SAMHSA Says 2019 NSDUH Findings Reflect Progress in Fighting Opioid Use Disorders, But Other Substance Use Disorders, Mental Illness Remain at Significant Levels

In releasing its findings from the 2019 National Survey on Drug Use and Health (NSDUH) on September 14, the Substance Abuse and Mental Health Services Administration said the survey “reflect[s] impressive progress” on the opioid epidemic in the U.S., but substance use and mental illness remain significant problems.

The prevalence of opioid use disorder was found to have decreased to 1.6 million cases, down from 2.1 million in 2018, while pain reliever misuse declined in youths ages 12 to 17 years and was trending downward in adults ages 18 to 25 years. The initiation of heroin use was found to have declined by 57 percent.

SAMHSA attributed the decreases to increased access to medication-assisted treatment and recovery supports.

However, it should be noted that survey findings indicate that 10.1 million individuals are still misusing opioids (3.7 percent of the population), 9.7 million (96.6 percent) of whom are prescription pain reliever misusers—5.1 million misusing hydrocodone, 3.2 million misusing oxycodone, and 269,000 misusing fentanyl—and 745,000 of whom are heroin misusers.

The survey data showed that prescription stimulant misuse also is trending downward in individuals ages 18 to 25 years, but among adults 26 years of age and older, methamphetamine use and past-month and past-year daily use increased.

Almost-daily cannabis use also increased significantly among adults 26 years of age and older, and past-year cannabis use in adolescents significantly increased. Among individuals with substance use disorders, 38.5 percent (extrapolated to 7.4 million Americans) struggled with illicit drugs, 73.1 percent (14.1 million) had an alcohol use disorder, and 11.5 percent (2.2 million) had both.

However, past-month alcohol use and past-year alcohol use disorder remained stable at about 55 percent and 5.1 percent, respectively, in all age groups, from 2018 to 2019, while alcohol use and alcohol use disorder was found to have declined significantly in young adults from 2016 to 2019.

The survey found no change in cocaine use among all age groups, but a significant increase in LSD use among teens. Of those surveyed, 25.5 percent (extrapolated to 13.1 million adult Americans) were found to have a serious mental illness. Major depressive episodes and other incidences of mental illness increased across age groups under 50 years of age. Serious mental illness significantly increased in adults ages 18 to 49 years. Major depressive episodes with severe impairment significantly increased in adolescents and young adults.

Suicidal thoughts and behaviors significantly increased in adults ages 26 to 49 years between 2009 and 2019. Among adults ages 18 or older, the percentage who had serious thoughts of suicide in the past year increased from 3.7 percent (or 8.3 million people) in 2008 to 4.8 percent (or 12.0 million people) in 2019. Over that same period, the percentage who made a suicide plan in the past year increased from 1.0 percent (or 2.3 million people) to 1.4 percent (or 3.5 million people).

Polysubstance use and comorbid substance use and mental disorders, were found by the survey to be common. The survey found that 3.8 percent of adults surveyed, (an extrapolated 9.5 million Americans) had both a substance use disorder and a mental illness.

NSDUH is an annual, comprehensive household interview survey of approximately 67,500 individuals from all 50 states and the District of Columbia on substance use, substance use disorders, mental health, and the receipt of treatment services for these disorders. The NSDUH is collected by field interviewers who read less sensitive questions to respondents and transition respondents to audio computer-assisted self-interviewing for sensitive items. NSDUH covers the civilian, noninstitutionalized population, ages 12 years of age and older. It includes responses from individuals in households, college dorms, homeless shelters, and the civilian populations of military bases. The survey does not include active military, long-term hospital residents, or homeless individuals who are not residents of homeless shelters.

SAMHSA notes that the data collected in 2019 is all pre-pandemic. With significant fear of illness and death, social isolation, the loss of familiar structure, unemployment and financial instability, and the loss of immediate access to “non-essential” medical care, it warns to expect substantial increases in substance use disorders, mental illness, and suicidality among all age groups in 2020.
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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

Early Bird Rate available until September 18:
$175 for members $245 for non-members
$225 for non-members to attend conference AND become a member of CRA.

Regular Rates after September 18:
$225 for members $295 for non-members
$275 for non-members to attend conference AND become a member of CRA.

Fall Back-to-School FREE CME/CEs Recorded Webinar Collections

Thanks to our partners, at SAMHSA 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 be 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:

**SHEREE LOWE, VICE PRESIDENT OF BEHAVIORAL HEALTH FOR THE CALIFORNIA HOSPITAL ASSOCIATION, SAYS RELYING ON HOSPITAL EMERGENCY DEPARTMENTS FOR PSYCHIATRIC CARE DISENFRANCHISES INDIVIDUALS IN CRISIS**

It started with a 2015 open letter from Sheree Lowe, Vice President of Behavioral Health for the California Hospital Association:

*California, like the nation, is struggling to ensure individuals with a suspected/potential mental illness are able to receive a timely psychiatric evaluation and access to an appropriate level of treatment, if needed. The California Hospital Association (CHA) represents over 400 hospitals. In 2011, these hospitals received over 1.1 million individuals in their emergency departments (EDs) in need of some level of behavioral health intervention. An analysis of emergency department utilization data between 2006 and 2011 verified that the overall use of EDs for behavioral health visits increased 47% during this 5 year time period and the trend data indicate this continues to increase each year. The vast majority of individuals arriving at a community medical/surgical hospital ED with a behavioral health need do not have a physical health condition that requires an emergency level of care intervention. This holds true for psychiatric emergency medical conditions as well. Unfortunately, however, there are often no alternative behavioral treatment settings available on a 24/7 basis. This forces hospital emergency departments, including those without behavioral health clinicians, to become the only available resource in many communities. The increasing dependence on medical/surgical hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources [emphasis ours]. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient’s family, other patients and their families, and of course the hospital staff.*

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**Learn More**

**Crisis Now Partners:**

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

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

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

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

RI International (d/b/a for Recovery Innovations, Inc.) is a global organization that offers more than 50 programs throughout the United States and abroad, characterized by recovery and a focus on what’s strong, not what’s wrong. More than 50% of employees report a lived experience with mental health, and the “Fusion Model” crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. www.riinternational.com www.zerosuicide.org www.twitter.com/RI_International
September is Recovery Month, an occasion to focus on the needs of the millions of people in the U.S. living with a substance use disorder (SUD) as well as celebrate those who are trying or succeeding in putting drug use behind them. The stresses and isolation of the COVID-19 pandemic are presenting enormous challenges for these individuals, but ultimately the altered realities of healthcare may create opportunities to reach more people with services and possibly increase the reach of recovery support systems.

Significant increases in many kinds of drug use have been recorded since March, when a national emergency was declared and our lives radically changed due to lockdown and the closure of businesses and schools. In late April/early May, the Addiction Policy Forum (APF) conducted a survey of 1,079 people with SUDs nationwide, on how they were being impacted by the pandemic. Twenty percent of the respondents reported that their own or a family member’s substance use had increased since the start of the pandemic. And an analysis of a nationwide sample of 500,000 urine drug test results conducted by Millennium Health (link is external) also showed steep increases following mid-March for cocaine (up 10 percent), heroin (up 13 percent), methamphetamine (up 20 percent) and non-prescribed fentanyl (up 32 percent).

Comprehensive national data are not yet available on overdoses, but data from some states such as Kentucky and Georgia as well as anecdotal reports suggest increases in overdose deaths and drug-related emergency room admissions in the first half of 2020 compared to last year. The Overdose Detection Mapping Application Program (link is external), a surveillance tool developed by the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA), reported increases in overdose reports in 62 percent of participating counties nationwide, and that overall overdose report submissions increased by 18 percent after stay-at-home orders commenced in mid-March. Clusters of overdoses seemed to shift from urban centers to suburban and rural locations. (One state, Kentucky, subsequently experienced a decline in overdoses after the state reopened.) In the APF survey, 4 percent of respondents reported an overdose since the beginning of the pandemic.

There are many anecdotal reports that people with SUDs are having to wait longer to obtain treatment, and closures of treatment centers have also limited access. More than a third (34%) of the respondents in the survey by APF had experienced disruptions accessing treatment or recovery support since the start of the pandemic, and 14 percent said they were unable to obtain needed services. There are reasons to expect that lower-income people and minorities could be especially affected. Despite implementing widespread COVID-19 testing, community health centers (link is external), which predominantly serve disadvantaged populations, are seeing declines in patient visits and are experiencing staffing problems.

The good news is that policy changes facilitating telehealth and expanding access to medications for opioid use disorder may compensate somewhat for these problems. People with opioid use disorders can now begin treatment with buprenorphine without an initial in-person doctor visit, which used to be the rule. Methadone treatment previously required daily supervised dosing with tightly controlled take-home options, but patients deemed stable may now obtain 28 days of take-home doses; others may receive 14 days of doses. Changes to Medicare and Medicaid rules are also enabling telemedicine consultations for SUD to be reimbursed more easily.

These developments may particularly benefit people who live in rural areas or who otherwise have had trouble accessing treatment in the past, and NIDA has provided supplemental funds to grantees to evaluate the impact of such changes. Inevitably, since many people with SUDs do not have computers or smartphones, other innovative methods, such as combining telemedicine with street outreach, will be critical to ensuring that all people receive the care they need.

The stresses of the pandemic and the social isolation resulting from distancing measures may take an especially great toll on people trying to achieve or in recovery from an SUD. Three quarters of the APF survey respondents reported emotional changes since the beginning of the pandemic, especially increased worry (62%), sadness (51%), fear (51%), and loneliness (42%). These emotions increase the risk for relapse, and unfortunately, circumstances since the pandemic have made peer support, for instance in 12-step meetings and similar groups, much more difficult.

While online recovery supports may not be an option for all and cannot fully capture the in-person experience, here, as in the realm of treatment, teleconferencing tools and smartphone apps are helping some people adapt to restrictions on physical gatherings. Several of the startups NIDA has helped through our Office of Translational initiatives and Program Innovations, for instance, have now adapted their tools to deliver counseling or facilitate peer connection during COVID-19.

COVID-19 continues to be an uncertain, ever-evolving reality, and its impacts are particularly being felt among those with addiction and those in recovery from substance use disorders. At this point, there is very sparse data on how SUDs are affecting COVID-19 susceptibility and outcomes, although findings are emerging and I will address them in a future blog. As we think about and support this community, this month and every month, we need to imagine and implement new ways of facilitating treatment delivery and needed recovery supports under these new circumstances.
Centers for Medicare and Medicaid Services Administrator Seem Verma announced September 13 through a Health Affairs Blog that Accountable Care Organizations (ACOs) in 2019 achieved $1.19 billion in total net savings for the Medicare program, savings she attributed at least in part to the Trump Administration’s revamping of the structure of the Pathways to Success program, which allowed ACOs to take on more risk more quickly.

Administrator Verma reported there are 541 ACOs serving 11.2 million fee for service beneficiaries in the Medicare program.

She said that the ACOs under Pathways to Success participation options performed better than legacy track ACOs, with net per-beneficiary savings of $169 per beneficiary compared to $106 per beneficiary for legacy track ACOs. While ACOs with more experience continued to achieve greater savings, new entrant ACOs under Pathways to Success achieved net per-beneficiary savings of $150.

ACOs (both legacy track and those in the new participation options established under Pathways to Success) that took on “downside risk” or responsibility for additional costs under the program continued to outperform ACOs that did not, with net per beneficiary savings of $152 per beneficiary compared to $107 per beneficiary, according to the Administrator. ACOs under the Pathways to Success policies that took on downside achieved net per beneficiary savings of $193 per beneficiary compared to $142 per beneficiary for those that did not.

Administrator Verma also said that nearly all the ACOs met CMS quality performance standards in 2019 after CMS extended the quality reporting submission period to ACOs and their health care providers in response to the COVID-19 public health emergency. She said that 92 percent of eligible ACOs earned quality improvement reward points in 2019, with ACOs showing the greatest improvements in the patient safety and care coordination quality domain. She said that ACO quality performance scores were comparable or better that those of other physician group practices.

The full 2019 financial and quality performance results for all ACOs in the Medicare Shared Savings Program are posted on the CMS website.

**New Jersey Assistant Commissioner Mielke Awarded 2020 NASADAD State Service Award**

New Jersey Department of Human Services Assistant Commissioner Valerie Mielke received the 2020 State Service Award from the National Association of State Alcohol and Drug Abuse Directors in a virtual awards ceremony on September 15.

The NASADAD honor is awarded annually to a State Director who has demonstrated outstanding leadership in his or her respective state.

The Association noted that during an earlier award ceremony where Ms. Mielke was honored by the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA), it was noted that “Assistant Commissioner Mielke has always emphasized the peer movement and supported the use of individuals with lived experience and recovery coaches.”

NASADAD Board President Cassandra Price of Georgia and awards chair Doug Thomas of Utah said in presenting the NASADAD award: “We could not agree more. Under STR and SOR, New Jersey launched the Support Team for Addiction Recovery (STAR) initiative to expand access to holistic recovery supports to individuals suffering from an opioid use disorder. In addition, through the Opioid Overdose Recovery Program (OORP), New Jersey supported non-clinical assistance, recovery support, and appropriate referrals for treatment for overdose survivors treated at hospital emergency departments.

“We also recognize your exemplary work on treatment and prevention as well. We applaud your initiative with the criminal justice system where you identified common goals, enhanced communication, and launched a partnership to expand access to evidence-based services – including medication assisted treatment (MAT), promote a seamless connection to community services and reduce overdose deaths. For primary prevention, you have long championed the benefits of the 20 percent set-aside within the Substance Abuse Prevention and Treatment (SAPT) Block Grant. You have educated the citizens of New Jersey about the need to invest in our nation’s youth to promote healthy families and communities.”

**Senators Cassidy, Warren Request Guidance be Issued to Schools, Universities on Addressing Students’ COVID-Related Mental Health Needs**

Senators Bill Cassidy (LA-R) and Elizabeth Warren (D-MA) on September 16 sent a joint letter to Education Secretary Betsy DeVos and HHS Secretary Alex Azar requesting that the agency heads issue guidance to K-12 schools and colleges and universities detailing how they should provide supports, services, and accommodations to address the increased needs of their students who face new or ongoing mental health needs that have arisen or been exacerbated by the ongoing pandemic. They also request that the guidance take into consideration the unique challenges to mental health for minority students, students with disabilities, students experiencing homelessness, and tribal nations to account for the unique and disproportionate effect the pandemic has had on those communities.

**CMS Withdraws Proposed MFAR Regulation**

The Centers for Medicare and Medicaid Services announced via Twitter on September 14 that it would not be moving forward (for now) with its proposed Medicaid Fiscal Accountability Rule (MFAR), which would have limited state intergovernmental transfers (IGTs) used to match Federal Medicaid payments and supplemental payments made to Medicaid hospital and nursing home providers. NASMHPD opposed the proposed regulation, as did the National Governors Association and the National Association of State Medicaid Directors.
The Centers for Medicare and Medicaid Services (CMS) on September 16 released its Medicaid § 1115 Substance Use Disorder (SUD) Waiver Meta-Evaluation Design, and posted the design, created under contract by RT International, on the Medicaid.gov website.

Section 1115 SUD demonstrations require states to increase access to SUD treatment services, increase capacity to provide those services, and implement widely recognized patient placement criteria and provider standards, care coordination policies, and other prevention and treatment strategies.

As of May 2020, 27 states and the District of Columbia were operating under approved demonstrations, and four states had applications pending.

The meta-evaluation will compare experiences among similar § 1115 SUD demonstrations across states to understand the overall effectiveness of the demonstrations and how variations in state demonstration features, and the context in which they are implemented, contribute to differences in effectiveness.

The meta-analyses will primarily use data from state demonstration monitoring and evaluation reports, augmented with limited stakeholder interviews and analyses of national surveys, Transformed Medicaid Statistical Information System (T-MSIS) data, and other national data sets. Through this work, RTI will collaborate with CMS and its other contractors to provide information, including best practices and recommendations on improving demonstration policy and implementation strategies, to inform national policy making and to support scaling up and diffusion of successful policies. An additional goal of the project is to inform CMS on the rigor and limitations of state evaluation, in order to support further improvements in CMS evaluation guidance for § 1115 demonstrations. By combining an in-depth look at the context, implementation, features, and outcomes across § 1115 demonstrations, the meta-analysis will complement state evaluations and provide added value to CMS.

Section 5052 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 offers states an additional option to address SUDs through a state plan amendment (SPA), rather than a § 1115 demonstration. Like the § 1115 demonstration, states can receive Federal matching dollars (FFP) for SUD residential treatment in institutions for Mental Diseases (IMDs). However, the features and conditions for the SPAs differ from the § 1115 demonstrations in several important ways. First, residential stays under the SPA authority are limited to a maximum of 30 days. Second, there is a much more specific and demanding maintenance of effort mandate for the SPA. Third, while both § 1115 demonstrations and the SPA require states to offer a full continuum of SUD services, the SPA requires the continuum of services to be in place at time of approval whereas the § 1115 demonstrations allow for a two-year implementation ramp-up. The SPA continuum also requires provision of early intervention and both intensive outpatient and partial hospitalization services, whereas early intervention services are encouraged under the waivers and states need only one of intensive outpatient and partial hospitalization services. Section 5052 also requires that participating IMDs be able to provide care at a lower level of intensity or have an established relationship with another facility that is able to provide care at a lower level of intensity.

Noting that It is theoretically possible that a state will have overlapping § 5052 and § 1115 demonstrations, but that states with an SPA are not required to conduct an evaluation of their program or submit monitoring data to CMS, the evaluators will include the § 5052 SPA states in their meta-analyses to the extent that they can access that data. To date, only one state (Idaho) has submitted a § 5052 SPA for approval.

The meta-analysis will include the following components:

1. Evaluators will use information abstracted from state demonstration special terms and conditions, implementation plans, evaluation designs, state quarterly and annual monitoring reports, and state evaluation reports to develop a detailed understanding of the activities and goals of each demonstration. This information will be used to understand the features of each demonstration, as well as contextual and implementation changes over time. This information will be coded and used in subsequent analyses.

2. To validate and flesh out understanding of state activities based on information abstracted from state documents, evaluators will engage in discussions with state leaders and may also include payers and providers. The discussions will aim to assess understanding of the features of each state’s demonstration, contextual characteristics, and implementation experiences as well as understanding of the demonstration itself, and an accurate understanding of policies and activities that predated the demonstration. This information will also be incorporated in targeted case studies of selected demonstration design and implementation topics.

3. Evaluators will analyze multiple national data sets that address outcomes specified in the CMS-mandated SUD demonstration milestones and goals to understand the baseline situation in each state, as well as trends prior to the start of the demonstration if data permits.

4. As data become available for the demonstration period, data from state monitoring reports and state evaluations will be used to analyze the relationship between outcomes specified by demonstration milestones and goals and demonstration features coded from report abstraction and discussions with state leaders. Descriptive analyses of monitoring report data on demonstration implementation and impacts will provide early information on how outcomes compare across groups of states whose demonstrations share common features. When results from state evaluations become available, evaluators will use forest plots and meta-regression of effect sizes reported by state evaluations to estimate the overall impact of demonstrations across states and identify factors that likely explain differences in state impacts.

5. Evaluators will supplement analyses of state monitoring and evaluation data with analyses of data from T-MSIS and other national data sets to assess the relationship between demonstration features and outcomes. The supplemental analyses will complement analyses of monitoring and evaluation data by providing metrics for outcomes that may not be reported for all demonstrations or are not measured consistently. T-MSIS may also support analyses that include comparison groups if these are not included in state evaluations. Depending on the data source and metrics, evaluators will use descriptive or multivariate regression analyses.

(Continued on next page)
Increased isolation and stress during mandated national, state, and long-term care facility lockdowns, lapses in facility care attributable to staffing shortages, and missed COVID-19 diagnoses are all being blamed as contributing factors to an increase in deaths from Alzheimer’s disease and dementia over the summer months more than 20 percent higher than the numbers normally projected for those diseases during those same months.

“There’s something wrong, there’s something going on and it needs to be sorted out,” Robert Anderson, chief of mortality statistics at the Centers for Disease Control and Prevention (CDC) told Politico in a recent interview. He has called the escalation in the number of deaths “highly unusual.”

In its article published September 16, Anderson told Politico: “It’s hard to explain exactly what’s going on. Is this because these people are further isolated and don’t have the will to live? I’ve heard that,” Anderson said. “Is it because they initially had Covid-19 and the disease was undetected and exacerbated their existing conditions? Or was it because in the midst of the pandemic, they’re not getting adequate care? I’ve heard all three explanations.”

It’s the second time this year that deaths from causes other than those directly caused by the coronavirus have spiked. The first, early in the pandemic, was attributed to dementia, as well as heart disease and pneumonia. The second is being attributed almost entirely to dementia — 61,000 deaths since June, which is 11,000 more than usual occur in the summer time frame. In a typical year, the CDC expects approximately 4,500 dementia deaths per week. But in recent weeks, that figure has been closer to 5,500.

Those who are experiencing cognitive decline can face a variety of issues even if they don’t develop the coronavirus, Julie Collins, Northwestern Indiana program manager for the Alzheimer’s Association Greater Indiana Chapter, recently told New Times.

“We’ve heard from many family caregivers who’ve said they’ve noticed a decline in their loved one’s health due to social isolation,” Collins said. “In some cases, separation from family and friends during the pandemic can escalate dementia-related behaviors, including confusion, wandering and aggression.”

Collins said depression and anxiety, as well as increased risks of cardiovascular, cognitive and mental health problems, can be associated with social isolation.

Cognitive impairment may impede communication, especially virtually, thus further contributing to social isolation and potentially causing more rapid cognitive decline,” Collins said. “While signs of distress or discomfort don’t necessarily indicate a serious condition like COVID-19, people living with Alzheimer’s and other dementias may not be able to communicate if they aren’t feeling well.” Collins said.

She recommends that caregivers “[o]nly show positive emotions if the person living with dementia is feeling an increased level of stress.” “Since it may be more difficult to communicate with words, using your eyes and gentle gestures may be helpful when communicating. Being patient and understanding will go a long way in this situation.”

Politico reported September 16 that its interviews with front-line facility workers identified dementia care as a major challenge. In addition to all the challenges directly linked to Covid-19 — shortages of testing, staff, and personal protective equipment — the spread of the virus has also disrupted daily routines in nursing homes that kept residents with dementia dressed, fed, socially engaged and out of harm’s way.

The workers interviewed by Politico said chronic staffing shortages have also made it significantly harder to keep residents with more advanced stages of dementia safe from the coronavirus.

Many staff have quit over fears they could bring the virus back home to their families, and also because of increased stress and intense feelings of futility. For instance, it is difficult to get an Alzheimer’s patient to wear a mask. One long-term care facility worker told Politico “You could put a mask on someone out in the hall 100 times, and it will be taken off 100 times.

Collins says that the masks used to prevent the spread of the coronavirus can be confusing and challenging for those with Alzheimer’s and dementia. “When assisting a loved one during difficult situations like putting on a mask, it’s essential to keep them comfortable. Caregivers might need to try different masks to find the one that works best for the patient. “There are many styles and fabrics of masks, so experiment if the first is not a great fit,” Collins said.

The absence of visiting family members, who can provide social support and help with hands-on care during normal times, adds to the burden. Although software applications like Skype, Duo, and Zoom have made it somewhat easier for families to visit with their seniors during lockdowns, those virtual visits with patients unfamiliar or uncomfortable with the software, or unable to understand how it works, must be assisted by staff when staff is in the patient room. And the timing for the visit must be coordinated with the staff’s rotation schedule.

The surge shows few signs of abating. The CDC told Politico that its latest projection revealed an additional 1,025 excess deaths due to Alzheimer’s disease and dementia in the third week of August. The CDC’s Anderson says the sudden increase in mortality has only a few parallels in modern times: the opioid epidemic, the 2017-18 flu season, and the coronavirus itself.
Update for Providers:

Significant Changes to SAMHSA 42 CFR Part 2 Privacy Regulations (September 2020)

Federal regulations governing the confidentiality of drug and alcohol treatment records impact the clinical and operational processes of a wide variety of providers across the country, including many NASMHPD members. Why is this notable right now? As a provider, you need to have an understanding of how recent regulatory updates and more changes to come in 2021 based on legislation included in the CARES Act will impact how you manage substance use disorder (SUD) treatment information to positively impact the lives of those you serve.

Based largely on legislation originally adopted in 1972, these regulations – commonly referred to as 42 CFR Part 2 – apply to providers receiving federal funds and were designed to prevent the disclosure of patients’ substance use treatment records to employers, landlords, law enforcement and other parties for fear of stigma, discrimination and legal ramifications. Much has changed since the 1970s, including the advent of integrated, coordinated care delivery models like health information exchanges (HIEs) and health homes, widespread use of electronic health records and connectivity tools, e-prescribing, medication-assisted treatment, and newer federal and state privacy and security safeguards.

As you are aware, many patients with a mental illness or SUD also have co-morbid chronic diseases or conditions such as diabetes, COPD, heart disease or emphysema. Access to a person’s complete health record, including SUD information, allows their treating providers to make fully-informed diagnosis and treatment decisions. It also helps prevent risk of serious or even fatal drug interactions and unintended prescribing errors due to lack of complete patient information.

New SAMHSA 42 CFR Part 2 Final Rule

In rare federal rulemaking attention to one topic, the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued multiple updated 42 CFR Part 2 Final Rules in the past three years. The most recent Final Rule was announced July 15, 2020 and took effect August 14. It retains the foundation for confidentiality protection of SUD patient records created by federally-assisted SUD treatment programs (“Part 2” programs). The rule also:

--- Adds care coordination and case management services to the list of payment and healthcare operations activities for which non-Part 2 providers may redisclose Part 2 records without patient consent beyond the initial consent provided to the Part 2 program provider;

--- Makes changes to facilitate the disclosure of records from Part 2 programs to non-Part 2 providers for treatment purposes, while allowing non-Part 2 providers to engage in their own clinical encounters and record-keeping knowing that those activities will not be subject to Part 2;

--- Offers revised guidance regarding Part 2 consent requirements in order to more explicitly allow patients to consent to disclosure of their records for the purpose of care coordination;

These changes are significant because they continue to move Part 2 regulations toward a focus on supporting whole-person care, improving outcomes, bending the healthcare cost curve, reducing stigma, and treating patients with SUD in parity with patients that have other medical conditions.

Here is a detailed summary of the latest Final Rule to help providers evaluate/adjust their processes and workflows and optimize the rule.

Read: Netsmart Summary: SAMHSA July 2020 Final Rule Amending 42 CFR Part 2

Passage of Protecting Jessica Grubb’s Legacy Act

Netsmart played a leading role in providing knowledge and expertise as part of a coalition of patient advocacy and other organizations successfully advocating for passage of the Protecting Jessica Grubb’s Legacy Act (the Legacy Act) as part of the CARES Act in March. Jessica Grubb died in 2016 at age 30 from an overdose of oxycodone after being prescribed the medication at discharge from a hospital following surgery. Despite letting doctors know she was in recovery from an opioid addiction, the information was not listed on her chart.

The Legacy Act makes significant statutory amendments that align 42 CFR Part 2 regulations more closely with HIPAA while retaining strong penalties for information breaches.

Read: Netsmart Summary: The Legacy Act

How Do the Two Relate?

The latest SAMHSA Final Rule discussed above is related to a SAMHSA Notice of Proposed Rulemaking issued Aug. 26, 2019 and is not linked to the passage of the Legacy Act. Provisions outlined in the Final Rule will be in effect until SAMHSA issues an updated new Final Rule in 2021 related to the Legacy Act as required by law.

Netsmart Advocacy on Behalf of Our Clients

Netsmart has been a long-time advocate for updating 42 CFR Part 2 regulations to provide the ability for a person with a SUD or a history of diagnosis, treatment or referral for SUD to easily consent to share their substance use treatment health data with their treating providers, while also retaining strong privacy and anti-discrimination protections and penalties. We provided input to the U.S. Department of Health and Human Services and SAMHSA in the previous Part 2 rulemaking processes on this topic, and will continue that involvement as SAMHSA initiates the Final Rule process for the Legacy Act.

Netsmart: Dave Kishler, Senior Industry Relations Strategist, dkishler@ntst.com
Workshop Themes and Tracks:

- Tackling Mental Health Disparities for Children of Color
- Mental Health, Substance Use, & 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.

See the Schedule - The Full Agenda is Coming Soon!

Registration Fees:
- $50 per person
- $45 per person for groups of 10 or more

Call for Presentation Proposals:
- Deadline is September 11
- Click Submit a Proposal to download the guidelines

Have questions about sponsorship or advertising? Inquire here to learn more.

More information about workshops, presenters, sponsors and more will be posted in the coming weeks. We look forward to seeing you in November.

OFFICE OF JUSTICE PROGRAMS-SPONSORED
WEBINAR RESCHEDULED

Lessons Learned: Increasing Access to Mental Health Services to Traditionally Underserved Victims of Crime
Tuesday, September 22, Noon to 1:30 p.m. E.T.

OVC Purpose Area 3b Grantees (Los Angeles LGBT Center, Clinical and Support Options, Inc (MA), and Center for Trauma & Resilience (CO)) will discuss lessons learned on increasing access to mental health services to traditionally underserved victims of crime through implementing trauma responsive services. The purpose of addressing the trauma experienced by victims of crime is not always understood by their providers. By understanding the impact of trauma on victim survivors, responding in way that enhances the realization that behavior is frequently an adaptation to trauma and that healing must be the focus of service and support, is key to ensuring organizations create an atmosphere where all victims of crime want to come to you for help/services. Grantees will discuss challenges and how they applied a trauma-informed lens to successfully overcome obstacles.

Register HERE

This product is supported by Grant Number 2017-VF-GX-K142, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.
National Recovery Month is a national observance held every September to educate Americans that substance use treatment and mental health services can enable those with mental and substance use disorders to live healthy and rewarding lives. Now in its 31st year, Recovery Month celebrates the gains made by those living in recovery.

**The Importance of Integrating Recovery Support Services: The Certified Community Behavioral Health Clinic Model**

*Thursday, September 24, 1:30PM E.T.*

This webinar will highlight Certified Community Behavioral Health Clinics (CCBHC) as an effective model for increasing access to and delivery of integrated, person-centered mental health, primary care, and substance abuse recovery services, including medication-assisted treatment (MAT). This webinar will feature Community Health Resources' (CHR), a CCBHC-Expansion grantee, and a person in recovery who has participated in, benefited from, and who currently provides recovery support services in the CCBHC-Expansion program.

**Opening Remarks:** Anita Everett, Substance Abuse and Mental Health Services Administration

**Moderator:** Anita Everett, David Barry, and Melinda Baldwin, Substance Abuse and Mental Health Services Administration

**Panelists:**
- Courtney Sheehan, Project Director, Community Health Resources Grant
- TBD, Clinician
- TBD, Recovery Coach or Person in Recovery

**WEBINAR CALL IN:** 1-800-369-1971

For Participants: URL: [https://www.mymeetings.com/nc/join/](https://www.mymeetings.com/nc/join/)
Conference number: PWXW1623549

Audience passcode: 9181581

Participants can join the event directly at: [https://www.mymeetings.com/nc/join.php?i=PWXW1623549&p=9181581&t=c](https://www.mymeetings.com/nc/join.php?i=PWXW1623549&p=9181581&t=c)

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**National Coalition on Mental Health and Aging Webinar Series**

**Social Determinants of Mental Health for Older Adults: A New Perspective**

*Wednesday, September 23, 2:00 p.m. to 3:00 p.m. E.T.*

This webinar will identify those socio-economic conditions (with an emphasis on discrimination and racism) that have an impact on the mental health of older adults, and actions that can be taken to address these conditions.

**Presenter:** Joel E. Miller, Executive Director and CEO, American Mental Health Counselors Association and Chair of the National Coalition on Mental Health and Aging

[Register HERE](https://ipsworks.org/index.php/training-courses/)

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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/](https://ipsworks.org/index.php/training-courses/)
The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) & The Western Interstate Commission for Higher Education (WICHE) Behavioral Health Program

The National Association of State Mental Health Program Directors (NASMHPD)

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

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.

Register HERE

Download Full Agenda (PDF)
Join Us for This Virtual Event

The Ohio State University Wexner Medical Center
Department of Psychiatry and Behavioral Health Presents

2020 Suicide Prevention Conference
Innovations, Interventions and Specialized Populations

Tuesday, Sept. 29
8 a.m. – 4 p.m.

Join us for this virtual event where we will explore innovations, examine intervention models and discuss care for specialized populations for suicide prevention. This one-day virtual conference will also offer CCME, OPA-MCE and CPE credits.

This panel of experts will examine health care utilization before suicide; share research and knowledge about implementation strategies, measures and outcomes to the Zero Suicide Model; identify key assumptions of emergence and pathways to suicidal behavior; and discuss tools, resources and strategies needed for suicide prevention.

The Suicide Prevention Conference 2020 is proud to welcome these distinguished presenters:

- Brian Ahmedani, PhD
- David Brent, MD
- Craig Bryan, PsyD, ABPP
- Brian Mustanski, PhD
- Kamesha Spates, PhD

Don't miss these local experts in the panel discussion:
Mark Hurst, MD
K. Luan Phan, MD

To learn more and register, visit wexnermedical.osu.edu/SPC2020

*The Ohio State University Center for Continuing Medical Education (CCME) designates this live activity for a maximum of 6 AMA PRA Category 1 Credit(s). Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Ohio State University Department of Psychiatry OPA-MCE (Ohio Psychological Association-Mandatory Continuing Education) Approved Provider #316225986

The Ohio State University Department of Psychiatry is an approved provider of continuing professional education (CPE) for Counselors and Social Workers for the Ohio Counselor, Social Worker and Marriage and Family Therapist Board. Approved Provider #RCS090902

It is recommended to check with your respective boards on eligibility to use AMA PRA Category 1 Credit toward recertification.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER
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.

The 2020 Un-Summit: A Leadership Forum
Weekly Live, Interactive & On Demand Content
September 24  November 19, 2020

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
Areas of interest include, but are not limited to:

diligence to ensure that the proposed technologies address an unmet need or substantially enhance existing capabilities.

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due
applications that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research.

This NOSI will also prioritize applications that have an impact beyond the circumstances created by the COVID-19 pandemic, for example,
SUD treatment/research programs, including racial/ethnic minorities, socioeconomically disadvantaged individuals, and rural populations.

This NOSI encourages research among subgroups that have been disproportionately impacted by COVID-19 or have difficulty accessing
patient safety and clinical outcomes monitoring to reduce the need for in-person clinical visits.

patients, including efforts to bring access to difficult to reach populations, and (2) conduct clinical trials of novel treatments using remote
treatment delivery and patient outcomes monitoring as exemplified by telemedicine. Few studies have demonstrated that remote delivery of
SUD treatment is feasible, safe, and efficacious. These remote delivery methods are generally still in the early stages of development, and
existing studies generally lack the scope required to inform dissemination into clinical practice. Therefore, there is a need to develop new
remotely-delivered SUD treatments and expand the dissemination of those already evaluated.

Similarly, clinical trials of SUD interventions generally require frequent in-person contact to monitor tolerability, adherence, and efficacy
outcomes. The COVID-19 pandemic halted most SUD clinical research, which is evidence that methods for conducting clinical trials remotely
are needed to overcome these challenges when participants cannot attend in-person clinic visits. Thus, there is an urgent need of research
to develop tools to reduce the frequency of in-person visits in SUD clinical trials.

We expect this NOSI to accelerate the development of (1) remotely-delivered SUD treatment interventions, and (2) remote methods for
collecting outcome measures evaluating the safety or efficacy of SUD treatments. These advances will facilitate the delivery of effective
treatments to those in need and permit the execution of clinical trials when physical access to clinical research sites is limited. Ultimately,
both these advances will lead to improved treatment options for individuals with SUD.

Research Objectives

NIDA encourages the submission of applications that will rapidly improve the ability to: (1) offer remotely-delivered SUD treatments to
patients, including efforts to bring access to difficult to reach populations, and (2) conduct clinical trials of novel treatments using remote
patient safety and clinical outcomes monitoring to reduce the need for in-person clinical visits.

This NOSI encourages research among subgroups that have been disproportionately impacted by COVID-19 or have difficulty accessing
SUD treatment/research programs, including racial/ethnic minorities, socioeconomically disadvantaged individuals, and rural populations.
This NOSI will also prioritize applications that have an impact beyond the circumstances created by the COVID-19 pandemic, for example,
applications that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research.

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due
diligence to ensure that the proposed technologies address an unmet need or substantially enhance existing capabilities.

Areas of interest include, but are not limited to:

• Development and evaluation of new or existing remote-delivery of treatments for SUD.

• Development and evaluation of new or existing remote-delivery interventions for SUD among patients with or at risk of
  limitations of mobility, such as:
  o Pregnant or recently postpartum women
  o Older adults
  o Low SES populations
  o Racial/Ethnic minority, or health disparity populations
  o Rural populations
  o Individuals living in Native-American nations
  o Comorbid medical or mental health conditions

• Development and evaluation of new or existing tools and methods for remote monitoring of SUD treatment recruitment,
adherence, tolerability, and outcome measures.

• Development and evaluation of research designs that may enhance the implementation of clinical trials that can be conducted
  remotely, in full or partially, and reduce the number and frequency of in-person clinical visits. These may include recruitment
  from a larger geographical area, or of patients who live in more rural areas, have disabilities, or have other specific
  barriers/challenges regarding attending in-person clinical visits (e.g., work during clinic hours, lack childcare, etc.).

Scientific/Research Contact: Evan S. Hermann, PhD. National Institute on Drug Abuse (NIDA),
Email: evan.herrmann@nih.gov.
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 lgarman@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
Applicant Town Hall Session: September 2020

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions? Please email DBHDDLearning@dbhdd.ga.gov

Get information on mental health services and resources near you, searchable by state or zip code: www.samhsa.gov/find-help
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.

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.

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:**

1. **Sept. 29, 12:00 pm** — **Spirituality in Treatment**: Systemic Treatment Models Bridging Faith and Mental Health Professionals
2. **Oct. 13, 12:00 pm** — **Spirituality and Post-Traumatic Growth**: Spirituality as Catalyst for Resilience
3. **Oct. 27, 12:00 pm** — **Spirituality and Severe Mental Illness**: Questions of Recovery versus Purposeful Renewal
4. **Nov. 10, 12:00 pm** — **Spirituality and the Life-time Course of Mental Illness**: Support for Patients, Caregivers, and Family by the Faith Community
5. **Nov. 19, 12:00 pm** — **Spirituality and Treatment**: Contributions to Faith and Forgiveness in Recovery
6. **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.*
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 Augustment 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)
Notice of Special Interest (NOSI)

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

(Continued from previous page)

Application and Submission Information

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

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

- **PA-20-185**: NIH Research Project Grant (Parent R01 Clinical Trial Not Allowed)
- **PA-20-183**: NIH Research Project Grant (Parent R01 Clinical Trial Required)
- **PA-20-184**: Research Project Grant (Parent R01 Basic Experimental Studies with Humans Required)Research Project Grant (Parent R01 Clinical Trial Required)
- **PA-20-200**: NIH Small Research Grant Program (Parent R03 Clinical Trial Not Allowed)
- **PA-20-196**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Basic Experimental Studies with Humans Required)
- **PA-20-195**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Not Allowed)
- **PA-20-194**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Required)
- **PA-18-775**: Pilot and Feasibility Studies in Preparation for Drug and Alcohol Abuse Prevention Trials (R34 Clinical Trial Optional) or any re-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 2020.
Student Mental Health: Responding to the Crisis

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

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

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

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

<table>
<thead>
<tr>
<th>View Event</th>
<th>View Programme</th>
<th>Register Interest</th>
<th>Book A Place</th>
</tr>
</thead>
</table>

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

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

2020 Attendee Breakdown by Sector.

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

WEBSITE FOR THE SAMHSA-SPONSORED

Center of Excellence for Protected Health Information

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)
Alterning Our Course:
NASHIA's Virtual SOS Conference

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

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

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

Location
All events are virtual.

Agenda

Sponsorship Opportunities

Join NASHIA for 2020

Contact Us
For more information, contact info@nashia.org.


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

Register and Sponsor HERE
Multi-Part Virtual Learning Community Webinar Series

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

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

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

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

For Additional Information, Contact Christina Walker, 443-790-4066

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

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

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

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

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

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

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

For more information, visit the AHRQ Cross-Sectional Innovation to Improve Rural Postpartum Mental Health Challenge website.
Training and Technical Assistance Related to COVID-19 Resources


Responding to COVID-19: highlight products and resources that can be useful when coping with the effects of widespread public health crises such as:

• Psychosocial Impacts of Disasters: Assisting Community Leaders
• Supportive Practices for Mental Health Professionals During Pandemic-Related Social Distancing

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

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

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

Upcoming Webinars
For access to all MHTTC trainings and resources, visit the Training and Events Calendar here and the Products and Resources Catalog here.

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

Stay informed! Subscribe to MHTTC Pathways HERE

MHTTC Pathways is a monthly eNewsletter that keeps you informed about what is happening within the MHTTC Network. It highlights events, training opportunities, resources, and the latest Network products. Special features help you stay updated on the latest on evidence-based practices, implementation science, and workforce development.

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**

**Sign Up to Receive the Rural Monitor Newsletter**

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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**

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**IIMHL and IIDL Leadership Exchange**

Valuing Inclusion, Resilience and Growth.

Kāingākautia te whakawahāi tāngata, te ngākau manawaroa, te puāwaitanga o te tangata.

**SAVE THE DATE**

28 Feb to 4 Mar, 2022

Christchurch, New Zealand

Te Pou o te Whakaaro Nui
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](#)
National Center on Advancing Person-Centered Practices and Systems

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

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

<table>
<thead>
<tr>
<th>September 2020</th>
<th>Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2020</td>
<td>Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice</td>
</tr>
<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>
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</thead>
<tbody>
<tr>
<td>90792+95</td>
<td>99204+95</td>
</tr>
<tr>
<td>90792+95</td>
<td>99214+95</td>
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<tr>
<td>Evaluation and Management Plus Psychotherapy</td>
<td>99205+95</td>
</tr>
<tr>
<td>30 (16-37*) minutes - E/M code [Audio only] - use the appropriate 99441-99443 code and 90823+95</td>
<td></td>
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<tr>
<td>45 (38-53*) minutes - E/M code [Audio only] - use the appropriate 99441-99443 code and 90826+95</td>
<td></td>
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<tr>
<td>60 (53+*) minutes - E/M code [Audio only] - use the appropriate 99441-99443 code and 90831+95</td>
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<tr>
<td>Psychotherapy Alone</td>
<td>Family Therapy</td>
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<td>90832+95</td>
<td>90846+95</td>
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<td>90834+95</td>
<td>90847+95</td>
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<tr>
<td>90837+95</td>
<td>90849+95</td>
</tr>
<tr>
<td>30 (16-37*) minutes</td>
<td>Patient not present</td>
</tr>
<tr>
<td>45 (38-53*) minutes</td>
<td>Patient present</td>
</tr>
<tr>
<td>60 (53+*) minutes</td>
<td>Group</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>90853+95</td>
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<tr>
<td>(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)</td>
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</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:

| 99441 | 5-10 minutes |
| 99442 | 11-20 minutes |

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

| 98966 | 5-10 minutes |
| 98967 | 11-20 minutes |
| 98968 | 21-30 minutes |
Tips for Telehealth Billing During the COVID-19 Pandemic

3 VIRTUAL CHECK-IN (G0212)
Physicians and others who can bill E/M services can bill for time spent talking to a new or established patient on the telephone or via telephone and video. Generally, the physician is responding to a contact made by the patient. This code should not be billed if the patient has been seen in the 7 days prior to the call or within 24 hours or the soonest available appointment after the brief check-in. The goal of this visit is to see if a patient needs to be seen for further evaluation or if the problem can be resolved through this call.

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

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

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

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

- SMI Adviser
- American Psychiatric Association
- Center for Connected Health Policy
- Centers for Medicare and Medicaid Services
- Federation of State Medical Boards
Cultivating Trauma-Informed Organizations and Services for People Living with Disabling Mental Health Conditions

Friday, September 25, Noon to 1:00 p.m. E.T.

Research has uncovered trauma as a core public health concern facing our nation, linking experiences of trauma to mental health conditions, substance use concerns, chronic physical health problems, housing instability, and shortened life expectancy. Additionally, experiencing trauma and victimization increases the risk for developing serious mental health conditions, which in turn increases risk for experiencing additional forms of trauma, including institutional trauma. For marginalized communities, including people of color, LGBTQ individuals, and people impacted by poverty, this can be further complicated by experiences of structural violence as well as collective forms of trauma.

This webinar will introduce participants to the various forms and effects of trauma, recognizing the effects of trauma in both people accessing care as well as staff and systems, while cultivating multi-dimensional responses to address trauma and prevent re-traumatization. It will also highlight evidence-based interventions for the treatment of trauma within the context of co-occurring disabling psychiatric conditions.

**Presenter:** Gabriela Zapata-Alma, LCSW, CADC, Director of Policy and Practice for Domestic Violence and Substance Use at National Center on Domestic Violence, Trauma & Mental Health

Register HERE

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)

Register HERE

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.

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Grant Statement
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REGISTER FOR THE ONLINE CONFERENCE
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.

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- 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

Recorded Webinars

- 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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NASMHPD Links of Interest

**Social and Economic Costs of Eating Disorders in the United States of America.** Deloitte Access Economics, June 2020

**Transmission Dynamics of COVID-19 Outbreaks Associated with Child Care Facilities — Salt Lake City, Utah, April–July 2020.** Lopez A.S., M.H.S., et al., Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, September 11

**Gen Z Says It’s Taking the Pandemic Seriously.** Sam Baker, Axios, September 11

**Flu vs. COVID: Ways to Identify Symptoms and Differences.** Alina Dizik, Wall Street Journal, September 14

**HHS Awards $79 Million to Support Health Center Response to Emergencies.** Department of Health and Human Services Press Release, September 8

**Trump Administration Takes Action to Expand Access to COVID-19 Vaccines.** Department of Health and Human Services Press Release, September 9


**International Commission on Microbiological Specifications for Foods (ICMSF) Opinion on SARS-CoV-2 and its Relationship to Food Safety.** International Union of Microbiological Societies, September 3

**Months After Recovery, COVID-19 Survivors Often Have Persistent Lung Trouble.** Francis Collins, M.D., NIH Director’s Blog, September 15

**Value-Based Care Opportunities in Medicaid.** State Medicaid Director Letter 20-004, Centers for Medicare and Medicaid Services, September 15


**Fever Checks Are No Safeguard Against Covid-19.** Roni Caryn Rabin, New York Times, September 13


**CMS Releases Medicaid and CHIP T-MSIS Data to Provide Public Access and Transparency into Program Performance.** CMS Press Release, September 16