**MHRN Steering Committee Meeting, October 26, 2018**

**Summary**

***Key points***

* Areas DSIR would welcome MHRN input:
  + Strategies to address opioid crisis - acknowledgeopioid abuse can’t be disentangled form MH issues and concerns, need coordinated approach to address crisis.
  + Racial/ethnic disparities
  + Youth mental health - transdiagnostic approaches to identify those in need, offer treatments that don’t target the syndrome but domains of impairment; area needs more flushing out operationally, through experimental therapeutics
* Involvement of stakeholders’ key to successful implementation
  + Engagement with HCS leaders prior to onset of research (design stage) through to implementation & evaluation of implementation – encourage discussions with MHRN before funding an R34
  + Unique & invaluable insights from those with lived experience needed from conceptualization of research to dissemination of findings
* Rapid implementation made possible by MHRN embeddedness in HCSs and engagement of key stakeholders from the beginning (examples - CV Wizard, SUAY, Automated Follow-up Pilot)
* MHRN – potential laboratory for ALACRITY Centers; share information with EPINET; partnerships, not competition
* MHRN currently engaged in 8-10 ISMICC goals or have had initial discussions about them
* Need better “marketing” of MHRN achievements - MHRN already well-aligned with NIMH & other agency priorities (NIDA, PCORI, FDA, etc.), other stakeholder priorities (DBSA, HCSs), & ISMICC recommendations
* Potential future MHRN - very useful to DSIR to think how MHRN can make contributions to ISMICC goals.
* Peer Support – lot of support expressed for peer-delivered interventions; need models for implementation in HCSs, ways to address administrative barriers; explore peer-provided respite services
* Some MHRN efficiencies
  + Ability for rapid recruitment and enrollment into studies
  + Data collection and interventions within the EHR environment
  + Ongoing engagement with key stakeholders at onset and throughout MHRN activities
  + Rapid implementation into large HCSs due to embeddedness & ongoing engagement
  + Reusable infrastructure:
    - Suicide Risk prediction – reusable code packages & experienced staff
    - Suicide Prevention Trial – repurpose methods of identifying & enrolling eligible participants

***Areas for improvement or opportunities***

* Marketing – improve publicizing of ongoing activities and achievements
* Training – better leveraging of graduate students, post-docs, clinical scholars, residents in HCS; need better systematic and documented approach
* More focused effort to incorporate implementation science & experimental therapeutics into MHRN activities; build capacity for implementation science; put what MHRN has done in the language of implementation science
* Methods development –Create Methods Core, Methods SIG; MHRN should be leading methods development
* Peer-delivered interventions
* Alternatives to traditional acute care (ER and hospital)
* Increasing use of “stranded asset” treatments (clozapine, LAI antipsychotics)
* Personalized treatment (esp. linkage with [AllofUs](https://allofus.nih.gov/))
* Clarify theoretical underpinnings of the research
* Emphasize innovation

***Action Items***

* Clarify (in our own minds and in a “renewal” application) how MHRN work to date and future plans support:
  + NIMH strategic plan objectives
  + ISMICC recommendations
  + ALACRITY centers initiative
  + EPINET initiative
  + HEAL initiative (especially NIMH plan for pragmatic trials of collaborative care)
* Look at reviewers’ comments regarding our MHRN II application
* Be explicit in how we support (with our own work or work by external investigators) NIMH’s emphasis on experimental therapeutics.