AHRQ Study Finds Widening Urban-Rural Mortality Gap is Due to Fewer Visits to Mental Health Care Providers by Rural Adults with Mental Health Needs

A study published in the December 2019 issue of *Health Affairs* found that a widening urban-rural mortality gap over the last decade immediately attributable to differential death rates from suicides, overdoses, and alcohol-related liver diseases has been caused by the fact that adult rural residents with mental health needs have fewer ambulatory mental health visits than their urban counterparts, even if they are already on prescription medications for mental health conditions.

The study by James B. Kirby, Ph.D. and his Agency for Healthcare Research and Quality (AHRQ) colleagues using 2010 to 2015 data from the Medical Expenditures Panel Survey (MEPS) was restricted to adults who scored 13 points or higher on the Kessler K6 Psychological Disease Distress Scale or 3 or higher on the Patient Health Questionnaire (PHQ-2) Depression Scale. It classified ambulatory mental health visits as all office-based or hospital outpatient visits in which the respondent reported mental health treatment as the main reason for the visit, a mental health condition was associated with the visit, or the visit was to a psychologist, psychiatrist, social worker, or other mental health specialist. Mental health drug fills included antidepressants, antipsychotics, anti-anxiety medications, and other medications commonly used to treat mental disorders.

Because the researchers believed a metropolitan-nonmetropolitan dichotomy, as defined by the Office of Management and Budget, masks important differences across nonmetropolitan areas by their proximity to metropolitan areas, they instead categorized counties into three groups: “urban” (metropolitan counties), “rural-adjacent” (non-metropolitan counties adjacent to metropolitan counties), and “rural-nonadjacent” (non-metropolitan counties not adjacent to metropolitan counties).

They estimated utilization differences adjusted for mental health using the Mental Health Component Scale of the Short-Form Health Survey (SF-12), self-rated health, the presence of multiple chronic conditions, age, sex, race/ethnicity, household income, and insurance status.

The AHRQ researchers found “stark differences” in the county level supply of psychiatrists, with 79 percent of rural non-adjacent counties lacking a psychiatrist, compared to 33 percent of urban counties in 2017-2018. But they reasoned this workforce shortage might actually reflect a difference in the demand for care rather than the driving force itself for a lesser rate of care visits.

They found that residents of rural non-adjacent counties had 73 percent fewer mental health care visits than urban county residents and 59 percent fewer visits than rural-adjacent county residents who, in turn, had 33 percent fewer visits than urban county residents. Specialist visits showed similar disparities, with rural-nonadjacent county residents having 73 percent fewer visits than urban county residents, and rural-adjacent county residents having 41 percent fewer visits than their urban counterparts.

Rural-nonadjacent county residents had 21 percent fewer prescription fills compared to urban county residents, and rural-adjacent county residents had 12 percent fewer prescription fills. Among those with a prescription drug fill, rural-nonadjacent county residents had 54 percent fewer ambulatory mental health visits than did urban county residents and 55 percent fewer specialist visits. Rural-adjacent county residents with at least one prescription drug fill had, on average, more ambulatory and specialist visits than their rural-nonadjacent county counterparts, but they still had fewer than urban county residents.

The fact that rural-urban differences in the use of prescription drugs were proportionately smaller than differences in the number of ambulatory visits suggested to the authors of the study that barriers to obtaining in-person mental health treatment in rural areas might be more severe than barriers to obtaining pharmacological treatment of mental health conditions. They suggest this might be attributable to an ability to obtain prescriptions outside normal working hours and in a variety of locations (for example, retail pharmacies and grocery stores).

The authors of the study posit that the fact that rural residents in the study who were taking prescription drugs for mental health conditions had far fewer in-person visits than did their urban counterparts illustrates that even among those who demonstrate a need for mental health care and willingness to seek it out, large rural-urban differences in the volume of ambulatory mental health visits persist.

The authors of the study suggest several potential approaches in remedying the rural care disparity: (1) incentives for providers who practice in underserved rural areas, such as the loan repayment programs under the National Health Service Corps administered by the Health Resources and Services Administration; (2) training in mental health treatment for non-physician providers and a revision of scope of practice laws to allow advanced practice nurses and physician assistants to screen for mental health conditions and provide basic mental health services such as prescription-writing; (3) task-sharing that allows or encourages local staff to work at the top end of their training while leaving scarce but highly-trained specialists to act more as consultants or supervisors than direct caregivers; and (4) a greater use of, and parity in reimbursement for, telemedicine in monitoring mental health and treating mental illness.
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December 2019 SMI Adviser Webinars / Learning Collaboratives

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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
New analysis published November 22 by the Centers for Disease Control and Prevention (CDC) in its Morbidity and Mortality Weekly Report finds that nearly half of traumatic brain injury (TBI)-related deaths are classified as intentional injuries by suicide or homicide.

Lead researcher, Jill Daugherty, Ph.D., Division of Injury Prevention at the CDC, and her colleagues examined trends in TBI-related mortality rates based on age, gender, and racial/ethnic groups. Data was analyzed from the National Vital Statistics System from 2000 to 2017. Injuries were categorized by intent, and unintentional injuries were categorized by mechanism of injury. During the 18-year study period, over 960,000 TBI-related deaths occurred in the U.S.

The authors of the study found there were 61,131 TBI-related deaths in 2017, accounting for 2.2 percent of approximately 2.8 million deaths in the U.S. that year. According to the new analysis, from 2015 to 2017, 44 percent of the TBI-related deaths were categorized as intentional injuries, i.e. resulting from suicide or homicide. The authors note that suicide was the primary factor of TBI-related deaths starting in 2009 to 2011, and continuing through 2015 to 2017. Firearms accounted for 97 percent of all TBI-related suicides for all age groups. Prior to 2009, unintentional motor vehicle accidents was the leading cause of TBI-related deaths.

The researchers found varying rates among the different racial/ethnic and gender groups over the 18-year study period. During the last 10 years of the study period, suicide surpassed unintentional motor vehicle crashes as the leading category of TBI-related deaths, due largely to non-Hispanic whites experiencing a 32 percent increase (increasing from 5.9 per 100,000 during 2006-2008 to 7.8 during 2015-2017). Homicide was the primary cause of TBI-related deaths for African Americans over the 18-year study period.

Across the 18-year period, males and American Indians/Alaska Natives experienced the highest rates of TBI-related deaths in comparison to other racial and gender groups. Unintentional motor vehicle accidents were the leading category of TBI-related deaths among American Indians/Alaska Natives throughout the 18-year study. Dr. Daugherty and her colleagues suggest “Lower rates of seat belt use and higher rates of alcohol-related motor vehicle crash deaths among AI/ANs, compared with other groups, might be contributing factors.”

For Hispanics, unintentional falls was the leading cause for TBI-related deaths beginning in 2012-2014 and continuing through 2015-2017.

The authors conclude, “Understanding the leading contributors to TBI-related deaths and identifying groups at increased risk is important in preventing this injury. Health care providers can play an important role in assessing patients at increased risk—such as those at risk for suicide, unintentional motor vehicle crashes, or unintentional falls—and provide referrals or tailored interventions.”

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
Fiscal Year 2020 Transformation Transfer Initiative

Invitation to Apply

(Proposals Due to NASMHPD by December 9, 2019)

Introduction

In a continued effort to assist states in transforming their mental health systems of care, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). The TTI provides, on a competitive basis, flexible funding awards to states, the District of Columbia, and the Territories to strengthen innovative programs. For Federal Fiscal Year (FFY) 2020, SAMHSA will present TTI awards of $150,000 to up to twenty (20) states or territories for projects establishing Incentives for Improving Outpatient Engagement. Awardees will contract with one or two community mental health providers and/or psychiatric hospitals to offer vouchers to incentivize patient attendance at first and subsequent outpatient appointments. Vouchers should be offered to patients leaving or at-risk of entering institutional care.

Proposal Parameters include:

- Maximum spend per patient is $75 (reflecting existing regulatory limitations), but how this total amount per person is divided is flexible as long as each individual contingency does not exceed $15.
- Voucher type is flexible depending on community demographics and generic vouchers can be used.
- Cash and lottery tickets are NOT allowed to be used as incentives.
- Patients eligible to participate include people leaving or transitioning from:
  - State Hospitals
  - Emergency Rooms
  - Jails and Prisons
  - Homelessness; or
  - Crisis Service Centers

Incentives for Improving Outpatient Engagement offers the perfect opportunity to support and leverage new or ongoing efforts that seek to ensure continuity of care. It can work to strengthen new or expanding initiatives in giving new outpatients what they need. Contingencies should be used to incentivize care compliance, including keeping appointments, complying with medication regimes, and other key activities related to health, such as tobacco cessation. All proposals should have a mechanism to track, monitor, and report appointment attendance outcomes. Competitive proposals will outline how they will use these attendance outcomes to make a natural comparison between those individuals in the incentive project and those individuals not in the incentive project, or a comparison with previous historical data and the new outcome data. All proposals must focus on SMI populations and all states and territories are eligible to apply.

Individuals leaving deep-end service settings who make early provider appointments are much less likely to cycle back into institutional care. Early engagement is very important to long-term success and the goal of this project is to help states and localities create strategies to be successful with early engagement. There are many barriers to successful engagement in mental health services, such as inadequate resources to bridge the multi-faceted gaps encountered once someone is discharged or released to the community. The aim of this TTI is to provide patients with flexible incentives to help bridge those gaps, and create better engagement outcomes. Successful early intervention and engagement are keys not only to enhancing attendance and clinical outcomes, but also empowering people to find their road into recovery and a better quality of life.

Applications for the TTI will be judged on the following criteria:

- tracking and Reporting Outcome data showcasing the effectiveness of these incentives;
- established partnerships with hospitals, community providers, family and peer organizations;
- identification of other state resources and infrastructure that allow for leveraging the TTI funds for the proposed initiative;
- involvement/collaboration of individuals with lived-experience in the development, review, planning and, when appropriate, the implementation of the initiative;
- expansion and sustainability plans after the TTI funding is exhausted; and
- realistic timeframes, concrete activities, and measurable outcomes for the proposed initiative.

(Continued on Next Page)

1 https://www.cambridge.org/core/services/aop-cambridge-core/content/view/5E3E809B3FC76807765328FC1F05CB7D/S1355514600004259a.pdf/why_dont_patients_attend_their_appointments_maintaining_engagement_with_psychiatric_services.pdf.
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4861685/.
TTI Timeline
- **December 9, 2019** - By 5:00 p.m. E.T., all proposals are due to NASMHPD. Please see submission details below.
- **January 2020** – TTI awardees are selected and announced by CMHS.
- **February 2020** – Subcontracts are initiated, finalized, and signed.
- **August 15, 2020** – All TTI projects will be completed and final reports submitted to NASMHPD.
- **August 24, 2020** – NASMHPD submits comprehensive TTI final report to CMHS.

Proposal Requirements

I. Initiative Description and Projected Budget
In three (3) pages or less, please describe your proposed initiative, how it would fit into your state’s larger reform or transformation goals, how it would improve your behavioral health system and/or other systems, and specifically the activities you would fund using your TTI subcontract, if awarded. Make sure to identify the following items:
- other agencies or organizations (including hospitals and community providers) which will be collaborating with you;
- other resources and infrastructure, in-kind, as well as financial, if any, which you will use to leverage these TTI award funds;
- involvement of individuals with lived-experience in the planning and, when appropriate, the implementation of the initiative;
- mechanism of tracking and reporting the attendance outcomes achieved with this initiative; and
- expansion and sustainability plans after the TTI funds are exhausted.

**NOTE:** The Federal government grant requirements prohibit spending technical assistance grant funds on food, beverages, and purchasing of equipment such as computers or other infrastructure/administrative items. There are also spending limits on certain items. Please contact the NASMHPD project director with any questions pertaining to items that you may or may not include in your proposal.

II. Initiative Timeline
In one page or less, please outline projected timeframes for your initiative. From implementation in February 2020 to a final report in August 2020, chart the projected path of your project and tie the timeframes to your projected outcomes.

III. Initiative Coordinator
Designate an individual within your State Office of Mental Health to be the coordinator and contact person for your TTI initiative. The designated individual will be the main contact person with NASMHPD and CMHS, will need to have the ability to negotiate and oversee deliverables for the project, and will know and understand your state’s or department’s contracting process. Please include their contact information and a resume within your proposed submission.

IV. Fixed-Priced Subcontract
In one page or less, please describe your state’s or department’s contracting process. Each TTI awardee will be expected to quickly (within 4 to 6 weeks) approve and sign a fixed-price subcontract with NASMHPD, outlining the work and outcomes the state will accomplish and produce under this technical assistance project. Deliverables under this subcontract include monthly written and oral status reports and a written final report. Given the short timeframe of the project, from award to final report, please outline how your contracting process will not hamper your ability to deliver your proposed outcomes in a timely manner.

Submission of Proposal

**By 5:00 p.m., E.T. of December 9, 2019** all proposals are due electronically or via certified mail to David Miller, NASMHPD Project Director. The proposal must be sent to NASMHPD by or on behalf of the State Mental Health Commissioner/Director with the acknowledgement that the proposal has his or her approval. Mr. Miller’s contact information is as follows:

David W. Miller
Project Director
NASMHPD
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 399-6892
david.miller@nasmhpd.org
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).

Webinar: Finding The Balance: Person-Centered Supports That Honor Both Safety and Dignity of Risk
Tuesday, December 17, 2:30 a.m. to 4:00 p.m. E.T.

Person-centered supports must ensure that people have opportunities to make informed choices and to be supported in managing the risks that come with those decisions. Direct support providers have a role in helping people to live lives of their choosing and often face the challenge of balancing the individual’s choice with the provider’s ‘duty of care’. The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) presents a webinar on finding the balance.

Participants in this webinar will:

1. Hear from people with disabilities about their experience in planning, navigating concerns about well-being, and seeking the ‘dignity of risk’;
2. Learn from direct support providers about the requirements, challenges, and successes of the delivery of quality person-centered supports in a way that considers health and safety while honoring a person’s right to make decisions that may not always be in their best interest; and
3. Understand what training is available for direct support providers that will equip them with the skills and strategies to help manage health and safety concerns in a person-centered way.

Register HERE.

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 NCAPPS website or the NCAPPS page of this newsletter for more information.
The Medicaid Innovation Accelerator Program (IAP) is a collaboration between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI) designed to build state capacity and support ongoing innovation in Medicaid. IAP provides targeted technical assistance to states’ ongoing delivery system reform efforts across four priority program areas: (1) substance use disorders; (2) Medicaid beneficiaries with complex care needs; (3) community integration through long-term services and supports; and (4) physical/mental health integration. IAP also provides assistance to states in four functional areas, which IAP sees as the building blocks to delivery system reform: (1) data analytics; (2) quality measurement; (3) value-based payment and financial simulations; and (4) performance improvement.

IAP’s Beneficiaries with Complex Care Needs and High Costs (BCN) program area offers technical assistance and resources to Medicaid agencies seeking to design, plan, and implement strategies to improve care coordination for Medicaid BCN populations. As part of this program area, over the last year, IAP focused on adult Medicaid beneficiaries with Serious Mental Illness (SMI) and posted two technical resources for Medicaid agencies focused on data analytics.

Components of Technical Assistance for Medicaid Agencies

This year, starting in January 2020, the IAP is offering up to eight months of technical assistance for up to 10 Medicaid agencies that aim to utilize data analytics to gain a better understanding of their adult population with SMI and to help inform related programmatic decisions. This technical assistance opportunity is open to Medicaid agencies at all stages of development, from those just beginning this work to those building on existing initiatives.

This technical assistance includes interactive webinars and coaching assistance. The technical assistance is provided through three inter-related components which will run sequentially. Participating Medicaid agencies can select one or all three to join.

• **Component 1: Build an SMI Population Profile (January – March 2020)**
  o Conduct analyses to further understand state populations with SMI using Medicaid claims and encounters data (demographic, cost, and utilization information)
  o Develop or start developing state Medicaid SMI population profiles

• **Component 2: Leverage External Data Sources (April – May 2020)**
  o Augment state SMI population profiles with external data sources (e.g. corrections, housing data)
  o Navigate challenges in data matching and other SMI data sharing barriers
  o Develop data sharing and use strategies with other state or external data partners

• **Component 3: Consider SMI Data-Informed Delivery System Reform (June – August 2020)**
  o Exchange lessons learned
  o Apply SMI data in the design if a consider delivery system reform initiative

States have the option to participate in one or more of the components depending on their existing SMI analyses to date. Since the three components in this cohort are meant to build on one another, states are encouraged to participate in all three components of the work. However, it is understood that some states may, for example, already have a SMI state-specific population profile, and therefore may only want to participate in components 2 and/or 3.

States are encouraged to complete each components’ activities during the component’s timeframe. Nevertheless, the coach team is available to support each states’ activities throughout the eight months. For example, the SMI population profile is not complete in the first three months, states can use the coaching team and the time during component 2 or 3 to complete the profile.

Expressions of interest (EOI) forms for the SMI technical assistance opportunity will be accepted between late November and early December of 2019. States will be selected for participation in early January 2020. The eight-month technical assistance activities will occur between late January and August of 2020.

• December 13, 2019: Expression of Interest form due
• December 2019- January 2020: One-on-one conference calls with individual states to review their EOI forms and discuss their state goals
• Mid-January: States selected
• January 27, 2020: SMI technical assistance kick-off webinar
• January 2020-August 2020: Technical assistance activities, webinars, and coaching
• August 2020: Technical assistance ends

How Do Interested States Apply for Technical Assistance?

Interested states are asked to submit the EOI form by midnight (ET) on December 13, 2019 with the subject line “SMI data analytics” to cms.iap.smi@healthmanagement.com. The EOI form can be found online on the IAP BCN web page. Please direct questions to Katherine.Vedete@cms.hhs.gov, using the subject line “SMI data analytic opportunity questions.”
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

2019 HealthCare.gov Platform Snapshot (Week 5) – Figures in [Brackets] are 2018 Week 5 Enrollment Numbers

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<td>Plan Selections</td>
<td>504,041 [773,250]</td>
<td>2,876,998 [3,198,163]</td>
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<tr>
<td>New Consumers</td>
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HealthCare.gov State-by-State Snapshot - Cumulative Plan Selections November 24 – November 30

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<tr>
<td>Florida</td>
<td>796,858 [799,188]</td>
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<tr>
<td>Georgia</td>
<td>173,337 [182,018]</td>
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<tr>
<td>Hawaii</td>
<td>6,535 [7,806]</td>
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<tr>
<td>Iowa</td>
<td>17,455 [18,999]</td>
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<tr>
<td>Illinois</td>
<td>81,107 [100,218]</td>
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<tr>
<td>Indiana</td>
<td>39,874 [47,974]</td>
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<tr>
<td>Kansas</td>
<td>28,264 [35,783]</td>
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<tr>
<td>Kentucky</td>
<td>26,982 [30,172]</td>
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<tr>
<td>Louisiana</td>
<td>27,916 [29,802]</td>
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<tr>
<td>Maine</td>
<td>16,613 [23,809]</td>
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<tr>
<td>Michigan</td>
<td>77,305 [96,042]</td>
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<tr>
<td>Missouri</td>
<td>66,442 [77,912]</td>
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<tr>
<td>Mississippi</td>
<td>37,576 [35,445]</td>
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<tr>
<td>Montana</td>
<td>13,006 [15,529]</td>
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<tr>
<td>North Carolina</td>
<td>162,150 [184,891]</td>
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<tr>
<td>Oklahoma</td>
<td>45,093 [51,169]</td>
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<tr>
<td>Oregon</td>
<td>47,245 [56,060]</td>
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<tr>
<td>Pennsylvania</td>
<td>102,477 [123,918]</td>
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<tr>
<td>South Carolina</td>
<td>73,429 [82,402]</td>
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<tr>
<td>South Dakota</td>
<td>10,156 [11,155]</td>
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<tr>
<td>Tennessee</td>
<td>62,220 [75,729]</td>
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<tr>
<td>Texas</td>
<td>400,436 [414,350]</td>
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<tr>
<td>Utah</td>
<td>74,439 [75,197]</td>
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<tr>
<td>Virginia</td>
<td>82,090 [100,457]</td>
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<tr>
<td>Wisconsin</td>
<td>69,728 [82,493]</td>
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<tr>
<td>West Virginia</td>
<td>5,999 [7,728]</td>
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<tr>
<td>Wyoming</td>
<td>8,840 [10,214]</td>
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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

**Friday, March 20, 2020**
*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.
Vibrant Emotional Health is Seeking Lifeline Committee Nominations

It is with great pleasure that Vibrant Emotional Health is announcing a call for nominations for membership to the three national advisory committees of the National Suicide Prevention Lifeline. Every three or four years, the Lifeline refreshes a portion of its membership to the Lifeline’s Steering Committee (SC), the Standards, Training and Practices Committee (STPC), and our (now called) Individual and Family Lived Experience Committee (LEC). Doing so allows for us to replace inactive members, enable new voices to inform our work, and ensures that membership best reflects the current and future needs of this evolving project. **We are, therefore, now inviting nominations for all three consulting bodies via an online nomination process.**

These three consulting bodies were established by Vibrant Emotional Health (then MHA-NYC) shortly after Lifeline was launched with SAMHSA and our partners (including the National Association of State Mental Health Program Directors) in 2005 and have a distinguished place in our field. We are unaware of any longer-standing national advisory groups that have consistently met for the purpose of preventing suicide in this country. They were established in order to facilitate continuous feedback from stakeholders regarding Lifeline activities and to help create community ownership of this national project with the mission to effectively reach and serve all persons at risk of suicide in the United States through a national network of local crisis centers. They have played a large role in helping the SAMHSA-funded Lifeline to create industry standards that have influenced suicide prevention and intervention practices nationally and internationally.

Among their many contributions, these committees have: had a substantial role to in promoting the voices of lived experience in the suicide prevention field and in the media at large; enabled expert consensus in applying evaluation and research best practices for the field (including in suicide risk/safety assessment, helping persons at imminent risk of suicide, follow-up practices, establish etc.); assisted in developing strategies that have successfully enhanced recognition of local crisis centers and the resources needed to support them; helped to establish and promote promising, innovative practices in digital interventions (chat, text, etc.); and helped to establish and disseminate a public health messaging framework designed to reduce suicide nationally. As we begin to focus on the road ahead, we once again turn to the collective knowledge of our network centers and all other suicide prevention stakeholders to assure the continuing success of these committees in influencing our work. In so doing, we are asking you to consider yourself or nominating either yourself or someone else to join us as a member of one of our essential advisory committees. Before nominating someone else, please review the document describing the purpose, structure and roles of each Committee to determine respective membership eligibility, needs, and expectations.

In the new iteration of the three Lifeline committees, most things — committee and member roles, structure and expectations — won’t change. We are likely to keep approximately 2/3 of our current membership on the committees to ensure some degree of stability and continuity, while making room for fresh perspectives. As always, we are seeking members who are seen as regional or national leaders in their area, who actively represent a constituent group’s experiences related to effective mental health, crisis and suicide prevention care, and outreach. We expect members to responsibly represent the perspectives of these groups, as well as act as ambassadors for the Lifeline and communicate to their constituent groups Lifeline’s initiatives, products, and activities. Each committee will have one face-to-face meeting and at least one web/phone/video conference call annually.

Nevertheless, some committee-related changes have occurred, or will occur. First, some name changes have been implemented in response to membership feedback. In 2018, the Lifeline changed the “subcommittee” designation for both the Consumer Survivor Family and the Standards, Trainings and Practice advisory groups to a “committee” title, to underscore their equivalent project influence to that of the Steering Committee. Since the original design of the “subcommittees” was to share and synthesize their respective recommendations with the Steering Committee’s efforts, the co-chairs from these “separate but equal” committees will no longer be required to also attend Steering Committee meetings (although they may be invited, as needed). In addition, the previously named “Consumer Survivor Family Committee” has been changed to the Individual and Family Lived Experience Committee (LEC), to reflect its composition more accurately.

The document describing Committee Roles, Structure and Selection Process also includes a description of Workgroups. Lifeline workgroups have continued to be a growing need for the Lifeline with each passing year. They involve convening subject matter experts to build consensus and execute work between committee meetings, towards developing more focused practice recommendations or products that often emerge from committee feedback. We expect that more workgroups will be required in the coming years, to maximize innovative and effective solutions, practices, and resources to address Lifeline service user needs.

How does the nomination process work? It is important to read thoroughly the information contained in the Lifeline Committee Roles, Structure, and Selection Process document about the function of each Committee, as well as the role of participating members, before entering the nomination process. You may nominate yourself or someone else that you believe would be a good candidate for committee membership. Nominations may be submitted for more than one committee; however, we ask that you submit nominations for no more than two persons. If you nominate yourself, we will need at least one other independent source to nominate you (unless you are a current or past committee member). If you are nominating another person, it is imperative that you inform the individual of your intent and obtain their informal permission to do so.

**All nominations must be submitted no later than December 6, 2019 using the Lifeline Committee Nominations Form.** Every effort will be made to notify individuals of their selection within five weeks of the nomination’s closing date. Selected individuals will be asked to provide confirmation of their intention to join the relevant committee, and provide us with their contact information and a brief biography which will be posted on the Lifeline website.

Please share this message with anyone that you believe would be a valuable contributor to any one of the three committees.
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.
The enrollment window is open for the 2020 Marketplace health insurance. Here are important dates to remember and some things you can do to get ready.

Key Dates & Deadlines
The 2020 Open Enrollment Period runs November 1 to December 15, 2019. This means you have six weeks to enroll in or renew a plan. Just 9 days remain. Plan coverage starts January 1, 2019.

3 Ways to Stay Connected with the Marketplace
Sign up for deadline reminders, useful tips, and more so you don’t miss your chance to enroll.

- Get important email or text updates. Visit the HealthCare.gov homepage, and enter your email address under “Get Important News & Updates.” Click “Sign Up.”
- Connect with someone in your community who can answer your questions. Enter your ZIP code for a list of groups and people near you. Some even offer help in languages other than English.

Find us on social media. Follow us on Twitter and like us on Facebook for late-breaking news and important updates.

SAMHSA’s GAINS Center Now Accepting Applications for Sequential Intercept Model (SIM) Mapping Workshops

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.
Approximately 100,000 young persons in the United States experience a first episode of psychosis every year. During the same interval, it is estimated that over one million children and adolescents experience problems in perception, thinking, mood, and social functioning suggestive of a pre-psychosis risk state. Given the highly disruptive and disabling nature of psychotic disorders, early intervention has been recommended as a means of preventing psychosis onset among at-risk individuals, as well as averting other adverse outcomes such as mood syndromes, substance abuse disorders, and functional decline in social, academic, and vocational domains.

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

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

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

Eligible Applicants
Public/State Controlled Institutions of Higher Education
Private Institutions of Higher Education
The following types of Higher Education Institutions are always encouraged to apply for NIH support as Public or Private Institutions of Higher Education:
- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)

Nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education)
Nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education)
Small Businesses
For-Profit Organizations Other Than Small Businesses
State Governments
County Governments
City or Township Governments
Special District Governments
Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)
U.S. Territories or Possessions
Independent School Districts
Public Housing Authorities
Indian Housing Authorities
Native American Tribal Organizations (other than Federally recognized tribal governments)
Faith-Based or Community-Based Organizations
Regional Organizations
Non-domestic (non-U.S.) Entities (Foreign Institutions) are eligible to apply. Non-domestic (non-U.S.) components of U.S. Organizations are not eligible to apply. Foreign components, as defined in the NIH Grants Policy Statement, are allowed.
NIMH Funding Opportunity Announcement

Clinical High Risk for Psychosis: Data Processing, Analysis, and Coordination Center (U24) – RFA – MH – 20 - 341

Open Date (Earliest Submission Date) / Letter of Intent Date: December 31, 2019
Application Due Date: January 31, 2020, 5:00 p.m. Local Time of Applying Entity
Earliest Start Date: September 2020

This Funding Opportunity Announcement (FOA) invites applications for a CHR Data Processing, Analysis and Coordination Center (DPACC) to support and extend the work of the proposed Clinical High Risk for Psychosis Research Network to be funded under RFA-MH-20-340. The DPACC will provide oversight and coordination of two parallel lines of inquiry: 1) The aggregation of extant CHR-related data sets and subsequent secondary analyses for refinement of multi-modal biomarkers and development of biomarker algorithms that predict individual clinical trajectory and outcomes and 2) the management, direction, and overall coordination, including data processing and analysis, for a new multi-site network(s) focused on dissecting the heterogeneity of the CHR syndrome. Toward achieving the first goal, the DPACC – in conjunction with NIMH and external working groups - will identify appropriate extant CHR data sets, aggregate and harmonize the data through development of a standardized processing and analysis pipeline for each data type, upload the data to the NIMH Data Archive (NDA), use computational techniques to identify and validate biomarker algorithms and/or risk calculators that predict the clinical trajectories and outcomes for individual patients, and establish a curated public data set that will serve as a resource for the research community.

Toward achieving the second goal of acquisition of new data via establishment of multi-site CHR cohort(s), the DPACC will provide the organizational framework for the management, direction, and overall coordination of a multi-site network(s) and will lead efforts, in conjunction with NIMH and external working groups to: (a) harmonize common data elements, standard measures, and uniform data collection procedures across multiple CHR/early psychosis research sites within the network; (b) assume responsibility for quality assurance and reliability assessments; (c) insure uniform standards for adverse event reporting, safety and protocol deviation monitoring; (d) build informatics infrastructure and pipelines necessary to gather, process and upload de-identified, patient-level data collected across all research sites to NDA; (e) develop data analysis, presentation, and reporting tools to facilitate analyses of clinical and biomarker date 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.
Mini-Symposium on Children in Families Affected by Addiction: Supporting the Health and Well-being of Children in Families Affected by Substance Use Disorders

Friday, December 6, 2019

Chevy Chase Conference Center, The Charlotte R. Bloomberg Children's Center
The Johns Hopkins School of Medicine
2nd Floor, Zayed 2119A, 1800 Orleans Street, Baltimore, MD 21287

Johns Hopkins Section of Adolescent & Young Adult Medicine at the Johns Hopkins Hospital, the Center for Prevention & Early Intervention at the Johns Hopkins Bloomberg School of Public Health and the National Association for Children of Addiction (NACoA) are hosting a day-long symposium and working session on Children in Families Affected by Addiction. It will include presentations from leaders in the areas of child and adolescent health, substance use prevention and early intervention, and related community initiatives. Invited participants will include key local, state and federal partners including representatives from the National Institute of Drug Abuse, NIAAA, and other key federal agencies and participants from the public health, child and family advocacy, substance use prevention and treatment, child welfare and primary care communities.

The event will afford an opportunity to examine what we know, and key lessons learned from previous and current research related to the impact on children growing up in families affected by substance use and substance use disorders. The goal is to envision how we can apply what we know, as well as lessons learned from evidence-based strategies and approaches that are appropriate for the primary care and broader communities. The organizers aim to develop an action plan and clarify steps that need to be taken by key stakeholders to support the health and well-being of children in families affected by substance use and substance use disorders.

Morning presentations will be from noted invited speakers, with ample time for discussion and input from participants. There will be a working lunch with special guest speaker, Jerry Moe, National Director of the Hazelden Betty Ford Children’s Program. The time following lunch will focus on summarizing the deliberations of the day, looking toward realistic steps that can be taken, and creating an action plan for ensuring that there is an active focus and voice for this important segment of the population.

Participants are being asked to RSVP to Gail Miller at gmille55@jhmi.edu or 410-955-2910.

Homeless and Housing Resource Network (HHRN)

Session Recordings Now on YouTube

Click Here for the Playlist

This 2-day national online conversation took place August 7-8, 2019. Subject matter experts from around the country discussed the most effective approaches to ending homelessness for individuals who have serious mental illness and/or substance use disorders. The summit sessions promoted collaboration across systems, drew on scientific evidence, and included practical tools and cutting-edge strategies for communities and agencies.

SAMHSA’s Homeless and Housing Resource Network supports federal, state, and local efforts to prevent and end homelessness among people with mental or substance use disorders through individualized technical assistance, webinars/e-learning opportunities, products, workshops, and SAMHSA’s Homelessness Programs and Resources web pages.

Advocates for Human Potential, 490 B Boston Post Road, Sudbury, MA 01776
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.

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 RI 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.

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**THIS WEEK: Ron Bruno, Executive Director of CIT Utah and 2nd Vice President at CIT International, Says Mental Health Should Not Come in a Police Car**

There are police departments throughout the United States that no longer answer calls they believe could result in “suicide by cop.” Around 100 shootings like this happen each year, making up roughly 10 percent of fatal police shootings. Ron Bruno, Executive Director of CIT Utah and 2nd Vice President at CIT International, says this is a philosophy taking hold in law enforcement agencies all over the country but, he quickly points out, people cannot just be left in distress. “Something has to be done, and that’s why we need to examine our crisis response system as a whole, carving out clear roles for law enforcement and mental health services.” Bruno says that law enforcement has a critical part to play in the mental health crisis response system, but it needs to be in a position of support to the mental healthcare system and only when necessary. “We have to challenge the belief that mental health crisis services must come in a police car.”

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**Crisis Now Partners:**

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

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

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

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

RI International (d/b/a for Recovery Innovations, Inc.) is a global organization that offers more than 50 programs throughout the United States and abroad, characterized by recovery and a focus on what’s strong, not what’s wrong. More than 50% of employees report a lived experience with mental health, and the “Fusion Model” crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. www.riinternational.com | www.zerosuicide.org | www.twitter.com/RI_International.
NOW RECRUITING

CSC OnDemand: An Innovative Online Learning Platform for Implementing Coordinated Specialty Care

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

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

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

What can teams EXPECT?

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

HOW CAN MY AGENCY TAKE PART?

Call our Research Coordinator, Effy: 347-762-9086
Or email: cscstudy@center4si.com
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT
Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SM-20-07)

Funding Mechanism: Grant
Anticipated Total Available Funding: $24,708,000
Anticipated Number of Awards: 6 to 24
Anticipated Award Amount: $1M to $3M per year
Length of Project: Up to 4 Years
Cost Sharing/Match Required?: Yes
Application Due Date: Monday, February 3, 2020

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2020 Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (Short title: System of Care (SOC) Expansion and Sustainability Grants). The purpose of this program is to improve the mental health outcomes for children and youth, birth through age 21, with serious emotional disturbance (SED), and their families. This program will support the implementation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children’s Mental Health Initiative or CMHI).

Eligibility: Eligibility is limited to public entities, which refers to the following:
- State governments and territories (i.e., the District of Columbia; the Commonwealth of Puerto Rico; the Northern Mariana Islands; the Virgin Islands; Guam; American Samoa; the Republic of Palau; the Federated States of Micronesia; and the Republic of the Marshall Islands);
- Governmental units within political subdivisions of a state (e.g., county, city, town);
- Federally recognized American Indian/Alaska Native (AI/AN tribal organizations, as defined in Section 5304(b) and Section 5304(c) of the Indian Self-Determination and Education Assistance Act.

Recipients that are currently funded under SM-17-001 or SM-19-009 are not eligible to apply for funding under this FOA.

Contacts:
Program Issues: Diane Sondheimer, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (240) 276-1922, diane.sondheimer@samhsa.hhs.gov.
Tanvi Ajmera, Center for Mental Health Services, SAMHSA, (240) 276-0307, tanvi.ajmera@samhsa.hhs.gov.


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TOBACCO PRODUCT USE AMONG HIGH SCHOOL STUDENTS

31.2% any tobacco product
27.5% e-cigarettes
7.6% cigars
5.8% cigarettes
4.8% smokeless tobacco
3.4% hookah
1.1% pipe tobacco

Learn more at bit.ly/NYTS-2019
Source: National Youth Tobacco Survey, 2019
FDA Grants Breakthrough Therapy Designation to Usona Institute's Psilocybin Treatment Research Program for Major Depressive Disorder

Usona Institute, a 501(c)(3) nonprofit medical research organization (MRO), has received Breakthrough Therapy Designation from the U.S. Food and Drug Administration (FDA) for the use of psilocybin in the treatment of major depressive disorder (MDD). Breakthrough Therapy Designation establishes the FDA’s organizational commitment to promoting an efficient development program for psilocybin in MDD.

More than 17 million people in the U.S. and 300 million worldwide suffer from MDD. The designation of psilocybin as a Breakthrough Therapy for MDD acknowledges both the unmet medical need in this broad population and the potential for significant improvements over existing therapies. Although there are several existing MDD treatments, Breakthrough Therapy Designation recognizes that psilocybin may offer a clinically significant improvement over these therapies. Psilocybin potentially offers a novel paradigm in which a short-acting compound imparts profound alterations in consciousness and could enable long-term remission of depressive symptoms.

“The results from previous studies clearly demonstrate the remarkable potential for psilocybin as a treatment in MDD patients, which Usona is now seeking to confirm in its own clinical trials. What is truly groundbreaking is FDA’s rightful acknowledgement that MDD, not just the much smaller treatment-resistant depression population, represents an unmet medical need and that the available data suggest that psilocybin may offer a substantial clinical improvement over existing therapies,” says Charles Raison, M.D., Director of Clinical and Translational Research at Usona. “Given that there is so much complexity with psilocybin and that Usona is charting new ground, these interactions will ensure that Usona and the FDA are aligned in approaching the development program with acceptable best practices.”

The new status follows the recent launch of Usona’s Phase 2 clinical trial, PSIL201, which will include approximately 80 participants at seven study sites around the country. Two of the seven study sites are currently recruiting, with the others expected to be active by the first quarter of 2020.

More information on Usona’s ongoing clinical trials is available at www.usonaclinicaltrials.org.

Usona Institute is a 501(c)(3) nonprofit medical research organization (MRO) that conducts and supports pre-clinical and clinical research to further the understanding of the therapeutic effects of psilocybin and other consciousness-expanding medicines. Its focus is on alleviating depression and anxiety in people for whom current medical treatments fall short in offering relief and a better quality of life.

Webinar: Making Health Care Transition Work for Youth with Autism

Friday, December 13
2:00 p.m. to 3:00 p.m. E.T.

On December 13, 2019, the National Institute of Mental Health is sponsoring a webinar about transitioning from pediatric to adult health care for youth with autism.

This webinar will feature a parent and daughter discussing their experiences and perspectives about making the health care transition.

Topics will include:
- What information and help from your health care provider would be most useful,
- Concerns about making the shift to adult care, and
- Suggestions for health care providers for pediatric and adult patients to make the transition successful for youth and young adults with autism and their caregivers.

This webinar will also provide new and useful resources available at Got Transition, the national resource center on health care transition supported by the federal Maternal and Child Health Bureau, Health Resources and Services Administration.

Presenters:
- Allysa and Lauren Ware, Family Voices
- Sarah McLellan, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services
- Peggy McManus, Got Transition/The National Alliance to Advance Adolescent Health

Pre-Registration is not Necessary. Join Webex Meeting HERE
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
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.
Direct Contracting Model (Global and Professional Options) Request for Applications

The Center for Medicare and Medicaid Innovation (Innovation Center) is excited to announce that the Request for Applications (RFA) for the Direct Contracting Professional and Global options is available at https://innovation.cms.gov/initiatives/direct-contracting-model-options/.

The Letter of Intent (LOI) for the Professional and Global options of Direct Contracting is open until December 10 for those organizations who did not submit a LOI previously. The LOI is available at https://app1.innovation.cms.gov/dc.

We encourage you to monitor the Direct Contracting website for future updates. Please contact the help desk with any questions or comments at DPC@cms.hhs.gov.

The application for organizations interested in starting in the first performance year will open in Spring 2020.

Direct Contracting is a set of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare fee-for-service (FFS). The payment model options available under Direct Contracting create opportunities for a broad range of organizations to participate with the Centers for Medicare & Medicaid Services (CMS) in testing the next evolution of risk-sharing arrangements to produce value and high quality health care. Building on lessons learned from initiatives involving Medicare Accountable Care Organizations (ACOs), such as the Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) Model, the payment model options available under Direct Contracting also leverage innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements.

The payment model options are anticipated to appeal to a broad range of physician practices and other organizations because they are expected to reduce burden, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in Medicare FFS or CMS Innovation Center models.

A key aspect of Direct Contracting is providing new opportunities for a variety of different organizations (Direct Contracting Entities or DCEs) to participate in value-based care arrangements in Medicare FFS. In addition to organizations that have traditionally provided services to a Medicare FFS population, Direct Contracting will provide new opportunities for organizations without significant experience in FFS to enter into value-based care arrangements.

Under Direct Contracting, there will be three types of DCEs with different characteristics and operational parameters. These three types of DCEs are:

1. **Standard DCEs** - DCEs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including Medicare-only and also dually eligible beneficiaries, who are aligned to a DCE through voluntary alignment or claims-based alignment. These organizations may have previously participated in section 1115A shared savings models (e.g., Next Generation ACO Model and Pioneer ACO Model) and/or the Shared Savings Program. Alternatively, new organizations, composed of existing Medicare FFS providers and suppliers, may be created in order to participate in this DCE type. In either case, clinicians participating within these organizations would have substantial experience serving Medicare FFS beneficiaries.

2. **New Entrant DCEs** - DCEs comprised of organizations that have not traditionally provided services to a Medicare FFS population and who will primarily rely on voluntary alignment, at least in the first few performance years of the model. Claims-based alignment will also be utilized.

3. **High Needs Population DCEs** - DCEs that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the DCE through voluntary alignment or claims-based alignment. These DCEs are expected to use a model of care designed to serve individuals with complex needs, such as the one employed by the Programs of All-Inclusive Care for the Elderly (PACE), to coordinate care for their aligned beneficiaries.
Reducing Substance Use Disorders Information Session

The Medicaid IAP Reducing Substance Use Disorders (SUD) program area is launching two new technical assistance opportunities for Medicaid agencies. All interested states are encouraged to attend an information session on Tuesday, December 17, 2019 from 2:00 pm to 3:00 pm EST.

During the information session, states will learn about the two technical assistance opportunities and state selection process and have an opportunity to ask questions. These collaborative learning opportunities are:

- Medication-Assisted Treatment (MAT): Participating states will focus on methods to improve and expand MAT delivery services.
- SUD Data Dashboards: Participating states will design and/or update SUD data dashboards for internal and/or external audiences.

These opportunities are open to states at all levels of expertise and experience. Additional information, including the Program Overview, Expression of Interest form, and webinar slides will be posted on the IAP webpage on the day of the webinar.

Register Now
Grants for the Benefit of Homeless Individuals (TI-20-001)

Funding Mechanism: Grant  Anticipated Total Available Funding: $5,204,000
Anticipated Number of Awards: 13  Anticipated Award Amount: Up to $400,000 per year
Length of Project: 5 years  Cost Sharing/Match Required?: No

Application Due Date: Monday, December 16, 2019

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for Federal Fiscal Year (FY) 2020 Grants for the Benefit of Homeless Individuals (Short Title: GBHI). The purpose of this program is to support the development and/or expansion of local implementation of a community infrastructure that integrates substance use disorder treatment, housing services and other critical services for individuals (including youth) and families experiencing homelessness.

Eligibility: Eligible applicants are domestic public and private non-profit entities. SAMHSA seeks to further expand the impact and geographical distribution of its targeted homeless programs. Therefore, recipients funded under the following announcement numbers are not eligible to apply for this funding opportunity:

- TI-17-009 (GBHI) – Grants funded in FY 2017, 2018, and 2019
- SM-18-014 (Treatment for Individuals Experiencing Homelessness) – Grants funded in 2018 and 2019

In addition, the statutory authority for this program specifies that these grants must be made to community-based public and private non-profit entities. Therefore, states are not eligible to apply.

Contacts:

- Program Issues: Michelle Daly, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration(SAMHSA). (240) 276-2789, Michelle.daly@samhsa.hhs.gov.

Expansion of Practitioner Education (FG-20-001)

Funding Mechanism: Grant  Anticipated Total Available Funding: $2,000,000
Anticipated Number of Awards: 10 to 20  Length of Project: 2 years
Anticipated Award Amount: Up to $250,000 per year for professional associations; Up to $100,000 per year for universities/professional schools  Cost Sharing/Match Required?: No

Application Due Date: Monday, December 16, 2019

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for Federal Fiscal Year (FY) 2020 Expansion of Practitioner Education (Short Title: Prac-Ed) grant. The purpose of this program is to expand the integration of substance use disorder (SUD) education into the standard curriculum of relevant healthcare and health services education programs. Through the mainstreaming of this education, the ultimate goal is to expand the number of practitioners to deliver high-quality, evidence-based SUD treatment. The National Survey on Drug Use and Health (NSDUH) 2018 data indicate that an unacceptably high 92% of individuals who meet criteria for needing SUD treatment do not receive it. SAMHSA is implementing this program as one of the many steps to reduce barriers to accessing and providing care.

Eligibility: Public or private non-profit professional associations representing healthcare professionals in the fields of medicine, physician assistants, nursing, social work, psychology, marriage and family therapy, health services administration OR public or private nonprofit entities which are universities, colleges or other professional schools.

Recipients who received funding under FG-19-001 are not eligible to apply for funding under this FOA.

Contacts:

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)

Funding Mechanism: Grant
Anticipated Total Available Funding: $1,761,000
Anticipated Number of Awards: 6
Anticipated Award Amount: Up to $300,000 per year
Length of Project: 5 years
Cost Sharing/Match Required?: No

Application Due Date: Monday, December 23, 2019

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.

WEBSITE FOR THE SAMHSA SPONSORED
National Center on Advancing Person-Centered Practices and Systems

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

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

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<td>Person-Centered Practice in Managed Care: Roles and Developments (Part 1 of 2)</td>
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UPCOMING EVENTS

Free Virtual Learning Collaboratives for December

Peer Support: From Position Description to Integrated Team Member – Starts December 2

Peer support is an important, evidence-based element of behavioral health service delivery. Obtain a top-to-bottom overview on the role of peer specialists and find best practices to integrate and support them within your current mental health care team. Earn up to 12.0 AMA PRA Category 1 Credits™.

In this 12-week, interactive learning experience you work together with colleagues to develop a step-by-step action plan. The plan serves as your evidence-based blueprint for how to bring peer support into your behavioral health agency, health system, or mental health practice. Learn and apply new skills in important areas such as how to:

- Integrate, sustain and support peer specialists in your organization
- Understand the roles and expectations of peer specialists, and ensure you utilize their skills in the best ways possible
- Avoid pitfalls and barriers by using an evidence-based approach
- Evolve your practice/organization to a recovery-oriented culture

Participate in live online discussions with faculty. Post comments, share ideas, and find guidance on interactive discussion boards. Add your experience and knowledge to build on the principles you find in the course and contribute each week to progress towards the final action plan. The time you invest in this learning collaborative helps you translate skills directly from concept into actionable care that benefits your practice or organization.

REGISTER HERE

Building and Using a Comprehensive Psychiatric Mental Health Nursing Assessment – Starts December 11

Focus on advanced skills and enhance your practice around serious mental illness (SMI) by building and using a comprehensive psychiatric mental health nursing assessment. Earn up to 6.0 contact hours of Nursing Continuing Professional Development (NCPD, formerly CNE).

This 12-week, interactive learning experience takes you on a deep dive into innovative assessment and monitoring strategies. It helps you address specific health care issues and risks you may encounter in patients with SMI, which helps you provide more effective care. Learn and apply new skills in important areas such as how to:

- Develop a treatment plan informed by assessment
- Establish a process for systemized tracking of symptom response, side effects, and common medical issues and comorbidities that may impact your patients who have SMI
- Understand current and evolving strategies in psychopharmacology to treat symptoms associated with SMI
- Monitor patient progress using documentation
- Implement tips and techniques on motivational interviewing and SBAR
- Use new approaches for psychosocial treatment planning

This course is an ideal opportunity to consult with faculty experts and get real-time feedback. Participate in group calls with colleagues, ask questions during virtual office hours, and share ideas about your assessment approach on interactive discussion boards. The time you invest in this learning collaborative helps you translate skills directly from concept into actionable care for individuals who have SMI.

REGISTER HERE
UPCOMING WEBINARS

Target Audiences: Counselors, Nurses/Nurse Practitioners, Psychiatrists, Physicians (Non-Psychiatrists), Psychologists, Social Workers, and Peer Specialists/Peer Support

The Role of Peer Support in Ending Social Exclusion and Loneliness
Friday, December 13, 12:00 p.m. to 1:00 p.m. E.T.

This webinar explores the benefits of peer support in combating loneliness and social exclusion, two factors that destroy health and happiness. Research has shown that the lack of “connectedness” to friends and community worsens psychiatric problems and leads to chronic illness and early mortality. Adults with mental health problems are one of the most excluded groups in society. People living with thought disorders, like schizophrenia, have the most difficulties in forming personal relationships of all disabilities. Social inclusion offers opportunities to re-engage with the community and form positive relationships. Mental Health America’s Social Self-Directed Care program and work compiled by the Temple University Collaborative on Community Inclusion emphasize the value of peer support in assisting individuals with serious psychiatric disorders form social connections and personal relationships.

Supporting Clients Who Have Been Justice-Involved
Friday, December 20, 12:00 p.m. to 1:00 p.m. E.T.

Individuals with SMI 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.

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.

Funded by SAMHSA

Grant Statement
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Check Out the SMI Adviser’s Clozapine Center of Excellence

Visit SMIadviser.org/clozapine and join the conversation.
TA Network Webinars & Opportunities

**YOU’RE NOT ALONE: EMBRACING STRUGGLES IN YOUTH ENGAGEMENT**

Direct Connect: Led by Youth M.O.V.E. National, this LC is a virtual forum for youth and young adults to develop professional skill sets via virtual training opportunities, connect as a community to share and gather new resources, and unite with other youth advocates and professional peers from across the country.

This webinar presented by Youth MOVE National Board V.P. David McClung will focus on lessons learned while supporting youth engagement and employment in systems work.

[Register HERE](#)

**STRATEGIES FOR OPERATIONALIZING YOUTH VOICE AND LEADERSHIP IN SYSTEMS OF CARE**

This session of the SOC Leadership Learning Community will focus on approaches for incorporating youth voice and leadership in all aspects of SOC implementation and expansion. Youth voice and choice are fundamental to the SOC philosophy. Centering youth voice in services and engaging youth in overall governance of SOCs is the goal, but what does this look like in practice?

During this webinar, presenters will identify best practices for operationalizing youth engagement at multiple levels of SOCs and will share a tool with specific indicators that can be used to assess progress. Presenters will also help leaders to reflect on strengths and opportunities for implementation in their sites and to access resources to support their efforts.

[Register HERE](#)

**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](#)

**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!


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

National Poll on Children's Health Report: Recognizing Children's Depression at Home and School, C.S. Mott Children's Hospital, November 18
Implementing the ASAM Criteria for SUD Treatment through Medicaid Managed Care, State Health and Value Strategies, Bailit Health, November 2019
Missed Opportunities: Evidence on Interventions for Addressing Youth Homelessness, Voices of Youth Count, Chapin Hall at the University of Chicago, October 2019
Stakeholders and Researchers Recommend Federal Actions to End Youth Homelessness, Matthew Morton & Beth Horwitz, Voices of Youth Count, Chapin Hall at the University of Chicago, 2019
Drug Utilization Review Annual Reports (National Fee for Service & MCO and State-by-State), Center for Medicaid and CHIP Services, November 2019
How to Reduce Suicides on the Psychiatric Ward, Soumya Karlamangla, Los Angeles Times, December 1
As Stigma Ebbs, College Students Seek Mental Health Help, Collin Binkley & Larry Fenn, Associated Press, November 19
‘Black Hole’ of Medical Records Contributes to Deaths, Mistreatment at the Border, Darius Tahir, Politico Magazine, December 1
Medicaid Innovation Accelerator Program: State Medicaid-Housing Agency Partnerships Toolkit, Centers for Medicare and Medicaid Services, September 2019
Biological Citizenship — A 53-Year-Old Man with Schizoaffective Disorder and PTSD Applying for Supplemental Security Income, Ippolytos Kalofonos, M.D., Ph.D., M.P.H., M.H.S., New England Journal of Medicine, November 21
Inaugural Survey of Territory Medicaid Directors, National Association of Medicaid Directors, November 2019
Accountable Care Organization Beneficiary Engagement Toolkit, Mathematica On Behalf of the Centers for Medicare and Medicaid Services, November 25
Reworking SUD Privacy Rules Top Priority for Policy Group of Behavioral Health Payers, Bailey Bryant, Behavioral Health Business, November 20