NASMHPD

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National Association of State Mental Health Program Directors

# Weekly Update

## House Retains Administration Cuts to Mental Health Programs to Fund Congressionally Authorized Substance Use Program Increases

The Labor-HHS Subcommittee of the House Appropriations Committee has retained the Trump Administration's $146 million cuts in SAMHSA mental health programs for Fiscal Year 2018, including $116 million in cuts to Mental Health Block Grants. Overall SAMHSA funding is at $3.5 billion – $306 million below FY 2017 levels, but $68 million more than requested in President Trump's budget.

The mental health program cuts included in a proposed Labor-HHS funding markup released July 12 and scheduled to be voted July 13 enable Congressional funders to include increases for SAMHSA substance use programs authorized under the 2016 Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act. Those increases include:

- $1.86 billion for the Substance Abuse Block Grant—the same as approved for FY 2017 and $3.4 million more than requested by the President;
- $747 million to address opioid and heroin abuse—the FY 2017 funding level and $44 million more than the White House request; and
- $500 million to the state response grants authorized under 21st Century Cures.

Despite the 21.8 percent cut in the Mental Health Block Grant funding, the 10 percent set-aside for First Episode Psychosis treatment programs remains as a state mandate. And despite the overall $146 million in cuts to SAMHSA mental health programs that includes a $30 million cut to Programs of Regional and National Significance (PRNS), the $15 million authorized by Congress for Assisted Outpatient Treatment grants championed by Rep. Tim Murphy (R-PA) remains funded.

The PRNS cuts include the elimination of funding for Mental Health First Aid programs, Behavioral Health Workforce Education and Training Grants, and the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grants—all program terminations requested in the President's budget.

It is likely, but not inevitable, that many of the House's cuts to mental health programs will be restored in the Senate's Labor-HHS funding legislation, with the final tally to be determined in conference committee.

On a more positive note, spending for National Institutes of Health is increased by $1.1 billion to $35.2 billion for FY 2018, a rejection of President Donald Trump's budget proposal to cut the agency's funding. The BRAIN (Brain Research through Application of Innovative Neurotechnologies) initiative is funded at $336 million, a $76 million increase, while Alzheimer's research is funded at $1.8 billion.

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# New Version of Senate ACA Repeal and Replace Legislation, Likely Lacks Republican Support for Floor Vote Scheduled for Next Week

The revised version of the Senate Better Care Reconciliation Act released for discussion on July 13 appears unlikely to garner the necessary votes to bring it to the Senate floor next week, as currently scheduled by Senate Majority Leader Mitch McConnell (R-KY).

In addition to a block of more than one-half dozen moderate Republicans threatening opposition *en bloc*, conservative Senator Rand Paul (R-KY) has also re-emphasized his opposition to the bill on philosophical grounds—saying it would not truly repeal the Affordable Care Act—and has said he will not vote to bring the bill to the floor. Representative Mike Lee (R-UT) could join him in that stance.

The newest version of the bill includes language sponsored by Senator Ted Cruz (R-TX) that permits insurers to issue individual health insurance policies without essential health benefits in an insurance rating area as long as they also issue policies in the same rating area at the required "metal" levels that include those benefits.

Insurance industry spokesmen have generally opposed that proposal, saying it would likely leave the richer policies with risk pools of sicker, older enrollees as younger, healthier enrollees move to the cheaper less robust array of benefits. Insurers say the result would be to push premiums even higher for the approximately 1.5 million enrollees with the richer policies.

The new version of the bill retains provisions in the previous version that would reduce Medicaid spending by an estimated $772 billion over 10 years by gradually eliminating Medicaid expansion and turning the program into a per capita cap block grant program. However the revised version of the bill now would exempt Medicaid spending from the cap during public health emergencies, and would allow states to apply for a waiver from the cap for home-based services for aged, blind and disabled enrollees. In addition, the alternative block grant option would allow states to opt to add the Medicaid expansion population.

Another Medicaid-related change would provide an enhanced, 100 percent Federal match for services provided by any provider through an Indian Health Service facility.

In addition, as expected, the revised bill increases the $2 billion substance use disorder and mental illness treatment fund in the earlier version of the bill to $45 billion, and adds $70 billion to the $112 billion already in the measure in the "stability fund" aimed at bringing down premiums. To appeal to lawmakers in high-premium states such as Alaska, one percent of the expanded stability fund grants would be reserved specifically to subsidize insurance in states where premiums are at least 75 percent higher than the national average.

The revised bill also includes a provision that would allow plan enrollees, for the first time, to use health savings accounts to pay insurance premiums.

A section-by-section summary of the bill is here. A summary of the new Cruz language in Title III of the bill is here.

Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) announced their own alternative to the bill, which would mirror a previous Cassidy proposal by allowing states to choose to continue ACA mandates, including the shared responsibility mandates for individuals and employers, at the state level. Federal dollars currently spent on Obamacare health insurance – an estimated $110 billion in 2016 -- would be block-granted to the states. Pre-existing condition protections would continue at the Federal level. The Senators will offer their bill as an amendment to the main measure, along with nearly a dozen other Republicans who told *BNA Healthcare Daily* they will offer unspecified amendments if the bill makes it to the floor.

Meanwhile, ten House Democrats in the New Democrat Coalition Healthcare Task Force released their own proposal for stabilizing the ACA's marketplace on July 12 which would:

- create a permanent annual $15 billion reinsurance fund, similar to the ACA's reinsurance program that existed from 2014 to 2016, to provide payments to insurers with higher-cost, sicker enrollees;
- continue the existing ACA insurer cost-sharing reduction (CSR) payments which reimburse them for discounts to low-income patients;
- implement "robust marketing strategies" to ensure that more people enroll during open enrollment periods and align enrollment with the tax reporting season;
- allow enrollees nearing retirement to buy into Medicare;
- expand the ACA's tax credit subsidies by age, geography, and income to help people buy insurance;
- expand the availability of catastrophic health plans with lower cost-sharing and premiums, that include essential health benefits and coverage for primary care for younger enrollees;
- ensure bidding areas in the individual market are drawn to include a balanced pool of enrollees so consumers in rural areas are not at a disadvantage;
- reduce enrollment churn by boosting and expanding use of the ACA's Basic Health Program option, in order to streamline coverage between Medicaid and the individual private insurance market;
- direct the Department of Health and Human Services to issue clear guidelines on § 1333 of the ACA, which allows states to enter into Health Care Choice Compacts that allow insurers to sell products across state lines in participating states; and
- ensure that health savings accounts (HSAs) are flexible and compatible with plans compliant with the ACA.

The New Democrat Coalition includes Representatives Kurt Schrader (OR), Ami Bera (CA), Ann MacLane Kuster (NH), Jim Himes (CT), Suzan Del Bene (WA), Ron Kind (WI), Scott Peters (CA), Kathleen Rice (NY), Terri Sewell (AL), and Peter Welch (VT).

Meanwhile, Senate Minority Leader Charles Schumer (D-NY) and three other members of the Senate Democratic leadership wrote to Senator McConnell on July 10 that Democrats have introduced several bills that could help to stabilize the individual health insurance marketplace. The letter urges the Majority Leader to work with Democrats on passing those measures.

## Trump Administration Approves § 1332 Waiver Funding Reinsurance in Alaska

The Trump administration has approved a § 1332 waiver submitted by Alaska to fund a reinsurance program designed to prevent that state's individual market from collapsing.

Alaska submitted its waiver application at the end of last year to the Department of Health and Human Services, seeking federal aid for a new reinsurance program that will backstop the only insurer offering plans in the state's Affordable Care Act Marketplace.

Under the approved plan, the Department of Health and Human Services will provide, over five years, an estimated $323 million to the newly created Alaska Reinsurance Program (ARP) to help offset claims from high-cost patients. The ARP is a state-operated reinsurance program which will cover claims in the individual market for individuals with one or more of 33 identified high cost conditions—none of which are behavioral health conditions—to help stabilize premiums. The ARP is administered by the state of Alaska and the Alaska Comprehensive Health Insurance Association.

Alaska projects that under the ARP and § 1332 waiver, premiums will be 20 percent lower in 2018 than they would have been without the waiver. In addition, Alaska predicts that an average of 1,460 additional individuals will have health insurance coverage due to the lower cost of healthcare through stabilization of the individual health insurance market. These projections were certified by independent actuaries and reviewed by the Federal government.

The ARP will lower premiums on the second lowest cost silver plan premium, resulting in the Federal government spending less in premium tax credits. The State will receive pass-through funding based on the amount of premium tax credits (PTC) that would have otherwise been provided to individuals absent the waiver. As required by Federal law, Alaska's 1332 waiver will not increase the Federal deficit.

The approval is effective January 1, 2018 through December 31, 2022. Approval was delayed, according to state officials, due to a long wait in resolving a state budget issue.

Minnesota, Iowa and Oklahoma are also considering reinsurance programs. Hawaii is the only other state with an approved § 1332 waiver.

**International Association of Peer Supporters (iNAPS)**

**11th Annual Peer Support Conference**

October 16 to 18, 2017

**Phoenix, Arizona**

**Early Bird Registration Rate Extended to July 30**

**REGISTER HERE**

### Health Resources and Services Administration (HRSA) Funding Opportunity Announcement

**FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS) Supplemental Funding Opportunity Technical Assistance - HRSA-17-118**

The purpose of the FY 2017 Access Increases in Mental Health and Substance Abuse Services (AIMS) supplemental funding opportunity is to expand access to mental health services, and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse. Health centers will enhance these services by increasing personnel. They will also leverage health information technology (IT) and provide training to support the expansion of mental health services, and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse, and their integration into primary care. HRSA will award approximately $195 million in AIMS funding to eligible health centers.

**Who May Apply -** Organizations receiving Health Center Program operational grant funding at the time of the AIMS funding opportunity release are eligible to apply for AIMS funding.

**How to Apply -** Applications must be submitted via HRSA's Electronic Handbook (EHB) application module. There is no Grants.gov submission required for the AIMS application. **Applications are due in EHB by 5 p.m. ET on July 26, 2017**.

**Contacts:**
**Program Information:** AIMS Technical Assistance Team, Bureau of Primary Health Care, bphcsupplement@hrsa.gov.

**Budget Information:** Mona D. Thompson, Grants Management Specialist, Office of Federal Assistance Management, mthompson@hrsa.gov.

# Study Finds Suicide Rate Not Linked to Availability of Psychiatric Beds

Research published June 14 in the journal *JAMA Psychiatry* found that the availability of psychiatric hospital beds and residential substance use disorder treatment beds is not statistically related to suicide rates, but that an increase in spending on mental health services has a small but significant positive impact on suicide rates.

Centers for Disease Control and Prevention (CDC) data indicates a 15 percent rise in the national suicide rate over the past 15 years, at the same time that the total number of psychiatric hospital beds in the U.S. has dropped from 34 beds per 100,000 residents to 22 beds per 100,000 residents. To explore what association might exist between suicide rates and psychiatric hospital bed capacity, researchers Robert Gibbons, Ph.D. and Kwan Hur, Ph.D. of the University of Chicago and John Mann, M.D. of Columbia University studied state-level data from the Area Health Resource File on the number of psychiatric hospital beds (private and public short-term hospitals), the number of residential substance use disorder beds, suicide rates, and per capita mental health spending from 1999 to 2013.

They found a simple inverse association between suicide rates and declining psychiatric hospital bed capacity when considering only a parallel time series and between-state differences in the availability of psychiatric hospital beds. Those between-state differences were associated with a 1.32 percent increase in the annual suicide rate per one fewer psychiatric hospital beds per 100,000 residents. However, the researchers found no within-state association between changes in the number of psychiatric beds and changes in suicide rates, and no significant between- or within-state effects on suicide rates from the availability of residential substance use disorder treatment beds.

The researchers did find "a small but significant between-state inverse effect of mental health spending on suicide rates, indicating a 0.01 percent reduction in the suicide rate for every dollar spent on mental health services." Their analysis did not find a significant within-state association with increased spending on services.

The authors conclude that future analysis should focus on how existing psychiatric beds are being used rather on than the total number of beds—for example, the proportion of high-risk patients being treated in outpatient and inpatient settings and how their suicide rates compare after adjusting for risk profiles. They caution that a focus on hospital bed capacity may overlook the importance of detection and treatment of patients at risk for suicide.

## SAMHSA Funding Opportunity Announcement

### Cooperative Agreements to Implement Zero Suicide in Health Systems (SM-17-006)

**Application Due Date: Tuesday, July 18, 2017** **Length of Project: Up to 5 years**

**Anticipated Total Available Funding: $7.9 million ($2 million for tribes and tribal organizations)**

**Anticipated Number of Awards: Up to 13** **Anticipated Award Amount: Up to $700,000/year**

**Cost Sharing/Match Required? No**

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2017 Cooperative Agreements to Implement Zero Suicide in Health Systems (Short Title: Zero Suicide). The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs, for individuals who are 25 years of age or older, that are designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk for suicide. Grantees will implement the Zero Suicide model throughout their health system.

Health systems that do not provide direct care services may partner with agencies that can implement the Zero Suicide model. For communities without well-developed behavioral health care services, the Zero Suicide model may be implemented in Federally Qualified Health Centers or other primary care settings.

**Eligibility -** Eligible applicants are statutorily limited to:

- States, District of Columbia, and U.S. Territories health agencies with mental health and/or behavioral health functions;
- Indian tribe or tribal organization (the term 'Indian tribe' and 'tribal organization' are defined in § 4 of the Indian Self-Determination and Education Assistance Act.);
- Community-based primary care or behavioral health care organizations;
- Emergency departments; or
- Local public health agencies.

**Contacts:**

**Program Issues:** James Wright, LCPC, Suicide Prevention Branch, Center for Mental Health Services, by email or at 240-276-1854
**Grants Management and Budget Issues:** Gwendolyn Simpson, Office of Financial Resources, by email or at 240-276-1408

THE ANNAPOLIS COALITION ON THE BEHAVIORAL HEALTH WORKFORCE

Committed to Promoting the Development of the Behavioral Health Workforce

## State Solutions Webinar Series

The quarterly State Solutions in Workforce webinar series, which launched in Fall 2016, continues highlighting innovative practices by the states in developing a behavioral health workforce.

A recording of the first webinar, which took place in September and highlighted initiatives in Nebraska, is available on-line.

January's webinar highlighted a Connecticut workforce development effort under a SAMHSA Mental Health Transformation Grant. Presenters included Michael Hoge (Annapolis Coalition), Barbara Bugella (State of Connecticut), and Elisabeth Cannata (Wheeler Clinic). They discussed two key initiatives – (1) curriculum reform in higher education related to evidence-based practices, and (2) improving supervision. The recording for this webinar should be available on SAMHSA's YouTube channel in the coming weeks.

The series is the brainchild of the leadership of the Behavioral Health Education Center of Nebraska (BHECN), which is directed by Dr. Howard Liu. Other sponsors of the series include SAMHSA, NASADAD, NASMHPD, and the Annapolis Coalition on the Behavioral Health Workforce.

**Webinar #4: Massachusetts's Career of Substance Website**
**July 19, 2017 at 2 p.m. E.T.**

To register or to be placed on the invitation list, email Valerie Kolock at SAMHSA.

## SAMHSA-Sponsored Webinar Opportunity

## Teaming Up for College Mental Health

***Tuesday, July 18, 3 p.m. to 4:30 p.m. Eastern Time***

Developed under contract by the National Alliance on Mental Illness (NAMI)

College is an exciting time of intellectual growth, new friendships and independence. But the transition from high school to college can also be a time of stress, which often impacts mental health.

In fact, 75 percent of all mental health conditions begin by age 24. That is why the college years are so critical for understanding and talking about mental health. Both NAMI and the NCAA are taking steps to raise awareness about the signs of mental health conditions in college students and where to seek help when they arise. Talking about mental health is important even if you don't live with a mental illness, and experiencing recovery starts with a single conversation.

This SAMHSA-sponsored webinar, hosted by NAMI and featuring the National Collegiate Athletic Association (NCAA), will highlight important information in NAMI's college guide, *Starting the Conversation: College and Your Mental Health*, including students' health privacy rights. It will also showcase the NCAA's commitment to the mental health and well-being of student-athletes through the Sport Science Institute.

**Presenters:**

- **Darcy Gruttadaro, J.D.**, Director of Advocacy, NAMI
- **Happy Carlock,** Coordinator of Advocacy and Public Policy, NAMI
- **Mary Wilfert**, Associate Director of Prevention and Health Promotion at the NCAA
- **Dr. Brian Hainline**, Chief Medical Officer at the NCAA, and Clinical Professor of Neurology at Indiana University School of Medicine and New York University School of Medicine

Closed captioning is available for this webinar.

**REGISTER HERE**

Please contact kelle.masten@nasmhpd.org via email or at 703-682-5187 with any questions regarding this webinar.

## Recovery to Practice Announces an On-Demand Continuing Medical Education (CME) Webinar Series

### Clinical Decision Support for Prescribers Treating Individuals with Co-Occurring Disorders

This two-course series offers information and resources for physicians, clinicians, and other practitioners serving individuals with serious mental illness and co-occurring substance abuse disorder.

In this scenario-based series, participants meet "Nick," a young father with many strengths and who is challenged by both substance abuse and mental illness. The course explores the question: How do I approach Nick and help him meet his needs in ways that are both clinically sound and recovery-focused?

The faculty are national experts in recovery, including psychiatrists, a psychologist, a social worker, a nurse, and peers. They offer tools, tips, and strategies for addressing Nick's needs, and those of other individuals facing similar challenges.

**Course 1: Principles, Assessment, and Psychopharmacology in Recovery-Oriented Care** REGISTER HERE

**Course 2: Engagement, Staged Interventions, and Recovery Supports for Co-Occurring Disorders** REGISTER HERE

Watch one or both courses at your convenience! Each course is approved for 1.5 AAFP (American Academy of Family Physicians) prescribed credits.

### Course Objectives

After viewing, learners will be able to:

1. Summarize a recovery-oriented approach to the treatment of individuals with co-occurring mental and substance abuse disorders.
2. Describe the process of recovery-oriented, strength-based engagement, assessment, and intervention, including psychopharmacology treatment, for individuals with co-occurring mental and substance abuse disorders.
3. Describe non-medication recovery and support approaches for individuals with co-occurring mental health and substance abuse conditions.

### Course Faculty

Curley Bonds, M.D.
Medical Director, Didi Hirsch Mental Health Services

Wayne Centrone, N.M.D., M.P.H
Senior Health Advisor, Center for Social Innovation
Executive Director of Health Bridges International

Chris Gordon, M.D.
Medical Director and Senior Vice President for Clinical Services, Advocates, Inc.
Associate Professor of Psychiatry, Harvard Medical School

Jackie Pettis, M.S.N, R.N.
Advisor and Trainer for Psychiatry to Practice Project

Ken Minkoff, M.D.
Senior System Consultant, ZiaPartners, Inc.
Clinical Assistant Professor of Psychiatry, Harvard Medical School

Kim Mueser, Ph.D.
Executive Director, Center for Psychiatric Rehabilitation, Boston University

Melody Riefer, M.S.W.
Senior Program Manager, Advocates for Human Potential

## Center for Trauma-Informed Care

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.

## Technical Assistance on Preventing the Use of Restraints and Seclusion

For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

The National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to your state.

To Apply for Technical Assistance, Click Here:

We look forward to the opportunity to work together.

## NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of 2015, NASMHPD launched an Early Intervention in Psychosis (EIP) virtual resource center, which was made possible through the generous support of the Robert Wood Johnson Foundation (RWJF). The intent of the EIP site is to provide reliable information for practitioners, policymakers, individuals, families, and communities in order to foster more widespread understanding, adoption and utilization of early intervention programming for persons at risk for (or experiencing a first episode of) psychosis. The site includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness – the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) – as well as a variety of other early intervention initiatives.

EIP is designed to provide an array of information through a consolidated, user-friendly site; and it is updated on a periodic basis. To view the EIP virtual resource center, visit NASMHPD's EIP website.

NASMHPD

## NASMHPD Annual 2017 Meeting

***Sunday, July 30 through Tuesday, August 1***

**Renaissance Capital View Hotel, 2800 S. Potomac Avenue, Arlington, Virginia**
***(Rooms Available at Government Rate at the Renaissance Capitol View)***

The 2017 NASMHPD Annual Meeting will run three full days, in collaboration with the NASMHPD Research Institute (NRI), and include a day of meetings for the NASMHPD Division representatives.

The NASMHPD Divisions include the Children, Youth and Families Division; the Financing and Medicaid Division; Forensic Division; the Legal Division; the Medical Directors Council; the Older Persons Division; and the Offices of Consumer Affairs (National Association of Consumer/Survivor Mental Health Administrators – NAC/SMHA).

The meeting will include extended time for State Mental Health Commissioners and Divisions to meet together as well as separately. There will also be a day with State Mental Health Commissioners and Divisions meeting together on NRI research data and initiatives that tie in with the Commissioners' and Divisions' priorities and concerns.

**Registration for State Mental Health Commissioners: $600**
**Registration for Additional State and/or Division Representatives: $400**

*Contact Yaryna Onufrey with any questions.*

## State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

**NASMHPD coordinates a variety of SAMHSA-sponsored technical assistance and training activities under the State TA Project.**

**To Request On-site TA:** States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals the state is seeking to address via the support.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: http://tatracker.treatment.org/login.aspx. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tatracker@treatment.org.

Note that technical assistance under this project cannot be specifically focused on institutional/hospital- based settings.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or NASMHPD's Pat Shea by email or at 703-682-5191.

## Technical Assistance Products for Services to Persons Experiencing a First Episode of Psychosis

With support from the Center for Mental Health Services, NASMHPD and NRI have developed a second set of technical assistance materials that address issues with programming for individuals experiencing a first episode of psychosis. The products are listed below.

> **Policy Brief***: The Business Case for Coordinated Specialty Care for First Episode Psychosis*

> **Toolkits:** *Supporting Full Inclusion of Students with Early Psychosis in Higher Education*

- *Back to School Toolkit for Students and Families*
- *Back to School Toolkit for Campus Staff & Administrators*

> **Fact Sheet:** *Supporting Student Success in Higher Education*

> **Web Based Course:** *A Family Primer on Psychosis*

> **Brochures:** *Optimizing Medication Management for Persons who Experience a First Episode of Psychosis*

- *Shared Decision Making for Antipsychotic Medications – Option Grid*
- *Side Effect Profiles for Antipsychotic Medication*
- *Some Basic Principles for Reducing Mental Health Medicine*

> **Issue Brief:** *What Comes After Early Intervention?*

> **Issue Brief:** *Age and Developmental Considerations in Early Psychosis*

> **Information Guide** : *Snapshot of State Plans for Using the Community Mental Health Block Grant (MHBG) Ten Percent Set-Aside for Early Intervention Programs (as of September 2016)*

> **Information Guide**: Use of Performance Measures in Early Intervention Programs

These products are in addition to those that were developed last year as well as other materials on first episode programming. They can be obtained at http://www.nasmhpd.org/content/information-providers. Any questions or suggestions can be forwarded to either Pat Shea (Pat.shea@nasmhpd.org ) or David Shern (David.shern@nasmhpd.org).

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Aaron J. Walker, M.P.A., Senior Policy Associate

## NASMHPD Links of Interest

Issue Brief: New Technologies for Improving Behavioral Health: A National Call for Accelerating the Use of New Methods for Assessing and Treating Mental Health and Substance Use Disorders, Kennedy Forum, July 2017

For Many, Medicaid Provides the Only Route to Mental Health Care, *NPR Health Shots,* July 9

The Implications of Cutting Essential Health Benefits, Robert Wood Johnson Foundation/Urban Institute, July 2017 (Analysis shows the Essential Health Benefits covered under the Affordable Care Act (ACA), and targeted for cuts in repeal and replace legislation, represent less than 10 percent of total monthly premiums.)

The Senate's Better Care Reconciliation Act: A $737 Billion Equity Gap for Medicaid Non-expansion States, Idaho, Missouri, Nebraska, Texas, Wisconsin & Wyoming Hospital Associations, July 2017

Insurance Coverage and Health Outcomes in Young Adults With Mental Illness Following the Affordable Care Act Dependent Coverage Expansion, Kozloff N, & Sommers B.D., *Journal of Clinical Psychiatry*, July 11, 2017

Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles, Office of the Inspector General of the Department of Health and Human Services (OIG), July 2017

Understanding the Dynamics of Drug Expenditure: Shares, Levels, Compositions and Drivers, Quintiles IMS (IMS Health), July 2017

Review by Dr. Lloyd I. Sederer of *Committed: The Battle Over Involuntary Psychiatric Care* by Dinah Miller, M.D. and Annette Hanson, M.D., *Psychology Today*, July 8