

MENTAL HEALTH WEEKLY

Essential information for decision-makers

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HIGHLIGHTS...

The **National Council for Community Behavioral Healthcare** last week sponsored a congressional briefing on how **Arkansas** and **Colorado** collect public mental health system data to measure the effectiveness of their mental health programs. A strong commitment from providers and reasonable treatment dollars are critical in gathering information, said officials. See story, top of this page.

The **National Council on Disability** last week released a report calling on Congress and the Administration to support efforts for full integration and participation for people with psychiatric disabilities. The report links elements of the 'livable' community framework, i.e., housing, employment, to mental health recovery. See story, bottom of this page.

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Community providers take message of accountability to Capitol Hill

Congress briefed on data collection at state level

The discussion was not tied to landmark legislation or an impending regulatory development, but participants in a congressional briefing sponsored by the National Council for Community Behavioral Healthcare (NCCBH) last week did not hesitate to call their opportunity to address congressional staffs a momentous occasion.

As much importance as participants place in last week's briefing topic — the work by some states to collect public mental health system data in a way that is informing service improvement — they are just as pleased with their rare opportunity to engage in a detailed discussion of

the community mental health system on Capitol Hill.

"The most fundamental thing we were doing was to put community mental health on the radar screen of Congress," Chuck Ingoglia, the National Council's vice president of public policy and practice improvement, told *MHW*.

"We were talking and sharing information about, of all things, mental health on Capitol Hill," Kenny Whitlock, executive vice president of the Mental Health Council of Arkansas, told *MHW*. "That just hasn't happened before. And the discussion was about efficiency, outcomes and management."

The March 18 briefing was sponsored by senators from the two

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NCD report calls for full integration for people with psychiatric disabilities

The National Council on Disability (NCD) last week released a new report, which calls on Congress and the Administration to fully include and integrate people with psychiatric disabilities into America's livable communities and ensure that they have the choices and opportunities available to people without disabilities.

The *Inclusive Livable Communities for People with Psychiatric Disabilities* report builds on previous reports released by NCD, *Livable Communities for Adults with Disabilities* and *Creating Livable Communities*, both of which set forth a 'livable' community framework. Both these earlier reports proposed necessary changes in public policies regarding housing; trans-

portation that is reliable and accessible; environments that are physically accessible, including work, education, and health care; and opportunities for participation in social and recreational activities.

The 2004 and 2006 NCD reports presented a framework for livable communities for adults with disabilities and federal policy and program examples in action that emphasize livable communities. Grounded in the six identified elements, a livable community:

1. Provides affordable, appropriate housing.
2. Ensures accessible, affordable, reliable and safe transportation.
3. Adjusts the physical environ-

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states that were showcased as prototypes for provider-driven data collection that has offered a clearer picture of public mental health system performance: Arkansas and Colorado. Whitlock and George DelGrosso, executive director of the Colorado Behavioral Healthcare Council, told congressional staffers and other parties in attendance how systematic data collection has both

investment of dollars.

“We showed them a fairly inexpensive process for gathering and disseminating information,” Whitlock said in reference to the presentations at last week’s briefing. “This is built with a few hundred thousand dollars,” not millions.

The Mental Health Council of Arkansas and its member provider agencies began the process of improving data collection in early

working with the kind of information that could build a case for system improvements, Whitlock said.

A major driver of the process was the notion that state support for mental health services was not keeping pace with the demand for indigent care, so Arkansas agencies were becoming more aware that they needed to maximize their limited resources. Yet the data collection effort did not emanate from any state mandate — it wasn’t until later in the process that the state decided it would require its publicly funded mental health provider agencies to collect information in a uniform manner.

In its initial work, the council and its member agencies discovered surprisingly that most of the data they needed to generate usable information was already being collected — it just wasn’t happening in a systematic fashion that allowed agencies to look at the big picture of how services were being delivered. Much of the service-related data was being furnished in a piecemeal manner to the various public and private insurance entities that the providers billed.

The provider associations in both Arkansas and Colorado have worked with David Lloyd, president of MTM Services, as their consultant for data collection efforts to inform quality improvement. Whitlock ex-

‘The most fundamental thing we were doing was to put community mental health on the radar screen of Congress.’

Chuck Ingolia

driven quality improvement and enhanced the credibility of public mental health services among state policy-makers.

“We hope the groups we spoke to realize that our community mental health systems are worth the investment,” Whitlock said.

Arkansas’ experience

Arkansas’ community mental health providers have demonstrated over the years that reliable information can be collected with a strong commitment from the provider agencies but a relatively reasonable

2002, and Whitlock says this did not occur with prodding from government regulators or another outside entity. “We wanted to make our services more efficient, and we needed management information to do that,” he said. “We also wanted to look at what we were doing clinically.”

It took many months for member provider agencies to achieve uniformity in how service data were being collected and what variables they were measuring. The data collection effort began in earnest in 2005, but it wasn’t until the following year that the group believed it was

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plained that providers have Web-based access to reports and graphs based on the data they submit, although some of the more sensitive information is protected from unrestricted access.

Lloyd also was a panelist at last week's congressional briefing, as was National Council president and chief executive Linda Rosenberg. "Trying to improve services without baseline information and ongoing measurement is like prescribing blood pressure medication without taking the patient's blood pressure," Rosenberg told *MHW*. "It may be the case that current mental health improvement initiatives aren't appropriate or helpful; consumers deserve better."

That is why the National Council wanted to tout the experiences of Arkansas and Colorado, and why it hopes that providers in other states are inspired by these examples.

In Arkansas, Whitlock said the ability to dig deeper into data has resulted in several improvements in efficiency, such as in the area of client no-shows for services. Once providers were able to get a clearer

picture of who isn't showing up for services and why, they could initiate changes to various processes of care in order to have an impact on the numbers.

Many agencies in the state also have taken a close look at the productivity of individual clinicians. This has resulted in the need to engage in a delicate balancing act, Whitlock said, as the importance of billable hours to these organizations has to be weighed against the need to remain focused to the helping mission of the community mental health center.

"We don't want this to become a numbers game," Whitlock said. "At the same time, we can't survive unless we're productive."

Looking ahead

The measurement focus of last week's briefing is closely related to a number of other ongoing initiatives at the National Council in the realm of process improvement. One such effort is the council's yearlong Access and Retention Quality Improvement Initiative, in which four community mental health organizations are identifying the factors that impede client

participation in treatment and are modifying service delivery processes to improve client engagement (see *MHW*, March 3).

The National Council tried to demonstrate to members of Congress through last week's briefing that states have had to make up for a gap in available data, caused in part by a federal block grant system that historically had not required data collection from recipients of funding.

Rosenberg said that "there is little to no federal or state support for systems that measure effectiveness at the point of service. National Council members, clear about their accountability to purchasers, end users and taxpayers, are emerging as the industry leaders — and the state associations in Colorado and Arkansas are examples of that leadership."

Ingoglia said that while last week's briefing did not attract a standing-room kind of crowd, it proved to be an important educational moment for the congressional staff members and advocacy groups in attendance.

"We want to do this on a regular basis," he said of these events. "I think we have a good story to tell." •

ACMHA summit presents physician dialogue on integrating care

While there have been many discussions in the behavioral health field about the importance of integrating behavioral health care and physical health care, this may be one of the few times a group of primary care physicians (PCPs) have actively joined in on the discussion during a field conference as witnessed during this month's American College of Mental Health Administration's (ACMHA's) annual summit.

The 2008 ACMHA Santa Fe Summit, "Impacting Healthcare Reform: Leadership in Moving the Mental Health and Substance Use Agenda," was held March 13-15 (see *MHW*, March 17).

During the session the atten-

dees heard from six primary care physician panelists about how collaborative efforts involving psychiatrists have helped PCPs verify diagnoses and make recommendations about a patient's illness, provided valuable information to the physicians, and referring patients with serious mental health conditions.

The physician panelists discussed their efforts to aggressively identify patients with mental illness and get them the help they need promptly. One physician likened it to co-managing patients suffering from coronary heart disease or congestive heart failure with cardiologists. He mentioned a similar collaboration with psychiatrists in caring for patients with mental illness.

Building a system of care

Larry Green, M.D., professor of family medicine at the Graham Center at the University of Colorado at Denver and Health Sciences Center, discussed the medical home concept, which he defined as modernized primary care in the information age.

"If you utter mental health, behavioral health or substance abuse and you insert primary care in the sentence, it still works," Green said. "The problem is our patients don't know how we're organized and they don't get it."

Viking Hedberg, M.D., a pediatrician at the Dartmouth-Hitchcock Plymouth Pediatrics clinic in New

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Hampshire, said that in order to meet the needs of teens within their community they created a center for adolescent health which brought together a number of stakeholders, including mental health practitioners, family therapists, a community mental health agency and a special activities coordinator.

"None of us can do it alone," Hedberg told attendees. Integrated care, however, may cost a little more money, he noted. "No one model fits everything. We've come up with a different local solution that is working nicely in our community," he added.

Hedberg added, "Investing early in the lifespan is critical. That's where we want 'a bang for your buck.' We need to invest in these young folks."

Jeffrey Peterson, M.D., a primary care pediatrician from Western Maine Pediatrics, acknowledged to attendees that his practice initially did exist in a primary care silo. Local mental health agencies and his practice did not communicate with one another very much. So, his practice initiated a collaborative that forced other physicians to talk to others in the behavioral health field.

Peterson noted that the collaboration resulted in phone calls that were returned promptly, more effective referrals and treatment plans that were routinely discussed. "The referral time dropped from six to 12 weeks to two weeks," he said. The overall quality of care for patients improved, added Peterson.

Nighat Qadri, M.D., medical director of internal medicine at the Crider Health Center, noted that many of her patients were referred from psychiatrists "It takes a team of people to help patients in need," Qadri said. "We [also] need to understand and be respectful of patients' cultural beliefs."

Raymond Rion, M.D., medical director at the Packard Community Clinic in Ann Arbor, Michigan, said he works closely with the local

'If you utter mental health, behavioral health or substance abuse and you insert primary care in the sentence, it still works.'

Larry Green, M.D.

community mental health system. "Fortunately, we worked with psychiatrists that were good teachers," he said. It's important "you get the right people on the bus," Rion said. He noted that he is pleased that the clinic has a full-time master of social work representative onsite, he said.

Karl Wilson, Ph.D., president and chief executive of the Crider Health Center in Missouri, "We are trying to work to build a system of care in the community," he said. "We're helping with kids' programs in school and helping them stay out of trouble."

"The issues we're facing are that people are dying 25 years earlier than they would otherwise," Wilson said. We can make primary health care much more humane. We need psychologists, social workers and peers," he said.

Dialogue important

Sandy Forquer, Ph.D., vice president of the public sector at United Behavioral Health, thanked the primary care physician panelists for engaging in such a 'spirited' discussion with the behavioral health community. "This is powerful," she noted. "We need to have this. We've previously talked among ourselves."

Forquer said that when she looked at the mechanisms which moved the field forward, it was dialoguing among psychiatrists and consumer groups years ago that helped. "The rest of us sat around

and watched and learned from the discussion. We need to start sponsoring these dialogues," she said.

Forquer later told *MHW* that the panel session "was a breakthrough conversation," She said she was reminded of earlier dialogue between consumers and psychiatrist that occurred in New York more than 10 years ago, while she served as deputy commissioner for Quality and Management Information Systems for the New York State Office of Mental Health.

"For ACMHA, this represented the first time there's been a conversation on this large of a scale with representatives from the primary care community," Forquer said. "The fact that six primary care physicians [were willing] to come and speak to an almost 100 percent behavioral health summit was also a breakthrough."

Forquer noted that in order to continue to foster recovery and hope in the primary care environment these conversations need to continue. "We need to really begin a dialogue about what recovery and hope are all about," she noted.

Recovery needed

Edward L. Knight, vice president of recovery, rehabilitation and mutual support at ValueOptions and a consumer of mental health services, asked the panel of primary care physicians about where recovery fits into the equation. "Where is recovery in all this?" he noted, adding that discussions involved compliance, life style, but not about recovery.

"The integration of mind and body is not the reduction of mind to body," he told physician panelists.

In response to Knight, Wilson said, "I think that recovery should be the shining light we put on integration." People need to make a better life for themselves, he said.

Hedberg added, "Our system is broken. If we don't do something different, it will fail. But within primary care, the whole issue of shared

decision-making” is key, he said. “How do we address chronic illness? Recovery is not the word we used, but it is the principle behind this.”

In a subsequent interview with *MHW*, Knight noted that not only was the word ‘recovery’ not used during the discussion, “but the concept, the practice wasn’t there,” he said. “I don’t think medical clinics are oriented in that direction,”

Knight said. “The coordination of physical health care and mental health care is very important.”

Knight cited a ValueOptions program in Massachusetts, EssentialCare, an intensive care management program, as an example of a model of integrated care that is not just provided through medical clinics. The program, a hybrid care management model, provides integrated care

management services to individuals with chronic medical conditions that is managed by the Massachusetts Behavioral Health Partnership (MBHP). MBHP works collaboratively with families, state agencies and providers.

“I would like to see consumers of mental illness engaged in dialogues with medical doctors about recovery,” he said. •

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ment for inclusiveness and accessibility.

4. Provides work, volunteer and education opportunities.
5. Ensures access to key health and support services.
6. Encourages participation in civic, cultural, social and recreational activities.

According to NCD, when the focus shifts specifically to people with psychiatric disabilities, it becomes plain that without expansion this six-element framework is insufficient to ensure the full integration of all people who have disabilities.

These elements of change apply to the estimated 24.6 million people with psychiatric disabilities. The new report expands NCD’s livable community framework to ensure full participation in the community for them.

Living in inclusive communities

Regarding the release of the new NCD report, “There was a need to pay attention to issues for people with psychiatric disabilities — so people can live in inclusive communities,” said Cynthia Wainscott, NCD member and immediate past president of Mental Health America.

“We’re hoping to use this report to achieve three things,” Wainscott told *MHW*. “We’d like to use it as an advocacy tool, as a resource, and a road map to a new place.”

“There’s hope for that now,” she said, citing an increase in treatment modalities, but also with the recovery movement, which demonstrates that people with severe psy-

chiatric disorders can live successfully in their communities.

The main barrier that people

with psychiatric disabilities face is that a community that eliminates all

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NCD outlines recommendations to support integration

Recognizing the need for major changes in public policies, the National Council on Disability (NCD) makes the following five core recommendations to support further efforts for full integration and participation for people with psychiatric disabilities:

Core Recommendation One: Congress should ensure that Department of Health and Human Services (HHS) appropriations continue to support anti-stigma campaigns and efforts to provide a funding base for self-help programs operated and run by mental health consumers and survivors, analogous to the funding provided under the Rehabilitation Act for operation of independent living centers.

Core Recommendation Two: Implement changes in federal and state funding and policy to encourage housing models that are integrated, in accordance with individual choice, and delinked from mandatory health services, while providing ongoing flexible supports.

Core Recommendation Three: Congress and Housing and Urban Development (HUD), HHS, and the Social Security Administration (SSA) should work to change federal and state funding and policy to eliminate the “benefits trap,” which discourages people with psychiatric and other disabilities from working, and to ensure that work opportunities are available for the full range of jobs, with ongoing flexible supports.

Core Recommendation Four: HHS should be authorized to change Medicaid policy and regulations as implemented by the Centers for Medicare and Medicaid Services (CMS). The agency should examine and consider the merits of existing models; for example, the Michigan state model reframes the definition of “medical necessity” to include “community integration,” and shifts funding to services based on “person-centered planning.” Such changes would allow a broader variety of recovery-oriented services to be eligible for Medicaid funding than is available currently.

Core Recommendation Five: Congress should ask the Government Accountability Office to assess and identify indicators of practices that seem to be working in HHS efforts to address cultural and linguistic issues through initiatives like the National Center on Cultural Competence (NCCC).

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the physical environment barriers still may not be fully accessible to people with psychiatric disabilities because of ingrained attitudes toward mental illness, the report noted.

Before people with psychiatric disabilities can even begin to take full advantage of the elements of the livable communities framework, they must be able to surmount an attitudinal barrier, according to the report. Stigma and discrimination surrounding mental illnesses create real obstacles for people with psychiatric disabilities as they attempt to rent apartments, get jobs, go to school or engage in many other aspects of community living.

“Stigma allows discrimination to continue,” said Wainscott. “We urge the federal government and other agencies to combat that.”

The report points to the shift from sheltered workshops to competitive employment as being effective in promoting integration. When the employment program was a sheltered workshop, less than 5 percent of clients made the transition to competitive employment.

The low expectations of the old sheltered workshop and day-treatment models helped produce poor outcomes because they instilled in people the belief that they were unable to work, the report noted.

People with psychiatric disabilities weren’t expected to move into the general labor force, added Wainscott. By contrast, when a full supported-employment model was used, about one-half of the clients were able to achieve competitive employment, she said.

“That demonstrates the power of attitude to keep something from happening,” Wainscott noted. When a shift of attitude occurs within the system itself, people with psychiatric disorders can work and be successful, she said. “We support that,” she said.

The report points to a number of states that have developed innovative models for using Medicaid funding to provide recovery-oriented services. These models are important because Medicaid, as a federal program, can be used in all states to implement and fund these approaches, the report noted.

“Michigan has reframed its [definition] of medical necessity to include integrated services,” said Wainscott. “Michigan, under Medicaid, has redefined medical necessity so that it includes community integration.

‘Stigma allows discrimination to continue. We urge the federal government and other agencies to combat that.’

Cynthia Wainscott

Added Wainscott, “We in the mental health community have (or exhibit) an attitudinal barrier. We need to work on that.”

‘Benefits trap’

One of the biggest barriers to employment is the benefit system itself, according to NCD. Often, this is what people call the “benefits trap,” where consumers with psychiatric illnesses obtain employment and then lose access to treatments that allowed them to get the job in the first place.

“One of the very concrete recommendations is to eliminate the benefits trap,” Wainscott said. “We measure policies that are in effect now that predate the recovery movement, based on expectations that people with psychiatric disabilities will need help forever.”

Wainscott added, “The trap there if you get a job and make a certain amount of money is that you lose access to treatments that allowed you to get the job in the first place. We need to rethink some policies based on inadequate expectations and the need to have those changed.”

They can use Medicaid for a wide variety of recovery-oriented services.”

“We hope this will be replicated,” Wainscott said, adding that the Deficit Reduction Act of 2005, allowed for increased opportunities for innovative Medicaid funding.

Wainscott cited one of the report recommendations, which calls for Health and Human Services (HHS) to implement changes in Medicaid policy and regulations to allow a much wider variety of recovery-oriented services to be eligible for Medicaid funding than is currently available.

Another recommendation calls for the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Mental Health Services (CMHS) to shift funding to services based on person-centered planning, she noted.

“We want to make policyholders aware that there are very successful things around this country” that are working for people with psychiatric disabilities, said Wainscott. •

For a copy of *Inclusive Livable Communities for People with Psychiatric Disabilities*, visit www.ncd.gov.

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Program Spotlight:**Housing program helps consumers integrate into communities**

Maryland's Main Street Housing, Inc. a program that takes an innovative approach to integrated permanent housing for people with psychiatric disabilities, is featured as one of two model housing programs in the National Council on Disability's (NCD) new report, which calls for full integration of people with psychiatric disabilities (see page 1).

Main Street Housing, Inc., is a subsidiary of On Our Own of Maryland, a consumer-run statewide organization. Program officials purchase and rehabilitate properties in scattered sites and rent them. The program's properties offer affordable rental units to individuals and families with psychiatric disabilities.

Program officials have purchased 12 properties throughout Maryland and plan to add three more buildings. By the end of the fiscal year, they will have a total of 21 units in 15 buildings for approximately 55 people, said Kenneth R.

Wireman, executive director.

"We're a community development housing program," Wireman told *MHW*. "Main Street is a transformational activity. "This housing program really changes lives. It provides consumers with a role in the community — not just in the mental health world," he noted.

Consumers with psychiatric disabilities take on a real societal role as tenants, he said.

"You're allowing the person to become part of the community without the stigma attached to [being in a] group home," he said. "It's their responsibility to maintain their tenancy and follow the terms of their lease."

Wireman coined the phrase "supportive accountability," in describing the value of the program. "We believe that a person with a mental health issue can be as accountable as anyone else for tenancy," he said. "All persons can grow extensively if it's done in a

supportive way."

Wireman, who is also a licensed social worker, doesn't provide case management for his tenants. He does, however, provide them with information about providers and licensed social workers in their community and allows them to make their own choices. "They choose the providers and services in their community," he said.

The program, which began about five years ago, receives community development funds, rather than just funds from mental health sources. Main Street Housing receives support from the Mental Health Hygiene Administration and from the state Department of Housing and Community Development, said Wireman. "We operate on a shoestring budget; we truly are a non-profit" entity," he said. •

For more information about Main Street Housing, Inc., visit www.onourownmd.org.

BRIEFLY NOTED**Alzheimer's Disease likely to strike 10 million "boomers"**

An estimated 10 million of America's "baby boomers" are likely to develop Alzheimer's Disease, according to a report released March 18 by the Alzheimer's Association. While as many as 5.2 million Americans currently have the disease, experts predict an accelerating rate of new cases, with nearly half a million new cases each year by 2010 and almost a million new cases each year by 2050. Alzheimer's is currently the seventh leading cause of death in the U.S. Harry Johns, president and CEO of the Alzheimer's Association, said that if progress is not made in altering the trajectory of the disease, the

consequences will be "staggering" for families, the economy and the long term care infrastructure. Johns said we must capitalize today on a "scientific landscape rich with possible disease-modifying treatments."

Study finds "normal" effect of race on face perception in schizophrenia

Individuals with schizophrenia, whether Caucasian or non-Caucasian, are better able to read emotional expressions in faces of persons of the same race, according to a study published online March 17 by the *American Journal of Psychiatry* (*AJP*). While this phenomenon is well established in healthy individuals, earlier research may have been biased in suggesting that non-Caucasians with schizophrenia had more difficulty with facial recognition than Caucasian patients. Lead

study author Amy Pinkham, Ph.D. and colleagues write that their findings could "provide valuable information about how (schizophrenia) manifests throughout development," with implications for early detection and intervention. Furthermore, the findings highlight the need to recognize racial diversity in treatment settings, said *AJP* Editor-in-Chief Robert Freedman, M.D.

STATE WATCH**Idaho likely to fund MH prison with bond revenue**

Idaho is likely to fund a new 300-bed mental health prison by selling \$70 million in bonds, following a unanimous vote by Idaho's Joint Finance-Appropriations Committee

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on March 11. The state is facing a \$38 million decline in fiscal year 2009 tax revenue due to recent federal tax breaks, requiring the project's funding to come from another source, the Idaho Business Review reported on March 12. Assured of Idaho's strong credit rating, Gov. Butch Otter has endorsed the bond proposal. Potential locations for the new facility are still under consideration, but will not include sites south of Boise and at the state hospital in Nampa, as once proposed.

RESOURCES

Reform Plans website allows stakeholders to compare MH policies

The World Health Congress announced on February 27 the launch of the Reform Plans website (www.ReformPlans.com) which allows stakeholders to compare presidential candidates' health care plans and policies, and facilitates discussion of the issues. The site also includes news, opinion and analysis "aimed at expanding and deepening the dialogue" around health care reform.

CALL FOR APPLICATIONS

The **Substance Abuse and Mental Health Services Administration (SAMHSA)** has issued a call for applications for FY 2008 National Child Traumatic Stress Initiative Community Treatment and Services Center Grants, to fund participation in a national network of intervention developers and service providers. SAMHSA expects about \$3 million in funding for up to seven grants for up to four years, at an estimated annual amount of up to \$400,000 year. Priority will be given to applicants in the Gulf Coast areas of Louisiana, Florida, Texas, Alabama and Mississippi that have provided services to those affected by Hurricane's Katrina and Rita. Apply online at www.grants.gov (No. SM-08-010) by April 29.

Coming up...

The **California Institute for Mental Health** will host the Eighth Annual California Information Management Conference, "Addressing the Needs of Mental Health, Alcohol and Other Drug Programs," on **April 9-10** in **Garden Grove, Calif.** For information, call (916) 922-0856 or visit www.cimh.org.

The **National Council on Disability (NCD)** will hold its next quarterly meeting on **April 21-23** in **Arlington, Va.** For more information, please contact Director of External Affairs, Mark S. Quigley, at mquigley@ncd.gov or at 202-272-2004, or visit www.ncd.gov.

The **National Council for Community Behavioral HealthCare (NCCBH)** is hosting its annual conference, "Simply the best, better than all the rest," on **May 1-3** in **Boston.** For more information, visit www.nccbh.org.

The **American Psychiatric Association (APA)** will hold its 161st annual meeting **May 3-8** in **Washington, DC.** For more information, visit www.psych.org/edu/ann_mtgs/am/o8/index.cfm.

For additional information, e-mail NCTSI@samhsa.hhs.gov.

NAMES IN THE NEWS

Ronald Manderscheid, Ph.D., Global Health Sector Director of Mental Health and Substance Use Programs for SRA International, Inc., has been appointed to Health and Human Services (HHS) Secretary Michael O. Leavitt's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Manderscheid will represent mental health and substance use interests on the committee.

Alan F. Schatzberg, M.D. has been voted president-elect of the American Psychiatric Association, effective following the group's annual meet-

ing May 3-8. Current president-elect Nada Stotland, M.D., M.P.H. will be elevated to president. Schatzberg will hold the post of president-elect for one year and then assume presidency in mid-2009. He is professor and chair of psychiatry and behavioral sciences at Stanford University School of Medicine.

David Shiel, LISW-CP and **Rhonda Faughender, LPC/S, NCC** have both been promoted within Palmetto Behavioral Health, a Charleston, South Carolina-based mental health provider offering services for mental illness and addictive diseases. Shiel has been promoted to clinical services director, from his previous position as executive director of adult services. Faughender has been named clinical manager, from her previous position as adult clinical program director.

In case you haven't heard...

Psychological counseling no longer requires interaction with another human. At least this is the premise of MindMentor, the first robot-psychologist created by Dutch clinical psychologists Jaap Hollander and Jeffrey Wijnberg. WebWire reported that English-speaking individuals around the world can log on to www.mindmentor.com and nearly half can expect to have their problems solved in just one session; a 2006 "test run" found that among 1600 clients, the success rate was 47 percent. One psychology professor reported that at the end of one hour-long session, his "outlook and spirits were lifted considerably." The MindMentor robot gets some help from his friends RoboRorschach (projective testing) and ProvoBot (provocative humor). Visit www.mindmentor.com.