Study of Neurologic Manifestations in Hospitalized COVID-19 Patients Finds Neurologic Symptoms in 42.2 Percent of Patients at Onset, 82.3 Percent at Any Point of the Disease

A study published in the September 2020 Annals of Clinical and Traditional Neurology of 509 consecutive patients admitted with COVID-19 to the Northwestern Medicine Health Care (NMHC) System in Chicago has found that neurologic manifestations were present at onset in 42.4 percent of patients admitted, at hospitalization in 62.7 percent of cases, and at any point in the course of the disease for 82.3 percent of the patients admitted.

Igor J Koralnik, M.D., Chief of Neu-ro-Infectious Disease and Global Neurology in the Department of Neurology at the Northwestern University Feinberg School of Medicine and his colleagues also identified independent predictors of any neurologic manifestations, encephalopathy (disease affecting brain function), and functional outcomes in the study, which took place between March 5 and April 6, 2020.

NMHC consists of one academic medical center (AMC) and nine other hospitals in the Chicago area. Covid-19 diagnosis was confirmed by SARS-CoV-2 reverse transcription-polymerase chain reaction (RT-PCR) assay of nasopharyngeal swab or broncho-alveolar lavage fluid. All laboratory and radiologic assessments were performed as part of routine clinical care.

The most frequent neurologic manifestations were myalgia (44.8 percent), headache (37.7 percent), encephalopathy (31.8 percent), dizziness (29.7 percent), dysgeusia (a foul, salty, rancid, or metallic taste) (15.9 percent), and anosmia (loss of sense of smell) (11.4 percent). In addition, reports of generalized fatigue at onset (214 [42.9 percent] patients) and any time during COVID-19 disease (404 [79.4 percent]) patients) were common. Strokes, movement disorders, motor and sensory deficits, ataxia (loss of control of body movement), and seizures were much more uncommon (0.2 to 1.4 percent of patients for each).

The authors found that independent risk factors for developing any neurologic manifestation were having severe Covid-19 and being of a younger age. Of all patients, 362 (71.1 percent) had a favorable functional outcome at discharge. However, encephalopathy was independently associated with worse functional outcome and higher morbidity and mortality within 30 days of hospitalization, independent of the respiratory disease severity requiring mechanical ventilation which affected 26.3 percent of patients.

Patients presenting with any neurologic manifestations were younger than those without (57.53 years of age vs. 62.98 and had a longer time from disease onset to hospitalization (7 days vs. 5 days).

Patients with encephalopathy were older than those without (65.51 years of age vs. 55.22), had a shorter time from COVID-19 onset to hospitalization (6 days vs. 7 days), were more likely to be male, and were more likely to have a history of any neurological disorder, cancer, cerebrovascular disease, chronic kidney disease, diabetes, dyslipidemia, heart failure, hypertension and smoking. There were no differences for patients with and without neurologic manifestations in their use of angiotensin converting enzyme (ACE) inhibitors, angiotensin-2 receptor blocker (ARB), corticosteroids, or immunosuppressants prior to admission.

Demographic, medical comorbidity, pre-hospitalization medication usage, and hospital course data used in the study were collected by electronic medical record review. Laboratory data were collected by automated electronic query. Neurologic manifestations were identified by review of clinical notes, diagnostic studies, and physician-documented diagnoses. The identification of neurologic manifestations, the dates of neurologic manifestation onset, and COVID-19 symptom onset dates was facilitated by electronic note templates implemented in the NMHC System as part of the CCOVID-19 response.

Encephalopathy was identified by (a) report of altered mental status or depressed level of consciousness, (b) physician-documented diagnosis of encephalopathy or the delirium encephalopathy syndrome, or (c) positive Confusion Assessment Method (CAM) evaluation, a clinical and research tool used by NHMC since 2008.

Functional outcome at hospital discharge was extracted from therapy and rehabilitation medicine physician documentation using the modified Rankin Scale (mRS): mRS 0–2 meant able to look after ones’ own affairs without assistance; mRS 3 meant that the patient ambulated unassisted but needed help with his or her own affairs; mRS 4–5 meant the patient was unable to ambulate unassisted and needed assistance for bodily care; and mRS 6 meant the patient died. The discharge mRS scores were determined independently by two reviewers and disagreements were reconciled by majority decision after review.
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Fall Back-to-School FREE CME/CEs Recorded Webinar Collections

WEBINARS

• Back-to-School with Free CME/CE Credit
• Individual Recordings Available for CME/CE Credit
• Webinar Archive

Thanks to our partners, at SAMSHA and at the California Tobacco Control Program, SCLC is able to offer FREE CME/CE credit to all eligible healthcare providers. Please use the discount code SAMHSA23, and for California providers use the discount code CADPH23, to waive the $65 fee.

Collection A: This Collection of recorded webinars from SCLC includes six webinars, for a total of 7.0 CE credits. Topics include veterans and tobacco, cessation efforts in public housing and community health centers, systems change for tobacco cessation, vaping and e-cigarettes in the behavioral health population, FDA regulations in tobacco products and non-daily smokers.
For more information and to register for this collection, click here.

Collection B: This Collection of recorded webinars from SCLC includes 10 webinars, for a total of 11.0 CE credits. Topics include update on cessation from the OSH, CDC, cessation for the Medicaid population, opioids and tobacco use, tobacco-free behavioral health settings, smoke-free public housing project, nicotine cessation across disciplines, improving cessation efforts by using data, race & structural racism in tobacco, using quitlines to reduce disparities among tobacco on American Indian, Alaska Native, and Asian populations, and the health effects of nicotine.
For more information and to register for this collection, click here.
#CrisisTalk is Transforming Dialogue in Behavioral Health

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

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

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

**THIS WEEK: DR. KEVIN HUCKSHORN ON TRANSFORMING FORENSIC STATE HOSPITALS WITH EVIDENCE BASED HUMANITY**

Dr. Kevin Huckshorn is known in the mental health community as a hospital fixer, taking hospital facilities on the cusp of losing certification, or worse, and breathing new life into them. She does so by infusing psychiatric hospitals and jails with evidence based, person centered practices like Trauma Informed Care and seclusion and restraint reduction. In 2017, that meant heading to Bridgewater State Hospital in Massachusetts, a state facility that started as an almshouse in 1855 and then, later, became an infamous psychiatric corrections facility. For years, it had the reputation as the harshest state hospital in the United States and found itself the subject of Frederick Wiseman’s 1967 documentary *Titicut Follies*, which highlighted the abuses and illegal commitment of patients that took place within its walls. The Massachusetts Superior Court banned the film from general public viewership until 1991, citing that it violated patients’ privacy, and ordered that all copies be destroyed. Later, on appeal, the court allowed doctors, social workers, teachers, and lawyers to view it.

When Dr. Huckshorn entered Bridgewater’s doors half a century after the documentary was released, she was part of a team tasked with transforming the facility from a prison to a hospital. In this case, she points out, the hospital was, in fact, a corrections facility, so it’s no surprise that it was run one like one. Just like a state’s mental health system is different from all others, so too are state psychiatric hospitals. For a long time, says Dr. Huckshorn, many state psychiatric hospitals were insulated and resistant to change. As time slipped forward, there were evidence based practices that desperately needed to be integrated into these hospital systems, including those designed to decrease injuries to staff and patients. Having been, to varying degrees, stagnant, some state civil and forensic hospitals suddenly found themselves in jeopardy, needing to update their policies and practices but without the financial or academic resources to do so.

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 percent of employees report a lived experience with mental health, and the “Fusion Model” crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. www.rinternational.com www.zerosuicide.org www.twitter.com/RI_International
Suicide Rates among Service Members Are on Par with General Population

Military suicide rates are comparable with the suicide rates for the U.S. adult population, after factoring for age and gender, according to the Department of Defense’s (DoD’s) Annual Suicide Report (ASR) released October 1.

As part of the Defense Department’s efforts to reduce military suicide rates, the DoD mandated in October 2018 an Annual Suicide Report “to serve as the official source of annual suicide counts and unadjusted rates for DoD and a means by which to increase transparency and accountability for DoD efforts toward the prevention of suicide.”

This year’s ASR indicates that 498 active duty military members died by suicide in Calendar Year (CY) 2019, with rates higher for Active Component and National Guard, and lower for the Reserve. Active Duty suicides rose from 324 in 2018 to 340 in 2019 (20.4 per 100,000 to 25.9 per 100,000 population), representing a 1 percent increase. This rate increase has been consistent since CY 2014. The National Guard saw a slight decline from 136 deaths by suicide in 2018 to 89 in 2019 (30.8 per 100,000 population to 20.3 per 100,000 population). The National Guard suicide rate was 20.3 per 100,000 National Guard members. The report notes that the CY 2019 suicide rate is statistically lower than the rate for CY 2017 (89 deaths by suicide versus 133, respectively) indicating that the DoD has made great strides in reducing the suicide rate among National Guard members. The report says, “We are cautiously optimistic, but focused on long-term, sustained improvement for our National Guard members.”

The Reserves saw the lowest suicide rates from 81 deaths by suicide in 2018 to 65 in 2019 (22.9 per 100,000 population to 18.2 per 100,000 population). Similar to the National Guard, suicide rates have statistically decreased from 2017 to 2019 (93 deaths by suicide to 65, respectively).

The ASR reports that suicide decedents were primarily enlisted, male, and younger (< than 30 years of age) service members. Active Component enlisted males under 30 years of age comprised the highest risk group (40.9 per 100,000 population) compared to the general population. Firearms were the primary means of suicide, ranging from 59.6 percent of suicide deaths to 78.7 percent of suicide deaths across the military services.

In addition, the report provides suicide data for military families in CY 2018. During that year 193 military family members (spouses and dependents) died by suicide, which was comparable to CY 2017 and the U.S. general population rates. The only exception was for male spouses, for whom the rate was statistically higher for ages 18 to 60 in comparison to the U.S. population. For military spouses, the suicide rate was 12.1 per 100,000 population. Male military dependents had a lower suicide rate than males in the general population (5.8 per 100,000) and age (< than 23 years old). Female military dependents were not reported due to a low number of cases. Firearms were also the leading suicide method for military spouses and dependents (57.0 percent of military spouses and 52.3 percent of military dependents, respectively).

According to an October 1 DoD press release, “[T]he Department is focused on piloting training—for Service members, particularly young and enlisted members, as well as military spouses—to address the most common help-seeking concerns and encourage seeking help early on, before life challenges become overwhelming. New efforts also aim to address common risk and protective factors with an integrated violence prevention approach.”

As an illustration, DoD is targeting trainings focused on protective environments through firearm safety messaging, such as educational videos focused on lethal means. In addition, DoD has implemented the Counseling on Access to Lethal Means (Calm) program to help military personnel and families increase their awareness of risk factors, lethal means safety practices (e.g., safely storing firearms), and the skills needed to intervene in a crisis situation.

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

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

After completing this course, attendees will be able to:

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

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

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

ENROLL HERE
The COVID-19 pandemic has disrupted or halted critical mental health services in 93 percent of countries worldwide while the demand for mental health is increasing, according to a new WHO survey. The survey of 130 countries provides the first global data showing the devastating impact of COVID-19 on access to mental health services and underscores the urgent need for increased funding.

The survey was published ahead of WHO’s Big Event for Mental Health – a global online advocacy event on 10 October that will bring together world leaders, celebrities, and advocates to call for increased mental health investments in the wake of COVID-19.

WHO has previously highlighted the chronic underfunding of mental health: prior to the pandemic, countries were spending less than 2 per cent of their national health budgets on mental health, and struggling to meet their populations’ needs.

And the pandemic is increasing demand for mental health services. Bereavement, isolation, loss of income and fear are triggering mental health conditions or exacerbating existing ones. Many people may be facing increased levels of alcohol and drug use, insomnia, and anxiety. Meanwhile, COVID-19 itself can lead to neurological and mental complications, such as delirium, agitation, and stroke. People with pre-existing mental, neurological or substance use disorders are also more vulnerable to SARS-CoV-2 infection – they may stand a higher risk of severe outcomes and even death.

Survey Finds Major Disruptions to Critical Mental Health Services

The survey was conducted from June to August 2020 among 130 countries across WHO’s six regions. It evaluates how the provision of mental, neurological and substance use services has changed due to COVID-19, the types of services that have been disrupted, and how countries are adapting to overcome these challenges.

Countries reported widespread disruption of many kinds of critical mental health services:

- Over 60 percent reported disruptions to mental health services for vulnerable people, including children and adolescents (72 percent), older adults (70 percent), and women requiring antenatal or postnatal services (61 percent).
- 67 percent saw disruptions to counseling and psychotherapy; 65 percent to critical harm reduction services; and 45 percent to opioid agonist maintenance treatment for opioid dependence.
- More than a third (35 percent) reported disruptions to emergency interventions, including those for people experiencing prolonged seizures; severe substance use withdrawal syndromes; and delirium, often a sign of a serious underlying medical condition.
- 30 percent reported disruptions to access for medications for mental, neurological and substance use disorders.
- Around three-quarters reported at least partial disruptions to school and workplace mental health services (78 percent and 75 percent respectively).

While many countries (70 percent) have adopted telemedicine or teletherapy to overcome disruptions to in-person services, there are significant disparities in the uptake of these interventions. More than 80 percent of high-income countries reported deploying telemedicine and teletherapy to bridge gaps in mental health, compared with less than 50 percent of low-income countries.

WHO has issued guidance to countries on how to maintain essential services – including mental health services – during COVID-19 and recommends that countries allocate resources to mental health as an integral component of their response and recovery plans. The Organization also urges countries to monitor changes and disruptions in services so that they can address them as required.

Although 89 percent of countries reported in the survey that mental health and psychosocial support is part of their national COVID-19 response plans, only 17 percent of these countries have full additional funding for covering these activities.

This all highlights the need for more money for mental health. As the pandemic continues, even greater demand will be placed on national and international mental health programmes that have suffered from years of chronic underfunding. Spending 2 percent of national health budgets on mental health is not enough. International funders also need to do more: mental health still receives less than 1 percent of international aid earmarked for health.

Those who do invest in mental health will reap rewards. Pre-COVID-19 estimates reveal that nearly US$ 1 trillion in economic productivity is lost annually from depression and anxiety alone. However, studies show that every US$ 1 spent on evidence-based care for depression and anxiety returns US$5.
World Leaders, Celebrities to Join WHO's Big Event for Mental Health on October 10

On 10 October, World Mental Health Day, world leaders and internationally-recognized celebrities and mental health advocates will come together for the World Health Organization’s Big Event for Mental Health. WHO’s first-ever online advocacy event for mental health will focus on the urgent need to address the world’s chronic under-investment in mental health – a problem that has been thrown into the spotlight during the COVID-19 pandemic.

Close to 1 billion people are living with a mental disorder, 3 million people die every year from the harmful use of alcohol and one person dies every 40 seconds by suicide. And now, billions of people around the world have been affected by the COVID-19 pandemic, which is having a further impact on people’s mental health.

The Big Event, which is free and open to the public, will be broadcast on 10 October from 16:00-19:00 CEST [10 a.m. to 1 p.m. E.D.T.] on WHO’s Facebook, Twitter, LinkedIn, YouTube and TikTok channels and website.

The Big Event, to be hosted by award-winning British television journalist Femi Oke, will feature an exciting line-up of performances and conversations with celebrities and activists about their motivations for advocating for greater investment in mental health, including:

- **Cynthia Germanotta**: President and Co-Founder (with her daughter Lady Gaga) of Born This Way Foundation and WHO Goodwill Ambassador for Mental Health
- **Alisson Becker**: goalkeeper for Liverpool Football Club and the Brazilian National Football Team and WHO Goodwill Ambassador for Health Promotion
- **Natália Loewe Becker**: medical doctor and WHO Goodwill Ambassador for Health Promotion
- **Talinda Bennington**: widow of Linkin Park lead vocalist Chester Bennington and founding partner of the mental health advocacy organization 320 Changes Direction
- **Klas Bergling**: father of DJ, musician and producer Tim Bergling, aka Avicii, and Co-founder of the Tim Bergling Foundation.
- **Korede Bello**: Nigerian singer and songwriter
- **Jonny Benjamin**: mental health campaigner, film producer and public speaker

During the event, national and international leaders who have championed mental health in their own countries and organizations will talk about the benefits of this commitment. They include:

- **Her Majesty Queen Mathilde of the Belgians**
- **Epsy Campbell Barr**: First Vice-President of Costa Rica
- **Sigrid Kaag**: Minister for Foreign Trade and Development Cooperation, the Netherlands
- **Peter Sands**: Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria
- **Muhammad Ali Pate**: Global Director, Health, Nutrition and Population, World Bank

The Big Event and this year’s World Mental Health Day campaign, with the slogan: Move for mental health: let’s invest, will highlight actions that can be taken at all levels to increase investments in mental health: at the individual level, taking personal action that supports one’s own mental health and that of friends, family and the wider community; at the national level, establishing or scaling up mental health services; and at the global level, investing in global programmes to promote mental health.

In addition to appearances from celebrities, advocates and world leaders, The Big Event will include short films highlighting WHO and partner initiatives that are improving mental health around the world. The films feature programmes spanning countries from Jordan, Kenya, Paraguay, the Philippines and Ukraine. They cover a range of mental health issues including self-help and stress management, adolescent mental health, mental health and health workers, suicide prevention and improving the quality of life of people with dementia and their careers. The winner of best mental health film, a newly created category in WHO’s Health for All Film Festival, will also be announced during the event.

For updated information about the Big Event for Mental Health, including the latest lineup of performances and participants, visit the Big Event web page. To learn more about World Mental Health Day, visit WHO’s campaign page.
PRESIDENTIAL EXECUTIVE ORDER 13954
SAVING LIVES THROUGH INCREASED SUPPORT FOR MENTAL AND BEHAVIORAL HEALTH NEEDS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. My Administration is committed to preventing the tragedy of suicide, ending the opioid crisis, and improving mental and behavioral health. Before the COVID-19 pandemic, these urgent issues were prioritized through significant initiatives, including the President’s Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS), expanded access to medication-assisted treatment and life-saving naloxone, and budget requests for significant investments in the funding of evidence-based treatment for mental- and behavioral-health needs.

During the COVID-19 pandemic, the Federal Government has dedicated billions of dollars and thousands of hours in resources to help Americans, including approximately $425 million in emergency funds to address mental and substance use disorders through the Substance Abuse and Mental Health Services Administration. The pandemic has also exacerbated mental- and behavioral-health conditions as a result of stress from prolonged lockdown orders, lost employment, and social isolation. Survey data from the Centers for Disease Control and Prevention show that during the last week of June, 40.9 percent of Americans struggled with mental-health or substance-abuse issues and 10.7 percent reported seriously considering suicide. We must enhance the ability of the Federal Government, as well as its State, local, and Tribal partners, to appropriately address these ongoing mental- and behavioral-health concerns.

Section 2. Policy. It is the policy of the United States to prevent suicides, drug-related deaths, and poor behavioral health outcomes, particularly those that are induced or made worse by prolonged State and local COVID-19 shutdown orders. I am therefore issuing a national call to action to:

(a) Engage the resources of the Federal Government to address the mental- and behavioral-health needs of vulnerable Americans, including by:
   (i) providing crisis-intervention services to treat those in immediate life-threatening situations; and
   (ii) increasing the availability of and access to quality continuing care following initial crisis resolution to improve behavioral-health outcomes;
(b) Permit and encourage safe in-person mentorship programs; support-group participation; and attendance at communal facilities, including schools, civic centers, and houses of worship;
(c) Increase the availability of telehealth and online mental-health and substance-use tools and services; and
(d) Marshal public and private resources to address deteriorating mental health, such as factors that contribute to prolonged unemployment and social isolation.

Section 3. Establishment of a Coronavirus Mental Health Working Group. The Coronavirus Mental Health Working Group (Working Group) is hereby established to facilitate an “all-of-government” response to the mental-health conditions induced or exacerbated by the pandemic, including issues related to suicide prevention. The Working Group will be co-chaired by the Secretary of Health and Human Services, or his designee, and the Assistant to the President for Domestic Policy, or her designee. The Working Group shall be composed of representatives from the Department of Defense, the Department of Justice, the Department of Agriculture, the Department of Labor, the Department of Housing and Urban Development, the Department of Education, the Department of Veterans Affairs, the Small Business Administration, the Office of National Drug Control Policy, the Office of Management and Budget (OMB), and such representatives of other executive departments, agencies, and offices as the Co-Chairs may, from time to time, designate with the concurrence of the head of the department, agency, or office concerned. All members of the Working Group shall be full-time, or permanent part-time, officers or employees of the Federal Government.

Section 4. Responsibilities of the Coronavirus Mental Health Working Group.

(a) As part of the Working Group’s efforts, it shall consider the mental- and behavioral-health conditions of those vulnerable populations affected by the pandemic, including: minorities, seniors, veterans, small business owners, children, and individuals potentially affected by domestic violence or physical abuse; those living with disabilities; and those with a substance use disorder. The Working Group shall examine existing protocols and evidence-based programs that may serve as models to better support these at-risk groups, including implementation and broader application of the PREVENTS, and the Department of Labor’s Employer Assistance and Resource Network on Disability Inclusion’s Mental Health Toolkit and Centralized Accommodation Programs.

(b) Within 45 days of the date of this order, the Working Group shall develop and submit to the President a report that outlines a plan for improved service coordination between all relevant public and private stakeholders and executive

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departments and agencies (agencies) to assist individuals in crisis so that they receive effective treatment and recovery services.

Sec. 5. Grant Funding for States and Organizations that Permit In-Person Treatment and Recovery Support Activities for Mental and Behavioral Health.

The heads of agencies, in consultation with the Director of OMB, shall:
(a) Examine their existing grant programs that fund mental-health, medical, or related services and, consistent with applicable law, take steps to encourage grantees to consider adopting policies, where appropriate, that have been shown to improve mental health and reduce suicide risk, including the following:
(i) Safe in-person and telehealth participation in support groups for people in recovery from substance use disorders, mental-health issues, or other ailments that benefit from communal support; and peer-to-peer services that support underserved communities;
(ii) Safe face-to-face therapeutic services, including group therapy, to remediate poor behavioral health; and
(iii) Safe participation in communal support -- both faith-based and secular -- including educational programs, civic activities, and in-person religious services.
(b) Maximize use of existing agency authorities to award contracts or grants to community organizations or other local entities to enhance mental-health and suicide-prevention services, such as outreach, education, and case management, to vulnerable Americans.

Sec. 6. General Provisions.
(a) Nothing in this order shall be construed to impair or otherwise affect:
(i) the authority granted by law to an executive department or agency, or the head thereof; or
(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.
(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.
(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.


[FR Doc. 2020-22510 Filed: 10/7/2020 11:15 am; Publication Date: 10/8/2020]

Addressing Food Insecurity and Poor Nutrition During COVID-19
Wednesday, October 14. 10:00 a.m. to 11:30 a.m. E.T.

Please join the Bipartisan Policy Center on October 14 as we explore public and private sector solutions to address food insecurity and improve diet quality during COVID-19.
Senators Murphy and Booker, Representatives Cardenas and Griffths Ask CMS Administrator Verma to Confirm State Health Care Coverage for Youth in Juvenile Justice under the At-Risk Youth Medicaid Protection Act Has Not Been Delayed

U.S. Senators Chris Murphy (D-CT) and Cory Booker (D-N.J.) and U.S. Representatives Tony Cárdenas (D-CA) and Morgan Griffith (R-VA) on September 29 sent a letter to Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma asking for confirmation of full state implementation of the At-Risk Youth Medicaid Protection Act.

The legislation passed in 2018 as part of the Senate opioid crisis response package, the SUPPORT for Patients and Communities. The lawmakers seek a response from Administrator Verma by October 30.

In 2017, Murphy and Booker reintroduced the At-Risk Youth Medicaid Protection Act, with a companion bill introduced in the House by Cárdenas and Griffith, that went into effect in 2019 after being signed into law as part of the opioid package the previous year. This At-Risk provisions ensure that children and young people up to age 21 who spend time in the juvenile justice system continue to receive health care coverage and treatments immediately after their release from custody. While many states have indicated that their state Medicaid program now suspends, as opposed to terminates, a juvenile’s medical assistance eligibility when a juvenile is in custody, it is not clear that every state has taken the necessary action to comply. In addition, the signers ask CMS to consider sharing best practices with states to facilitate connecting formerly incarcerated juveniles with health care services.

The bipartisan letter states:

We write to ask the Centers for Medicare and Medicaid Services (CMS) to assure Congress that all state Medicaid programs have fully adopted certain health care protections for juveniles involved in the justice system that were enacted in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018. Based on legislation we led in the Senate and House of Representatives, the At-Risk Youth Medicaid Protection Act, this provision allows a young person who is otherwise eligible for Medicaid to continue health care coverage immediately following release from the juvenile justice system. We urge CMS to work with states to assure compliance with the law, and to provide guidance as needed.

Additional NASMHPD Links of Interest

**Medical Algorithms Have a Race Problem**, Kaveh Waddell, *Consumer Reports*, September 18

**Remembering Dr. Lorna Breen on National Physician Suicide Awareness Day**, Michael Myers, M.D., *Psychiatry and Behavioral Health Learning Network*, October 5

**A New Film Looks at an Orchestra for People With Mental Illness**, Jane E. Brody, *New York Times* Personal Health, October 5 online & October 6 in print

**Laurie Santos Says Self-Care Doesn’t Have to Be Selfish**, Hope Reese, *New York Times*, October 7

**Charting a Typical Coronavirus Infection**, Katherine J. Wu & Jonathan Corum, *New York Times*, Updated October 5 online, October 6 in print


**Promoting and Protecting the Health of Women: Saving Lives by Preventing Drug Overdoses**, Karin A. Mack, Ph.D. and Natasha Underwood, Ph.D., Conversations in Equity Blog, Centers for Disease Control and Prevention, October 7


SAMHSA Allowing Flexibility for COVID-19-Affected Grant Recipients During Public Health Emergency Period, Now Extended to January 23

SAMHSA is allowing flexibility for grant recipients affected by the loss of operational capacity and increased costs due to the COVID-19 crisis.

The flexibilities are available during the Public Health Emergency time period, which was extended to January 23 by Health and Human Services Secretary Alex Azar on October 2. Flexibility may be reassessed upon issuance of new guidance by the Office of Management and Budget post the emergency time period. The following information and resources are available to assist grant recipients during the COVID-19 emergency.

**FAQs•COVID-19 FAQs for SAMHSA Grant Recipients (PDF | 104 KB)**

**COVID-19 Re-Budgeting Request More Than 25 Percent or $250,000**

Grant recipients have the flexibility to re-budget (e.g. 25% or less of the current budget or $250,000, whichever is less) as long as the activities are allowable under the FOA, within the scope of your grant application, and in line with the statutory requirement of the award. Grant recipients must keep documentation of all costs and SAMHSA may request this documentation during the grant period.

If the re-budgeting of funds is more than 25% of the current budget or $250,000 whichever is less you MUST submit a COVID-19 post award amendment through eRA Commons.

**COVID-19 Sample Revised Budget (DOC | 25 KB)**

SAMHSA eRA Commons COVID-19 Post Award Amendment Reference Sheet (PDF | 818 KB)

An organization that incurs costs related to the cancellation of events, travel, or other activities necessary and reasonable for the performance of the award due to the COVID-19 pandemic, may charge these costs to its award. An organization that has contracts with providers or other vendors, must adhere to terms of the contract’s cancellation clause(s), as appropriate. Grant recipients should not assume additional funds will be available should the charging of cancellation or other fees result in a shortage of funds to eventually carry out the event or travel. Grant recipients are required to maintain appropriate records and cost documentation to substantiate the charging of any cancellation or other fees related to interruption of operations or services.

**CMS Releases Medicaid and CHIP Enrollment Trends Snapshot Showing COVID-19 Impact on Enrollment**


The monthly snapshot reveals over 4 million new Medicaid and CHIP enrollments between February and June 2020 – a nearly 5.7 percent increase since the PHE began in March 2020.

Medicaid enrollment increased 6.2 percent to nearly 4 million new recipients. New CHIP enrollment increased by 23,495 – about one-half of one percent. Overall enrollment sharply increased with the COVID-19 PHE, and again with the passage of the Families First Coronavirus Response Act (FFCRA) continuity of coverage (maintenance of effort) requirement.

Between May 2020 and June 2020, total percentage change in Medicaid and CHIP enrolment by 1.0 to 2.0 percent in 37 states. In 7 states—Georgia, Kentucky, Nevada, New York, Oklahoma, Utah, and Wyoming—total Medicaid and CHIP enrollment increased by between 2.0 and 3.5 percent. An additional 7 states had modest changes of less than 1.0 percent between May 2020 and June 2020.

From July 2019 to June 2020, national Medicaid and CHIP enrolment increased by 3,601,571 individuals (5.1%). National Medicaid enrolment increased by 3,434,063 individuals (5.3%). National CHIP enrolment increased by 167,508 individuals (2.6%).
Bipartisan Coalition of 43 State and Territorial Attorneys General Urge Hollywood's Creative Community to Protect Young Viewers from Tobacco Imagery

California Attorney General Xavier Becerra and Nebraska Attorney General Doug Peterson on October 5 led a coalition of 43 state and territorial attorneys general in urging the creative community to take action to protect young viewers from tobacco imagery in streamed movies and programs. The bipartisan coalition directed letters to five creative guilds as part of an ongoing effort to reduce youth exposure to tobacco. Last year, the coalition sent letters urging the streaming industry to limit tobacco imagery in their video content. The creative guilds' assistance and support is critical to stopping the renormalization and glamorization of tobacco use, especially youth vaping.

Tobacco is the number one preventable killer in the United States, with over 480,000 Americans dying from tobacco-related diseases every year. A growing body of evidence indicates that vaping can permanently damage lungs and lead to a lifetime of tobacco and nicotine use.

In the race to launch new platforms, provide more content, and capture audiences, many streaming companies failed to consider the impact that easy access to movies and programs with tobacco imagery would have on children. In 2012, following a decade of studies, the Surgeon General concluded that “[t]here is a causal relationship between depictions of smoking in the movies and the initiation of smoking among young people.” More recently, a study by the Truth Initiative found that children who watch episodic programs with tobacco content are significantly more likely to begin vaping than those who are not exposed to such content. Even those with low levels of exposure were more than twice as likely to start using e-cigarettes, and those with high exposure were over three times more likely.

In today's letters, the bipartisan coalition urges Hollywood's creative guilds to use their collective influence to persuade members of the creative community to depict tobacco imagery more responsibly and to encourage streaming companies to:

- Adopt best practices that steer young viewers away from content with tobacco imagery, such as excluding tobacco imagery in future content targeting children, with limited exceptions;
- Only recommend and promote tobacco-free titles for children and families;
- Mitigate the historic and cumulative impact of watching tobacco imagery by running strong anti-tobacco spots, especially before content with smoking or vaping;
- Display prominent and forceful tobacco warnings before content with tobacco imagery; and
- Offer effective parental controls, so families may be empowered to choose smoke-free content.

Letters were sent to the Directors Guild of America, Producers Guild of America, Screenwriters Guild of America, Screen Actors Guild-American Federation of Television and Radio Artists, and International Alliance of Theatrical Stage Employees.


Additional NASMHPD Links of Interest

**National Association of Medicaid Directors FY 2020 Annual Report**, October 2


**Mask Mandates: A Public Health Framework For Enforcement**, Rebekah E. Gee & Vin Gupta, *Health Affairs* Blog, October 5

**COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations**, Centers for Disease Control and Prevention, September 16


**How COVID Spreads**, Centers for Disease Control and Prevention, October 5 (updated)
British Researchers Study Prevalence, Management, and Outcomes of COVID-19 Infections in Seniors and Individuals with Dementia in London Mental Health Inpatient Wards

A British retrospective observational study of the Prevalence, Management, and Outcomes of SARS-CoV-2 Infections in Older People and Those with Dementia in Mental Health Wards in London, published October 5 in the Lancet Psychiatry, finds that patients in psychiatric inpatient settings who are admitted without a known COVID-19 infection have a high risk of infection with COVID-19 and a higher proportion of deaths from COVID-19 than those in the community.

In England and Wales, National Health Service (NHS) subacute care is divided into acute Trusts or general hospitals for physical illnesses and mental health Trusts. A mental health Trust is an NHS-funded organization providing mental health services to a specific geographical area and can consist of several sites.

The researchers, led by gerontologist Gill Livingston, M.B.Ch.B., M.D., Division of Psychiatry, University College London, studied data for 344 inpatients in the older adult services in 16 wards of five London mental health National Health Service (NHS) Trusts: Camden and Islington NHS Foundation Trust; East London NHS Foundation Trust; South London and Maudsley NHS Foundation Trust; Central and North West London NHS Foundation Trust; and Barnet, Enfield and Haringey MH NHS Trust. The Trusts cover 14 boroughs in inner and outer regions of Greater London with approximately 4.6 million people, equating to 51 percent of the population of London, and 7 percent of the United Kingdom population. The authors note that the population in London is substantially ethnically diverse, comprising 59.2 percent white people, 18.4 percent Asian people, 11.9 percent Black people, and 10.6 percent mixed or other ethnic groups in 2018.

Site clinicians at each Trust gathered detailed data using a standardized electronic data collection form for all patients who had suspected or confirmed COVID-19 and clinical details about each site. Patients were determined to have COVID-19 if they had a positive SARS-CoV-2 PCR test, or had relevant symptoms indicative of COVID-19, as determined by their treating physician. The researchers included patient data for all older people (older than or equal to 65 years of age) and people with young-onset dementia (with no age restrictions) who were psychiatric inpatients at one of the five participating London mental health Trusts between March 1 and April 30, 2020. Patients were included whether they were already a current inpatient on March 1 or admitted during the study period. The authors excluded inpatients younger than 65 years who lacked a diagnosis of dementia and those who developed COVID-19 outside of the two-month study period.

Of the 344 inpatient records studied, 131 patients (38 percent) were diagnosed with COVID-19 during the study. The mean age of patients who had COVID-19 was 75.3 years; 68 (52 percent) were women and 47 (36 percent were from ethnic minority groups. Of the 131 diagnosed patients, 16 (12 percent) were asymptomatic and 121 (92 percent) had one or more disease-related comorbidities, 108 (82 percent) were compulsorily detained, and 74 (56 percent) had dementia, of whom 13 (18 percent) had young-onset dementia.

On average, NHS Trust sites received COVID-19 testing kits 4 to 5 days after a patient first clinically presented with COVID-19, and 19 (15 percent) of patients diagnosed with COVID-19 died of COVID-19-related causes during the study period, a much higher percentage than in the general population in the community. In three of five NHS Trusts in London, personal protective equipment (PPE) had become available before the first suspected case of COVID-19 was noted. In two Trusts, PPE became available 2 to 7 days after the first suspected case of COVID-19 and many cases were likely to have already developed undetected COVID-19 before isolation.

The authors found that the London psychiatric wards achieved isolation of people who might be infectious and some gave oxygen treatment on the ward, administered anticoagulation, and had much closer liaison with physicians. Some Trusts also tested patients for D-dimer, ferritin, lymphocyte count, and vitamin D in addition to other pathology tests that were usually done. The authors suggest that such measures could be widely implemented for future waves of COVID-19 or other pandemics, to ensure that the same treatment that is available in wards for physically ill people is also available in mental health wards. They say that in these circumstances, Implementation of the long-standing policy of parity for mental health is urgently needed.
AHRQ Establishes National Nursing Home COVID Action Network

The Agency for Healthcare Research and Quality (AHRQ) announced September 29 that it is partnering with the University of New Mexico’s ECHO Institute in Albuquerque and the Institute for Healthcare Improvement (IHI) in Boston to establish a National Nursing Home COVID Action Network. The network will provide free training and mentorship to nursing homes across the country to increase the implementation of evidence-based infection prevention and safety practices to protect residents and staff.

Nursing home residents are especially vulnerable to SARS-COV-2 (COVID-19) due to their age, their underlying frailty, and their communal living conditions. And nursing home staff who care for them are among the most needed and most at-risk essential workers. It is estimated that almost 56,000 nursing home residents and staff have died from COVID-19, representing more than one-quarter of the nation’s known COVID-19 deaths.

"Protecting vulnerable older Americans in nursing homes is a central part of our fight against COVID-19, and we’ve learned that improving infection control in many nursing homes is not a matter of will but of skill," said HHS Secretary Alex Azar. "AHRQ is deploying its unique expertise in partnership with Project ECHO and IHI to help nursing homes protect both their residents and staff from the virus, slowing the spread and saving lives."

"Expanding the use of proven safety practices will directly benefit nursing home residents and staff members and help save lives," said AHRQ Director Gopal Khanna, M.B.A. "AHRQ has a proven track record of producing science and research to address critical needs such as responding to COVID-19 and achieving 21st century care for all Americans. We are pleased to be working with the ECHO Institute and IHI on this new initiative."

The new network is being created under an AHRQ contract worth up to $237 million that is part of the nearly $5 billion Provider Relief Fund authorized earlier this year under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. While $2.5 billion has already been distributed to help fund testing, personal protective equipment, and other supplies, another $2 billion is available for Medicare and Medicaid-certified nursing homes that show improvement in infection control.

The ECHO Institute is recruiting academic medical centers and large health centers across the country to serve as training centers for local nursing homes. Over 15,000 nursing homes that are certified to participate in the Medicare and Medicaid programs will be able to participate in a 16-week training program using a standardized curriculum developed by the IHI. Nursing homes that actively participate are eligible to receive $6,000 in compensation to cover staff training time.

While the curriculum will continue to be refined as new evidence emerges and the pandemic evolves, topics to be covered in the early weeks include:

- Minimizing the Spread of COVID-19.
- COVID-19 Testing.
- Managing Social Isolation during COVID.

Weekly virtual training sessions will be facilitated by small multidisciplinary teams of subject matter and quality improvement experts. Sessions will combine short lectures that provide immediately usable best practices with case-based group learning. Between sessions, a robust community of practice will foster peer-to-peer learning supported by additional expert consultation.

Sanjeev Arora, M.D., Project ECHO’s director and founder, said he looks forward to leading the initiative in partnership with AHRQ. "At a time when the dissemination of best practices in health care is more critical than ever, we are honored to help address this urgent need for nursing homes," he said.

Project ECHO (Extension for Community Healthcare Outcomes) was established to provide training and telementoring for health care professionals and staff across the nation and around the world. It includes over 250 training partners across the United States. AHRQ funded the initial establishment and evaluation of Project ECHO beginning in 2004. The new network’s training program will use the evidence-based process pioneered by Project ECHO and referred to as the ECHO Model, which is an interactive, case-based approach based on adult learning principles.

"The ECHO model is a proven approach that brings experts and providers together to learn and solve clinical and operational challenges," said Mark Parkinson, President and CEO for the American Health Care Association/National Center for Assisted Living. "We strongly encourage providers to participate in the COVID Action Network to get access to experts and learn the latest best practices to prevent the spread of COVID-19."
Medicaid Home and Community-Based Services Quality Measure Implementation

Webinar #1: HCBS CAHPS® Survey: A Quality Improvement Tool for States and MLTSS Plans

Wednesday, October 14, 2:00 p.m. to 3:00 p.m. E.T.

The Center for Medicaid & CHIP Services (CMCS) will hold informational webinars about the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS®) Survey and Functional Assessment Standardized Items (FASI) in a new initiative to support Medicaid HCBS programs with implementation of these tools.

HCBS CAHPS® is the first cross-disability experience survey for adults in state Medicaid HCBS programs. CMS developed the survey for voluntary use by state Medicaid programs, including fee-for-service HCBS programs and managed long-term services and supports (MLTSS) programs. The survey is CAHPS trademarked and has quality measures endorsed by the National Quality Forum. CMS and the Agency for Healthcare Research and Quality (AHRQ) have also established a free HCBS CAHPS database to facilitate comparison of survey results across programs and states. Connecticut's HCBS CAHPS® state approach will be featured in this webinar.

Register HERE

Webinar #2: Functional Assessment, Interoperability, and Quality Outcomes: What is New and Why It Is Important

Wednesday, October 28, 2:00 p.m. to 3:00 p.m. E.T.

The second webinar will review FASI - a set of standardized items that measure functional status and need for assistance with everyday activities among individuals applying for or receiving HCBS. FASI helps develop a person-centered service plan in HCBS programs.

Speakers will describe the structure and the value of using FASI, including FASI’s role in facilitating interoperability across acute, post-acute, and HCBS. The webinar will feature a state approach from Colorado. These webinars kick-off a series of technical assistance events, including quarterly webinars, office hours, and respective communities of practice for HCBS CAHPS® and FASI, called Early Adoption Work Groups, that will launch in winter 2020. Please forward this announcement to others who may be interested in your state. If you have any questions, please email HCBSMeasures@lewin.com.

Register HERE

Tuesday, October 13, 3:00 p.m. to 4:00 p.m. E.T.

Older adults and adults with chronic conditions, including many people dually eligible for Medicare and Medicaid, face increased risk of adverse outcomes related to the flu, including hospitalization and death. Dually eligible individuals are also at greater risk for severe outcomes due to COVID-19. With a greater risk of infection from COVID-19 or flu this season, flu vaccinations for dually eligible individuals are particularly important. Evidence shows that flu vaccinations decrease flu severity and flu-related hospitalizations. Additionally, flu vaccination uptake may reduce health care system burden during the COVID-19 pandemic.

Health plans can play a key role in facilitating access to and educating members on the importance of annual flu vaccinations. In this panel discussion, health plans will share promising practices for promoting flu vaccinations, including establishing flu vaccine committees, developing effective communication and outreach strategies with the input of member advisory councils, and partnering with community organizations in vaccination delivery. Panelists will also discuss how they are adapting these strategies during COVID-19. By the end of this webinar, attendees should be able to:

- Identify strategies for establishing and leveraging flu vaccination committees
- Describe ways for gathering member input on flu vaccination outreach and communication
- Identify strategies for messaging and promoting flu vaccination in the context of COVID-19
- Identify opportunities for partnering with community organizations in flu vaccination delivery

Featured Speakers:
- Brad Lucas, MD; Chief Medical Officer, Buckeye Health Plan
- Deonys de Cardenas, RN BSN, JD; First Choice VIP Care Plus Plan Lead, Executive Director, First Choice VIP Care Plus

Intended Audience:
This webinar is intended for a wide range of stakeholders, including health plan administrators, clinical leadership, care coordinators, and case managers at health plans (including Medicare-Medicaid Plans (MMPs), Dual Eligible Special Needs Plans (D-SNPs), and managed LTSS plans), as well as providers and other health care and community-based organizations who are interested in strategies related to the communication and delivery of flu vaccinations during the COVID-19 public health emergency.

Register HERE
Training Opportunity: Strategies for Non-Opioid Pain Management: A Panel Discussion

**Tuesday, November 10, 2:30 p.m. to 3:30 p.m. E.T.**

Chronic pain is a common health concern in the United States, particularly among people dually eligible for Medicare and Medicaid. However, clinicians face challenges in treating pain in a manner that meets the needs and preferences of people experiencing pain. While opioids are commonly prescribed to treat acute and chronic pain, there are ongoing considerations surrounding their risks and benefits. Inappropriately treated pain may result in the increased use of illicit drugs and other substances to help relieve pain, substance use disorder, as well as increased suicide risk.

In treating chronic pain, it is important for providers and health plans to adopt pain management strategies that are person-centered, tailored to each individual, and that optimize health, function, and quality of life. This panel will discuss non-opioid pain management strategies for dually eligible individuals, including effective, person-centered pain management options; challenges health plans and clinicians face in providing effective chronic pain management support; and strategies for addressing pain needs during the COVID-19 pandemic.

**Featured Speakers:**
- Beth Darnall, PhD, Clinical Professor, Stanford University School of Medicine, Department of Anesthesiology, Perioperative and Pain Medicine
- Eve Gelb, Senior Vice President, Member and Community Health, SCAN Health Plan
- Donna Lynn Foster, Member/advocate, SCAN Health Plan

**Intended Audience:**
The target audience for this webinar includes providers and health care professionals serving people experiencing pain; and staff at health plans, including Medicare-Medicaid Plans (MMPs), Dual Eligible Special Needs Plans (D-SNPs), and managed LTSS plans

**Register HERE**
Veterans Administration Suicide Risk Management Consultation Program
Virtual Lecture Series

Welfare Checks and Therapeutic Risk Management
*Wednesday, October 14, 2:00 p.m. to 3:00 p.m. E.T.*

Now, more than ever, the increased effort to address suicide crises by clinicians, health care teams and communities has involved the use of welfare checks.

This presentation will apply the principle of therapeutic risk management as a patient-centered approach to scenarios prompting consideration for welfare checks.

Following this live, knowledge-based virtual training, clinicians and health care teams will be able to:

- Understand and balance the ethical principles of autonomy, non-maleficence, and beneficence.
- Discuss the relationship between risk-benefit analysis and clinical decision making for suicide risk.
- Apply a standard of care to challenging clinical situations and safety issues.

**Audience:** The primary target audience for this activity consists of physicians, nurses, psychologists, pharmacists and social workers.

**VA Providers:**

[Register in TMS]

**Non-VA Providers:**

[Register in TRAIN]

**Audio:** You can join the audio by phone. Dial into the meeting using VANTS: 800-767-1750; access code 52655#

**Credit/hours:** 1-hour CE for registered providers

**Accreditations:** JA IPCE, ACCME, ACCME-NP, ANCC, APA, ASWB, NYSED

Visit the SRM website for additional details on the lecture series and to learn more about SRM.

This course is jointly offered by the Office of Rehabilitation and Prosthetic Services, the Veterans Health Administration Employee Education System and the Office Mental Health and Suicide Prevention.
CDC Guidance on Holiday Celebrations

As many people in the United States begin to plan for fall and winter holiday celebrations, CDC offers the following considerations to help protect individuals, their families, friends, and communities from COVID-19. These considerations are meant to supplement—not replace—any state, local, territorial, or tribal health and safety laws, rules, and regulations with which holiday gatherings must comply. When planning to host a holiday celebration, you should assess current COVID-19 levels in your community to determine whether to postpone, cancel, or limit the number of attendees.

Virus spread risk at holiday celebrations

Celebrating virtually or with members of your own household pose low risk for spread. In-person gatherings pose varying levels of risk. Event organizers and attendees should consider the risk of virus spread based on event size and use of mitigation strategies, as outlined in the Considerations for Events and Gatherings. There are several factors that contribute to the risk of getting infected or infecting others with the virus that causes COVID-19 at a holiday celebration. In combination, these factors will create various amounts of risk, so it is important to consider them individually and together:

- **Community levels of COVID-19** – Higher levels of COVID-19 cases and community spread in the gathering location, as well as where attendees are coming from, increase the risk of infection and spread among attendees. Family and friends should consider the number and rate of COVID-19 cases in their community and in the community where they plan to celebrate when considering whether to host or attend a holiday celebration. Information on the number of cases in an area can be found on the area’s health department website.

- **The location of the gathering** – Indoor gatherings generally pose more risk than outdoor gatherings. Indoor gatherings with poor ventilation pose more risk than those with good ventilation, such as those with open windows or doors.

- **The duration of the gathering** – Gatherings that last longer pose more risk than shorter gatherings.

- **The number of people at the gathering** – Gatherings with more people pose more risk than gatherings with fewer people. CDC does not have a limit or recommend a specific number of attendees for gatherings. The size of a holiday gathering should be determined based on the ability to reduce or limit contact between attendees, the risk of spread between attendees, and state, local, territorial, or tribal health and safety laws, rules, and regulations.

- **The locations attendees are traveling from** – Gatherings with attendees who are traveling from different places pose a higher risk than gatherings with attendees who live in the same area. Higher levels of COVID-19 cases and community spread in the gathering location, or where attendees are coming from, increase the risk of infection and spread among attendees.

- **The behaviors of attendees prior to the gathering** – Gatherings with attendees who are not adhering to social distancing (staying at least 6 feet apart), mask wearing, hand washing, and other prevention behaviors pose more risk than gatherings with attendees who are engaging in these preventative behaviors.

- **The behaviors of attendees during the gathering** – Gatherings with more preventive measures, such as mask wearing, social distancing, and hand washing, in place pose less risk than gatherings where fewer or no preventive measures are being implemented.

People who should not attend in-person holiday celebrations

**People with or exposed to COVID-19**

Do not host or participate in any in-person festivities, if you or anyone in your household

- Has been diagnosed with COVID-19 and has not met the criteria for when it is safe to be around others
- Has symptoms of COVID-19
- Is waiting for COVID-19 viral test results
- May have been exposed to someone with COVID-19 in the last 14 days
- Is at increased risk of severe illness from COVID-19

**People at increased risk for severe illness**

If you are at increased risk of severe illness from COVID-19, or live or work with someone at increased risk of severe illness, you should

- Avoid in-person gatherings with people who do not live in your household.
- Avoid larger gatherings and consider attending activities that pose lower risk (as described throughout this page) if you decide to attend an in-person gathering with people who do not live in your household.
Join the 6th Annual Global Peer Support Celebration Day!

**Thursday, October 15, 2:00 p.m. to 3:30 p.m. E.T.**

As peer support has become increasingly vital to the recovery and wellbeing of people around the world amidst the pandemic, Global Peer Support Celebration Day (GPSCD) 2020 appreciates and recognizes the outstanding efforts of peer supporters everywhere.

Led by N.A.P.S., GPSCD this year will feature a diverse panel of peer support voices, including peer support leaders and allies, as they speak on critical topics and advances in the field of peer support and recovery.

We invite you to join this virtual celebration on October 15, as we come together to celebrate peer support and peer supporters around the world.

**Please register to join this worldwide celebration.**

While you’re at it, let us know how you’re also celebrating GPSCD in your local communities! Share your celebration posts on social media with the hashtags #GPSCD2020 #GlobalPeerSupportCelebrationDay.

On behalf of the Board of N.A.P.S., we look forward to hosting you as we unite to celebrate peer supporters and the critical work. Stay tuned for more info on GPSCD and the N.A.P.S. Annual Meeting.

Anthem

*Thank you to our generous sponsor for supporting the 2020 GPSCD Webinar!*

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**Third Annual Crisis Residential Conference**

**October 14 & 15**

The third annual Crisis Residential Conference is taking place virtually October 14 & 15. Hosted by the Crisis Residential Association, this conference brings together the best ideas in residential alternatives to psychiatric hospitalization. Boasting a spectacular lineup of nationally recognized speakers and thought leaders, attendees will learn about innovations and best practices in the field of behavioral health crisis care.

You can see our agenda of keynotes, breakout sessions, TED Talks, and networking opportunities along with information and registration for the conference at [https://www.crisisresidentialassociation.org/conference.html](https://www.crisisresidentialassociation.org/conference.html).

$225 for members  $295 for non-members
$275 for non-members to attend conference AND become a member of CRA
2020 Virtual Mini-Conference
Equity in Access, Services, and Outcomes for Children, Youth, and Families During COVID-19
November 10 & 12, 1:00 p.m. to 4:15 p.m. E.T.

Workshop Themes and Tracks:
- Tackling Mental Health Disparities for Children of Color
- Mental Health, Substance Use, and Family and Peer Virtual Support Services that Work

Each workshop time period will feature workshops addressing the conference themes as well as topics such as peer support, family/youth leadership, co-occurring mental health/substance use disorders, trauma-informed services, etc. Learn more about attending, presenting, sponsoring and advertising in the event program below. See the full line up of workshops below!

Tuesday, November 10

Opening Statements & Welcome
1:00 to 1:15 p.m. E.T.

Plenary Panel featuring State and Local Chapters on the Conference Themes – 1:15 to 2:15 p.m. E.T.

Conference Logistics – 2:15 to 2:30 p.m. E.T.

Break – 2:30 to 2:45 p.m. E.T.

Workshops – 2:45 to 4:15

Parenting and Family Support
1. Positive Solutions for Families of Young Children: Denise Bouyer, SPAN Parent Advocacy Network (New Jersey)
2. Adversity is NOT Destiny: Intergenerational Grandfamily Peer Support: Glenda Clare, Fragile Families Network (North Carolina)
3. Shadows & Light: Untold Stories - Addressing Trauma: Paula Ray & Sandy Thompson, Families Inspiring Families (Nebraska)

Youth Peer Support

Equity
1. Getting Rid of Mental Health Stigma in the Caribbean Community: Samantha Samuels & Ollinda Richard-Hodge, Young Dreamers International (Georgia)
2. A Collaborative Approach to Cultural and Linguistic Appropriateness in Evaluating Children’s Mental Health Programs: Allison Stevens, PEP; Lexie Beck, Youth MOVE and Alejandra Ruiz, Division of Youth & Family Services (Nevada)

Technology/Virtual Support
2. Flexibility and Creativity: Using Technology to Support Families: Maria Silva, Allegheny Family Network (Pennsylvania)

Substance Use
1. Mental Health Interventions and Treatment Approaches for Substance Dependent Pregnant and Parenting Women and Their Young Children: B. Fellows, University of MD School of Medicine Psychiatry & Jessica Lertora, Zero to Three (Maryland)

Thursday, November 12

Workshops – 1:00 to 2:30 p.m. E.T.

Parenting and Family Support
1. Why Will No One Play With Me? The Play Better Plan Parent Training and Your Social Skills Curriculum: Carolyn Maguire, NE Coaching (Massachusetts)
2. When Worrying Takes Over: Helping Kids with ADHD and their Parents Overcome Anxiety and Build Resilience: Sharon Saline, Clinical Psychologist (Massachusetts)

Youth Peer Support
1. Youth Advocacy/Engagement During COVID-19: Christina Smith, Calling All Youth MOVE (Michigan)

Equity
1. Level the Playing Field- Social Support and Social Capital for Improved Mental Health Outcomes with Black and Brown Families: Ronik Radlauer Group (Florida)
2. Children’s Mental Health Justice 101: Navigating Fractured Systems and Advocating for Justice: Dionne Bensonsmith, Dr. Tammy Nyden, Angela Riccio, Mothers on the Frontline (California)

Technology/Virtual Support
1. Technology to Reach and Serve Latinx Families: Brenda Figueroa & Fanny Ochoa, SPAN Parent Advocacy Network (New Jersey)

Substance Use
1. Opioid Crisis Methamphetamine Surge Awareness & Combat: Vicki Hill, The Struggle WithIN (Nevada)
2. Creating Safety: Being a Supportive Adult: Working with Youth Who Have Experienced Trauma: Angie Geren, Arizona Recovers (Arizona)

Break – 2:30 to 2:45 p.m. E.T.

Keynote Presentation & Discussion – 2:45 to 4:15 p.m. E.T.

Register Here!

Sign Up to Sponsor and/or Advertise

We look forward to seeing you in November
The 61st Annual Conference (1st Virtual Conference)

Implementing Behavioral Health Crisis Response at State and Local Levels: New Paradigms, Partnerships, and Innovative Approaches

One (1) Session, Six (6) Consecutive Weeks
Each Thursday, September 17 to October 22, 2:00 p.m. to 4:30 p.m. E.T.

This year, the National Dialogues on Behavioral Health conference that is usually convened in New Orleans was going to focus on cutting edge and innovative approaches to behavioral health crisis response at both state and local levels. But then, another crisis came along almost to underline the importance and significance of the topic that we had selected.

The behavioral health world, including its crisis response systems, has been scrambling to adapt and adjust to the new realities of the COVID-19 Pandemic. We thought it was critical that we take these new realities into account, both in terms of conference content and conference format, to dialogue on this important topic. Join us for 6 consecutive weeks as we address the emerging issues and innovations related to behavioral health crisis response in this new environment.

CONFERENCE RATE: ONLY $100.00 FOR ALL SIX SESSIONS OR ONLY $25.00 FOR EACH INDIVIDUAL SESSION.

FOR MORE INFORMATION AND TO REGISTER FOR THE CONFERENCE, GO TO OUR WEBSITE: WWW.NATIONALDIALOGUESBH.ORG

CONTINUING EDUCATION CREDITS APPLIED FOR AND PENDING FOR SOCIAL WORKERS


The IPS Employment Center offers several self-paced online courses, which include reading material, videos, homework assignments based on routine work responsibilities, and interactive feedback with instructors. The 12-week online IPS Practitioners course (available in English and Spanish) focuses on the evidence-practice of supported employment and supported education. The 10-week online IPS supervisors course helps supervisors to develop skills to improve program performance and outcomes. The 5-week Vocational Rehabilitation course teaches Vocational Rehabilitation counselors about IPS and their role partnering with IPS programs.

For more information, https://ipsworks.org/index.php/training-courses/
Let’s Move Forward in Our Journey

We are excited to present our first Virtual Fall 2020 CSAVR Conference integrating live and recorded sessions led by highly respected leaders in our field and some amazing special guests.

SCHEDULE

CSAVR Leadership Forum
- Monday, November 2, 1:00 p.m. to 4:00 p.m. E.T.
- Wednesday, November 4, 1:00 p.m. to 4:00 p.m. E.T.

Directors Forum
- Thursday November 5, 1:00 p.m. to 4:00 p.m. E.T.

2020 Fall Virtual Conference
- Monday, November 9, 1:00 p.m. to 4:15 p.m. E.T.
- Tuesday, November 10, 1:00 p.m. to 4:00 p.m. E.T.
- Wednesday, November 11, 1:00 p.m. to 4:00 p.m. E.T.
- Thursday November 12, 1:00 p.m. to 4:00 p.m. E.T.
- Friday November 13, 1:00 p.m. to 4:30 p.m. E.T.

Download Full Agenda (PDF)
Leadership (and Partnership) Starts with You

Register Now for the 2020 UnSummit!

Special Team Pricing:
$75 off per person for 3 or more attendees
For every 5 registrations, get one free

Registration Rates:
CBHL Member: $175
Non-Member: $250
8.5 CEU/CMEs: $75-$100

Curious how we can 'move the needle' for improved health when working in diverse communities with different cultures, agendas and expectations for leadership? Want to explore your role as a leader? When to step up and when to step back while building authentic community partnerships?

Leadership within a partnership differs from leadership in a traditional, hierarchical organization. Join us for a dynamic, interactive and flexible 9-week UnSummit where together we will explore best practices for partnering with communities to improve health outcomes.

Why join yet another virtual event?
- Unique learning package delivered over 9 weeks
- Flexible with live, interactive and on demand content
- Up to 8.5 CEUs available for physicians, psychologists & social workers
- A robust interactive event app
- Dynamic keynote speakers
- Engaging panel presentations paired with interactive follow up discussions
- Opportunities to network and build resilience with colleagues
- On demand case study presentations to share innovative partnerships
- Opportunities to connect with thought leaders from around the country!

Visit Us On-Line
The Technology, Mind and Society Showcase is coming soon—are you registered?

Join thousands of your peers virtually this fall as APA brings together scientists, applied practitioners, IT executives, students, policymakers and industry leaders for great new content, in a safe, convenient and more compact format. TMS 2020 will examine how psychological science can inform the development and adaptive use of new technologies that affect people’s lives. Registration is FREE.

We are honored to announce the following keynote speakers for this premier interdisciplinary showcase for emerging research and innovation:

- Jeremy Bailenson, Stanford University
- Lisa Feldman Barrett, Northeastern University
- Maja Matarić, University of Southern California
- Rosalind Picard, Massachusetts Institute of Technology

**REGISTER FOR FREE**

- Get the latest research and cutting-edge practices in this rapidly evolving field
- Hear thought-provoking discussions with globally recognized experts
- Engage with vendors through virtual exhibits
- Submit your questions during live access and open dialogue

Reserve your place now and discover the role psychological science plays in human and technology interaction.

In cooperation with

[Image of AAAI logo]
An Important Grant Award Announcement

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

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

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

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

For more information, please contact Lynda Gargan, Executive Director, at lgargan@ffcmh.org.
**Notice of Upcoming Targeted PCORI Funding Announcement**

**Suicide Prevention: Brief Interventions for Youth -- Cycle 3 2020**

- **Announcement Type:** Research Award
- **Total Funds Available:** $30 Million
- **Maximum Project Period:** 5 years
- **Total Direct Costs:** $10 million
- **Earliest Start Date:** November 2021
- **Applicant Town Hall Session:** September 2020
- **Application Deadline:** January 12, 2021, 5 p.m. E.T.

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

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

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

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

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

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

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

Interventions must be evidence-based and/or in widespread use and reproducible. This Targeted PFA preannouncement is provided to allow potential applicants additional time to identify collaborators, obtain stakeholder input on potential studies, and develop responsive, high-quality proposals.
Webinar: Improving Care for Children with Chronic and Complex Needs –
A Look at the National Care Coordination Standards for Children and Youth with
Special Health Care Needs

Wednesday, October 21, 2:00 p.m. to 3:00 p.m. E.T.

This webinar will discuss the need for and core elements of the new National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN). Informed by a group of national experts, including state Medicaid agency officials, health services researchers, families of CYSHCN and more, the Care Coordination Standards feature the structures and processes needed to deliver high-quality, family-centered, and equitable care for CYSHCN.

State health officials from the national work group will highlight their experiences in implementing care coordination programs and how states can use or adapt the National Care Coordination Standards for CYSHCN to improve care coordination for children with chronic and complex conditions. Speakers will include:

- David Bergman, M.D., Emeritus Faculty, General Pediatrics, Stanford University School of Medicine
- Cara Coleman, J.D., Program Manager, Family Voices
- Jeffrey Brosco, M.D., State Title V CYSHCN Director, Florida Department of Health, Professor of Clinical Pediatrics, University of Miami
- Wendy Tiegreen, M.S.W., Director, Office of Medicaid Coordination & Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities

Register HERE

www.samhsa.gov/find_help

Get information on mental health services and resources near you, searchable by state or zip code:
The MHTTC Network – School Mental Health Initiative

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

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

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

To view a compilation of MHTTC resources specific to school mental health during the COVID-19 pandemic, visit our website.

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Virtual Native Talking Circle: Staying Connected in Challenging Times

**Bi-Weekly, Mondays, 12:30 p.m. C.T.**

Talking circles are based on the tradition of sharing circles. Please join us together for our virtual talking circle. This event is held bi-weekly. This group will be facilitated by a Native guest and will focus on concerns about yourself, your family, your work, and/or your tribal community that you may be experiencing during these uncertain times. There is no fee or expectation to participate in this event. This is a respectful meeting space. Come share your concerns, offer support, and respect the group’s privacy.

October 19

November 2

Register HERE
Research shows that spirituality positively impacts health and wellness – including for individuals living with mental illness, and for their families. Understanding the critical intersections of spirituality and mental health can increase the overall effectiveness and quality of treatment across an individual’s continuum of care.

Faith leaders and mental health practitioners are working together, developing strong and successful examples of what can be replicated around the nation. This webinar series seeks to share:

- Research demonstrating the outcomes possible when considering spirituality and mental health together, rather than as separate areas of study.
- Testimonies of personal and lived experiences, highlighting what can be achieved, and engaging diverse communities.
- Examples of spirituality and mental health being addressed together to improve the health and wellness outcomes for clients and their families.

**REGISTER FOR THE ENTIRE SERIES**

**WEBINAR SCHEDULE:**

- **Oct. 13, 12:00 pm** — Spirituality and Post-Traumatic Growth: Spirituality as Catalyst for Resilience
- **Oct. 27, 12:00 pm** — Spirituality and Severe Mental Illness: Questions of Recovery versus Purposeful Renewal
- **Nov. 10, 12:00 pm** — Spirituality and the Life-time Course of Mental Illness: Support for Patients, Caregivers, and Family by the Faith Community
- **Nov. 19, 12:00 pm** — Spirituality and Treatment: Contributions to Faith and Forgiveness in Recovery
- **Dec. 8, 12:00 pm** — Spirituality and Community-wide Crisis: Building Systems to Support Connection and Recovery

*If you have any questions about this new series, please email us at partnerships@hhs.gov.*
Payers' Behavioral Health Management and Policy – A Webinar Series

Prepare Your 2021 BH Strategy and Operations by Gaining Insight into Legislative, Regulatory, and Pandemic Response Efforts

A Complimentary Event:

Payers' Behavioral Health Management and Policy

A Webinar Series

Tuesday, October 20, 12:00 p.m. to 4:10 p.m. E.T.

Wednesday, October 21, 11:30 a.m. to 3:25 p.m. E.T.

Brought to you by World Congress and the Association for Behavioral Health and Wellness

Prepare Your 2021 BH Strategy and Operations by Gaining Insight into Legislative, Regulatory, and Pandemic Response Efforts

As the presidential election nears, pandemic response continues, and the need for increased access and coverage of behavioral health services is necessary to meet a growing demand, World Congress in collaboration with the Association for Behavioral Health and Wellness, is pleased to host a series of free informational webinars as our annual Payers' Behavioral Health Management and Policy programming. Health Plans, Managed Behavioral Healthcare Organizations (MBHOs), and Government representatives headline the speaking faculty to share their insights, experiences, and expertise on the policy, operations, and management of behavioral health. Learn about their efforts to advance the coordination, integration, and payment of behavioral health care services to increase access and ensure those with mental health and substance use disorders are identified and receive the care they need.

Join your peers to shape the future of behavioral health and learn about payers' COVID response, implications of the upcoming election, telebehavioral health, and continued efforts around parity, integrated care delivery, and value-based payments to understand the impact to your organization’s BH strategy and operations in 2021.

Register NOW
See the Agenda
Meet the Faculty
Disasters have the potential to cause emotional distress. Some are more at risk than others:
- Survivors living or working in the impacted areas (youth & adults)
- Loved ones of victims
- First Responders, Rescue & Recovery Workers.

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

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

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

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

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

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

If you have trouble sleeping:

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

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

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

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

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

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

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

You Are Not Alone.
Research on Co-Morbid Substance Use, Substance Use Disorders, and Other Psychiatric Disorders

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

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

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

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

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

(More on following page)
Research on Co-Morbid Substance Use, Substance Use Disorders, and Other Psychiatric Disorders

(Continued from previous page)

Application and Submission Information

This notice applies to due dates on or after October 5, 2020 and subsequent receipt dates through May 8, 2023

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

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

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

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

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

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

Scientific/Research Contact: Amy B. Goldstein, Ph.D., National Institute on Drug Abuse (NIDA), 301-827-4124, amy.goldstein@nih.gov.
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 and 2018 Beyond Beds series of papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

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

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

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

- Effects of CMS’ Measure of Antipsychotic Prescribing Practices for Nursing Facilities on Utilization of Antipsychotic Medications and Changes in Diagnostic Patterns
- Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders
- A Public Health Approach to Trauma and Addiction
- Traumatic Brain Injury and Behavioral Health Treatment
- Recovery-Oriented Cognitive Therapy: a Theory-Driven, Evidence-Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems
- Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now?
- Schools as a Vital Component of the Child and Adolescent Mental Health System
- Addressing Intersecting Social and Mental Health Needs among Transition-Aged Homeless Youth

The NASMHPD Technical Assistance Coalition series will continue in 2021.
SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation uses its Virtual Learning Community (VLC) model to deeply explore topics of interest to the field centered around a common theme. VLCs are composed of a series of webinars, small discussion groups, and webinar supporting materials. These communities are open to the field at no cost to the participant.

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

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

**Webinar: Ways to Support Employment after Incarceration**  
*Thursday, October 29, 12:30 p.m. to 2:00 p.m. E.T.*

This webinar presents three perspectives on employment as a necessary component of successful transition back into the community.

[Register HERE](#)

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

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

[Register On-Site](#)

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**Mental Health & Wellness Guide for Public Service Professionals**

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

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

[Access the Guide HERE](#)
Training and Technical Assistance Related to COVID-19 Resources

<table>
<thead>
<tr>
<th>TTC</th>
<th>Resource Type</th>
<th>Title</th>
<th>Link</th>
</tr>
</thead>
</table>

The MHDD-NTC is a collaboration between the University Centers Kentucky, University of Alaska Anchorage, and Utah State University.

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

Please visit their website at https://mhddcenter.org/
Mental Health in a Pandemic: Q&A with Thomasine Heitkamp and Dennis Mohatt, Co-Project Directors of the Mountain Plains Mental Health Technology Transfer Center (MHTTC)

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

Rural Healthcare Surge Readiness: Behavioral Health

COVID-19 Rural Healthcare Surge Readiness

Up-to-date and critical resources for rural healthcare systems preparing for and responding to a COVID-19 surge.

New Rural Health Funding & Opportunities from the Past 30 Days

Site Selection for Rural Home Hospital Randomized Controlled Trial
A request for proposals from rural hospitals to launch and evaluate a home-based acute care intervention, called Rural Home Hospital, which is an adaptation of the Home Hospital Model for rural communities.

Geographic coverage: Nationwide
Application Deadline: Nov 16, 2020
Sponsors: Ariadne Labs, Brigham and Women’s Hospital, Harvard T.H. Chan School of Public Health

Community Connect Broadband Grant Program
Grants for communities without broadband access to provide residential and business broadband service and connect facilities such as police and fire stations, healthcare, libraries, and schools.

Geographic coverage: Nationwide and U.S. Territories
Application Deadline: Dec 23, 2020
Sponsors: U.S. Department of Agriculture, USDA Rural Development, USDA Rural Utilities Service

IIMHL and IIDL Leadership Exchange
Valuing Inclusion, Resilience and Growth.
Kāingākautia te whakawahāiti tāngata, te ngākau manawaroa, te puāwaitanga o te tangata.

SAVE THE DATE
28 Feb to 4 Mar, 2022
Christchurch, New Zealand
The National Center of Excellence for Eating Disorders (NCEED) was created to serve as the centralized hub dedicated to eating disorders education and training for both healthcare providers and the general public. NCEED is partnering with the 3C Institute to develop and launch an interactive, web-based, educational, training platform to ensure that high-quality trainings are provided to health professionals across multiple disciplines.

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

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

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

Information, Training, and Technical Assistance

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

NCEED has gathered information to help support the community as the COVID-19 crises evolve. Resources were created to provide guidance on how to support yourself, your loved ones and your patients:


**Knowledge Informing Transformation**

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

**GET THE TOOLKIT 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 new NCAPPS website for more information.

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

<table>
<thead>
<tr>
<th>October 2020</th>
<th>Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2020</td>
<td>Person, Family, Clan, Community: Understanding Person-Centered Thinking, Planning, and Practice in Tribal Nations</td>
</tr>
<tr>
<td>December 2020</td>
<td>Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

1 TELEHEALTH VISITS THAT REPLACE OFFICE VISITS

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

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

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

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

<table>
<thead>
<tr>
<th>Initial Psychiatric Evaluation</th>
<th>Evaluation and Management Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>90792+95</td>
<td>99204+95</td>
</tr>
<tr>
<td>90792+95</td>
<td>99213+95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation and Management Plus Psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 (16-37*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90832+95</td>
</tr>
<tr>
<td>45 (38-52*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90836+95</td>
</tr>
<tr>
<td>60 (53+*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90838+95</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychotherapy Alone</th>
<th>Family Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>90822+95</td>
<td>90846+95</td>
</tr>
<tr>
<td>90824+95</td>
<td>90847+95</td>
</tr>
<tr>
<td>90827+95</td>
<td>90849+95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Therapy</th>
<th>Patient not present</th>
<th>Patient present</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>90853+95</td>
<td>(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2 TELEPHONE VISITS

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

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

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

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

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

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

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

- Those that bill evaluation and management services should use:
  - 99421 5-10 minutes
  - 99422 11-20 minutes
  - 99423 21-30 minutes

- Those that cannot bill evaluation and management services should use:
  - G2061 5-10 minutes
  - G2062 11-20 minutes
  - G2063 21-30 minutes

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

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

- SMI Adviser
- American Psychiatric Association
- Center for Connected Health Policy
- Centers for Medicare and Medicaid Services
- Federation of State Medical Boards
Self-Directed Care for Individuals with Serious Mental Illness  
Friday, October 9, Noon to 1:00 p.m. E.T.

Underlying the goal of recovery for people with SMI, is the concept of self-determination. This is a process of taking back control of lives which have been overwhelmed by the debilitating nature of SMI and the loss of control resulting from reliance on a system that fosters dependence. Self-determination encompasses concepts such as free will, civil and human rights, freedom of choice, independence, self-direction, and individual responsibility. The challenge to the mental health system was to develop a philosophy that places the individual at the center of the system, and specific programs that deliver on it. Self-directed Care provides this, and enables individuals to assess their own needs, determine how and by whom these needs are met, and manage the funds to purchase the services. A support broker can help the individual develop their budget using their plan and a fiscal entity handles the payments. This webinar will take a comprehensive look at Self-Directed Care and its benefits for individuals with SMI.

Presenters:  Patrick Hendry, Mental Health America  
David Sarchet & Megan Cobb, Florida Self-Directed Care (SDC)

Integrating Equity and Diversity in Digital Mental Health Interventions for Depression  
Thursday, October 15, 3:00 p.m. to 4:00 p.m. E.T.

Digital Health and telemedicine are being rapidly rolled out for serious mental illness treatment. As we develop and implement interventions, it is crucial that we integrate the voices and needs of diverse populations in order to make real positive public health impact. This presentation will describe the challenges and needs in developing interventions for underserved populations with an emphasis on Spanish speaking patients in a public sector setting. The presentation will describe a text messaging CBT intervention to increase engagement and improve quality of care among Spanish speaking patients with depression.

Presenter: Adrian Aguilera, PhD, University of California, Berkeley

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

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

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

Grant Statement
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Dissemination and implementation science in a dynamic, diverse, and interconnected world: meeting the urgent challenges of our time.

As the global health workforce continues to respond to the COVID-19 pandemic, the dissemination and implementation (D&I) science community can respond by bridging the gap between research, practice, and policy.

Attend the AcademyHealth-sponsored virtual Science of D&I Conference in December and join a growing, vibrant community using evidence to inform decisions that will improve the health of individuals and communities – setting the field up for a strong future.

Join us Online to:

- Learn about the latest innovations in the science of D&I;
- Explore new research findings and contribute to the next set of research priorities;
- Identify and understand challenges facing D&I research; and
- Engage in unique virtual networking opportunities with leading experts in the field.

SMI Adviser Coronavirus Resources

- Managing the Mental Health Effects of COVID-19
- Telepsychiatry in the Era of COVID-19
- Serious Mental Illness and COVID-19: Tailoring ACT Teams, Group Homes, and Supportive Housing
SAMHSA’s Early Serious Mental Illness Treatment Locator is a confidential and anonymous source of information for persons and their family members who are seeking treatment facilities in the United States or U.S. Territories for a recent onset of serious mental illnesses such as psychosis, schizophrenia, bi-polar disorder, or other conditions. These evidence-based programs provide medication therapy, family and peer support, assistance with education and employment and other services.

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

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

You Can Access the SMI Treatment Locator HERE

Social Marketing Assistance Available

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

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

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

Tip Sheets and Workbooks

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

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

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

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

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


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

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

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

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

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

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

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

Engaging with Schools to Support Your Child with Psychosis
Supporting Students Experiencing Early Psychosis in Middle School and High School

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

Helping Families Understand Services for Persons with Early Serious Mental Illness: A Tip Sheet for Families
Family Involvement in Programming for Early Serious Mental Illness: A Tip Sheet for Clinicians

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

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

For more information about early intervention in psychosis, please visit
https://www.nasmhpd.org/content/early-intervention-psychosis-eip
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Aaron J. Walker, M.P.A., Senior Policy Associate

NASMHPD Links of Interest

RENEWAL OF THE NATIONWIDE PUBLIC HEALTH EMERGENCY FOR COVID-19 UNDER THE PUBLIC HEALTH SERVICE ACT – DECISION, Health and Human Services Secretary Alex Azar, October 1

JOINT CMS AND ACF INFORMATIONAL BULLETIN: SUPPORT FOR FAMILY-FOCUSED RESIDENTIAL TREATMENT-TITLE IV-E AND MEDICAID GUIDANCE, Centers for Medicare and Medicaid Services & Administration for Children and Families, October 5

PSYCHOTHERAPY AT A DISTANCE, Markowitz J.C., M.D., et al., AMERICAN JOURNAL OF PSYCHIATRY In Advance, October 2020

SAFETY AND IMMUNOGENICITY OF SARS-CoV-2 mRNA-1273 VACCINE IN OLDER ADULTS, Anderson E.J., M.D., et al., NEW ENGLAND JOURNAL OF MEDICINE, September 29

PERSPECTIVE: RETHINKING COVID-19 TEST SENSITIVITY — A STRATEGY FOR CONTAINMENT, Mina M.J., M.D., Ph.D., Parker R., Ph.D., & Larremore D.B., Ph.D., NEW ENGLAND JOURNAL OF MEDICINE, September 30

WHY TRUMP’S TESTING STRATEGY FAILED HIM, Sarah Owermohle, POLITICO, October 3

SOME INSURERS END PANDEMIC WAIVERS OF FEES AND DEDUCTIBLES FOR TELEHEALTH, Reed Abelson, New York Times, October 3

THE COST OF BRAND DRUG PRODUCT HOPPING, Alex Brill, Matrix Global Advisors, September 2020

CASE SERIES OF MULTISYSTEM INFLAMMATORY SYNDROME IN ADULTS ASSOCIATED WITH SARS-CoV-2 INFECTION — UNITED KINGDOM AND UNITED STATES, MARCH–AUGUST 2020, Morris S.B., M.D. et al., Centers for Disease Control and Prevention. MORBIDITY AND MORTALITY WEEKLY REPORT, October 2

POLICY BRIEF: COVID-19 AND THE NEED FOR ACTION ON MENTAL HEALTH, United Nations, May 13

THE ASSOCIATION BETWEEN CARDIO-RESPIRATORY FITNESS AND INCIDENT DEPRESSION: THE MAASTRICHT STUDY, Gianfredi V., et al., JOURNAL OF EFFECTIVE DISORDERS, September 29

PREVALENCE OF MENTAL ILLNESS AND MENTAL HEALTH CARE USE AMONG POLICE OFFICERS, Jetelina K.K., M.P.H., Ph.D., et al., JAMA NETWORK OPEN, October 7