

MENTAL HEALTH WEEKLY

Essential information for decision-makers

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A Westchester County program is achieving improved outcomes and reduced costs courtesy of its one-year initiative to coordinate care and help consumers with serious mental illness find solutions. The Westchester Care Coordination Program is a recovery-focused and person-centered initiative. To date, the program has resulted in a 52 percent reduction in overall costs and a 63 percent reduction in inpatient days. *See page 5*

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NASMHPD initiative to address treatment, service needs of deaf population with MI

With an eye toward advancing mental health treatment and access to services for the deaf population with mental illness, the National Association of State Mental Health Program Directors (NASMHPD) and the National Coalition on Mental Health and Deaf Individuals (NCMHDI) have embarked on an effort to address the needs of a population they say has traditionally been underserved and underrepresented.

NASMHPD and NCMHDI will work toward identifying and promoting research priorities, training and developing a workforce to understand and work with this population, and making use of technological resources. Both groups convened August 7-8 to identify incremental action steps that are doable,

could impact the system and be done over the next six to 12 months.

"Many people don't understand how isolated the community is," Robert W. Glover, Ph.D., executive director of NASMHPD, told *MHW*. "We need to be much more culturally sensitive if we're going to be supportive of their needs." This population has traditionally not been well served in the public mental health system, said Glover.

The effort will be funded in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), added Glover.

NCMHDI, a non-profit organization, was established in 2008 to provide leadership and support in the areas of public mental health and

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New affiliation continues expansion for largest community-based provider

Just over a year after executing a much-watched merger of three community behavioral health organizations in Indiana and Tennessee, the agency now known as Centerstone of America is capitalizing on another opportunity to expand its service base and enhance its negotiating position with payers.

The Columbus, Ind.-based Centerstone of Indiana operation and the Richmond, Ind.-based Dunn Center have approved an affiliation

in which the operations will be integrated under the Centerstone name as of Sept. 1. A legal merger of the two entities will become official in January.

Having become the largest community behavioral health organization in the country last year, Centerstone now finds itself separating from the pack further, with the latest affiliation resulting in a company with about 1,800 employees, 128 service locations in Indiana and Tennessee and about \$118 million in annual revenue. And the growth period likely isn't over, according to Centerstone of Indiana's CEO.

"We're looking at possibly growing to over \$200 million, with future agreements with partners in

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Bottom Line...

Centerstone executives expect market factors to move so many more mental health centers toward expansion that they foresee several others exceeding Centerstone in size before long.

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deaf and hard of hearing populations in the U.S. The Coalition is an affiliate of NASMHPD.

"The population of consumers who are deaf and mentally ill are not seen on the public radar yet," said Candice M. Tate, Ph.D., president and chief executive of NCMHDI. "There's nobody knocking on the doors demanding they be servicing them, and if there is, their concerns are not being heard and responded to in an efficacious manner," Tate told *MHW*.

In advancing the importance of treating the deaf population with mental illness it is important to bring to the table both state- and federal-level administrators so that they will be informed and can work for positive change in a way that had not been done before, said Tate.

Tate, who is a licensed clinical psychologist, was 2½ years old when her family noticed she had a hearing impairment. Tate noted that 35 years ago it was unprecedented to identify hearing loss that early in a child. "Teaching me sign language was strongly discouraged in the belief that it would impede my learning English language," said Tate, who was formally diagnosed as deaf when she was 16.

"NASMHPD's strong interest in working with this population stemmed from its work in reducing

seclusion and restraint," said Meighan Haupt, associate to the executive director of NASMHPD, told *MHW*. The seclusion and restraint meeting last year hosted by NASMHPD included medical directors, deaf consumers, and those who direct mental health services for people who are deaf, and SAMHSA.

Action steps

Suggestions include:

- Organizing a small research consensus conference to address common research goals.
- Developing a cost-effectiveness study or a study on how evidence-based practices that apply to the hearing population can or cannot be applied to the deaf population.
- Participating in SAMHSA and the National Institute of Mental Health (NIMH) advisory council meetings.
- Working with state officials to determine how many people in state mental health systems are deaf. Potential topics might address: Does the state have a mechanism for identifying sign language users?; demographics of the state's deaf population; and a description of the services provided.

There are more than 5 million deaf individuals in the U.S. who need mental health treatment every

year, according to the report on the proceedings of the Expert's Meeting on Deaf and Hard of Hearing Mental Health Systems hosted by NASMHPD last year.

Only about 2 percent of these deaf individuals receive appropriate treatment for mental illness due to barriers in the effective diagnosis of mental illness.

"Research is going to be one of our biggest goals," said Tate. "We need to understand how DSM-IV TR diagnoses potentially manifest differently in the deaf population. What does a diagnosis look like?" Depression or schizophrenia can manifest differently in the deaf population than it would in the hearing population, she said.

'Unique' culture

"The idea is that the deaf population has a unique culture, which has significant clinical implications, including over-and under-diagnosis based on differing manifestations of symptoms," said Tate. "It's important to show that there is a disparity in this group [in order] to initiate crucial research on how clinical symptomatology differs in deaf populations and develop evidence-based practices and treatment specifically for this population."

Regarding the deaf population as a whole, untrained hearing clinicians were likely to minimize the

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‘It’s difficult to convey to administrators that funding is needed when you can’t define the population or show service disparities between hearing and deaf populations.’

Candice M. Tate, Ph.D.

language differences of their clients, believing that an interpreter would be automatically capable of providing a 100 percent accurate translation, enough to provide an accurate diagnosis and treatment, she said.

Using professionals who are fluent in American Sign Language (ASL) is generally the most appropriate option in working with deaf consumers with mental illness, said Tate.

“Oftentimes deaf people were inadvertently committed to a psychiatric hospital when they did not have a diagnosis of severe mental illness at all,” Tate said. This created a fear and mistrust by the deaf population of the mental health field that still exists today, she added.

“Challenges from a system perspective are knowing that we do not have census data or survey results to determine how many are deaf and hard of hearing in the U.S.,” she noted. “Funding in the state system is typically based on population and numbers.”

Tate added, “It’s difficult to convey to administrators that funding is

needed when you can’t define the population or show service disparities between hearing and deaf populations.”

Underserved deaf populations are not covered by the Health Resources and Services Administration’s (HRSA’s) definition of underserved populations, said Tate. To that end, NCMHDI and NASMHPD will prepare a white paper to clarify the definition of HRSA’s medically underserved population to include the deaf community.

In the short term, the goal is to redefine this population as one covered by HRSA’s definitions, she said. “It should potentially open up a funding stream supported by HRSA,” Tate said. It would also be important to receive funding or resources in order to hire mental health professionals who can work with this population, she noted.

Collaborative effort

Tate noted that the groups’ long-term goals for policy change will focus on examining telehealth,

telemedicine and telepsychiatry as a viable resource. “A fully functioning telemedicine system, which can potentially provide needed services to the deaf community, can also be used for numerous other non-deafness related services,” she said.

For example, telemedicine can be used by specialty doctors for peer-to-peer consultation, by other minority populations to gain access to culturally appropriate professionals, or to provide services to rural populations and those that cannot travel far for medical reasons, said Tate.

It is important that the field know that there are cost-effective and practical ways to address this issue, Tate said. “If you don’t, there’s risk in not providing appropriate services, especially in today’s economy,” she said. “It’s very important that officials and the field realize that we are not pointing fingers at them.”

Tate added, “We want to work with them and meet on their turf and propose practical solutions,” she said. Our goal is to help states provide appropriate services that are not a drain on the system.” •

Bottom Line...

Mental health professionals who are interested in learning more about the development of an effective system of care and other efforts in addressing the treatment needs for deaf and hard of hearing populations should visit www.nasmhpd.org/NCMHDI.cfm.

State Budget Watch

Mich.’s budget proposal threatens consumer access to MH drugs

For nearly five years a public law has allowed Michigan Medicaid consumers with mental illness to



have open access to medically necessary medications, but a recommendation in the governor’s budget proposal could mean the return of a prior authorization policy that could compromise their care resulting in cost-

ly, unintended consequences, said advocates.

Gov. Jennifer Granholm proposes to save \$7 million in the state’s general fund for fiscal year 2010, which begins Oct. 1, by placing mental health medications on the state’s preferred drug list. The move would threaten the Michigan Public Act 248 of 2004 that protects many behavioral health drugs from

prior authorization in the state’s Medicaid program.

According to the law, if a mental health drug has no generics and is not a controlled substance, Michigan Medicaid cannot subject the drug to prior authorization. Protections in that law also extend to medications for cancer, epilepsy, HIV-AIDS, and organ replacement;

Continues on next page

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however, only psychiatric medications appear to be impacted by the proposed budget.

“The executive branches’ proposal assumes a level of savings that would require the 2004 public law to be undone,” Mark Reinstein, Ph.D., president and chief executive of the Mental Health Association in Michigan, told *MHW*. “To date, no one has introduced a repeal of the 2004 law. This is unacceptable. The mental health community doesn’t like that one bit.”

Reinstein and advocates across the state concede that prior authorization compromises the quality of care for consumers with mental illness. Disrupted access to mental health medications would result in increases in hospital and emergency room visits, incarceration and homelessness, not to mention exorbitant costs for those services.

A study by the National Alliance on Mental Illness (NAMI) Ohio conducted last year found that while the savings from prior authorization of the psychotropic drugs would be less than \$6 million, estimates of unintended costs — i.e., homelessness, lost wages and incarceration — would amount to more than \$23 million annually for Ohio.

Reinstein’s sentiment was echoed by many in the advocacy community. “NAMI opposes any changes in the current statute [that would] prohibit access to psychiatric medications,” Sherri Solomon, R.N., executive director of NAMI Michigan, told *MHW*. “In 2004 we fought long and we fought hard” to protect psychiatric medications from prior authorization, she said.

Non-Medicaid cuts

Granholtz is also proposing to cut \$40 million from non-Medicaid community mental health programs for fiscal year 2010. The programs are administered by Department of Community Health, responsible for managing the state’s Medicaid and mental health services. Phone calls

Bottom Line...

Following successful advocacy efforts in convincing lawmakers about the need for a state parity law, Michigan’s mental health community will now increase its advocacy efforts to address problems with medication access and the proposed cuts. A press conference is scheduled this week.

to the department were not returned.

Granholtz had already cut \$10 million from the community mental health non-Medicaid budget for the last quarter of the 2009 fiscal year. The state Senate passed its 2009-2010 budget that would cut \$61.8 million from those services.

The mental health services and programs slated for funding cuts to individuals who do not qualify for Medicaid include reductions in mental health initiatives for older persons, the mental health court pilot projects, mental health respite services and substance abuse services.

Earlier this year the House had proposed a 2 percent increase for community mental health non-Medicaid, Reinstein said. “The state’s economic picture has gotten even bleaker since then,” he said. Unless officials choose to use federal stimulus Medicaid additions to shore up mental health, the House’s 2 percent increase won’t hold, said Reinstein. “We’ll just have to try minimizing the damage as much as we can,” he added.

Budget impact on CMHCs

The immediate cost of prior authorizations in terms of clinical and administrative time would impact the budgets of the local community mental health centers [CMHCs] agencies,” Kathleen Gross, executive director of the Michigan Psychiatric Society, told *MHW*.

“Restrictions require clinical staff time to review medication options, time on the phone requesting a prior authorization, and often a great deal of time documenting

the need for the exception request.” Appeals are also time-consuming, she noted.

Gross added, “The follow-up costs of restricting medications include the clinical impact for a patient who fails to stabilize on a preferred medication. Restrictions inevitably result in glitches and patients leave the pharmacy without their medication. The costly consequences of a break in medication therapy are well documented. Crisis appointments and hospitalizations are costs borne by the [CMHCs].”

The governor’s proposed prior authorization of mental health drugs and the Senate-passed budget bill are both dependent upon the repeal of Public Act 248 of 2004, said Gross. “If the legislature passes the Senate version of the budget, and does not have the will to repeal or amend the protections in current law, then a \$7 million hole in general funds is created.”

She added, “That’s more funds exiting out of the public mental health system. We do not want to see that hole become yet another cut for the [CMHCs].”

Increased services, stressed providers

The proposed cuts could “decimate our community-based care for anyone who doesn’t have Medicaid,” said Mike Vizena, executive director of the Michigan Association of Community Mental Health Board.

“Even more concerning is that because of the economic crisis most of our services [have seen] a 10 to 20 percent increase in request for services for non-Medicaid consumers,” he told *MHW*. Many consumers are facing home foreclosures, loss of jobs, and other economic-related stressors, he said. “We have a lot of poor consumers, but they’re not poor enough to qualify for Medicaid,” Vizena said.

“Almost all care for people with mental health, developmental disabilities and substance abuse [issues]

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Coordinating care program improves outcomes, reduce costs

by Grant E. Mitchell, M.D.

In the December 8, 2008 edition of *Mental Health Weekly*, Westchester County (NY) described a new program — *Westchester County Care Coordination*. Westchester's Care Coordination Program is recovery-focused and person-centered. By being recovery-focused and person-centered, government and providers are far more likely to help individuals with serious mental illnesses find solutions. Westchester's program currently enrolls only those with the highest Medicaid and incarceration costs and the least time spent living in the community. With documented successes, it is the County's goal to make this philosophy and subsequent practice — letting individuals decide what leads to recovery — available county-wide.

Program Design and Goals

Westchester's Care Coordination Program — a collaboration between the Westchester County Department of Community Mental Health and the Mental Health Association of Westchester — is modeled after the Western Care Coordination Project, NY (WCCP). The County selected the Western Project given its outcomes to date. For example, average inpatient days decreased from 21.2 to 8.8, emergency room visits by 55 percent, suicide and self-harm by 55 percent, and arrests by 18 percent. Gainful activities like work and vocational/educational readiness have increased by 27 percent. While the Western program is available to all those in receipt of mental health services, Westchester chose to enroll a subset of the adult population, specifically those individuals with the highest utilization of services and poorest outcomes. This decision was based on resources and Medicaid claims data.

In 2006, baseline costs of services for this group ranged from \$50,000 to \$480,000 per individual. High costs were associated with multiple hospitalizations, homelessness, limited access to integrated treatment, criminal justice involvement, and medical problems. Through care coordination, Westchester's goal was will improve outcomes and reduce costs.

Performance and Outcomes — Accountability

In 2006, the Westchester County leadership instituted a program to ensure that community

needs are met by providing the most effective and efficient services. The County reached agreement that services — those that promote quality of life for all living within the geographic jurisdiction — should fall within the following categories (1) Safety and Security, (2) Health and Environment and (3) Fiscal Responsibility. County departments were required to establish performance goals and to document outcomes.

The Department of Community Mental Health Care Coordination program meets these government's standards, while addressing the needs of those with the most serious mental illnesses. Below are the descriptions of the ways in which the Department will meet standards and improve outcomes:

- **Safety & Security:** A reduction in crime and subsequent number of days of incarceration for individuals with serious mental illness and other co-occurring disorders.
- **Health & Environment:** Program enrollees will have fewer inpatient hospital days and increased access to those services that improve health and promote community living.
- **Fiscal Responsibility:** The Care Coordination program will use more appropriate resources to reduce costs and improve lives (e.g. fewer days in jail/inpatient). Cost reductions will be experienced in other county programs (e.g. county jail) benefiting both program enrollees and the tax payers overall.

To date, the Care Coordination program has resulted in (1) a 72 percent reduction in days incarcerated, (2) a 63 percent reduction in days inpatient, and (3) a 52 percent reduction in overall costs.

While the Care Coordination program has only completed its first year of operations, Westchester County believes that the outcomes will only improve. So far the data shows that individuals who have lived in institutions can live successful lives in the community.

Grant E. Mitchell, M.D., is commissioner of the Westchester County Department of Community Mental Health. For more information regarding program design and implementation, please contact Melissa Staats at mms5@westchestergov.com.

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is provided through local community mental health boards or provider organizations that work under contract," to the state, said Vizena.

Community mental health providers say they continue to face challenges in meeting the needs of the uninsured. "At my own [CMHC], the disparity between the comparatively generous Medicaid funding and the wholly inadequate and disastrous general fund funding is seriously distorting our service provision," Jonathan Henry, M.D., medical director of the Michigan Community Mental Health Authority

of Clinton, Eaton, and Ingham counties, told *MHW*.

"We are not able to offer much besides what amounts to catastrophic coverage to our indigent patients," Henry told *MHW*. "The situation is positively Catch-22 and diabolical for patients who actually get ill enough to be admitted to the hospital — there is nowhere for them to go to get needed treatment post-discharge."

Added Henry, "We are fairly losing our own minds trying to manage this chaos. This is no way to run a system!"

Henry said he doesn't pretend to

know the answers. "We are trying not to lose our morale," he said. "We are endeavoring to come up with every plausible creative idea we can."

The state's final fiscal 2010 budget will be settled through Conference Committee. The Community Board and several of its advocacy partners, including NAMI Michigan and the Michigan Mental Health Association, plan to hold a press conference this week in order to bring attention to the governor and lawmakers about the implications of their proposed cuts, said Vizena. "People with disabilities have very few voices advocating on their behalf," he said. •

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two other states," Centerstone's Robert Williams, Ph.D., told *MHW*. Williams said the target states have not yet been identified, but the general idea is to diversify operations to the extent that the overall organization never finds itself overly vulnerable to the vagaries of one state's Medicaid restructuring plan or budget crisis.

For the short term, Williams sees the affiliation with Dunn Center as similarly attractive to last year's merger of the then-Tennessee based Centerstone and Indiana's Quinco Behavioral Health Systems and the Center for Behavioral Health, in that the new partner brings complementary competencies and a similar mission.

"We will be able to create new, specialized, research-based programs and services to meet the needs of more individuals of all ages," Williams said. "By combining resources we will also be able to attract additional funding that will allow us to expand our ability to meet the needs of our clients and communities."

The funding picture already has improved in some ways since last year's historic merger, with Centerstone having received two new grants from the Substance Abuse and Mental Health Services

Administration (SAMHSA) in the areas of co-occurring disorders and homeless services, Williams said.

Service mix

The affiliation between Centerstone of Indiana and Dunn Center will result in a combined company offering mental health and substance abuse services to more than 24,000 people in 17 central and southern Indiana counties. Williams will continue to serve as CEO of Centerstone of Indiana, while Dunn Center CEO Kay Whittington, Ph.D., will become chief implementation officer for the combined company.

Williams sees the affiliation as offering Centerstone the opportunity to "get a little larger footprint" and to develop additional specialized behavioral health services. He cited in particular Dunn's "centers of excellence" in foster care services and affordable housing as areas that will bring new competencies to the larger company.

Williams emphasized that the 2008 merger already has demonstrated that a joining of forces can prove stronger than what already healthy individual facilities were previously able to achieve on their own. He said, for example, that the joining of Quinco Behavioral Health Systems and the Center for Behavioral Health in Indiana gener-

ated a 63.2 percent increase in the number of at-risk youths served in specialized community programs and diverted from inpatient care.

Moreover, Williams sees this type of expansion for community mental health facilities as necessary at a time when public and private payers are demanding a seamless continuum of services and smaller organizations find it virtually impossible to meet all the requirements.

"The managed care companies we negotiate with are \$250 million companies or larger in revenues," Williams said. "If we were a \$15 or \$20 million organization, they would just dictate terms to us, largely."

He also sees Centerstone's growth into a two-state operation, with plans to enter more states, as serving the valuable function of elevating the organization's national profile at a time of potentially dramatic policy change. He said that in recent months, Centerstone twice has been invited to be represented in small-group discussions with members of Congress as they try to shape national health care reform. Perhaps as the former Quinco chief executive, Williams would not have received the same seat at the table, he speculates.

From the state of Indiana's perspective, the latest joining of two already competent agencies that

individually had demonstrated access to a continuum of services doesn't have a major effect on the relationship between the state and the providers, according to the director of the state Division of Mental Health and Addiction. Gina Eckart told *MHW* that the organizations worked closely with the state agency when the affiliation talks began in order to smooth over any potential concerns, and their existing public funding will essentially be combined when the organizations officially join forces.

Eckart did say that the state is closely watching an intensifying pace of merger activity in general among public providers of behavioral health services. "We may see organizations take mergers a step further, as there are conversations going on to execute mergers of a behavioral health center with a qualified health center in primary care," she said.

National phenomenon

Donald Hevey, executive director of Mental Health Corporations of America (MHCA), told *MHW* that economic hardships and the impending retirements of many CEOs from the Baby Boomer generation are likely to result in an increase in community mental health organization mergers and other affiliations.

Oftentimes the planned retirement of an organization's chief executive will move that organization's board toward the idea of affiliating with another provider agency. "Yet the adage 'if you've seen one merger, you've seen one merger' still applies," Hevey said, as the specifics of each case differ to a degree.

Charles Curie, former SAMHSA administrator and now principal of consulting firm The Curie Group, sees activity such as what is happening in Indiana as reflecting national trends that have been apparent for some time. Yet he believes the motivation for most current mergers and affiliations differs somewhat from activities of a generation ago, when

Whole Health Campaign releases recommendations to address HC reform

The Whole Health Campaign (WHC), an unprecedented collaboration among more than 107 mental illness and substance use prevention, treatment, research and recovery organizations, this month released a series of new policy papers outlining the urgent message that mental illness and substance use be considered a health care policy priority during the reform process.

The papers focus on access, quality, choice and cost of care for people with these disorders and their family members.

"It's critical that legislators and consumers alike insist these issues are addressed — especially when a third of uninsured individuals and their families are struggling with these issues," said Eric Goplerud, Ph.D., director of the Center for Integrated Behavioral Health Policy at George Washington University.

The WHC, which formed during the 2007 Santa Fe Summit hosted by ACMHA: The College for Behavioral Health Leadership, supports policies that promote research, prevention, early intervention and treatment of mental illnesses and substance use.

The series of policy papers discuss and provide specific recommendations for the education of health care professionals, wellness promotion and chronic disease prevention initiatives, improving health care leadership, access to affordable and timely universal coverage, financing health care reform, integrating health care and addressing disparities.

"We greatly appreciate the legislators' efforts to address substance use and mental illness in their reform bills," said Ron Manderscheid, Ph.D., director of mental health and substance use programs at Global Health Sector, SRA International, Inc. and president-elect of ACMHA: The College for Behavioral Health Leadership.

"The policy papers that we've created demonstrate why it's time for mental illness and substance use research, prevention, treatment and recovery to become an integral part of America's health care system," said Manderscheid. "We look forward to keeping these issues in the final package."

Visit www.wholehealthcampaign.org to download the policy papers.

partnerships were pursued mainly to achieve economies of scale.

"A lot of consolidations lately are about the ability to develop and have access to the capacities and competencies that larger organizations can attain," Curie told *MHW*.

Much of this is being mandated through the push for integrated, holistic care and for better outcome evaluation, he said. On the mental health side of the equation, the desire for more behavioral health care screening in primary care settings is leading the health care com-

munity to embrace organizations that can offer integrated services and be viable, cooperative partners in a large system of care, Curie indicated.

Williams emphasizes that Centerstone by no means will engage in growth that has no larger purpose, and adds that the company has become "pickier" about identifying partners with the skill sets it believes it needs to acquire. Even though it is now the nation's largest community-based provider, "Our goal isn't to be

Continues on next page

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the largest community provider in the country," he said.

Williams added, "We'd like in 10 years to be the ninth largest. We would like our colleagues out there to emulate what we've done." •

BRIEFLY NOTED

U.S. spending on MH care rising more than other health care

The rate of spending on mental illness in the United States is accelerating at a rate greater than that for any other health care category, according to a report from the Agency for Healthcare Research and Quality (AHRQ), released August 5. The country spent about \$35 billion on treating mental health disorders in 1996, compared with \$58 billion in 2006. The number of Americans seeking treatment for mental illness climbed from 19 million to 36 million. The report coincides with a study released August 3 finding that Americans' spending on antidepressants nearly doubled between 1996 and 2006 (see *MHW*, August 10).

Suicide prevention project targets LGBT community

On August 10 the American Foundation for Suicide Prevention (AFSP) announced it has received a \$45,000 grant from the Johnson Family Foundation (JFF) to fund its "Knowledge to Practice Initiative," designed to reduce suicidal behavior in the lesbian, gay, bisexual and transgender (LGBT) community. JFF

Coming up...

The **Depression and Bipolar Support Alliance (DBSA)** will hold its 2009 National Conference on **Sept. 10-13** in **Indianapolis, Ind.** For more information, visit www.dbsalliance.org.

The **National Mental Health Consumers' Self-Help Clearinghouse** has planned the Alternatives 2009 conference, "Uniting Our Movement for Change," to take place on **Oct. 28-Nov. 1** in **Omaha, Neb.** Visit www.alternatives2009.org for more information.

The **Center for Latino Health at the New York University Institute of Community Health and Research** will hold the Third Annual Latino Mental Health Conference on **Oct. 30-31** in **New York City**. For more information, visit www.med.nyu.edu/CMECoursePDF/CME/CME-5962-Brochure.pdf.

Executive Director Andrew Lane cites a higher rate of suicide among LGBT youth. In developing partnerships among national and local suicide prevention programs and leading LGBT groups, the initiative aims to leverage research in developing new prevention projects. The AFSP hopes its initiative will provide a foundation for a national approach to LGBT suicide prevention.

STATE NEWS

Miss. MH leaders discuss reform

A committee of Mississippi mental health officials held a hearing on August 7 to discuss a significant reform of the state's mental health system. "What the committee hopes to do is to see what services are being provided that we need to expand and what services need to shift into another area," said Senator Hob Bryan (D-Armory). One topic of discussion was the shift away from

institutional treatment. "We have got to provide increased access in our community programs," said Ed Legand, director of the Department of Mental Health. This need was spelled out in United Cerebral Palsy's 2009 Case For Inclusion report (www.ucp.org). Mississippi ranked lower than any other state in its provision of Medicaid services for people with disabilities (a score of 25.4 compared with Vermont's top ranking 86.3).

NAMES IN THE NEWS

Stephen H. Feinstein, Ph.D., is the new president of the National Alliance on Mental Illness (NAMI) board of directors. Feinstein, an experimental psychologist, has served on the NAMI board for five years and was previously the president of NAMI Kansas.

OBITUARY

Eunice Kennedy Shriver, a dedicated advocate for individuals with intellectual disabilities, died on August 11 at the age of 88. She had suffered a series of strokes in recent years, according to a family friend. Among her many advocacy efforts, Shriver founded the Special Olympics and served as executive vice president of the Joseph P. Kennedy Jr. Foundation.

In case you haven't heard...

The increasing number of employers who rely on temporary or fixed-term workers to power their businesses may do well to consider the long-term and global mental health impact of this approach. This is the conclusion reached by Amélie Quesnel-Vallée, lead investigator of a new study presented at the annual meeting of the American Sociological Association (Aug 8-11). Working with nationally representative surveys from 1992 to 2002, the study found workers who perceive their employment as being temporary "seem susceptible to declining mental health for as long as they continue to work in these so-called 'disposable' or 'second class' jobs," said Quesnel-Vallée.