these individuals, which can lead to personal burn out and difficulty with compassion. This can be especially true for patients with histories of aggression or even violence. In addition, individuals with SMI in the criminal justice system often have co-occurring substance use disorders and medical conditions that compound their complexity. The criminal justice system utilizes a rubric called the Risk-Need-Responsivity paradigm to identify individual risk of criminal recidivism. Interventions such as specific cognitive behavioral strategies are often used in criminal justice contexts to address some of the criminogenic thinking associated with such recidivism. This framework has been applied to broad populations even while more research is needed to determine how these methods can best fit for persons with SMI. This webinar will review these various topics to assist mental health professionals in supporting their patients who have had criminal justice involvement.

Presenter: Debra Pinals, M.D., University of Michigan

Register HERE

Improving Lives Through Employment and Education  
Friday, January 10, 12:00 p.m. to 1:00 p.m. E.T.

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

Presenter: Deborah Becker, M.Ed., Westat

Register HERE

Sharing Clinical Notes with Patients: Benefits, Risks & Challenges  
Thursday, January 16, 3:00 p.m. to 4:00 p.m.

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

Presenter: Charlotte Blease, Ph.D., Beth Israel Deaconess Medical Center/Harvard Medical School

Register HERE

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

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

Grant Statement
Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818 01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
A Free, New Resource for All Mental Health Professionals Who Treat Serious Mental Illness

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

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

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

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

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

Visit SMIadviser.org
Let SMI Adviser help you provide evidence-based, person-centered care to individuals who have SMI.
Check Out the **SMI Adviser’s Clozapine Center of Excellence**

Visit SMIadviser.org/clozapine and join the conversation.
Building Effective Partnerships with Schools

School systems present a range of potential opportunities and challenges for families dealing with behavioral health needs. This webinar will present strategies and lessons learned from three organizations actively partnering with local school systems to better serve and support children and youth with behavioral health disorders and their families.

Register HERE

Understanding the Family First Prevention Service Act: Implications for Tribal Programs

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

Register HERE

Family Engagement and Leadership: Strengthening Systems, Services and Communities

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

Register HERE

2020 Training Institutes, July 1 to 3, 2020

Early Bird Savings!

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

Register NOW

33rd Annual Research and Policy Conference on Child, Adolescent, and Young Adult Behavioral Health

Since 1988, this annual conference has been a leader in promoting the development of the research base essential to improved service systems for children and youth with mental health challenges and their families. Known widely as “The Tampa Conference,” this annual gathering of more than 700 researchers, evaluators, policymakers, administrators, parents, and advocates is sponsored by Child & Family Studies at the University of South Florida, in partnership with the Children’s Mental Health Network, Morehouse School of Medicine, the National Wraparound Initiative, Casey Family Programs, Florida Institute for Child Welfare, Institute for Translational Research Education in Adolescent Drug Abuse, Transitions to Adulthood Center for Research, Pathways to Positive Futures, Child & Family Evidence Based Practice Consortium, Family-Run Executive Director Leadership Association, the National Technical Assistance Network for Children’s Behavioral Health, and the Movember Foundation.
SAMHSA’s Early Serious Mental Illness Treatment Locator is a confidential and anonymous source of information for persons and their family members who are seeking treatment facilities in the United States or U.S. Territories for a recent onset of serious mental illnesses such as psychosis, schizophrenia, bi-polar disorder, or other conditions. These evidence-based programs provide medication therapy, family and peer support, assistance with education and employment and other services.

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

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

You Can Access the SMI Treatment Locator HERE

Social Marketing Assistance Available

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

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

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

Tip Sheets and Workbooks

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

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

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

**Engaging Stakeholders**
- Involving Families in Social Marketing
- Social Marketing in Rural and Frontier Communities
- The Power of Partners
- Involving Youth in Social Marketing: Tips for System of Care Communities
- The Power of Telling Your Story
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 Beyond Beds series of 10 papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

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

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

The NASMHPD Technical Assistance Coalition series will continue in 2019.

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

- **Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes**
- **Weaving a Community Safety Net to Prevent Older Adult Suicide**
- **Making the Case for a Comprehensive Children’s Crisis Continuum of Care**
- **Achieving Recovery and Attaining Full Employment through the Evidence-Based IPS Supported Employment Approach**
- **Changing the Trajectory of a New Generation: Universal Access to Early Psychosis Intervention**
- **Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness**
- **A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness**
- **Medical Directors' Recommendations on Trauma-informed Care for Persons with Serious Mental Illness**
- **Speaking Different Languages: Breaking Through the Differences in the Perspectives of Criminal Justice and Mental Health Stakeholders on Competency to Stand Trial Services: Part 1**
Visit the Resources at NASMHPD’s
Early Intervention in Psychosis (EIP) Virtual Resource Center

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

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

**Training Guides**

**Training Videos: Navigating Cultural Dilemmas About** –

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

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

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

**Training Webinars for Receiving Clinicians in Community Mental Health Programs:**

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

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

**Trauma, PTSD and First Episode Psychosis**

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

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

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

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

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

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

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

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

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

For more information about early intervention in psychosis, please visit

https://www.nasmhpd.org/content/early-intervention-psychosis-eip
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NASMHPD Links of Interest
The Surgical Complication That Can Damage Your Brain, Sumathi Reddy, Wall Street Journal, December 9
San Francisco Hopes To Improve Care For People With Mental Illness Living On Streets, Brian Krans, Kaiser Health News, December 13
Nation’s Youngest Children Lose Health Coverage at an Alarming Rate, Elisabeth Wright Burak, Maggie Clark & Lauren Roygardner, Georgetown University Health Policy Institute Center for Children and Families, December 2019
ER Visits for Attempted Suicide Greatly Raise Odds for Future Tragedy, Health Day, December 13 & Association of Suicide and Other Mortality With Emergency Department Presentation, Sidra Goldman-Mellor et al., JAMA Network Open, December 13
Massachusetts Case Probes The Role Schools Play In Teen Suicide Prevention, Jenifer McKim, New England Center for Investigative Reporting at WGBH News / National Public Radio, December 15
With Judicial Commission On Mental Health, Texas Civil And Criminal Courts Join Forces, Terri Langford & Caroline Covington, Texas Standard, November 28
From Surviving to Thriving: Factors Associated with Complete Mental Health among Childhood Sexual Abuse Survivors, Fuller-Thomson E., et al., Social Psychiatry and Psychiatric Epidemiology, September 29
Private Coverage of Methadone in Outpatient Treatment Programs, Polsky D., Ph.D., Arsenault S., M.A. & Azocar F., Ph.D., Psychiatric Services On-Line, December 11
Draft for Public Comment: Manual for State Payment of Medicare Premiums, Centers for Medicare and Medicaid Services, December 13, 2019 (Comments Due by February 29, 2020 to ModernizetheMSPS@cms.hhs.gov).
CMCS Informational Bulletin: Guidance to State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020, Center for Medicaid and CHIP Services, December 17, 2019
Association of Opioid Prescribing Patterns With Prescription Opioid Overdose in Adolescents and Young Adults, Chua K-P, M.D., Ph.D., et al, JAMA Pediatrics, December 20
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