

# MENTAL HEALTH WEEKLY

Essential information for decision-makers

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## HIGHLIGHTS...

**Behavioral health leaders and consumers convened in New Mexico** last week for the **ACMHA annual Santa Fe Summit** to discuss the **integration of behavioral health services and primary health care**. Various sessions addressed **improving integrated health care, exploring the government's role in providing mental health services** as well as **changing relationships and reimbursement issues**. *See story, top of this page.*

The **Robert Wood Johnson Foundation** recently released its **report on the integration of primary care and behavioral health**. More than **13 initiatives profiled** in the report are **conducting successful integrations of primary care and behavioral health for public-sector populations**. *See story, bottom of this page.*

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## Exclusive Conference Report: ACMHA Santa Fe Summit

### Annual summit addresses integration of behavioral and physical health care

The American College of Mental Health Administration (ACMHA) last week convened its annual Santa Fe Summit, attracting about 160 behavioral health leaders and consumers for a round of discussions on integrating behavioral and physical health care.

This year's conference builds on the last three themes of previous ACMHA summits, Gail P. Hutchings, MPA, president and chief executive of Behavioral Health Policy Collaborative and chair of the ACMHA Summit Planning Committee, told summit attendees. She cited the 2004 summit, "Regaining Relevance: Reinventing Behavioral Health," to 2005, "Tracking the Transformation,"

to the 2006 summit, "Cross-System Collaboration: Catalyst for Transforming Behavioral Health."

The 2007 conference theme was titled "Mind and Body Reunited: Perspectives on the Integration of Behavioral and Physical Health-care." Summit attendees had an opportunity to branch out into smaller work groups to address whether or not integration is what is needed to improve health and behavioral health outcomes for consumers.

The conference, with its focus on integrating behavioral and physical health care, was kicked off by David Satcher, M.D., Ph.D., former U.S. Surgeon General and Assistant

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### New analysis of integrated care projects indicates more than one path to success

Those leaders who may be contemplating initiatives to integrate publicly funded physical and behavioral health services could be disappointed if they expect the latest analysis of such projects to offer definitive conclusions on the best way to achieve integration.

The analysis, conducted by consulting firm Health Management Associates and originally commissioned by the Robert Wood Johnson Foundation, deliberately examines a diversity of paths to integration, concluding that the type of structure being implemented is much less important than whether that structure matches the goals that implementers are trying to achieve.

"The main point is that integration does not belong to mental health

agencies as their baby, or to primary care agencies as their baby," Alicia Smith, co-author of *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives*, told *MHW*. "The important point is, 'What does an implementation need to look like for its goals to be accomplished?'"

Smith, a senior consultant with Health Management Associates, presented highlights of the final report, released in February, to attendees of last week's Santa Fe Summit held by the American College of Mental Health Administration (ACMHA). The Robert Wood Johnson Foundation originally was interested in examining efforts to integrate general medical and substance abuse services, but

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Secretary for Health. Satcher is currently director of the National Center for Primary Care at the Morehouse School of Medicine.

"We spend more money on health care than any country in the world," said Satcher during his opening remarks. It's approaching \$2 trillion dollars. Meanwhile, there are about 47 million uninsured in this country, he said. "The front line people are growing increasingly frustrated," Satcher noted.

The last few years have seen a decline in people going into the primary care system, he said. "We need qualified primary care providers," Satcher said. "We need to integrate primary care and mental health."

The term primary care was first used during the 1960s, he noted. Primary care is defined as continuous coordinated care servicing as patients' medical home with record-keeping, consultation and referral as needed, he noted.

The definition of mental health is defined as the successful performance of mental function, resulting in productive activity, fulfilling relations with others and the ability to adapt to change in our lives and successfully cope with adversity, he said.

"We have a lot of change to adapt to in our lives and environment — we have a lot to cope with," he said. "Mental health is not some-

thing to take for granted; there is a continuum between mental health and mental illness," he explained. A person can be in good mental health today, but not tomorrow. Disasters such as Hurricane Katrina bring out and exacerbate mental health disorders in people, he said.

Satcher indicated that the Report of the Surgeon General on Mental Health contained "good news" in that "we have the research ability to recognize, diagnose and treat mental health conditions effectively." A range of treatment exists, he noted. "The bad news is that despite the ability to diagnose and treat [mental illness], fewer than one-half of adults get the help they need and fewer than one-third of children get the help they need," he said.

Integration 'critical'

"We've said in our report that mental disorders are physical disorders," noted Satcher. "Integration is really critical. The more we learn about the brain, the more we appreciate the fact that mental disorders are physical disorders."

Satcher cited statistics from another one of his reports, the "Action Agenda for Children's Mental Health," which found that one in 10 American children suffers from mental illness severe enough to cause some level of impairment. "What we need is a network that

looks out for children if children are recognized as having mental health problems," he said. Schools, churches, scouting can all play a role in ensuring that children get the help that they need, he added.

Satcher also emphasized that the current health care system in this country is not sustainable in terms of cost, access or quality. "The way things are [now], the health care system is on a course to disaster," said Satcher. "Our health care system is not sustainable the way it operates. We've got to make the commitment to universal access."

Satcher noted that there are a few states currently trying to achieve universal access, such as Massachusetts and California. "We need to get our best minds together," he said.

The insurance industry about a month ago even recommended universal access to health care, he said. This was the same group that led a previous effort against Hillary Clinton in 2002 to defeat the Clinton universal health plan, he said. "Something is changing in our country," he added.

One participant asked Satcher how the field can begin to move forward and change things. Satcher suggested moving the research forward. "We have to continue to do the science," he said. "Science is not a one-time thing. Keep doing the

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research." The field also needs to put more pressure on people who are making policy, Satcher said. "We've got to become better advocates and find more partners."

"You have got to integrate primary care providers and mental health providers," he said. "You've got to find a way to integrate; you've got to have partnerships." Mental health problems are not adequately addressed in the primary care setting, Satcher said. "This is not an either/or, this has got to be a partnership," he said.

Satcher also emphasized organizing at the local level and informing others about important issues involving integrated health care. "Educate people about these issues, educate people running for office," he noted. "Make sure they have all the information they need."

It's also important to develop replicable models, he said. "Show that the work is sustainable," he noted. "You can impact the way things are done."

Terry L. Cline, Ph.D., administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) also addressed the conference and offered his perspectives on integrated care and the issue of health care reform.

Cline closed his remarks with a plea to the attendees. "We are in a time of great urgency and we have opportunities that will come and go depending on what we do. There is a lot of attention to health care reform as the current system cannot be maintained. Something needs to change and so there is a great push to reform health care across the country."

Cline added, "We have an opportunity to influence how that model looks. Change will happen and so we must not wait until tomorrow, but engage in that process today. Decisions are being made daily that will impact the people we serve and care about. As the leaders in our field, we have to be very active in this reform process."

## Consumer speak out about lack of integrated care

The theme of integration weaved its way through ACMHA conference presentations and panel sessions. During one session, "Consumer and Family Voices in Integration/Coordination," panelists delved into their personal experiences that addressed the importance of integrating care.

Edward L. Knight, vice president of Recovery at Value Options, after recounting a harrowing experience involving care for a physical condition in an emergency room, told attendees that consumers should be listened to. Consumers should also ultimately be in charge of their own care, he added. Knight said that substance abuse treatment often involves lifestyle changes while the mental health area doesn't address that area.

Knight told attendees to stop underestimating consumer survivors. "Consumers should be taught to be their own care managers," he said. "We need to get primary care physicians and mental health to a point where they listen to someone when they have a mental illness," he said.

Another panelist, Andrew Toribio, a 19-year-old from New Mexico, discussed an early drug problem that began in the fifth grade, followed by subsequent school difficulties and gang-related behavior, and ultimately, suicidal thoughts. With the help and support of the court, a judge and his family, he was able to persevere, he said. Toribio said his ambition now is to begin a career in nursing.

Jacki McKinney, co-director of the Philadelphia Trauma Initiative at the Philadelphia Office of Behavioral Health, told attendees about the racism, sexism and stigma that she encountered in the health care system. She mentioned that when her daughter was pregnant she encountered difficulties in receiving care. Although her daughter had adequate insurance coverage, she also mentioned her past addiction problems and was made to feel "shamed and blamed" throughout her entire pregnancy, McKinney said. A nurse care manager eventually provided much support, she added.

## Improving integrated health care

Benjamin G. Druss, M.D., the Rosalynn Carter Chair in Mental Health at Emory University and Barbara J. Mauer, MSW, a consultant at the National Council for Community Behavioral Healthcare, co-authored the report, *Mind and Body Reunited: Improving Care at the Behavioral and Primary Healthcare Interface*, which was made available to summit attendees prior to the meeting.

The study noted that improving the treatment of mental and substance use disorders in primary care settings and improving the medical care of people with serious mental health (MH) and substance use (SU)

disorders served in behavioral health settings has been a growing area of focus over the last decade.

During their presentation, Druss told attendees that safety net providers offer care to vulnerable, uninsured populations regardless of their ability to pay for those services. "Community mental health centers are the backbone of the medical primary care safety net," he said.

Between 1998 and 2003, the number of persons receiving MH/SU care in community health centers increased four-fold, from 210,000 to 800,000, said Druss. Community health centers are managing the bulk of MH/SU for uninsured persons, he noted.

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Druss also noted that at the federal level, the Center for Substance Abuse Treatment has sponsored screening and brief intervention programs in 17 states. The programs have resulted in intervention efforts to more than 420,000 people in emergency room settings, he said.

Druss cited recent reports which have addressed the issue of morbidity and mortality in people with serious mental illness (SMI). "People with SMI are dying 25 years earlier than the general population," he said. Most of the mortality is due to key risk factors in lifestyle areas, such as poor diet, lack of exercise and smoking, he said.

"People with schizophrenia have a 90 percent smoking rate," he said. He also noted some problems associated with medications for

treatment of mental illness. "Unfortunately a lot of medications have an adverse effect on the obesity and health of the clients we serve," he said.

There is however good literature showing a reduction of risk factors, improved outcomes and reduced cardiovascular disease, he noted. "A modest reduction in two or more of the risk factors can have a dramatic effect on improved health," said Druss.

Fifteen years ago the field started talking about co-occurring disorders, Barbara J. Mauer, told attendees. Co-occurring disorders are not the exception, it's an expectation, she said. "We should be expecting and looking for it and addressing it," she said. Mauer asked attendees about the array of capacity and services in their community. "A trained

workforce is a big issue," she said. "Do we have the staff capacity? The skill set to work in a primary care setting is very different [than what] mental health providers have to do," she said.

Druss said future needs in the area of integrating primary care and behavioral health will involve discussions with the research community to ensure that real world settings are a part of research efforts. It's important to use proven models for care of depression in primary care and medical care in specialty mental health/substance use settings, he noted.

"We have to be able to pay for this kind of coordination of care," he said. "We have to assure that policies for the sharing of information support coordination while protecting privacy." •

## Summit addresses government involvement in integrated care

Alexander Ross, ScD, senior health policy analyst at the Health Systems and Health Services Resource Administration (HRSA), Department of Health and Human Services, presented "Exploring HRSA's Increasing Role in Providing Mental Health Services: A Look at Changing Relationships and Reimbursement Issues for Community Health Centers and Community Mental Health Centers," at last week's American College of Mental Health Administration's (ACMHA) annual Santa Fe Summit.

Ross discussed some examples of HRSA's activities and work with the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Ross told attendees he is well aware of the financial barriers regarding the provision of mental health services in primary care settings. Through the work of the federal agencies, those barriers can be addressed, he said.

"One thing we hope to do is share with the broad mental health

community a tool box to use," he said. "We want to identify what services are known to be effective in successful collaboration care models for providers of evidence-based mental health care in primary care settings, including service definitions and reimbursement codes," he said.

Ross cited Aetna's initiative to encourage primary care physicians to become more involved in mental health service delivery. "Aetna is the first national insurer to integrate medical and mental health care at the primary care level," said Ross.

Ross also mentioned an initiative in Florida involving a medical managed care organization which has a contract with Magellan to provide mental health care services to about 140 patients in a pre-paid medical mental health plan.

In Delaware, a program called "Connections," integrates mental health and substance abuse treatment. Primary care physicians identify individuals who need to be seen by clinical licensed social workers, he said. The program's success laid

the foundation for the state's Medicaid program and the Delaware Division of Substance Abuse and Mental Health to collaborate on a new initiative to provide behavioral health care for federally qualified health care patients.

Ross also noted that New Jersey's state Medicaid agency created extensive network of behavioral health services. "We need to know what works in your state and why," he told attendees. Ross can be reached at [aross@hrsa.gov](mailto:aross@hrsa.gov).

## CMS update on reimbursement

Peggy A. Clark, MSW, technical director of the Center for Medicare and Medicaid Services (CMS), spoke to summit participants about reimbursement for mental health services.

Clark noted that the general coverage rules regarding medical services are that the services must be medically necessary. State Medicaid officials have latitude in deciding medical necessity, she said.

"Every single Medicaid program is unique," said Clark. "Each time

the state wants to add or modify services they must ask CMS for approval.” Clark noted that people who review these requests don’t necessarily have a mental health background. “You need to think about ways to make it easier to understand for quicker approval of the added mental health services or state plan,” she told attendees.

Clark noted that Health Care Common Procedure Coding System and the Current Procedural Terminology codes are used by providers in the claims they submit to identify the medical services, items and products they provide on an annual basis. “Our federal authorization requirement pertaining to codes is very broad,” she said.

“Mental health services provided to Medicaid beneficiaries by psychiatrists are coverable reimbursement as long as it is determined by the state to be medically necessary,” she added.

There are no federal Medicaid regulations that require the state to only reimburse one face-to-face visit per day, she noted. “States may, however, impose such a requirement or may follow Medicare’s same day billing policy which permits one medical visit and one mental health visit to a clinical psychologist, clinical social worker or other mental health professional to be billed on the same day,” she said.

## Cherokee Health Systems

Dennis Freeman, Ph.D., chief executive officer of Cherokee Health Systems in Tennessee, discussed his organization’s approach to integrating behavioral health services during his presentation, “Taking a Road Less Traveled: Evolution of an Integrated Care System.”

**‘We resist the notion of targeted populations — we provide services to all.’**

Dennis Freeman

The organization, which offers comprehensive primary care and mental health programs and services, has 21 clinical locations in 14 Tennessee counties. Cherokee Health Systems has 526 employees, 39 psychologists, 39 primary care providers and 34 care managers, he said.

Freeman noted that behavioral health consultants at Cherokee Health Systems work within a primary care setting and are involved in assessment, brief intervention and consultation with patients. They provide brief, targeted, real-time inter-

ventions to address psychosocial aspects of primary care, he noted.

“We see about 15,000 new patients annually in our model which provides significant penetration in the populations we serve,” Freeman told attendees. Behavioral health consultants are embedded full-time members of the primary care team, he added.

Consultation and co-management in the treatment of mental disorders and psychosocial issues are the new behavioral medicine paradigm, he said. “These interventions by behavioral health consultants improve our internal efficiency,” he said.

Through this integrated care model, program officials found a 28 percent decrease in medical utilization for Medicaid patients, he said. Freeman also noted a 20 percent decrease in medical utilization for commercially insured patients and a 27 percent decrease in psychiatry visits. Results also revealed a 34 percent decrease in psychotherapy sessions, he added.

“We resist the notion of targeted populations — we provide services to all,” he said. As a federally qualified health center (FQHC), we are subjected to more oversight and additional reporting requirements. All that is a small price to pay for the benefits, he noted. FQHC is the best available platform for community mental health [programming] he said. •

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those involved with the project quickly realized that most of the innovative integration projects around the country incorporated both substance abuse and mental health services.

Although Smith believes that more than the 13 initiatives profiled in the report are conducting successful integrations of primary care and behavioral health for public-sector populations, she adds that those who worked on the analysis encountered many programs that called themselves “integrated” but really weren’t achieving actual effi-

ciencies for clients.

“The integration programs that we could identify could say things like, ‘This team of *these* clinicians is in place to do *X, Y and Z*,’” Smith said.

Still, as the report states, “Service integration can mean different things and may take on many forms, ranging from providing educational resources to clinicians to facilitate referrals, co-locating clinicians in the same setting, coordinating care across providers and systems, collaborating and jointly deciding on treatment, and jointly planning and financing services.”

The report sought not to evaluate the merits of one form over another, but to illustrate the diversity of existing approaches, to identify commonalities among them, and to present considerations for future planning of integrated services initiatives.

### From the simple to the complex

The 13 initiatives analyzed in the Health Management Associates report have pursued a variety of policy and programmatic goals, and range from the narrowly focused to those that have embraced dramatic

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change in how services are delivered and financed.

Smith cited the work of the Cleveland Coalition for Pediatric Mental Health as an example of a successful integration initiative that focused on achieving modest goals. Financed with monies from two charitable foundations, the coalition initially set out to compile a list of available mental health resources so that pediatricians could link children in need with appropriate community providers. That generated a web-based resource guide that is available to 400 pediatricians in Cuyahoga County.

In addition, the coalition has begun pilot-testing a web-based diagnostic, management and tracking tool that allows parents to complete a survey of their child's behavior before the child enters the exam room for a pediatric office visit. The Child Health and Development Interaction System (CHADIS), currently in use for children up to age 8 in three pediatric primary care practices, is designed to give pediatricians more time and opportunity to address identified mental health concerns.

"[The coalition] recognizes that pediatricians are on the front line in their role as PCPs and are often in the best position to detect psychosocial, emotional and behavioral issues and to assist in preventing their exacerbation," the report's description of the Cuyahoga County project states.

Smith added that this effort is highly replicable because it does not require major system change. At the other end of the spectrum among the programs studied for the report is the effort of the Washtenaw Community Health Organization in Washtenaw County, Mich., an initiative that Smith terms the most complicated of those examined for the report.

A collaborative partnership involving Washtenaw County government, the county mental health center, local private health clinics and the University of Michigan Department of

## Future challenges for integrated services efforts

Alicia Smith of Health Management Associates, co-author of the newly released report on integrating publicly funded physical and behavioral health services, lists these as the four major challenges facing leaders of the ambitious efforts now under way:

1. To ensure sustainability, the implementers of these initiatives must establish a **business case** for their program.
2. Initiatives must ensure **payer involvement** in the process. Smith told *MHW* that when payers see benefits accruing to them from integrated services efforts, programs are more likely to be sustainable over the long term.
3. The various agencies involved in these initiatives still must overcome a variety of lingering **obstacles to success**. These include addressing ingrained cultural differences between primary care and behavioral health, and negotiating complexities of provider certification that often mean providers can be paid for some services but not others.
4. Programs must maintain clear and open **communication** about goals and expectations. "Many organizations want to do integration but have no clue what it means," Smith said. "The word does not have one prescribed definition."

Psychiatry, the effort began in the mid-1990s in response to the state's move to privatize public mental health services. It has evolved into an initiative to create an integrated "medical home" for all consumers in the public mental health system.

"This initiative has been 10 years in the making," Smith said.

A comprehensive menu of behavioral health and primary care services are provided to consumers at half a dozen primary care safety-net clinics, most of which include co-located psychiatrists and other mental health professionals for at least part-time hours. Mental health services include a number of evidence-based interventions such as assertive community treatment, trauma-focused cognitive-behavioral therapy, and integrated treatment for co-occurring mental health and addictive disorders.

The Washtenaw initiative operates under a "braided" system of funding encompassing Medicaid and Medicare funding; mental health and substance abuse block grant funds; and state and local funds. One

ongoing challenge lies in the requirement that the Washtenaw Community Health Organization maintain separate funding streams for mental health, substance abuse and primary care, and return any unspent state monies in these categories at the end of each fiscal year. "This limits the flexibility needed to be completely effective within the model," the report states.

### Common elements

Despite the vast differences in approach among the initiatives profiled in the report, the analysis cites many common elements seen across these efforts, including:

- Use of communication tools and a requirement that collaboration occur among clinicians and systems.
- A conceptual framework based in the belief that treating the whole person is the paramount consideration for providers.
- Use in most instances of case managers or care managers to facilitate communication among

providers and also between the providers and clients.

- Use of routine screenings and assessments to uncover behavioral health problems.
- Ability to demonstrate positive outcomes, including the financial benefits of integrating services in many cases. One of the initiatives examined, the Rebuilding Lives PACT Team Initiative in

Columbus, Ohio, has been able to demonstrate improvements in housing status and perception of quality of life among clients.

The report states that it is important not to assume that integrated care initiatives always must require a complete system overhaul. It is often desirable for behavioral health and primary care organizations to pursue modest goals that

can pay significant dividends.

“In many cases, the delivery system prior to a pilot was so fragmented, and comorbidity so prevalent, that even relatively straightforward strategies — like making a screening tool available or coordinating patient plans of care within a managed care organization’s case management team — could result in measurable improvements in care and cost,” the report states. •

## MHA issues new public policy position statements

Mental Health America has issued new public policy position statements reflecting its official stance on four issues affecting the mental health of Americans. These policy positions guide advocates, policymakers and mental health stakeholders as they promote quality mental health systems.

The new statements include:

**Health And Wellness For People with Serious Mental Illnesses:** states Mental Health America’s commitment to reducing high rates of morbidity and mortality among individuals with serious mental illnesses and offers strategies for fed-

eral and state governments, providers and consumers, families and communities in reducing these disparities.

**Participant Protections in Psychiatric Research:** recommends measures to protect the health, safety and rights of individuals with mental health conditions participating in psychiatric research.

**Access to Healthcare:** outlines the need for innovative approaches to increase access to and improve the quality of health care, and supports a national plan to provide an array of comprehensive, culturally- and linguistically-appropriate health care services for all people.

**Electroconvulsive Therapy (ECT):** provides an overview of benefits and risks and recommendations for states in monitoring ECT’s use and ensuring conformity with current clinical guidelines.

The Mental Health America board of directors reviews and updates the association’s policy position statements every five to seven years to reflect its evolving role in mental health advocacy and to address new issues affecting the nation’s mental health. A full list of position statements is available at [www.mentalhealthamerica.net/go/position-statements](http://www.mentalhealthamerica.net/go/position-statements). •

### BRIEFLY NOTED

#### Report finds extensive global ADHD drug use

In a report in the journal *Health Affairs*, lead researcher Richard Scheffler and colleagues write that worldwide use of drugs to treat attention-deficit/hyperactivity disorder (ADHD) more than tripled between 1993 and 2003. The U.S. accounted for 83 percent of the market share in 2003, for reasons that the authors write are not entirely clear. The study found that roughly 1 in 25 U.S. children and adolescents were taking an ADHD medication, although the increase in prescribing among children could be leveling off. Long-acting medications contin-

ue to drive up spending. The study authors recommend that countries continually compare data and “weigh carefully the potential benefits versus the potential liabilities.”

#### Rep. Tubb Jones calls for Minority MH Awareness Month

Congresswoman Stephanie Tubbs Jones (D-Ohio) has announced a resolution to establish a Bebe Moore Campbell National Minority Mental Health Awareness Month, named for the late advocate, best-selling author and co-founder of the National Alliance for the Mentally Ill (NAMI) Urban Los Angeles. Tubbs Jones stated in a March 8 press release that events like Hurricane Katrina serve to highlight “the urgent need to address the

issue of mental illness among minority communities.” Barriers such as inadequate insurance and stigma lead to late diagnoses and poor care. Tubbs proposes that official recognition could go a long way in raising awareness locally and nationally and ultimately improving services and cultural competence.

#### African Americans face depression treatment gap

The results of the largest psychiatric epidemiologic study of African Americans in the United States suggest that although depression occurs more often in non-Hispanic whites, African Americans and Caribbean blacks experience depression that is both more severe

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and more persistent. However, cultural and social stigma continue to prevent many minority groups from seeking treatment, said Raymond Crowel, Psy.D., vice president of research, practice and policy at Mental Health America (MHA). And according to Crowel, healthcare systems and providers often “lack cultural and linguistic competency skills” to treat mental illnesses in minorities. The study appears in the March issue of *Archives of General Psychiatry*.

## STATE WATCH

### Massachusetts tests new health coverage plan

Massachusetts residents making more than \$29,400 a year will now be able to choose from “lower cost” health insurance plans offered by seven insurers, with enrollment scheduled to begin on the first of May, reported the Cape Cod Times on March 9. Residents making less than this amount will qualify for subsidized health care. The state has mandated that all residents must be enrolled in a private or subsidized plan by July 1 or face tax penalties. Advocates hoping for an innovative approach to affordable coverage complain that the new plans remain too pricey for many individuals. In two weeks, the Commonwealth Health Insurance Connector Authority will vote on even lower-cost plans that lack mandatory drug coverage.

## BUSINESS

### HealthCentral Network and NARSAD to collaborate

The HealthCentral Network, Inc. reported on March 7 an agreement with NARSAD: The Mental Health Research Association to combine HealthCentral’s online consumer mental health community with the “cutting edge” research

## Coming up...

The **Network for the Improvement of Addiction Treatment (NIATx)** will hold its first annual summit, “Improving Access and Engagement in Addiction and Behavioral Health Treatment,” on **April 23-25** in **San Antonio, Texas**. For more information and to register, visit [www.NIATx.net](http://www.NIATx.net).

**Netsmart** will host its first annual global customer conference, “Connections 2007: Connecting the Community,” on **April 30-May 3** in **Orlando**. For more information and to register, visit [www.netsmartconnections.com/index.asp](http://www.netsmartconnections.com/index.asp).

The **World Fellowship for Schizophrenia & Allied Disorders**, the **Schizophrenia Society of Canada** and the **Schizophrenia Society on Ontario** will sponsor the 2007 International Conference. “Lighting the Path: Hope in Action.” on **September 27-30** in **Toronto, Canada**. For more information and to register, visit <http://conference.world-schizophrenia.org>.

funded by NARSAD’s donor community. In one of their first collaborations, the groups will develop online consumer-oriented videos from NARSAD’s mental health research symposium on brain disorders affecting children and adolescents (March 10).

## RESOURCES

### SAMHSA report: MH services in the nation

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced the

release of a compendium of the most current information available on mental health services, “Mental Health: United States 2004.” Published every two years by SAMHSA’s Center for Mental Health Services, the resource addresses issues such as mental health care in primary settings. This edition is the first to address quality improvement in the mental health field. The free compendium is available at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/default.asp>. Or call SAMHSA’s National Mental Health Information Center at 1-877-SAMHSA-7.

### Correction

In the March 5 issue of *Mental Health Weekly*, based on information in a New York advocacy policy report, we indicated that Michael Seereiter accepted a position as New York Governor Eliot Spitzer’s Deputy Secretary for Health and Human Services. We have since learned that his new title is Program Assistant.

## In case you haven’t heard...

*Is optimism always best? This is the title of a review study led by the University of Florida’s Kate Sweeny, which suggests that although our society tends to focus on the benefits of optimism, there are also benefits to pessimism. People who are overly optimistic about the future tend to be ill-prepared to handle setbacks, write the study authors, whereas a healthy dose of pessimism can provide “protection from an emotional blow.” The review concludes that both optimism and pessimism serve a similar goal of preparedness, and that a balance between the two leaves people the best equipped for all eventualities. The report was published in Current Directions in Psychological Science.*