



ACMHA News

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2009**

**Santa Fe
Summit
March 12-14**

Registration Now Open for the 13th Santa Fe Summit

2009 Summit to Focus on Behavioral Health in Health Care's Shift to a Health and Wellness Paradigm

This March, join your colleagues in Santa Fe to plan the transition from a "sick care system" to one grounded in health, wellness, prevention, and early intervention.

Despite the ailing economy, health care reform is in the air.

Just last week in his January 8th confirmation hearing, Secretary of Health and Human Services nominee Tom Daschle made clear that health and wellness will be guiding principles in the design of the Obama Administration's health reform package.

As behavioral health specialists, we have a critical role in making sure behavioral health is

central to health care reform and the health care system's shift to a focus on health and wellness.

What do we need to know and do to lead this transition? What have we already learned that can transform the American health care system into one that works for all?

At the 13th ACMHA Santa Fe Summit, we will address the changing health care environment and the new role of behavioral health in the health and wellness movement. In panel discussions and small work groups, we will examine critical aspects of the shift toward a health and wellness perspective, including:

- The case for behavioral

health in health and wellness,

- Peer-delivered best practices in self-directed care management approaches,
- The potential for eliminating health and behavioral health disparities,
- The transformative power of health information technology,
- Teaching integrated and client-centered care in medical schools, and
- Integrated health care models that facilitate a health and wellness focus.

To learn more and register for the 2009 Summit, please visit http://www.acmha.org/summit/summit_2009.cfm.

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Members to Vote on ACMHA's Proposed Name Change

Following 18 months of extensive consultations with the ACMHA membership, the Board of Directors unanimously recommends to the membership that the name of the College be changed to:

ACMHA: The College for Behavioral Health Leadership.

At the membership meeting in September 2008, the Board of Direc-

tors presented the name change for consideration, and there was consensus to move forward with an electronic vote of the membership.

The name change will take place if a majority of the College membership votes and if a majority of voting members support the name change.

The Board believes that a new name is

needed to better reflect our mission and vision for the next 30 years:

To be recognized as the premier forum for the exchange of new policy ideas that contribute to improvement in the lives of people with mental health and substance use conditions and the systems that provide treatment and prevention services.

Changing ACMHA's

name after nearly 30 years must not be undertaken lightly. After length discussions, the Board recommends this new name to communicate our mission and direction amidst the challenges of the 21st century.

ACMHA Executive Director Kris Ericson will send voting instructions to the membership later this week.

The Hiatus Between Policy and Practice in the Veteran's Affairs Response to PTSD

HG Whittington, MD, ACMHA Emeritus Member, Psychiatrist

It probably is true, as a French philosopher observed, that the only thing we learn from the study of history is that neither individuals nor nations learn anything from the study of history. Certainly, we seem to re-discover after every war that combat damages the human psyche and that recovery is neither easy nor certain.

And we also discover that nations, after spending enormous sums to fight a war, try to save money on the backend by depriving veterans and their families of the needed services to recover from the horrors of modern war, and that the favorite way to do that is to pretend that they are simply malingering in search of disability compensation.

We need only look at how long it has taken to accept the Gulf War Syndrome as a legitimate illness, and even longer to acknowledge the damage done by Agent Orange exposure, to not be surprised that our societal response to PTSD from the wars in Iraq and Afghanistan has been sluggish at best.

I went out of retirement in 2007 to work at the Phoenix Veterans Affairs Hospital because I wanted an opportunity to work with returning Iraq and Afghanistan veterans.

I had received my residency training largely at the VA in Topeka, dealing with residual psychiatric illness in World War II veterans; was myself deployed to Korea as a general medical officer in the United States Air Force (although just after the cease fire); and many years later worked in the VA Clinic in Lubbock, Texas with Vietnam Veterans.

I was the first psychiatrist assigned full time to work with the Iraq-Afghanistan veterans, who had been returning to Phoenix steadily for four years.

By the end of 2008, at the age of 79, I felt that I needed to cut down to half time, and gave notice three months in advance. When there was no discernable progress in finding a replacement for me, I felt that I would

be a co-conspirator if I agreed to spread myself even thinner, and so decided to retire. At the time I left the decision was to replace me with a Physician Assistant.

Under political and public opinion pressure, the armed services and the Veterans Administration had set up screening procedures, but the follow-through had been uneven and dependent on local conditions.

The program in Phoenix was fragmented and poorly coordinated, and often priorities did not mesh with clinical realities. For example, marital problems and divorce are rampant among the returning veteran population and yet there was only one part-time marriage counselor available; anger management is also a ubiquitous problem and there was only one group to address that problem directly.

Because of the biological components of PTSD, psychiatric services are clearly essential to deal with the profound sleep disturbances, flashbacks, aggressive behavior, and substance abuse. Phoenix VA was devoting the bulk of psychiatric and psychosocial services to Vietnam Veterans, over thirty years after that conflict ended.

Resources were wasted by such ventures as Arts and Crafts groups, which could easily be obtained at the Senior Citizen and Recreational Centers through the metropolitan area.

At any one time, over 10 psychiatrists dedicated their efforts to this population, while the acute needs of returning Iraq-Afghanistan veterans are unaddressed.

Most discouraging is that PTSD in the Iraq and Afghanistan vets is clearly treatable and, in the vast majority of cases, doing so would result in complete remission if an integrated bio-psycho-social approach were implemented under competent professional direction.

Instead, needed professional resources are still devoted to the treatment failures of the post-Vietnam era,

misallocated and dispersed because of the antiquated hierarchical and bureaucratic organization of the Phoenix VA, which results in a mélange of warring "land barons" each defending his own turf. It is sad when there are not enough resources to meet clinical needs; even sadder when resources exist but are dispersed by inefficient management and uninspired leadership.

The veterans of this all-voluntary military, many of whom are middle-aged men and young women with dependent children (from National Guard and Reserve units), deserve better.

Unlike draftee forces, they enter with a very low prevalence of psychiatric disorders and, until recently, individuals with antisocial conduct disorders were not accepted. They have thoroughly middle-class values, are patriotic and loyal; and importantly, they are not drunk or stoned most of the time when in combat zones, as most armies throughout history have been. Random drug testing is pursued with varying degrees of vigor, but continued drug use in theater is very likely to be detected. They are all high-school graduates, many with college credits, and wanting to be married, own a home, and have and raise children. These are not the alienated individuals that have made up armies throughout history. They are citizen soldiers, in the best sense of that word.

And they deserve better than we are giving them; they are capable of recovery and rehabilitation from the disabling effects of PTSD. The Veterans Affairs system has the resources to do this job, given motivation, leadership, and commitment.

I can only hope that the new administration will provide the vision and talent necessary to reshape and focus the efforts on this preventive effort, rather than waiting for them to become chronic and enmeshing them in learned helplessness and system dependence.

Update on the Whole Health Campaign

Eric Goplerud, PhD, ACMHA President

The Whole Health Campaign (WHC) is a collaboration of over 106 prominent national, state, and local mental health and addiction prevention, treatment, and recovery organizations working to make sure that the current healthcare debate includes both mind and body. The WHC was initially organized at the 2007 ACMHA Santa Fe Summit, and ACMHA members continue to be key participants in the group.

Through the WHC we have developed an active, collaborative organization made up of independent mental health and addiction prevention, treatment, and recovery leaders and organizations that act in concert to promote the principles of the WHC .

- Ensure equitable and adequate mental illness and addiction treatment coverage in all public and private health care plans.
- Support policies that promote individual and family recovery from mental illnesses and addictions as integral to overall health.
- Commit to investing in America's future through prevention, early intervention, and research on mental illnesses and addiction.

The work done by the WHC is unique in the history of behavioral health and has already led to several notable successes, including:

- Created a common platform on healthcare reform that the nation's leading mental health and addiction prevention, treatment, and recovery organizations endorse and vigorously support.
- Became a trusted and influential resource to the presidential candidates, the presidential campaigns, and the parties on mental illness and addiction prevention, treatment, and recovery.
- Secured planks in the Republican and Democratic Party Platforms that support the WHC's principles.

- Actively engaged the candidates, parties, and campaigns at rallies, debates, and meetings to raise awareness of the importance of addressing mental illness and addiction in their plans for healthcare reform and other domestic initiatives.

When President Obama is inaugurated on January 20, reform of the financing and delivery of healthcare in our nation will be a high priority. The WHC is working with the Obama transition team, members of Congress and their staffs, and organizations that will be influential in shaping the health reform agenda so that behavioral health is integral to any proposed solutions.

The WHC has provided the Obama transition team with the following recommendations:

Ensure that national health reform promotes individual and family recovery from mental illnesses and addictions as integral to overall health and wellbeing. This means that mental health, substance use, and primary health care services are fully integrated, and that mind and body issues are fully considered in the care of each person. This goal has multiple critical action steps. [Access the full report online for complete list.](#)

Improve public health structure and leadership. Behavioral health issues play a critical role in virtually all public health concerns from chronic and infectious disease prevention to emergency preparedness. The WHC strongly recommends that the development of a common leadership structure for public health must integrally include mental and substance use conditions.

Improve the public health workforce. The WHC recommends creation of a federal grant or loan repayment program for undergraduate and graduate students who commit to entering governmental public health. Such a program should apply to students in all sectors of public health,

including behavioral health. A certification system for the treatment of behavioral health patients is also key in providing effective treatment. Multi-specialty training, such as that involving mental health, substance use, and primary care providers, must be promoted.

Improve public health accountability. If public health is to be accountable, we will need to develop national public health effectiveness measures to assess the progress being made to improve national health and wellness. A detailed assessment of population surveys conducted by the US Department of Health and Human Services should be undertaken by an external panel of experts.

The WHC strongly recommends that the U.S. Department of Health and Human Services Secretary's Advisory Committee on Healthy People 2020 could be charged with establishing and overseeing this critical review.

The federal government should take the lead in producing guidelines for effective treatment of mental illnesses and addictions, and assure that they are applied consistently across the many government agencies and programs that provide or pay for behavioral health care.

Fund enhanced prevention and early intervention. A number of health experts have recommended the creation of a Wellness Trust to cover key clinical and community-based prevention and intervention services for all Americans. Community-level behavioral health interventions should be included and covered by the Wellness Trust.

You can learn more about the Whole Health Campaign and read Dr. Goplerud's full text from the ACMHA Electronic Library at:

http://www.acmha.org/library/current_events.cfm

Business Planning for Optimizing Recovery

Johnny W. Allem, MA, ACMHA Board Member

Rapidly emerging science, technology, and practice innovations hold great promise for individuals and institutions devoted to behavioral health. When these promises become reality, major benefits will accrue to people experiencing illnesses of the body and the mind as well as the general health of society.

Simply applying these new practices to old business models, however, is not likely to deliver either better outcomes or wider access to care. It behooves the professions dedicated to recovery-oriented systems of care to foster business model innovation.

The challenges are not hard to identify:

- Our business models were often created to provide acute care to people very advanced in illness.
- Our workforce is aging, undervalued, and poorly rewarded.
- Our attempts to manage from results and data are stifled because we often don't agree on what to measure and how to measure it.

Pressure for new results, accountability, and access will intensify as national parity legislation becomes effective, new practices become popular, and healthcare reforms are crafted.

It is imperative that we engage entrepreneurial solutions to meet these expectations and participate in a new era of health and wellness. ACMHA, the nation's leading organization for behavioral health managers and leaders, is the appropriate forum for focusing on the "how" of service delivery.

Business model innovation is not foreign to the traditional work of ACMHA. The current climate, however, calls for a sharper focus and deeper commitment.

It might take the form of a "**LEADING-EDGE INITIATIVE**," specifically advancing interest and coverage of leading-edge business models. This initiative could:

- Devote more presentation time to business model innovations that deliver evidence-based care and recovery support;
- Initiate awards and recognition of front line service delivery programs that pioneer new business models and practices; and
- Encourage news coverage and literature on examples from the frontier of business model development.

I believe that the behavioral health clinic of the future will deliver services of variable intensity, applied at early screenings as well as crisis interventions. The service menu will adjust to timely data over continuums measured in years.

My own view builds on the retail optometrist franchise, placing service availability in the neighborhood, with viable links to primary care. Such a retail unit could make the customer more involved and responsible for care and outcomes. Family and support networks could flourish.

Each retail unit would contain all required levels of professionalism, including psychosocial, counseling, resource referral and peer coaching. Space for group therapy and support meetings would help stimulate recovery building over time.

Reinvention should begin with the customer point of view, including practical application of information technology. The ability to replace clipboards and paper verification of insurance details and health histories in the doctor's office has long been available.

We could meet every patient – new or repeating – with touch screen data verification and entry that is more reliable and easier to recall. In fact, most restaurants and dry cleaners arguably manage real time data with more efficiency than our point of service healthcare venues.

Possibilities have never been brighter for improved outcomes and better health:

- We can intervene in earlier stages of illness when chances for recovery are higher and costs much lower.
- We understand that addressing co-occurring disorders simultaneously dramatically improves outcomes.
- We know recovery-oriented systems of care are superior to traditional care delivery tracks.
- We understand continuity of care through a variety of service levels and venues that assure stable and resilient recovery.
- We have access to new recovery supporting medications, plus improved treatment regimens.
- We value the inclusion of the individual and the family as partners in recovery planning and execution.

Among the relevant questions requiring research and innovation are:

- How to efficiently respond with brief interventions in early incidence of illness?
- What kind of business platform best delivers varying intensities of care for longer continuums of care?
- Can neighborhood franchise models be effective?

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ACMHA Interest Group Focuses on Research

Jennifer Magnabosco, PhD, Co-Facilitator, ACMHA Research Interest Group

A new Research Interest Group has been formed for ACMHA members to join. During the 2008 Summit, **Ron Manderscheid** and **Eric Goplerud** held an open meeting to discuss the possibility of establishing a group within ACMHA focused on mental health and substance abuse research.

Over 25 Summit attendees met and agreed that such a group could effectively support the professional and personal goals of ACMHA's members and its affiliates.

During the meeting four ACMHA members volunteered to co-facilitate the group's development with Ron Manderscheid and Eric Goplerud: **Deborah Altschul**, Research Psychologist, University of New Mexico's Center for Rural and Community Be-

havioral Health; **Jennifer Magnabosco**, Associate Director and Senior Research Associate, The Leavey Center for the Study of Los Angeles at Loyola Marymount University; **Maria Monroe-Devita**, Director of The Washington Institute for Mental Health, Research and Training at the University of Washington; and **Stephanie Oprendek**, Consultant, California Institute of Mental Health.

This core group decided that an initial survey was needed to formalize the group's membership and learn more about members' interests in research activities and their professional experiences. A web-based survey addressing this need was sent to all ACMHA members during Fall 2008.

This initial survey yielded a high response, with 45 ACMHA members completing it and joining the group. Result highlights from the initial survey are now available online at http://www.acmha.org/library/current_events.cfm.

Upcoming activities for the group include further analysis of survey results, calls to plan activities, and a meeting at the 2009 Summit. If you would like to join or have ideas about the group, please contact one of the co-facilitators or Ron Manderscheid at ronald.manderscheid@sra.com.

We look forward to making the group a meaningful and supportive activity for members and a resource that enhances ACMHA's capacity to more effectively integrate research into its endeavors!

Volunteer Photographers Wanted for Summit 2009

Are you a shutterbug? Do you salivate at the sight of an SLR camera? Do you have a dark room in your basement or the newest photo editing software for your desktop? Have you ever crashed your computer, downloading too many photos?

If you answered "yes" to any of the above, do we have an opportunity for you!

We are looking for ACMHA members to take photos of speakers and attendees during the 2009 Santa Fe Summit. If you are interested, please con-

tact ACMHA Executive Director Kris Ericson at executive.director@acmha.org. We gratefully welcome any and all help! With your keen eye and photo skills, you will be helping to make the 2009 Summit a memorable experience for everyone. Thank you!

Optimizing Recovery

(continued from previous page)

How can the industry attract, reward, and hold a new generation of professionals at varying levels of experience and skill?

What are effective ways of engaging and training recovery peers?

What incentives are required to encourage entrepreneurs and business model innovation? Does the behavioral health industry engage the best ratio of non-profit and for-profit suppliers? Can fee-for-service funding arrangements be crafted for "team" approaches to care?

What incentives are required to obtain long-term outcome data? What are appropriate accountability requirements?

How can customer engagement and responsibility be strengthened? How can care providers better respond to customer demands and viewpoints?

Society desperately needs the promises our science and technology offer. Leadership and management innovation is an appropriate province of ACMHA and a large part of our mission.

Every year that we speed the adaptation of our business models and service structures saves lives, money and community social capital.

As the Obama Administration tees up an era of change, we in ACMHA have a unique opportunity to contribute to systems change.

Individually, we bring the necessary skills, knowledge, and talent. Together, we will create a tomorrow of great promise, great prevention and great healing.

American College of Mental Health Administration



From Controversy to Consensus...

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About ACMHA

Founded in 1979, the American College of Mental Health Administration has 30 years of experience serving as the "brain trust" of the behavioral health field.

For more information,
please visit the ACMHA web site at
www.acmha.org.

Feedback Sought on *ACMHA News*

What do you want to see in *ACMHA News*?

This is the second issue of the ACMHA newsletter and we want to be sure you are getting the ACMHA

news you want and need.

Please email your comments, suggestions, and ideas to ACMHA Communications Committee Chair [Laurie Alexander](mailto:Laurie.Alexander@acmha.org). Thank you!

Last Chance: Member Survey Input

Thank you to everyone who has completed the 2008 ACMHA Member Survey. Your feedback aids the work of all ACMHA committees and the Board of Directors. Member input is key in crafting an appropriate strategic plan for the College and assuring

that we stay focused on our mission and vision.

Add your voice by completing the online survey at www.surveymonkey.com/s.aspx?sm=kwaRFZfV19ZwK30Awz8SJg_3d_3d no later than January 20!

Getting to Know the ACMHA Membership

Scott M. Craven, MBA, MSW
OptumHealth Behavioral Solutions

Tell us a little bit about yourself.

I am Vice President of Public Sector Services and External Development for OptumHealth Behavioral Solutions (formerly United Behavioral Health). My role is to represent clinical operations in new business development and work with external groups in identifying how we can respond best to the needs of consumers, families, and professionals in our public sector efforts.

What do you consider the most important trend in recent years?

The most important change is emerging in consumer and family empowerment, which shifts the power structure to one in which professionals facilitate and support recovery and resiliency as defined by the consumer and create solutions

for system change that are responsive to the needs of consumers and purchasers. This is a profound paradigm shift in which we, as professionals, can become servant leaders of change.

What urgent healthcare issues would you like to see the new Obama Administration tackle?

One priority needs to be financing and administrative simplification that supports and incentivizes integration of medical and behavioral care. We have wrestled with this split for too long, and one of our biggest barriers lies in siloed funding.

My personal perspective is that assuring universal coverage needs to be another priority. Individuals without healthcare coverage often avoid care until conditions worsen. The "uncompensated" cost of care is

ultimately born by all of us in higher premiums and higher taxes, along with poor health outcomes.

How can ACMHA and the behavioral health field in general support emerging leaders?

Today, the interrelationship between practice, administration, financing, research, and public policy require that effective behavioral health leaders be "multilingual." Our future depends upon individuals becoming competent not only in behavioral health, but also in business management, social and economic policy, research, and knowledge management.

ACMHA could help by identifying and promoting centers of excellence in which these skills can be found and by providing mentoring opportunities for emerging leaders.