Weekly Update

House of Representatives to Begin Voting on Opioid-Related Legislation Next Week

House Majority Leader Kevin McCarthy (R-CA) announced June 6 that the chamber will begin voting on a long list of opioid-related bills next week.

Rep. McCarthy said the House will vote on dozens of bills over a period of two weeks. “It will take us two weeks to finish this process, but at the end of the day, we’ll continue to make America safer and more secure and more prosperous,” he said when announcing the schedule.

Rep. McCarthy did not indicate which of the 57 bills voted out of the Ways and Means Committee or the 7 bills voted out of the Energy and Commerce Committee will be considered on the House floor. However, of special note are:

- **H.R. 3331**, sponsored by Rep. Doris Matsui (D-CA), which would provide incentive payments for behavioral health providers for adoption and use of certified electronic health record technology;

- **H.R. 5795**, the Overdose Prevention and Patient Safety Act, sponsored by Rep. Earl Blumenauer (D-OR) with Markwayne Mullin (R-OK) and 18 other bipartisan cosponsors, which would align the treatment referral disclosure restrictions under 42 CFR Part 2 with the treatment and payment disclosure restrictions under the Health Insurance Portability and Accountability Act, while increasing penalties for unauthorized disclosures, prohibiting disclosures in civil and criminal legal proceedings, imposing a duty to notify where unauthorized disclosures occur, and reiterating existing prohibitions against discrimination against individuals with substance use disorders who are in treatment;

- **H.R. 5102**, the Substance Use Disorder Workforce Loan Repayment Act of 2018, which would authorize a education/training loan (up to $250,000) repayment program for substance use disorder treatment workers who work six years in Mental Health Professional Shortage areas or localities with a high overdose death rate;

- **H.R. 5327**, the Comprehensive Opioid Recovery Centers Act 2018, bipartisan legislation sponsored by Reps. Brett Guthrie (R-KY) Gene Green (D-TX), Larry Buschon (R-IN), and Ben Ray Lujon (D-NM), which would establish a grant program to create at least 10 comprehensive opioid recovery centers across the United States to provide the full continuum of treatment services for substance use disorder, including medication-assisted treatment, withdrawal management, counseling and case management, residential rehabilitation, recovery housing, community-based and peer-supported recovery services, and job training and placement assistance;

- **H.R. 5797**, the IMD Care Act, sponsored by Rep. Mimi Walters (R-CA), which would create an exception to the Medicaid Institution for Mental Disease (IMD) exclusion of Medicaid reimbursement for inpatient care to allow for 30 days of inpatient treatment for opioid use disorders (only) under a State Plan Amendment, in addition to the §1115 waivers for a continuum of care for all substance use disorders currently allowed by the Centers for Medicare and Medicaid Services;

- **H.R. 5684**, the Protecting Seniors from Opioid Abuse Act, sponsored by Rep. Mike Kelly (R-PA), which would expand eligibility for medication therapy management programs established under Medicare Part D to include enrollees who are at risk for prescription drug abuse in addition to those enrollees with multiple chronic conditions currently eligible;

- **H.R. 5197**, the Alternatives to Opioids in the Emergency Department (ALTO) Act, bipartisan legislation sponsored by Reps. Bill Pascrell (D-NJ), David McKinley (R-WV), Diana DeGette (D-CO), and Scott Tipton (R-CO), which would require the Secretary of Health and Human Services to conduct a demonstration program to test alternative pain management protocols to limit the use of opioids in emergency departments; and


Still to be scheduled is a vote in the Senate on the omnibus Opioid Crisis Response Act legislation voted out by the Senate Health Education Labor and Pensions (HELP) Committee on April 24 or the 22 bills posted by the leaders of the Senate Finance Committee on the committee website on May 23.

Insiders on Capitol Hill are suggesting that Democrats are trying to delay a Senate vote until after the November elections to prevent Republicans from heralding passage while campaigning of the Republican-led initiative to battle the opioid abuse epidemic.

A report issued March 30 by the Centers for Disease Control and Prevention (CDC) said that opioid addiction took the lives of 115 Americans each day in 2015-2016.
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**NASMHPD Links of Interest**
Upsurge in Injury Mortality among U.S. Children and Adolescents Attributed in Part to Suicide

The overall death rate for children and adolescents between the ages of 10 to 19 rose 12 percent between 2013 and 2016, after a 33 percent decline from 1999 to 2013.

The rise is attributed to injury deaths from suicide, homicide, and unintentional injuries or accidents, according to a report released June 1 from the Center for Disease Control and Prevention (CDC) National Center for Health Statistics. The report examined recent trends in fatal injuries for youth 10 to 19 years in all 50 states and the District of Columbia between 1999 and 2016. A total of 9,716 youth died by injury in 2016 with unintentional injury accounting for almost half of the deaths (4,999), followed by suicides (2,553) and homicides (1,963).

Unintentional injury declined by 49 percent from 1999 to 2013, and increased 13 percent from 2013 to 2016. Motor vehicle traffic (MVT) deaths were the leading method of unintentional injury in 2016, higher than suicide or homicide rates for youth 15 to 19 years. Drowning remained the second leading method of unintentional death for children 10 to 14 years. Poisoning was the second leading unintentional injury for 15-19 year olds, primarily due to opioid overdoses (including heroin).

Homicide rates fluctuated during the study period with a 35 percent decline between 2007 and 2014 to a 27 percent rise in 2016. In contrast, the death rate for suicide saw a reverse trend starting in 2007. The suicide rate declined 15 percent from 1999 to 2007, then sharply increased by 56 percent from 2007 to 2016. With suicide deaths surpassing homicides (2,553 and 1,963 respectively) in 2016, suicide became the second leading cause of death for those age 10 to 19 years. Females had a higher rate of suicide than males. Female suicide rates sharply rose by 70 percent between 2010 and 2016, whereas males had a 44 percent increase. Suffocation, firearms and poisoning accounted for 92 percent of all suicide deaths in 2016.

Non-injury deaths from cancer and heart disease were the fourth and fifth leading cause of death.

The authors note that children and youth injury death rates are 25 percent lower than in 1999, but say, “The recent upturn shows that persistent as well as emerging challenges remain.” They further note, “These results also document the increases in poisoning deaths (i.e., primarily opioid drug overdoses) and suicide in this young population, which may inform public health prevention efforts.”

The Training Institutes offer an extensive array of sessions designed to provide practical, hands-on training and strategies that can be applied to the systems of care in states, tribes, territories, and communities. The Training Institutes is an opportunity for leaders in the field of children’s services to share the latest research, policy, and practice information and resources and learn from one another.

Sessions will focus on approaches that are relevant, adaptable and innovative within critical areas in children, youth, and young adult service systems. Presenters and attendees will include experts and leaders in the field of children’s services, including state, county, tribal, and territorial children’s system leadership, direct service providers, state purchasers from Medicaid, behavioral health, child welfare, juvenile justice, and public health, parents, youth, and young adults, policymakers, clinicians, researchers, and evaluators.

Register HERE

PREREGISTRATION UNTIL JULY 23 - $925; REGISTRATION AFTER JULY 23 - $1,025

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Centers for Disease Control and Prevention (CDC) Suicide Rate Fact Sheet (from Suicide Rising Across the U.S.)

PROBLEM:
Suicide rates increased in almost every state.

Suicide rates rose across the US from 1999 to 2016.

Increase 38 - 58%
Increase 31 - 37%
Increase 19 - 30%
Increase 6 - 18%
Decrease 1%


Differences exist among those with and without mental health conditions.
People without known mental health conditions were more likely to be male and to die by firearm.

No known mental health conditions
Sex
Female 16%
Male 84%

Method
Poisoning 10%
Suffocation 27%
Other 8%

Known mental health conditions
Sex
Female 31%
Male 69%

Method
Poisoning 20%
Suffocation 31%
Other 8%
Firearm 41%

Many factors contribute to suicide among those with and without known mental health conditions.

Problematic substance use (28%)
Job/Financial problem (16%)
Loss of housing (4%)
Crisis in the past or upcoming two weeks (29%)
Physical health problem (22%)
Criminal legal problem (9%)

Relationship problem (42%)

Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SAVE THE DATE: NASMHPD ANNUAL 2018 COMMISSIONERS MEETING

Sunday, July 29 – Tuesday, July 31
Westin Arlington Gateway Hotel, 801 North Glebe Road, Arlington, Virginia 22209

This year’s meeting will be a meeting of State Mental Health Commissioners/Directors and will build on the previous year’s concept of Beyond Beds and intersect with the recommendations in the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) report.

In addition, we are delighted that Tuesday, July 31 will be in partnership with Westat and will focus on the Social Security Administration’s 20-state Supported Employment Demonstration. This important study will determine if providing evidence-based mental health and vocational services to individuals who have applied for and been denied Social Security disability benefits (SSI or SSDI) leads to better outcomes. Applicants denied benefits are at high risk for disability, and the goal of the Demonstration is to help them find jobs and avoid long-term disability.

Further details on registration for the NASMHPD Annual 2018 Commissioners Meeting and other logistics will be provided in the near future. In the meantime, if you have any questions, please contact Meighan Haupt at meighan.haupt@nasmhpd.org.

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.

June Trainings

California
June 21 - 22 - Southern California Alcohol and Drug Programs, Downey

Maryland
June 11 - John L. Gildner Regional Institute for Children and Adolescents, Rockville
June 13 - Baltimore City Health Department
June 28 - Anne Arundel Health System, Annapolis

Virginia
June 13 - Arlington County Behavioral Healthcare Division, Arlington

Tennessee
June 26 - 27 - Moccasin Bend Mental Health Institute, Chattanooga

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

DISASTER HEALTH CORE CURRICULUM

The Uniformed Services University National Center for Disaster Medicine and Public Health is proud to announce a free, eight-hour, online Disaster Health Core Curriculum for All Health Professionals intended for a wide range of health care professionals.

The course consists of eleven, 30-minute to one-hour online training lessons covering a variety of disaster health topics such as personal or family preparedness, communication, ethical and legal issues encountered in disasters, and much more.

This curriculum is free and designed to be taken in pieces or as a whole to be flexible for our busy healthcare professional learner.

The foundation of this curriculum is the Core Competencies for Disaster Medicine and Public Health.

Click Here to Access the Lessons
At present, there are 57 federal staff assigned, from the 10 federal departments and agencies on the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) and the National Institute of Mental Health and the United States Interagency Council on Homelessness, to participate in Implementation Workgroups formed to address each of the five focus areas of the ISMICC December report to Congress. In late March, more than 48 of those federal staff met for a day to hear from ISMICC members about their rationale for and expectations of the recommendations and to prioritize those recommendations. Ron Homberg of NAMI observed the morning session.

The ISMICC Chair, Assistant Secretary of Mental Health and Substance Use Dr. Elinore F. McCance-Katz, began the meeting by describing the problems that ISMICC was designed to address. Four members of ISMICC—Ken Minkoff, Conni Wells, Elena Kravit, and David Covington—attended the meeting. Their presence and their passion were critical to helping federal staff understand the real-world impact of the recommendations and provided insight into how and why ISMICC formulated them.

Three federal ISMICC designees—John Collett (Department of Education), John McCarthy (Veterans Affairs), and Jennifer Sheehy (Department of Labor)—described their agencies’ interest and investment in ISMICC recommendations. Staff were then convened into the five Implementation Workgroups. Throughout the afternoon, ISMICC non-federal members circulated through each of the workgroups in 20-minute sessions to clarify the recommendations and to answer questions.

For the rest of the day, workgroups met to develop their ongoing meeting schedule, to understand how participating departments’ and agencies’ missions align with some or all recommendations in the workgroup, and to agree on at least three initial priorities (listed below). Workgroups varied in size from nine to 16 members.

The Data Workgroup recognized the interdependence of the four recommendations within the data subset of Focus Area 1 and prioritized them. In addition, they committed to working with the Treatment and Recovery Workgroup to developing a priority research agenda for SED/SMI. The Access Workgroup prioritized recommendations that aligned with the missions of all of the participating federal departments. Their first two recommendations reflected the core of an effective crisis response system and the third underscored the importance of taking care of our nation’s youth. The Treatment and Recovery Workgroup identified recommendations viewed as foundational to all of the others within their area of focus. They viewed the comprehensive continuum of care, as well as housing, as critical to the ability of people with SMI and SED to recover and thrive in the community. Their third priority, establishing screening and early intervention as a national expectation, was also considered a fundamental recommendation of their focus area. The Justice Workgroup developed a framework based on the essential themes of reducing justice involvement and bringing treatment to people who are justice-involved. The group prioritized recommendations that best fit this framework. Two other recommendations emerged as areas to further investigate as information and additional partners come to the table. The Finance Workgroup prioritized recommendations based on already effective practices and/or opportunities that may exist for expansion and better coordination across departments.

Implementation Workgroups began meeting on their own in April within their agencies and across departments to advance the various recommendations.

As always, SAMHSA staff—including Dr. Anita Everett and I—want to thank our ISMICC members, federal staff, and other stakeholders for the time and talent they have invested in this enterprise.

### Group 1 Data

**SAMHSA stewards:** Kirstin Painter and Christopher Jones

1. **Evaluate the federal approach to serving people with SMI and SED.**
2. **Use data to improve quality of care and outcomes.**
3. **Ensure that quality measurement efforts include mental health.**
4. **Improve national linkage of data to improve services.**
5. **Develop a priority research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services.** (prioritized with Group 3).

### Group 2 Access

**SAMHSA stewards:** Richard McKeon and Steven Dettwyler

1. **Define and implement a national standard for crisis care.**
2. **Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization.**
3. **Prioritize early identification and intervention for children, youth and young adults.**

### Group 3 Treatment and Recovery

**SAMHSA stewards:** Justine Larson and Cindy Kemp

1. **Provide a comprehensive continuum of care for people with SMI and SED.** The group committed to developing a standard continuum of care for serious mental illness and serious emotional disturbance that includes cross-federal input.
2. **Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation.**
3. **Make housing more readily available for people with SMI and SED.**

### Group 4 Justice

**SAMHSA stewards:** Larke Huang and Jennie Simpson

1. **Develop an integrated crisis response system to divert people with SMI and SED from the justice system.**
2. **Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail.**
3. **Reduce barriers that impede people’s abilities to immediately access treatment and recovery services when they are released from correctional facilities.**
4. **Establishing and incentivizing best practices for competency restoration that use community-based evaluation and services.**
5. **Strictly limiting or eliminating the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED.**

### Group 5 Finance

**SAMHSA stewards:** Chris Carroll and David Devoursney

1. **Implement population health payment models in federal health benefits programs.**
2. **Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.**
3. **Pay for psychiatric and other behavioral health services at rates equivalent to other health care services.**

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**ISMICC Blog**

David Morrisette, Ph.D., LCSW, CAPT, US Public Health Service, Office of the Chief Medical Officer, SAMHSA
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our Beyond Beds series of 10 white papers highlighting the importance of providing a continuum of care.

Following are links to the reports in the Beyond Beds series.

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care
Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment
Older Adults Peer Support - Finding a Source for Funding Forensic Patients in State Psychiatric Hospitals: 1999-2016
The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders
Crisis Services’ Role in Reducing Avoidable Hospitalization
Quantitative Benefits of Trauma-Informed Care
Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014
The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity
The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System
Forensic Patients in State Psychiatric Hospitals – 1999 to 2016
Mindfulness Meditation is an evidenced-based, VA-supported mind-body technique that helps you face the challenges and stressors of everyday life. Research has shown a connection between your mind and your body that can be used to improve health. When your mind is relaxed and focused on healing, your body can relax and focus on healing too. Meditation can be safely used in conjunction with other medical treatments such as prescribed medication or exercise.

Mindfulness Meditation teaches acceptance and awareness of what’s going on around you as well as what’s going on inside of you. It has been effective in treating health conditions such as insomnia, anxiety, high blood pressure, chronic pain and PTSD. Mindfulness Meditation can be practiced sitting down, lying down, stretching, eating, even while walking the dog!

TWO MINDFUL MEDITATION CLASSES will be offered monthly to Veterans with a break in July; one topic the first two Fridays of each month. Take any or all classes! We encourage you to take as many as you can!

JUNE – OCTOBER 2018 DATES:  
11 a.m. to Noon E.T. ALL DATES  
June 1 & 8 - Mindful Movement  
August 3 & 10 - Mindful Breathing  
September 7 & 14 - Mindful Body Scan  
October 5 & 12 - Mindful Movement

This class will be offered via telephone using a toll free number: 1-800-767-1750 with Access Code 54220#. No registration is required. FOR MORE INFORMATION: Call Debbie Skeete-Bernard, RN, MSN at 1-973-676-1000, extension 2714.
Within the public mental health system, self-direction supports people in developing and directing their own services to help reach their own goals for recovery and independence. New York State’s Office of Mental Health has begun implementing a self-direction pilot that pairs each person’s own recovery plan with a flexible budget to purchase goods and services relevant to their goals. This webinar will: 1) Provide an overview of self-direction models and outcomes research to assist people with serious mental illnesses; 2) Describe how New York’s model was developed and adopted during a shifting Medicaid managed care environment, including successful advocacy strategies; 3) Discuss operational concerns such as provider training and outreach during New York’s first pilot year; and 4) Report on early participant outcomes related to the pilot.

Presenters:
- Bevin Croft, PhD., MPP, Research Associate, Human Services Research Institute (HSRI)
- Briana Gilmore, MSc., Director of Planning and Recovery Practice, Community Access
- Keith Aguiar, Self-Direction Pilot Program Manager, Community Access
- Oyeama (“Zisa”) Okpalor, NY Program Participant

Register HERE
The Centers for Medicare and Medicaid Services (CMS) on June 4 released the Medicaid and CHIP Scorecard that Administrator Seema Verma promised at the Medicaid Directors’ Conference in November.

The first version of the Scorecard includes measures voluntarily reported by states, as well as Federally reported measures in three areas: state health system performance; state administrative accountability; and federal administrative accountability. States are not ranked…yet.

The state voluntary reporting measures include the following behavioral health measures:

- Follow-Up After Hospitalization for Mental Illness (adults) after 7 days;
- Follow-Up After Hospitalization for Mental Illness (adults) after 30 days;
- Use of multiple concurrent antipsychotics in children and adolescents (ages 1 to 17); and
- Initiation and engagement in alcohol and other drug dependence treatment for adults.

The State Health System Performance measures show how states serve Medicaid and CHIP beneficiaries in six areas:

- Promoting communication & care coordination;
- Reducing harm in care delivery;
- Promoting prevention & treatment of chronic diseases;
- Strengthening engagement in care;
- Making care affordable; and
- Working with communities to promote healthy living.

States’ administrative accountability is being judged on:

- State Plan Amendments: Days Awaiting Information from States
- Managed Care Capitation Rate Review: Timing of States’ Submissions

The federal administrative accountability measures look at:

- State Plan Amendment and § 1915 waiver processing;
- CMS managed care rate review time; and
- Time from submission to approval for § 1115 demonstration waivers.

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**SAMHSA-Sponsored Webinar**

**Beating the Clock: Reducing the Duration of Untreated Psychosis**

*Tuesday, June 26, 2:00 p.m. to 3:30 p.m. ET*

Developed under contract by the National Alliance on Mental Illness

The “duration of untreated psychosis” is the time between the onset of psychosis and accessing appropriate treatment. The shorter the period of untreated psychosis, the better the outcomes for people. Unfortunately, people with early psychosis typically experience significant delays in accessing treatment and services - an average of 74 weeks in the U.S. With stakeholder collaboration, communities, families and caregivers can help identify young adults with psychosis quicker – and get them into effective programs that support recovery and keep lives on track.

This webinar will discuss strategies for engaging people in evidence-based first episode psychosis programs, building awareness through targeted outreach, collaborating with systems partners, encouraging help-seeking, and how all of this can impact the trajectory their wellness.

**Presenters:**

- **Marla Zometsky** has been with the Fairfax-Falls Church Community Services Board (CSB) for over 10 years and is currently the Project Manager for the Turning Point program, a Coordinated Specialty Care program for individuals 16 to 25 years of age who have experienced the onset of psychosis. Ms. Zometsky previously served as a senior clinician with the CSB’s Intensive Case Management team, supporting homeless adults with serious mental illness. In addition, she has experience working in a residential substance abuse program for adolescent males, providing services through a school-based mental health program and facilitating cultural-adjustment workshops for immigrants and refugees. She is a CSB facilitator for Mental Health First Aid.

- **Tom Schuplin** had worked at PRS, Inc. a non-profit mental health agency headquartered in Oakton, Virginia for 35 years. He was the Director of Day Programs and guided the programs’ conversion from standard psychosocial programs to Recovery Academies. He then became the Director of Special Projects and designed, developed and currently assists in the operation of Coordinated Specialty Care Programs for individuals with first episode psychosis in Fairfax and Loudoun Counties in Virginia. He also designed, developed and currently assists in the operation of a Primary Care Behavioral Health Integration Program (PCBHI) in Fairfax Virginia. Additionally he oversees a substance abuse peer program in Loudoun County. Currently, Mr. Schuplin works as an independent consultant and resides in Richmond, Virginia.

**Register [HERE](#)**

Closed Captioning is Available for this Webinar

We do not offer CEU credits. However letters of attendance are offered upon request.

Questions? Contact NASMHPD’s Kelle Masten via [email](#) or at 703-682-5187
Funding Mechanism: Grant
Anticipated Number of Awards: Up to 25
Anticipated Award Amount: Up to $2M/Year
Length of Project: 2 years
Anticipated Total Available Funding: $47,951,359
No Cost-Sharing/Match Required
Applications Due: July 9, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2018 Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants (Short Title: CCBHC Expansion Grants). The purpose of this program is to increase access to and improve the quality of community behavioral health services through the expansion of CCBHCs. CCBHCs provide person- and family-centered services and are available in the 24 states that participated in the FY 2016 Planning Grants for Certified Community Behavioral Health Clinics (SM-16-001). The CCBHC Expansion grant program must provide access to services for individuals with serious mental illness (SMI) or substance use disorders (SUD), including opioid disorders; children and adolescents with serious emotional disturbance (SED); and individuals with co-occurring disorders (COD). SAMHSA expects that this program will improve the behavioral health of individuals across the nation by providing comprehensive community-based mental and substance use disorder services; treatment of co-occurring disorders; advance the integration of behavioral health with physical health care; assimilate and utilize evidence-based practices on a more consistent basis, and promote improved access to high quality care.

CCBHCs provide a comprehensive collection of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. CCBHCs provide services to any individual, regardless of their ability to pay or their place of residence.

The 21st Century Cures Act established the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). In December 2017, the ISMICC issued a Report to Congress that outlined five major areas of focus and recommendations intended to support a mental health system that successfully addresses the needs of all individuals with SMI or SED and their families and caregivers. Certified Community Behavioral Health Clinics Expansion Grants align with the following recommendations:

2.1. Establish standardized assessments for level of care and monitoring of consumer progress.
2.7. Use telehealth and other technologies to increase access to care.
2.8. Maximize the capacity of the behavioral health workforce.
3.1. Provide a comprehensive continuum of care for people with SMI and SED.
3.9. Make integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders and other substance use disorders.
3.10. Develop national and state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI and SED.
5.2. Adequately fund the full range of services needed by people with SMI and SED.
5.8. Expand the Certified Community Behavioral Health Clinic (CCBHC) program

States were funded to develop CCBHCs in FY2016 through Planning Grants for Certified Community Behavioral Health Clinics (SM-16-001) This CCBHC expansion announcement creates opportunities to support the expansion of the CCBHC model in those states which participated in the 2016 Planning Grant program.

ELIGIBILITY: Eligibility is limited to certified community behavioral health clinics or community-based behavioral health clinics who may not yet be certified but meet the certification criteria and can be certified within 4 months of award in the following states: AK, CA, CO, CT, IA, IL, IN, KY, MA, MD, MI, MN, MO, NC, NJ, NM, NV, NY, OK, OR, PA, RI, TX, and VA.

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT
Infant and Early Childhood Mental Health Grant Program
(FOA No. SM-18-018)

Funding Mechanism: Grant
Anticipated Number of Awards: Up to 9
Anticipated Award Amount: Up to $500,000/year
Anticipated Total Available Funding: $23.4 million
Length of Project: Up to 5 years
Applications Due: June 29, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2018 Infant and Early Childhood Mental Health Grant Program. Eligible children for services include children from birth to not more than 12 years of age, who are at risk for, show early signs of, or have been diagnosed with a mental illness including a serious emotional disturbance. The purpose of this program is to improve outcomes for these children by developing, maintaining, or enhancing infant and early childhood mental health promotion, intervention, and treatment services, including: (1) programs for infants and children at significant risk of developing, showing early signs of, or having been diagnosed with a mental illness, including a serious emotional disturbance (SED) and/or symptoms that may be indicative of a developing SED in children with a history of in utero exposure to substances such as opioids, stimulants or other drugs that may impact development; and (2) multigenerational therapy and other services that strengthen positive caregiving relationships. Programs funded under this FOA must be evidence-informed or evidence-based, and culturally and linguistically appropriate. SAMHSA expects this program will increase access to a full range of infant and early childhood services and build workforce capacity for individuals serving children from birth to age 12. Programs must describe a pathway to sustainability and will be expected to develop a plan for the dissemination of the program to other sites and settings.

WHO CAN APPLY: Eligibility for this program is statutorily limited to a human services agency or non-profit institution that:

- Employs licensed mental health professionals who have specialized training and experience in infant and early childhood assessment, diagnosis, and treatment; OR is accredited or approved by the appropriate State agency, as applicable, to provide for children, from birth to 12 years of age, mental health promotion, intervention, and/or treatment services; and
- Provides infant and early childhood services or programs that are evidence-based or that have been scientifically demonstrated to show further promise but would benefit from further applied development.

CONTACTS: Program Issues: Jennifer Oppenheim, via email or at (240) 276-1862.
Grants Management and Budget Issues: Gwendolyn Simpson via email or at (240) 276-1408.

U.S. Preventive Services TASK FORCE

The U.S. Preventive Services Task Force seeks comments on a draft recommendation statement and draft evidence review on screening and behavioral counseling interventions in primary care to reduce unhealthy alcohol use in adolescents and adults. The Task Force found that clinicians should screen all adults for unhealthy alcohol use and offer brief counseling to those who drink above recommended limits. The Task Force also found that more research is needed to make a recommendation for adolescents. The draft recommendation statement and draft evidence review are available for review and public comment from June 5, 2018 to July 2, 2018 here.

DRAFT RECOMMENDATION SUMMARY

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
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</thead>
<tbody>
<tr>
<td>Adults age 18 years or older, including pregnant women</td>
<td>The USPSTF recommends that clinicians in primary care settings screen for unhealthy alcohol use in adults age 18 years or older, including pregnant women, and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.</td>
<td>B</td>
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<tr>
<td>Adolescents ages 12 to 17 years</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents ages 12 to 17 years.</td>
<td>I</td>
</tr>
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</table>

PUBLIC COMMENT ON DRAFT RECOMMENDATION STATEMENT AND DRAFT EVIDENCE REVIEW: SCREENING AND BEHAVIORAL COUNSELING INTERVENTIONS IN PRIMARY CARE TO REDUCE UNHEALTHY ALCOHOL USE IN ADOLESCENTS AND ADULTS

The U.S. Preventive Services Task Force seeks comments on a draft recommendation statement and draft evidence review on screening and behavioral counseling interventions in primary care to reduce unhealthy alcohol use in adolescents and adults. The Task Force found that clinicians should screen all adults for unhealthy alcohol use and offer brief counseling to those who drink above recommended limits. The Task Force also found that more research is needed to make a recommendation for adolescents. The draft recommendation statement and draft evidence review are available for review and public comment from June 5, 2018 to July 2, 2018 here. See the full draft recommendation statement.
Funding Mechanism: Grant
Anticipated Total Available Funding: $11,200,000
Anticipated Number of Awards: Up to 28
Anticipated Award Amount: Up to $400,000 per year
Length of Project: Up to 4 years
Cost Sharing/Match Required?: Yes

Applications Due: June 11, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2018 Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) Grant Program (Short Title: CHR-P). The purpose of this program is to identify youth and young adults, not more than 25 years old, at clinical high risk for psychosis and provide evidence-based interventions to prevent the onset of psychosis or lessen the severity of psychotic disorder. It is expected that this program will: (1) improve symptomatic and behavioral functioning; (2) enable youth and young adults to resume age-appropriate social, academic, and/or vocational activities; (3) delay or prevent the onset of psychosis; and (4) minimize the duration of untreated psychosis for those who develop psychotic symptoms. SAMHSA and the National Institute of Mental Health (NIMH) encourage partnerships between service grant applicants and mental health researchers to evaluate the effectiveness of stepped-care intervention strategies for youth and young adults at clinical high risk for psychosis. Research studies conducted within the context of the CHR-P program should be proposed through separate NIH research project grant applications. NIMH plans to issue a Notice directing research grant applicants to appropriate funding mechanisms.

[1] For the purpose of this FOA, youth and young adults refers to individuals up to the age of 25 years.
[2] Clinical high risk for psychosis refers to individuals who exhibit noticeable changes in perception, thinking, and functioning which typically precedes a first episode of psychosis (FEP). During this pre-psychosis phase, individuals exhibit one or more of the following: attenuated psychotic symptoms, brief intermittent psychotic episodes, or trait vulnerability coupled with marked functional deterioration.
[3] Stepped care refers to an approach in which patients start with the least intensive evidence-based treatment. Patients who do not respond adequately to the first–line treatment are offered an evidence-based treatment of higher intensity, as clinically indicated.

WHO CAN APPLY:
Eligibility is statutorily limited to the following public entities:

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

Proposed budgets cannot exceed $400,000 in total costs (direct and indirect) in any year of the proposed project.

CONTACTS: Program Issues: Emily Lichvar, Child, Adolescent and Family Branch, Center for Mental Health Services (CMHS) via e-mail or at (240) 276-1859 or Tanvi Ajmera, Child, Adolescent and Family Branch, CMHS via e-mail or at (240) 276-0307.

Recovery to Practice (RTP) Initiative invites you to attend...

Recovery-Oriented Engagement Practices - Spring 2018 Series

Engagement in treatment and services has often been seen as a success of the clinician or a failure of the person being served. As we have learned more about seeking recovery, we know that engagement is a joining together of the person, the provider, and, frequently, other important people in the person's life - with everyone contributing to and responsible for engagement and alliance.

In this series, we explore three distinct elements of engagement. The first webinar looks at therapeutic alliance and its impact on engagement and outcomes. The second webinar considers how Wellness Recovery Action Plan (WRAP) tools for crisis and pre-crisis planning can promote engagement and positive relationships between individuals and service providers. The final webinar discusses social media and other technology as emerging tools for outreach and engagement in behavioral healthcare.

Archived: Therapeutic Alliance and its Impact on Engagement
Forrest (Rusty) Foster, M.S.W., Senior Implementation Specialist at the Center for Practice Innovations, Columbia University and Regina Shoen, Advocacy Specialist with the New York State Office of Mental Health, Office of Consumer Affairs will present clinical frameworks for strengthening engagement and alliance in therapeutic relationships, based on recovery oriented principles and practices.

Archived: Engagement via a Crisis or Pre-crisis Tool within a Wellness Recovery Action Plan (WRAP)
Nev Jones, M.A., M.A., PhD, Assistant Professor, University of South Florida and Matthew R. Federici, M.S., C.P.R.P. Executive Director of The Copeland Center will draw from the tools and resources in peer provided practices to identify respectful and meaningful approaches to engagement.

Archived: Social Media/Technology for Outreach and Engagement
John Naslund, PhD, Harvard Medical School, Global Health and Social Medicine will share his research and experiences working alongside individuals living with serious mental illness and community mental health providers. He will discuss ways to use technology and social media to overcome engagement challenges in a 21st Century world through systemic large-scale implementation of CT-R sharing evidence of culture change.

Click on the Name of Each Session Above to Register

You may attend one or all the webinars in this series. Registration will be necessary for each session. A one-hour continuing education credit, through NAADAC, is available for each session and brief quiz completed. Each session will be recorded and archived for future viewing.

NAADAC statement: This course has been approved by Advocates for Human Potential, Inc., as a NAADAC Approved Education Provider, for 1 CE. NAADAC Provider #81914, Advocates for Human Potential, Inc., is responsible for all aspects of their programming.

29th Annual Federation of Families for Children's Mental Health Conference
Houston, Texas
November 1st-3rd, 2018

CALL FOR PRESENTATIONS

The National Federation's Annual Conference brings together family members, young adults, and professionals and focuses on current issues and trends pertaining to children's mental health, from the perspective of a family-driven and youth-guided approach.

Join hundreds of mental health advocates and professionals from across the nation to share your expertise in: Family and Caregiver Support, Supports for Special Populations, Collaboration and Integration of Services Across Multiple Systems, Trauma Informed Care, Research to Practice, Engaging Youth and Young Adults, Organizational Development and Sustainability, Evidence Based Practices, Parent Peer Support Today or Providing Services and Outreach in the Digital Age.

Early Bird registration rates apply for presenters! There is also still time to be a conference exhibitor or sponsor. Learn more here.

Submit Your Presentation HERE

National Federation of Families for Children's Mental Health
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.

Technical Assistance Opportunities for State Mental Health Authorities

Through NASMHPD, SAMHSA supports technical assistance (TA) for state behavioral health agencies to improve mental health service systems and facilitate effective use of the Mental Health Block Grant. Under the State TA Contract, states can request off-site (such as telephone and web-based) or on-site TA, including in-person training and consultation on issues important to promoting effective community-based services. TA is provided by national experts selected jointly by the state and NASMHPD, and SAMHSA provides support to pay for consultant fees and travel expenses. States can request TA on a broad range of topics, including:

- **Improving Services & Service Delivery Systems.** Examples include tailoring care to specific groups such as older adults; implementing programs for persons in early stages of psychosis; expanding the use of person-centered treatment planning; developing crisis response services; implementing and ensuring fidelity to evidence-based practices; increasing early identification & referral to care for young people; and promoting trauma-informed, recovery-oriented care.

- **Systems Planning/Operations.** Examples include support for strategic planning; merging mental health and substance abuse agencies; leadership development; staff development; cross sector collaboration; and integration of behavioral health and primary care.

- **Expanding the Peer Workforce.** Examples include training and certification of peer specialists; peer whole health training; supervision of peer specialists; and using peer specialists to work with individuals who are deaf and hard of hearing.

- **Financing/Business Practices.** Examples include maximizing Medicaid coverage; addressing behavioral health under a managed care model; drafting performance-based contract language with providers; rate-setting practices; and compliance with Mental Health Block Grant requirements.

State Mental Health Commissioner/Directors or designees may request TA by submitting a TA request directly into SAMHSA’s online TA Tracker at [http://tatracker.treatment.org/login.aspx](http://tatracker.treatment.org/login.aspx). If you’ve forgotten your password or have other questions about using the online system, please send an e-mail to tatracker@treatment.org.

For assistance in developing a TA request, please contact your SAMHSA Project Officer or Jenifer Urff, NASMHPD Project Director for Training and Technical Assistance, at [jenifer.urff@nasmhpd.org](mailto:jenifer.urff@nasmhpd.org) or by phone at (703) 682-7558. We’re happy to discuss ideas and ways that we can support you in strengthening the mental health service system in your state.
CCF Annual Conference
July 24-26, 2018
Washington Marriott Georgetown
1221 22nd St NW
Washington, DC 20037

We hope you will join us this year for our Annual Conference, happening July 24-26, 2018! The conference will be located at the Washington Marriott Georgetown (1221 22nd St NW) in Washington, D.C. We will send more e-mails in the coming months with information on registration and booking hotels. If you have any questions, please reach out to Kyrstin at Kyrstin.Racine@georgetown.edu.

Please note that space is limited and priority is given to state-based children’s advocacy organizations.

New On-Demand Continuing Medical Education (CME) Course:
Clozapine as a Tool in Mental Health Recovery

This one-hour course offers information and resources for physicians, clinicians, and other practitioners serving people experiencing psychotic symptoms who are considering exploring the use of clozapine. Through a “virtual grand rounds,” this course will help you better understand the FDA guidelines, which individuals might benefit from clozapine, the risks and benefits of the medication, and how to engage in shared decision-making with individuals about using clozapine.

In this course, you'll meet Robert, a young man with hopes of attending college and becoming a writer, who also struggles with psychotic symptoms. The course will explore the scientific evidence and best practices for how clozapine may be used as a tool to help him move closer to achieving his goals; as well as how to engage with Robert in a strengths-based, recovery-oriented way.

The faculty are national experts in recovery-oriented pharmacology, who present tips on how to engage with individuals experiencing psychotic symptoms and using clozapine as an effective tool to help them move closer to achieving their goals.

Register HERE!

Course Objectives

After viewing, learners will be able to: explain some of the benefits of initiating clozapine for psychotic symptoms and advancing recovery; articulate how shared decision-making has a role in initiating clozapine; describe the clozapine Risk Evaluation and Mitigation Strategy (REMS); and identify methods for recognizing and managing benign ethnic neutropenia, or BEN, for primary care and psychiatry providers.

Professionals will receive 1 CME credit for participation in this course. (CME provided by American Academy of Family Physicians.)
TA Network Webinars and Activities

The Opioid Epidemic’s Impact on Youth and Families
Friday, June 15, 11:00 a.m. to 12:30 p.m. E.T.

This learning community on working with youth with co-occurring substance use and mental health disorders will focus on the opioid epidemic’s impact on youth and families.

Facilitators: Michael Fox, Angela Lariviere, and Rick Shepler, Center for Innovative Practices, Case Western Reserve University

To Join, Call: Toll Free Number 1-800-216-6327 Toll Number 1-719-325-2711 Participant Passcode 868456

SOC Expansion Leadership Learning Community: Improving Outcomes for Youth Dually Involved in Juvenile Justice and Child Welfare Systems
Wednesday, June 20, 2:30 p.m. to 4:00 p.m. ET

This learning community will focus on youth who are involved in both the juvenile justice and child welfare systems, many of whom have serious behavioral health challenges. This session will provide an overview of the Crossover Youth Practice Model (CYPM), developed by Georgetown University’s Center for Juvenile Justice Reform as an evidenced-based system reform model to impact this population.

Register HERE

Creating High-Integrity Peer Support in Early Psychosis Programs
Friday, June 22, 1:00 p.m. to 2:30 p.m. ET

This webinar will explore peer support as a critical discipline within early psychosis teams. Presenters will review the unique history and role of the peer support profession and how it differs from clinical perspectives. The webinar will discuss how agencies and early psychosis programs can most effectively integrate and support peer support specialists. There will be a discussion of common questions and challenges as well as resources for continuing education.

Register HERE

NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

NOW AVAILABLE
Snapshot of State Plans for Using the Community Mental Health Block Grant 10 Percent Set-Aside to Address First Episode Psychosis

As a condition of receiving a Community Mental Health Services Block Grant (MHBG), states are required to ensure that 10% of their MHBG funding is set used to support programs for people with early serious mental illness, including first episodes of psychosis. The Snapshot of State Plans provides an overview of each state’s funding, programs, implementation status, and outcomes measures under the set-aside.

To view the Snapshot or other new resources to support early intervention in psychosis, visit the What’s New section of the NASMHPD website here: https://www.nasmhpd.org/

To view the EIP virtual resource center, visit NASMHPD’s EIP website.
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NASMHPD Links of Interest

SERVICES IN SUPPORT OF COMMUNITY LIVING FOR YOUTH WITH SERIOUS BEHAVIORAL HEALTH CHALLENGES: RESpite CARE, Kelly English, PhD, Rebecca Bertell Lieman, MSW, Suzanne Fields, MSW & Melissa Schober, MPM, Massachusetts Department of Mental Health & The Institute for Innovation and Implementation, School of Social Work, University of Maryland, Baltimore, TA Network, May 2018

STRENGTHENING PARTNERSHIPS BETWEEN EDUCATION AND HOMELESSNESS SERVICES, Christina Dukes, United States Interagency Council on Homelessness, May 3

HOW MUCH IS YOUR STATE SPENDING ON YOU?, America Counts Staff, United States Census Bureau, May 2018

BIGGER HUMAN BRAIN PRIORITIZES THINKING HUB — AT A COST, National Institute of Mental Health Press Release & NORMATIVE BRAIN SIZE VARIATION AND BRAIN SHAPE DIVERSITY IN HUMANS, Reardon P.K. et al., SCIENCE, May 31

TRANSITION TO THE ICD-10 IN THE UNITED STATES: AN EMERGING DATA CHASM, Khera R., MD, Dorsey K.B., MD, PhD & Krumholz H.M., MD, SM, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, June 4

HUD-HHS PARTNERSHIPS: A PRESCRIPTION FOR BETTER HEALTH, Bipartisan Policy Center, June 5

THE BURDEN OF OPIOID-RELATED MORTALITY IN THE UNITED STATES, Gomes T., PhD, et al., JAMA Network Open, June 2018

HUNDREDS OF ILLINOIS CHILDREN LANGUISH IN PSYCHIATRIC HOSPITALS AFTER THEY’RE CLEARED FOR RELEASE, Du{(a Eldeib, Pro Publica Illinois & The Atlantic, June 5

CONGRESS’ FOCUS ON OPIOIDS MISSES LARGER CRISIS, Roll Call, June 6

PERSPECTIVE: INTEGRATING MEDICAL AND NONMEDICAL SERVICES — THE PROMISE AND PITFALLS OF THE CHRONIC CARE ACT, Amber Willink, Ph.D., and Eva H. DuGoff, Ph.D., NEW ENGLAND JOURNAL OF MEDICINE, June 7

MENTAL HEALTH ATLAS 2017, World Health Organization, June 2018