

Call for Poster Presentations at Summit 2011

ACMHA invites proposals for a poster session at the 2011 Summit, March 16 – 18, in New Orleans.

Posters will present research activities related to the Summit's theme of disruptive behavioral health interventions.

Relevant topics include disruptive innovations in

leadership, health reform implementation, workforce issues, integrated service delivery, information technology, outcomes/performance measurement, disparities/cultural competence, evidence-based practice and policy, approaches to recovery-oriented care, consumer-operated services, private

and public partnerships, financing, and research methodologies.

The deadline for submission is December 15, 2010.

More information, including abstract requirements and submission instructions, is online at www.acmha.org/member_news.shtml.

Wanted: Learners and Mentors for Mentorship Program

ACMHA is seeking learners and mentors for its 2011 Emerging Leadership Mentoring Program.

Entering its fifth year, the mentorship program connects geographically dispersed mentors and learners from across the behavioral health field.

Mentor-learner dyads develop a learning contract and commit to meet

at least monthly by phone over the program year.

Dyads also participate in quarterly program-wide calls and meet in person at the ACMHA Summit.

There is no charge to participate.

Learners may include ACMHA members or non-members who are emerging leaders in the field.

Learners are paired with mentors who are distinguished leaders in behavioral health and are active in the College.

Applications are due December 15.

To learn more or to apply to be a learner or mentor, visit www.acmha.org/member_news.shtml.

Now Accepting Nominations for ACMHA Board Posts

ACMHA is taking nominations for the following positions on its Board of Directors:

- President-Elect,
- Treasurer,
- Secretary,
- Summit 2013 Chair,

- Leadership Committee Chair,
- Membership Committee Chair, and
- Member At Large (two positions).

Descriptions of the positions and their terms, as well as nomination instruc-

tions have been sent via listserv and can be obtained again from the office.

Nominations are due by December 17, 2010.

Please direct any questions to Jeannette Harrison (jet102@aol.com), Nominating Committee Chair.

Registration Opening Soon!

SUMMIT 2011

NEW ORLEANS

MARCH 16-18

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Summit 2011: What is a Disruptive Innovation and Why Should I Care?

Dale Jarvis, BA, CPA, Managing Consultant, MCPP Healthcare Consulting, Inc.

My first job in healthcare was at the Ann Arbor Free People's Clinic where I was hired in 1975 as the first financial manager with accounting experience.

As I began to learn about health-care financing, I was struck by how much money was flowing to hospitals and specialists and how little money was available for our clinic or other primary care clinics and prevention projects.

I marvel at the notion that 35 years later we still have what can be described as a *sick care* system (in contrast to a true *health care* system).

My accounting professors and Deep Throat (in Bob Woodward's account of Watergate) weren't alone in their advice to "follow the money." Large quantities of money flow *after* we become sick - to hospitals, emergency rooms, surgeons, and other specialists that treat the consequences of poor lifestyles, social disparities, and unmanaged chronic health conditions.

Only three percent of health care dollars are spent on prevention. Most primary care practices are "loss leaders" in multi-specialty groups. And mental health and substance use services in most states and private health plans are dramatically underfunded.

Picture this *sick care* system as an upside-down triangle with two sections. The wide, upper portion of the triangle represents the 75 percent of American healthcare spending related to the treatment of chronic health conditions. The bottom, small, pointy part of the triangle represents all care provided further upstream – primary, secondary and tertiary prevention services; primary care; dental care; recovery-oriented behavioral healthcare, etc.

In order to move to a true *health care* system we need to *flip the resource triangle* and direct substantially more resources to prevention and early intervention services and supports.

Only by flipping the resource triangle will we be able to address the underlying determinants of health, prevent health conditions from becoming chronic health conditions, and dramatically improve the management of chronic health conditions and serious behavioral health disorders.

What a nice sound bite! My 30-plus-year effort to flip the resource triangle was starting to feel like the 800-plus-year search for the Holy Grail – until I stumbled across a book in early 2009 by a Harvard business

They suggest in *The Innovator's Prescription: A Disruptive Solution for Health Care* (2009) that problems facing the American health care system mirror nearly every other industry in its early phases.

Products and services in new industries "are so complicated and expensive that only people with a lot of money can afford them and only people with a lot of expertise can provide or use them" (*Innovator's Prescription*, 2009).

Historically, this phase has been followed by the advent of new methods of production and distribution that disrupt the status quo and result in goods or services that are more affordable and widely available to the general public.

Often the *disruptive innovator* companies become the new market leaders, replacing the old guard.

A classic example is the evolution of the computer industry. Mainframe computers costing millions of dollars and requiring legions of employees to operate were replaced by minicomputers from companies such as Digital Equipment Corporation (DEC).

This allowed midsized companies to gain access to computing power at a much lower cost.

Harnessing Disruptive Innovations to Thrive in the Age of Health Reform

Summit 2011
March 16-18
New Orleans, LA

Registration opens soon!

More information online at
[http://acmha.org/
summit_agenda.shtml](http://acmha.org/summit_agenda.shtml)

professor, Clayton Christensen, and two physicians, Jerome Grossman and Jason Hwang.

The Innovator's Prescription: A Disruptive Solution for Health Care

In the mid-1990s, Christensen coined the term *disruptive technology*, which later morphed into *disruptive innovation*. His initial work was based on a change process that has dramatically disrupted the status quo in industries that produce goods and services such as computers, software, automobiles, airplane travel, and books.

About five years ago Christensen, with the help of colleagues Grossman and Hwang, began focusing on health care.

Read more online at:

[http://www.acmha.org/
content/
summit/2011/Jarvis
Disruptive_Innovatons_111510.pdf](http://www.acmha.org/content/summit/2011/Jarvis_Disruptive_Innovatons_111510.pdf)

Additional information about
Summit 2011: Harnessing Disruptive
Innovation to Thrive in the Era of Health
Reform is online at: [http://acmha.org/
summit_agenda.shtml](http://acmha.org/summit_agenda.shtml)

Nominate Your Colleagues for ACMHA Annual Awards

ACMHA is currently accepting nominations for its four annual awards.

The Timothy J. Coakley Behavioral Health Leadership Award honors consumer and family members' leadership.

The King Davis Award recognizes emerging leaders impacting access to and quality of care for populations of color.

The Walter Barton Distinguished Fellow Award recognizes outstanding contributions to the College.

And the Saul Feldman honors significant lifetime contributions to the field.

Award criteria, nomination form, and submission instructions are online at www.acmha.org.

All but the Barton Award are open to both members and non-members. The nomination deadline is January 14, 2011. The awards will be presented at the 2011 ACMHA Summit in New Orleans. For more information contact [Kris Ericson](mailto:Kris.Ericson), executive director.

Peer Leader Interest Group Forming

Deborah Fickling, Behavioral Health Ombudsman, Medical Assistance Division, NM Human Services Department

During the September All-Member Call ACMHA announced the formation of the Peer Leader Interest Group.

For me, some qualities of peer leaders include the following:

- They are passionate about recovery, reducing prejudice and discrimination, and transforming mental health and substance use care so that all service provision is truly person-centered;
- They show promise for leadership in mental health and sub-

stance use systems and wish to enhance their knowledge through dialogue and interaction;

- They have the ability to work effectively with the diverse constituencies that make up the behavioral health community;
- They are able to make recommendations that will positively influence the future of the field; and
- They do not set out to be

leaders, but become them by the quality of their actions and the integrity of their intent.

Have more ideas? Know any peer leaders who fit this description?

If you are interested in contributing to the group's evolution or would just like to know more about it, please contact me by phone (505-827-6250) or email deborah.fickling@state.nm.us

ACMHA Groups Hold Recovery-Oriented Leadership Webinar

Richard Van Horn, MDiv, President Emeritus, MHA of Los Angeles and ACMHA Mentorship Program Co-Facilitator

On November 8, members of the Emerging Leader Interest Group and the 2010 Mentorship Class joined together to consider the impact of leadership models on the "recovery vision."

The presentation was led by Dave Pilon, President and CEO, Mental Health America of Los Angeles; Bruce Anderson, Principal, Community Activators; and Sharon Kuehn, Executive Director, The California Network of Mental Health Clients.

The webinar focused on ways leaders can make their systems recovery-oriented.

Dave and Bruce frequently lead workshops on this topic. Their efforts

grew out of their experience as line staff exposed to recovery through various training experiences, especially the Immersion experience at the MHA Village, only to find that that management tends to be either unaware or resistant to recovery orientations.

The problem line staff often confronts is that leadership is focused on reimbursement of services, and many recovery-oriented activities are not reimbursable despite their potential for saving money and pain in the long run.

There is also the lingering view of mental illnesses as chronic, with the

only possible goal being mitigation of symptoms and continued maintenance care.

As numerous integrated service programs, client-run services, and psychosocial programs have attested over the past two decades, recovery is a real option and orienting leadership to this fact is of paramount importance.

The webinar gave our Emerging Leader Interest Group and Mentorship Class participants a good introduction to the issues and potential of training leaders in the recovery model.

Membership Campaign Underway, Receive a \$200 Summit Discount

Now is a great time to invite colleagues who are leaders in mental health and substance use policy, administration, research, and service delivery to join ACMHA.

Membership benefits include:

- Reduced Summit registration,
- Member-only teleconferences and webinars on critical issues,
- The Emerging Leadership Mentorship Program, plus ACMHA committees and interest groups,
- BYOCC (Bring Your Own

Credit Card) events hosted by ACMHA colleagues,

- Access to National Council and Magellan Health Services webinars,
- Free subscription to *Behavioral Healthcare*, and discounted rates for *Mental Health Weekly* and *Alcohol & Drug Abuse Weekly*, and much more!

Your recommendations are valuable in recruiting new members to the College.

You can refer new members by logging onto the *Members Only* page on the ACMHA web site and selecting the link to "Invite a Colleague to Join."

Your colleague will be sent a special invitation with instructions on how to apply for membership.

If you recommend four or more people who apply and are approved as members by February 1, 2011, you will receive a \$200 reduction in your 2011 Summit registration fee.

Invite a colleague today!

2010 Honor Roll of ACMHA Donors

ACMHA is grateful for the financial contributions of individuals and organizations to support the College's work.

Member dues and registration fees cover only half of ACMHA's operational budget. Supporting members and organizations help fill the gap and grow the College.

ACMHA extends deepest thanks to its 2010 supporters.

Supporting members:

- Laurie Alexander,
- Deborah Altschul,
- Keith Cherry,
- Colette Croze,
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Supporting organizations:

- Abt Associates,
- Anasazi Software,
- Deloitte Consulting,
- InfoMC,
- Magellan Behavioral Health,
- OptumHealth,
- SAMHSA,
- ValueOptions, and
- Westat.

ACMHA makes every effort to ensure this list's accuracy. Please notify us if we did not acknowledge your contribution!

Critical Issue Series Continues, Archive Developed

ACMHA's webinar series on health reform continues December 8 with a presentation on health insurance exchanges by Joel Ario, US Department of Health and Human Services.

The 12-month series is hosted by President-Elect Ron Manderscheid and

focuses on health reform and its implications for behavioral health.

Sponsored by the Substance Abuse and Mental Health Services Administration the series is free and open to all.

Sessions are archived at

www.acmha.org/current_events_critical_issues.shtml. Future topics and registration for each session is also available online.

Questions may be directed to [Kris Ericson \(kris.ericson@acmha.org\)](mailto:kris.ericson@acmha.org).

Using Technology to Deliver Substance Use Treatment and Recovery Support

Mike Boyle, Retired President/CEO, Fayette Companies

The behavioral health field needs to embrace and utilize new technologies if our future is to be vibrant. The use of technology within behavioral health has predominately been limited to administrative functions such as service reporting and billing procedures or adopting electronic medical records.

Virtually all treatment is delivered face-to-face by practitioners. In behavioral health care organizations, labor costs typically account for the vast majority of total expenses.

In contrast, the labor is less than 10 percent of the production costs of a Toyota vehicle due to the high use of technology in their plants.

I propose that we need to bring technology into the delivery of treatment and recovery support services.

While I will focus on substance use treatment in my examples, I believe they apply equally to mental health. Using technologies delivered through web-based application, stand alone computer software, or smart phones are all components of a new approach termed E-Health.

Let me provide a few examples currently in use to address substance use illnesses.

First, several NIDA-funded studies have demonstrated that evidence-

based clinical treatments can be delivered through computerized applications.

These studies have shown outcomes that are equal or superior to the same treatment delivered solely by clinicians. Review of three of these studies can be found in NIDA Notes, Vol. 22, No. 5 (http://www.nida.nih.gov/NIDA_notes/NNvol22N5/Computer.html). More such computerized approaches and studies can be expected in the near future.

A University of Wisconsin NIAAA-funded study using smart phones for recovery support following residential treatment is currently underway within my former organization, Fayette Companies.

Services provided through the phones include a discussion board with other participants, information on a variety of recovery related topics, a panic button to request immediate assistance from self-identified supportive persons when at high risk for drinking, notification of activities in the community that provide healthy and enjoyable alternatives to drinking, and maps and information for mutual aid meetings.

Another interesting feature is a GPS tool that serves as an automated rescue function when someone approaches an identified high risk location such a bar where they previously drank with their friends.

In January 2011, a new generation of phones will be introduced that will allow face-to-face services through web conferencing.

While study recruitment only began in February, preliminary results for persons completing the first follow-up are very positive.

The intervention includes a weekly survey on recovery protection and risk factors developed by researchers at the University of Pennsylvania.

This survey is delivered and completed through the phones.

It appears from comparing changes on the weekly scores with reports of relapse that changes within the domains surveyed may indicate increased risk for return to drinking.

Full text and additional Arm Chair Reflections are online at:

http://www.acmha.org/current_events_arm_chair_reflections.shtml

This piece originally ran as a "From the Field" article in Alcohol and Drug Abuse Weekly.

Magellan/ACMHA Webinars Reach Hundreds

ACMHA has just completed a year-long webinar series in conjunction with Magellan Health Services. The final session – Recovery Coaches and Peer Wellness – was offered in November.

"Through these forums, we engaged the public sector behavioral health community in the discussion of treatment trends and research, health care policies and strategies," said Tom Lane, Magellan's national director, con-

sumer and recovery services.

ACMHA's partnership with Magellan supports the College's commitment to facilitating an exchange of ideas to help improve the lives of people with mental health and substance use disorders and the systems that provide treatment services.

The breadth of topics offered during the course of the year allowed ACMHA and Magellan to reach a vari-

ety of stakeholder groups in the behavioral health community.

Magellan has archived the webinars and made them available at <http://www.magellanhealth.com/training>.

The College looks forward to future collaborations with Magellan Health Services.

Tomorrow's Success Depends on our Greatest Asset: Our Workers

Michael T. Flaherty, PhD, Institute for Research, Education and Training in the Addictions and Northeast Addiction Technology Transfer Center, Pittsburgh; and Member, Board of Directors, The Annapolis Coalition;
John A Morris, MSW, The Annapolis Coalition and The Technical Assistance Collaborative, Inc.

Here is the dilemma: health care, predominantly a service industry, today takes up 16% of our GDP (Organization for Economic Cooperation and Development, 2010) and we can't really expand that percentage much without hurting our international competitiveness—or so we are told and believe. We are therefore in a conundrum.

In behavioral care today, only about 20% of those needing care receive it. As parity and healthcare reform advance, we will likely increase the opportunity for more Americans to access specialty behavioral care by both improving access overall and earlier recognition of problems that are then prevented from reaching specialty or acute care.

The dilemma: increased specialty access coupled with earlier recognition and increased prevention, but no significant increase in health care spending or costs. How can we do this?

Over the past months, many exceptionally qualified individuals have reflected on this in earlier ACMHA Arm Chair Reflections. Again and again, experienced practitioners and leaders all point to one common element that will make or break everything as we move forward: the skills and competencies of our workers, peers to highest-degreed professionals.

In May 2009, Richard Beinecke, DPA, underscored the need for developing leaders and leadership competencies for behavioral health to meet the new day (Beinecke, 2009).

In January 2009, Leighton Huey, MD, a colleague on the Annapolis Coalition, described the trained and educated worker as "ground zero" of reform (Huey, 2009). He also pronounced something we all need to

hear again: "Reforming the system and how its workforce functions clearly involves complex challenges that will take decades to achieve."

Those of us who practice in the substance use and mental health field know that "health care reform" cannot be so rapid that we lose the specialty understanding and clinical skills gained—at times very painfully—over the years.

Indeed, according to SAMHSA, all specialty providers should be co-occurring capable (Center for Substance Abuse Treatment, 2005) and that is clearly not the case today.

Additionally, we must insure that the earlier interventions and the care provided by non-specialty providers (e.g., medical homes, federally qualified health centers) truly understand care of serious and persistent mental illness and the nature of addiction.

Recently, in a presentation at a prestigious conference on drug dependency, a group of primary care providers challenged this author by publicly asking, "You behaviorists all torture your patients. Why not just give them the medication and let them go home?" My presentation was on risk management in methadone treatment.

Study after study confirms similar perceptions in primary care of recurrent depression, anxiety, OCD, ADHD, and many other illnesses. What we need here is a "parity in understanding" of behavioral healthcare and medical care, lest the solution—laudable as it may be—becomes part of the next problem.

Our safest and best solution to the apparent conundrum is our worker, our workforce.

The longstanding deterioration of our behavioral health workforce has been well documented by numerous

entities, including the Institute of Medicine (2001, 2003, 2006), Abt Associates (2006), Annapolis Coalition (2007), Addiction Technology Transfer Center National Office (Murphy and Hubbard, 2009), and most recently SAMHSA with its Description of a Modern Addictions and Mental Health Service System (2010) and draft Strategic Plan for 2011-2014 (October, 2010).

As the deterioration continues, there is a simultaneous expansion in the complexity of the knowledge base and practice environment: proven evidence-based practices; new medications; electronic records; case or care management coordination; the need to link and engage individuals, families and communities in care; de-institutionalization with new models and less structure; recovery linkages and supports...the list is virtually never-ending.

Even our understanding of certain illnesses is radically changing. For example, addictions are increasingly accepted as being more chronic than acute in nature, more often needing continuing care.

We now know that trauma trumps all else if we are to abate the growing suicide problem in America, not to mention what we are learning about the role of trauma in the criminal justice population and the increased awareness of the impact of extended deployments on military members and their families, in many cases complicated by new understandings of the previously undetected effects of head injury.

Full text and additional Arm Chair Reflections are online at:

[http://www.acmha.org/
current_events/arm_chair_reflections.
shtml](http://www.acmha.org/current_events/arm_chair_reflections.shtml)

Where Do We Go From Here? Defining Policy Priorities Post-Parity

Saul Feldman, DPA, Chairman Emeritus, United Behavioral Health

After a long and consuming search, we have achieved parity, the behavioral health equivalent of the Holy Grail.

A great and very welcome accomplishment for sure, but where to from here? What next for behavioral health policy? Is there now or is there likely to be again so dominant an issue in behavioral health, one that can once again unify the too frequent dissonance between behavioral professionals, advocacy groups, etc.?

While the quest for parity was undoubtedly and appropriately the dominant issue in behavioral health, one on which so many of us worked so long and so hard, it may also have had an unintended negative effect – too little attention paid to what may be the other important policy issues that deserve our attention.

What are and/or should these be? How and by whom should they be identified, defined, prioritized, and communicated to those with responsibility to fund and provide behavioral health services?

It seems to me that there does not now exist a mechanism, a non-government entity with sufficient credibility and expertise to take all of this on.

I think that ACMHA could well play a leading role here, as a sponsor of something that could be called a Council on Behavioral Health Policy.

It would be similar to but of course on a much smaller scale than the Council on Foreign Relations, for example, a vehicle that has been so helpful in influencing the shaping of this country's foreign relations policies.

Such a council would consist of the most highly respected and well-regarded people in the behavioral health field, with the experience and wisdom to serve on a deliberative body

that could have several basic functions as follows:

1. To discuss and describe what the council believes to be the major policy issues in behavioral health going forward and how these might be addressed;
2. To assign priorities to these issues by virtue of their relative importance;
3. To make policy recommendations to federal, state, and local government behavioral health entities as well as to the major professional associations and advocacy groups; and
4. As appropriate, to provide consultation to those entities as they consider and seek to implement those recommendations from the council that they deem to be worthy of their consideration.

Integration is among the policy issues that I consider to be very important but not what has become the conventional and by now tiresome use of the term, i.e., the integration of behavioral and medical care. I can think of no other single issue that has been getting more attention in the behavioral health field than has this one.

While such integration is clearly important, it seems to me it is serving as a "Convenient Truth," not consciously so, to distract our attention away from the significant, difficult to resolve, and long-standing integration issues within our own field.

Is not the relative neglect of these behavioral health integration issues at least as damaging to good patient care as the behavioral/medical integration problems?

Our behavioral health integration issues include the continuing gaps between inpatient and outpatient care, the separation both in training and service of substance use and mental health ser-

vices, the rivalry and competition between behavioral health providers from different disciplines - trained in different places with different curricula, familiar with the research, etc., published in their own professional journals but not those of the other disciplines, etc., etc.

And what about the too great distance of behavioral health from the other human services? In my judgment, too little attention is being paid to these issues, ones that we may be able to do something about, and too much to medical-behavioral integration about which we can potentially do much less.

Another major issue that has been addressed from time to time by such as the Annapolis Coalition and others is the quality of the behavioral health workforce itself.

I have written about this elsewhere, about the proposals and recommendations from various highly respected commissions about this issue that go back for many years and have for the most part had only a slight, if any, impact on the way the behavioral health workforce is trained – in separate enclaves, with teaching methods that are not always current, with little if any interdisciplinary training, and with inattention to the changes around them, including the increased importance of consumers in treatment decisions and other societal changes.

Full text and additional Arm Chair Reflections are online at:

[http://www.acmha.org/
current_events_arm_chair_reflections.
shtml](http://www.acmha.org/current_events_arm_chair_reflections.shtml)

ACMHA Member News

Janice Cooper Heads Up Liberian Mental Health Department

This fall Janice L. Cooper, PhD, left her position as interim director of the National Center for Children in Poverty to take on a challenging new job - Country Director for Mental Health for the Republic of Liberia.

As a Carter Center employee, she will serve five years as the country's mental health lead, with the goal of turning over leadership to the Liberian government at the end of her tenure.



Janice Cooper, PhD, in Monrovia, Liberia

How did this exciting position come about?

Of course, it was an ACMHA connection that started it. Thom Bornemann [of the Carter Center] and I

facilitated a session at an ACMHA Summit and have been friends ever since.

I am a native of Liberia. Prior to this project, I had not been home in 16 years.

What are your top priorities?

We have launched a three-pronged strategy to increase mental health capacity in the country.

The first is support of the government's implementation of a national mental health policy.

The second is the creation of a post-basic specialty mental health program for registered nurses and physician assistants. Former ACMHA President Gail Stuart is the lead psychiatric nursing consultant on the program.

We will also help the Ministry of Health and Social Welfare address the integration of psychosocial workers into the mental health workforce.

The final component is an advocacy, stigma reduction, and family support arm.

Here, we are working on education and communication strategies; supporting families and enhancing natural supports; and developing community leadership in support of mental health promotion, prevention and treatment.

Remembering ACMHA Founding

Member Tony Broskowski

ACMHA founding member Tony Broskowski passed away unexpectedly on October 3 at the age of 69.



Tony Broskowski (left), Mary Jane England, and H.G. Whittington at the 1990 ACMHA Summit

Tony was a pioneer in management information systems/managed behavioral health systems, and a beloved colleague and mentor to many in behavioral health.

ACMHA members shared many fond remembrances of Tony on the ACMHA listserv. He will be missed!

New Members Elected to College

The Board of Directors and Membership Committee would like to extend a warm welcome to ACMHA's newest members, each of whom brings talent and commitment to the College!

- **Bill Belzner**, MA, MHHS, Director of Behavioral Health, Presbyterian Medical Services, NM;
- **Marianne Burdison**, Director, Business Development, Centpatico Behavioral Health, LLC, TX;
- **Cynthia Campbell**, Manager, Business Development, Centpatico Behavioral Health, LLC, TX;
- **Stan W Granberry**, PhD, Executive Director, National Behavioral Consortium, LA;
- **Dale Klitzker**, MSW, PhD, Presi-

dent & CEO, The Providence Center, RI;

- **James W. Kuemmerle**, ACSW, LCSW, Executive Director, Armstrong/Indiana MH/MR/EI Program, PA;
- **Sue Martone**, Assistant Deputy Director, Allegheny County, Dept. of Human Services, Office of Behavioral Health, PA;
- **David L. Moulthrop**, President/CEO, Rogers Behavioral Health System, Inc, WI;
- **Elizabeth M. Pace**, MSM, RN, CEAP, Chief Executive Officer, Peer Assistance Services, CO; and
- **Tony Rothschild**, President & CEO, Common Ground, MI.

It's Good to Share

Do you have some news that you would like to share with the ACMHA membership?

The Member News section of the ACMHA newsletter features short pieces on members' current or recent projects, awards, appointments, and more.

Too modest to report your own accomplishments, why not submit a colleague's?

Please email your members news items to Communications Committee Chair Laurie Alexander at laurie.alexander09@gmail.com

Taking the Very First Steps in Health Reform

Ron Manderscheid, PhD, Executive Director, NACBHDD

With national health reform (i.e., the Accountable Care Act, or ACA) underway, I have been asked to provide a brief summary of the Coalition for Whole Health's activities, recent health reform implementation highlights, and key resources for staying informed.

In June, by unanimous consent, the Whole Health Campaign and the Coalition for Whole Health combined into a single entity under the latter name.

The coalition represents over 110 national and state mental health and substance use organizations. The Coalition is co-chaired by Paul Samuels from the Legal Action Center and me.

Participating organizations agreed to monitor reform regulatory developments and provide formal comments on draft regulations.

Thus far, the coalition has provided comments on proposed regulations for grandfathered health plans, prevention, and health insurance exchanges.

It has also monitored the formal comments provided by other entities

(e.g., the Coalition on Disability) and has encouraged members to sign on to other entities' comments.

Finally, the coalition has formed a criminal justice work group to investigate how persons with behavioral health conditions in such settings can receive appropriate care under the ACA.

Simultaneously, HHS has been busy rolling out the reform implementation process in the field. Numerous activities have been undertaken at a rapid pace, including:

- The creation of consumer information exchanges in every state,
- The awarding of an initial round of state health insurance exchange planning grants, and
- The distribution of funds to Medicare beneficiaries enrolled in Part D to close the donut hole.

With so much occurring at such a rapid pace, it is difficult to stay apace.

NACBHDD issues a biweekly single-page e-update called *Headline DC* for

members. SAMHSA is about to start issuing single-page documents for key stakeholder groups.

Other helpful sources include the Alliance on Health Reform's monthly archived seminars, the Foundation Center's PubHub Alerts, and federal reports from entities like the Congressional Budget Office.

A new online version of the Federal Register (www.federalregister.gov) has a health and public welfare section with opportunities for comment on forthcoming regulations, and George Washington University has a new website (www.healthreformgps.org) to provide information updates.

I also recommend strongly ACMHA's Critical Issue Series, which is archived online.

These developments are very energizing. I hope that you share this energy as well.

Mental Health and Development at Home and Abroad

Richard Dougherty, PhD, President, BasicNeeds US and DMA Health Strategies

In September I attended the World Health Organization's release of *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group*, a key report on the need for mental health in development assistance for resource-poor countries.

The report summarizes the research on people with mental illnesses as a highly vulnerable population with significant social cost if their conditions go untreated, but notes that they are often ignored in development efforts.

Sound familiar? We hear the same refrain here when we talk about health reform, job training or housing assistance. A worthy goal? Absolutely. However let's not export our current mental health system to developing countries. That is not possible or even desirable.

What does a mental health system

do with only two psychiatrists for every million people? Or if they have only six drugs and an inconsistent supply?

The answer to both is not to bring in evidence-based depression interventions or recommend expanded formularies. The low-resource setting must focus first on building personal and community capacity, developing jobs, and partnering with the health system to provide access to medications and treatment.

Self-help, community capacity, and national advocacy for resources and effective policies are at the heart of a development model for mental health.

At BasicNeeds, we believe that this is the only way to create a system on the scale needed for resource-poor settings. We have proven it through our efforts in nine countries serving over 37,000 people and families last year.

This reflects the same kinds of goals set out for the transformation of the US public mental health system. Securing homes and jobs for consumers requires development strategies, not treatment.

But, overall, the primary model for our public mental health system continues to be individualized and treatment- and symptom-driven.

In the era of parity and expanded coverage, a strength-based, capacity-building paradigm is needed for our public funding.

Perhaps a human and community development model can provide a framework for reshaping the behavioral health system.

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Members Invited to Submit "From the Field" Pieces

The editors of *Mental Health Weekly* and *Alcohol and Drug Abuse Weekly* invite ACMHA members to submit "From the Field" pieces for publication.

"From the Field" articles are 650- to 700-word essays about an issue of importance in the field. ACMHA members Mike Boyle (see p. 5 *this issue*), Harvey Rosenthal, and Ron Manderscheid have had submissions included during the last quarter.

ACMHA distributes these published pieces to its membership and posts them online as Arm Chair Reflections at http://acmha.org/current_events_arm_chair_reflections.shtml

Do you have some thoughts you'd like to share with the field?

Individuals interested in submitting an article should contact Kris Ericson at executive.director@acmha.org.

Getting to Know the ACMHA Membership

Andy Sekel, PhD, Chief Executive Officer, OptumHealth Behavioral Solutions

Tell us about your new role as CEO of OptumHealth Behavioral Solutions.

I'm really excited to be at OptumHealth during this unique time of change and possibility.

Today, our goals are to help support the transformation of behavioral health care – to work with consumers, providers, and, of course, our customers to improve the ways we help people pursue wellness and recovery.

As CEO I see my primary responsibility as connecting our organizational priorities to the needs of our many stakeholders.

This involves reviewing the way we work with providers and finding new ways to be an asset to them and their practice.

It also includes ensuring that we are continually driving evidence-based practices to maximize quality, including peer support for people with chronic conditions and technology that supports medical-behavioral integration.

I came to this job after leading the OptumHealth Behavioral Solution Pub-

lic Sector business for three years.

Prior to that, I had a diverse career teaching at higher education institutions, working at university counseling centers, and founding and managing a regional managed behavioral health organization and provider group that served both public and private sector consumers.

How do you see the behavioral health field changing in the next year?

I think federal mental health parity will continue to affect all of us – consumers, providers, and companies like OptumHealth.

Pressure on access will also continue, especially for people on Medicaid, where the need for services far outweighs the supply.

In fact, I predict access problems are going to get far worse until, collectively, we find new ways of expanding services.

That's something we're heavily focused on here at OptumHealth, investing in solutions like expanded telepsychiatry and additional innova-

tive online services.

I remain confident that we will be better able to support people holistically, with models like the health care home and integrated chronic care management taking root.

What advice would you give other ACMHA members on being an effective leader in the behavioral health industry?

The work we do has a tremendous impact on people. Remembering that and focusing on the values that first brought us to this work has always been number one for me.

Given how important the work is, I believe it's critical for new leaders to bring as much curiosity, creativity and compassion to it as they can every day.

But we must also remain relentlessly focused on discipline and execution.

Our compassion and ideas can only have a lasting impact when they are effectively tested, implemented and evaluated.