MENTAL HEALTH WEEKLY
Essential information for decision-makers

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National Council 43rd Annual Conference

Field urged to participate in national dialogue on mental health

The signing of the Community Mental Health Act (CMHA) 50 years ago by President John F. Kennedy that led to the establishment of community mental health centers around the country provided an appropriate spotlight on the National Council for Behavioral Health's annual conference in Las Vegas April 8–10. Behavioral health attendees were encouraged to not only celebrate the recent twin victories of parity and the Affordable Care Act (ACA), but also to actively participate in the national dialogue on mental health spurred by recent tragedies.

Presentations and discussions during the conference addressed behavioral health and primary care integration, trauma-informed care, veteran care and criminal justice issues, along with the ongoing push for a federal designation for community behavioral healthcare organizations. Presenters included U.S. HHS Secretary Kathleen Sebelius, historian Doris Kearns Goodwin, former First Lady Rosalynn Carter and former U.S. Congressman Patrick Kennedy.

"There is renewed focus on talking about mental illness borne out of tragedies in Aurora, Virginia Tech and Newtown," Linda Rosenberg, president and CEO of the National Council, told the nearly 4,000 attendees during the opening session. "This is our moment to promote and enlighten public policy in which mental illness and addiction are openly discussed."

Rosenberg said she is encouraged by the bipartisan support leveled at the Excellence in Mental

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Establishment of federal status key agenda item for the field

Without a clearly defined definition, community behavioral health center providers cannot be reimbursed for their actual costs of providing services, fueling even more ammunition for the establishment of a federally qualified behavioral health center (FQBHC) and the passing of bipartisan legislation that addresses this need, attendees heard during the National Council for Behavioral Health conference in Las Vegas April 8–10.

A federal definition would mean that community behavioral health centers can have a foundation from which they can build, said Chuck Ingoglia, vice president for public policy at the National Council for Behavioral Health (National Council). "The centers would become a known entity with data supports," he said. "The status within Medicaid becomes more fixed. We're entering a time of even greater uncertainty

Bottom Line...

The full Senate is expected to consider mental health legislation, including The Excellence in Mental Health Act, this week. The legislation would increase access and early intervention in communities around the country.

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Health Act (S. 264) that would strengthen community treatment networks and support for community mental health and addiction treatment agencies to become federally qualified community behavioral health centers (FQBHCs) (see related story beginning on page 5). "In today's climate, that's reason enough to celebrate," she said.

Rosenberg cited President Obama's new Brain Research through Advancing Neurotechnologies (BRAIN) initiative, a 10-year research effort to advance understanding of disorders like autism, schizophrenia, Alzheimer's and traumatic brain injury. This initiative will do for the brain what heterogeneity did for genetics, Rosenberg said.

More than 100,000 people have already been trained in Mental Health First Aid, the public education program that helps the public identify, understand and respond to signs of mental illnesses, said Rosenberg. "Imagine if we all learned Mental Health First Aid for signs of anxiety, suicide and distress," she noted, adding that the National Council recently launched a youth version of the program.

Rosenberg urged plenary session attendees to encourage Congress to support Mental Health First Aid and make mental health issues more accessible to the general population, and ensure that behavioral health treatment is adequately funded.

Reaching out to youth

The ACA will allow more than 6.6 million 19-to-26-year-olds to stay on their parents' insurance plan at that critical age when we know behavioral health issues are likely to emerge or be exacerbated.,U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius told attendees during a plenary session, which has been billed as her first behavioral-health-only audience.

'If we do not reach out to them, they're not going to get coverage and get the help they need.'

Kathleen Sebelius

Just because coverage is expanding for young people doesn't mean they know about it, she said. "Seventy-five percent of adult mental health conditions appear by the age of 24," Sebelius said.

Sebelius added, "If we do not reach out to them, they're not going to get coverage and get the help they need. I'm asking your help to reach out. We need your help to find them and let them know affordable coverage is within their reach and get them signed up."

Enrollment for many insurance plans is slated to begin Oct. 1, she said. "If we get people signed up for coverage this fall, we'll be that much closer to our goal of every American having access to the behavioral health care they need.

The biggest impact of the ACA is its expansion of coverage for a new health insurance market and the expansion of Medicaid, she said. "Before the federal parity law, it was permissible to treat disorders differently," said Sebelius. "Thanks to two historic laws we're closing the gap in coverage," Sebelius said. "The president is committed to issuing the final rule on the [federal parity] law as we speak. That's a huge step forward. The parity law combined with the ACA will ensure behavioral health benefits and federal parity join together in the new landscape."

Sebelius noted that the president's new budget (released April 10) will invest in the mental health workforce to train more than 5,000 mental health professionals who can serve young people, and advance new state-based strategies to prevent young people

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ages 16 to 24 with mental health problems from falling through the cracks when they leave home.

Sebelius noted that the president and vice president have asked her and Secretary of Education Arne Duncan to start a National Dialogue on Mental Health. She encouraged attendees to support the launch of this national dialogue. "We need to expand the conversation that started after Newtown," said Sebelius. "We need help from all of you to move that agenda forward [and help] to reduce the shame that keeps people from seeking the help they need."

"We're eager for your input and expertise to ensure the biggest possible reach," she said. Sebelius suggested these conversations take place before school audiences and in community centers and houses of worship, with faith leaders, and at kitchen tables around the country.

"Providers have a critical role," she said. "Make sure our neighbors, families and friends get the help they need. Let them know that prevention works, treatment is effective and you do recover — a message that needs to be heard over and over again," Sebelius said.

Sebelius added, "I look forward to working with all of you to bring behavioral health issues out of the shadows once and for all." •

Providers encouraged to excel, become the 'Mayo Clinic' of BH

In this new healthcare environment, the behavioral health community needs to position its organizations and programs to provide comprehensive, whole-health care that supports resiliency and recovery, yields excellent outcomes and provides high client satisfaction, said presenters at the National Council of Behavioral Health's annual conference in Las Vegas April 8-10 (see story beginning on page 1). The ultimate goal would be to become the Mayo Clinic of behavioral health and be viewed by the community as a preferred place of care, they said.

At the Mayo Clinic, a team of specialists add value to care planning, said Dale Jarvis, consultant at Dale Jarvis and Associates, who presented during the conference. "The specialists consult with you and come up with a care plan that most of the time works," Jarvis told the standing-room attendees. "When you go there you receive amazing customer services."

"How do you leverage the hard work you're already doing to be seen as your [community's] behavioral health center of excellence?" Jarvis said.

If behavioral health organizations want to thrive in this new healthcare system, it's a good idea for them to become a behavioral health center of excellence (BH-COE), said Jarvis. The National Council has launched a yearlong project to field-test a BH-COE definition with centers across the country, he said.

Bottom Line...
Addressing the whole health needs of consumers and being positioned as high-performing, cost-effective service providers are essential to being labeled as centers of excellence.

The philosophy of a BH-COE should be customized for each organization, added Jarvis. "It would not be like an NCQA [National Committee for Quality Assurance, a nonprofit organization dedicated to improving healthcare quality] or a medical home organization. It's a more flexible organization," Jarvis said. "We're still trying to figure this out, but like the Mayo Clinic, it would be a great place [at which] to work and a great place to get care."

'How can we help consumers recover unless we believe ourselves? Without that belief there's not much hope we can give them.'

Linda R. LaGanga

Seven key elements

According to Jarvis, a BH-COE will need to focus on the following in order to be successful:

1. Rapid access/open access
2. Comprehensive whole-person/whole-family care
3. Culture of resiliency and recovery
4. Outcomes-based care
5. High-value services
6. World-class customer service
7. Staff engagement and wellness

"CBHOs [Community behavioral health organizations] will not be viewed by the community as a preferred place of care without getting high marks on all seven," said Jarvis.

Beyond the seven elements, "each community would need to develop its own roadmap and [figure out] what's best for the organization and for the clients," he added.

Most BH-COEs should provide mental health, substance use and co-occurring disorder treatment services, noted Jarvis. For an organization to provide cost-effective services, it must think about its clients and about what science says works. "We're going to come up with a care plan about what might work best for

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a person, and which of those might be less costly — and ultimately what would keep a person out of jail, the emergency room or [away from] a cardiologist's knife," he said.

Jarvis asked the standing-room attendees to respond to the idea of a BH-COE using a five-finger method. A resounding yes means five fingers, three fingers indicates they're semi-intrigued but need to think about it more and one finger means the idea is "horrible" and not good for the field, he said. More than three-quarters of the room held five fingers up.

One attendee noted that he was on the fence about the proposed philosophy of a center of excellence. "I think we should get rid of the behavioral [reference] and say health center instead because of the silos," he said.

Another attendee said, "I gave it a five but I have concerns that we will make a Taco Bell mistake," she said. When the restaurant made changes to its business philosophy, it ended up refurbishing its kitchen area, which eventually took up about two-thirds of its restaurants and left almost no place for its customers to sit, she said.

Patient-centered approach

Linda R. LaGanga, director of qualilty systems and operational excellence at the Mental Health Center of Denver (MHCD) and one of the session panelists, said she was pleased with the concept itself. "I'm a fan of the Mayo Clinic," she told attendees. The clinic focuses on patient-centered value and safety and services are important for their patients, she said. "Patients fly in from all over the country because they know they receive the best treatment available," said LaGanga.

The MHCD had transformed its own organization to be more focused on its consumers and their recovery, she said. Belief in your organization is important, she noted. "How can we help consumers recover unless we believe ourselves," LaGanga said. "Without that belief there's not much hope we can give them."

LaGanga noted, "What is your center [doing] to transform recovery? What do consumers think and what are they experiencing? The MHCD conducted a survey of our consumers to understand what elements of our system they think are the most helpful to their recovery."

The MHCD embarked on a lean process initiative that drove down the "no-show" rates. "We listened to consumers," LaGanga said. "We made sure people knew how to get to the center," LaGanga added. "When they showed up, we asked them why."

As part of the MHCD's wellness culture, the center also embraced a comprehensive whole-person/whole-family care approach that includes services for foster families and independent living skills training. It also includes juvenile justice and social services, she noted. Key features include rapid access to intake and care planning, bi-weekly meetings of care teams and ongoing care management. •

President's FY 2014 budget increases SAMHSA funding, supports BH workforce

The president released his FY 2014 budget April 10, which includes funding for new efforts to increase access to mental health services to protect children and communities, and $3.6 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), representing a $4 million increase over FY 2012.

According to the new budget, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more strategically by:

- targeting resources to evidence-based prevention and treatment interventions,
- improving providers' capacity to bill insurance to increase access, and
- issuing additional guidance to states to ensure that existing programs support but do not supplant insurance coverage.

The budget's proposed funding of $50 million supports a collaboration between SAMHSA and the Health Resources and Services Administration (HRSA) to increase the behavioral health workforce by an additional 5,000 mental health professionals.

The president's proposal includes $130 million for SAMHSA that will fund:

- **Project AWARE (Advancing Wellness and Resilience in Education) State Grants:** $40 million to ensure students with signs of mental illness get a critical first referral to treatment, and that local organizations are all coordinating appropriately; and
- **Mental Health First Aid:** $15 million to fund Mental Health First Aid to train teachers and other adults who interact with youth to detect and respond to mental illness in children and young adults, including how to encourage adolescents and families experiencing these problems to seek treatment.

The proposed SAMHSA budget increases mental health surveillance by $88 million. The new proposal will fund Children's Mental Health Services at $117 million. Funding for Projects for Assistance in Transition from Homelessness is $65 million. The proposal for Protection and Advocacy for Individuals with Mental Illness is $36 million.

Editor's note: Mental Health Weekly will follow-up with more information about the president's proposed budget and with reaction from the field.

FQBHCs need partnerships with FQHCs for integrated care

While legislation that would require behavioral health organizations to receive a federal definition is still pending, once they achieve that status, behavioral health organizations may have to consider becoming a federally qualified health center (FQHC) or an FQHC look-alike in order to provide integrated care services. Attendees heard thismessage during a session at the National Council for Behavioral Health annual conference, April 8–10 in Las Vegas.

The Excellence in Mental Health Act (S. 264) would establish national standards for federally qualified behavioral health centers (FQBHCs). Having FQBHC status makes every service provided by a community behavioral health agency mandatory within Medicaid, such as psychiatry and case management services, Kathleen Reynolds, vice president of health integration and wellness promotion at the National Council for Behavioral Health, told session attendees (see related story beginning on page 1).

"Being an FQBHC does not make you an FQHC," Reynolds said during the session "FQBHC, FQHC, and FQHC-LA: Alphabet Soup or Opportunity?" FQBHC status does not give organizations the ability to provide physical health services. "Partnerships will still be necessary between FQBHCs and FQHCs to provide integrated care," she said.

FQBHC eligibility and requirements would include providing such services as outpatient clinic mental health services, crisis mental health services, substance abuse services and integrated care for dual disorders and outpatient clinic primary care screening and monitoring of key health indicators, Reynolds noted. Additionally, FQBHCs must maintain linkages and, where possible, enter into contracts with FQHCs, she said.

Partnerships between FQBHCs and FQHCs are not about competition, said Reynolds. "This is about getting healthcare services to a population of people who are dying because they're not receiving those services," she said.

There are three types of FQHCs approved by the Centers for Medicare & Medicaid Services (CMS):

1. Organizations that receive a grant under Section 330 of the Public Health Service Act via the Health Center Program (80 percent of FQHCs).
2. Organizations that meet requirements of the Health Center Program without receiving a grant (look-alikes).
3. Organizations that qualify as an outpatient health program or facility operated by a tribe or tribal organization.

A look-alike FQHC needs to be providing care for six months at the time of application, whereas an FQHC needs to be operational within 120 days, said Suzanne Daub, integrated health consultant for the National Council. Another hallmark of FQHCs is that the governing board must be composed of 51 percent consumers. Ideally not business people, these are folks from the neighborhood that represent the neighborhood. "That's a very powerful way to govern an organization," said Daub.

It's important to note that consumers who show up at an FQHC's door do not see themselves walking through the door of a CMHC," she said.

Consider program intent

For any organization considering becoming an FQHC or an FQHC-LA status, the first question to ask is 'what is the intent of the program?'" Amelia Clark, from Meridian Health Services, told attendees. "Why do we want to move in this direction? Is part of your business model to be a part of primary care? If you're looking to integrate, it's a distinct paradigm shift."

CMHCs and FQHCs may refer to providers differently, said Clark. For example, a provider for a CMHC could refer to a provider as a nurse practitioner whereas someone from an FQHC could mean a medical doctor of physician's assistant. To avoid confusion, Clark says she recommends using the term prescriber when talking about providers who prescribe medications.

'As a long-standing behavioral health organization the focus is on integration, not dismissing patients if we thought they were drug seeking.'

Amelia Clark

"Do you have [PC] providers who understand how to work with your population?" Clark asked. "We had a primary care physician also wanting to dismiss patients if they were drug-seeking," she said. "In an integrated model, that won't work. You don't get to call the shots about who you keep as a patient and who you don't."

Clark added, "As a long-standing behavioral health organization, the focus is on integration, not dismissing patients if we thought they were drug-seeking. My recommendation is to think about training primary care providers about how to work with your clients." •

You can e-mail Kathy Reynolds at kathyr@thenationalcouncil.org for more information.

Community support important for criminal justice populations

Interventions that are focused on families to address behavioral health and trauma are integral to promoting recovery, along with involvement from community partnerships and key stakeholders, said panelists during a workshop at the National Council for Behavioral Health conference in Las Vegas (see story beginning on page 1).

"When you're dealing with incarcerated populations, remember your intention," Kelli Finley of Community Works told attendees during the session, "Families and the Revolving Door: Collaborating with Criminal Justice to Adopt Trauma- and Family-Focused Interventions." There's always going to be barriers. There are going to be parents who aren't willing to engage in services," she said. "You might be working with a child who wants that family involvement."

Finley said it is important to explain to parents what you're doing and encourage them to go to parenting classes, if warranted.

"When Community Works started its family therapy program four years ago, no one was interested," she said. "We had a mom in denial who said, 'I do not have a problem. Who are you to tell me about my family?'" It turns out the woman had been a victim of rape multiple times since the age of 12, and had several addictions. "You cannot underestimate how little they value themselves," she said. "You must participate in a solution. Persistence is mandatory in this work."

If you deal with a jail population, they're not necessarily interested in what you have to offer. "You need to speak in a way that's loving and accepting," said Finley. "It's a little marketing — a PR ploy: 'You don't have to like me, you don't have to like my service, you don't have to like therapy, but I want you back with your kids.'"

"Use the power of silence, taking a minute to breathe," she said. "Look at the individual in front of you and struggles they are going through so you can know the next best steps for your client and for your program."

"Things move at a snail's pace," added Finley. "Build those relationships you need to make change, and families and children will benefit from that."

Making change, engaging families

"A requirement of engaging families is getting your community partners — including community behavioral health organizations — and stakeholders," including families of incarcerated individuals at the table, Joanne McGerr, family services unit manager of the prisons division at the Department of Corrections in Colorado, told session attendees. "Develop strong partnerships. That will sustain your program. Families help you drive change. They're going to talk."

Implementing strategies to work with incarcerated populations includes reviewing policies that are in effect and determining if they are family-friendly, she noted. If not, develop a mechanism to change them, she noted. Identify early in the incarceration phase whether the inmates have families and obtain the demographics, she said. Additionally, train law enforcement to keep child safety issues in mind during the arrest phase, McGerr noted.

"We work with a lot of communities to try to effect change," she said. "We really depend on community partners to be diverse about who they provide services to. If individuals are ready for support services, we ensure they get into community mental health services." Mental health providers are included in these partnerships to help families, she said.

"Start with the family's needs: 'What do you need and how can we be of assistance?'" she said. "We want to empower [incarcerated individuals] to have access to healthcare, whether it's their mental health or physical health."

Incarceration rates are growing phenomenally, added McGerr. "We're seeing inter-generational incarcerations," she said. "Increasing incarceration rates are also depleting communities of color." In adult corrections, 17 percent are African Americans, who make up 3.6 percent of the state populations, McGerr said.

'Look at the individual in front of you and the struggles they are going through so you can know the next best steps for your client and for your program.'

Kelli Finley

McGerr said her department helped to set up legislation that required interagency sharing of information. Eighty-two percent of individuals incarcerated had children under the age of 18, "which translated into 20,000 kids under 19 'incarcerated' in my system," she said. They shared data with the state Department of Social Services, which helped with grant funding and avoided duplication of services, she said. "It helped us provide more targeted services for children under 18," she said. •

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regarding options, services and payment rates."

Unlike behavioral health organizations, hospitals, nursing homes, rural health centers and other facilities have the federally qualified health center (FQHC) status, Ingoglia told attendees during the Town Hall session, "FQBHC: What Is It and Why Should I Care?" There is no federal definition for psychiatric rehabilitation treatment facilities or mental health or addiction treatment facilities," he said.

Ingoglia told attendees that Medicaid makes up a major share of public spending. "Why does this create a problem?" he noted. "Everything we do in the Medicaid program is an optional program. What are the implications for that? FQHCs and other safety net providers get paid for their actual costs and providing services, while behavioral health centers cobble together patchwork funding for their services."

Ingoglia added, "We're seeing state governments turning increasingly to managed care in the Medicaid program."

About every six months or so, articles appear citing Medicare fraud at community mental health centers (CMHCs), said Ingoglia. "I get calls from the Hill and I have to explain that those incidents are occurring in for-profit CMHCs." These incidents are not occurring in any of the National Council's nonprofit CMHCs, he noted.

Without a federal status, behavioral health providers do not have access to national data that would, for example, let them know how many psychiatric treatment facilities are in the country and what type of services they provide, said Ingoglia. "This creates a problem for us," he said.

Legislation support

The field is encouraged, however, by legislation that creates a federal definition for FQBHCs. The Excellence in Mental Health Act (S. 264) was introduced by Sen. Debbie Stabenow (D-Mich.) on Feb. 7. Its companion bill (H.R. 1263) was referred to committee March 19. "The first hurdle is getting the bills consolidated," said Ingoglia.

The legislation makes FQBHC services mandatory in Medicaid and improves reimbursement for Medicaid services. It also creates a loan fund to support the modernization and construction of community-based mental health and addiction treatment facilities.

'We want to make sure we're responsive to community needs and that people have access to the right kind of services.'

Chuck Ingoglia

According to S. 264, eligibility for an FQBHC is restricted to nonprofit or public organizations that must provide:

- outpatient clinic mental health and substance abuse services,
- outpatient clinic primary care screening and; monitoring of key health indicators,
- targeted case management and psychiatric rehabilitation, and
- peer support/counselor services and family supports.

The organization must also maintain linkages, and, where possible, enter into contracts, with FQHCs.

"This gives us a benefit from which we can build," said Ingoglia." Benefits also include assured Medicaid reimbursement that at least covers your costs. What should our system look like? "What's the standard? We want to make sure we're responsive to community needs and that people have access to the right kind of services."

Meanwhile, the Senate Committee on Health, Education, Labor and Pensions (HELP) held a committee vote on April 10 on a bipartisan mental health package that includes suicide prevention and addressing mental health in schools. The Excellence in Mental Health Act was not expected to be a part of that mental health package, said Ingoglia, adding that he expects it will be offered as an amendment within another week or so.

Advocacy needed

Linda Rosenberg, president and CEO of the National Council, encouraged attendees to connect with their elected officials about mental health and addiction public policies. "There is a broad recognition that behavioral healthcare is seen as part of overall health," Rosenberg said. However, roadblocks remain for behavioral health organizations to be equal partners with other safety net providers, she said.

Examples include a lack of capital for improvements in health IT, or new service lines. Additionally, there is no federal status to support improvement and no national data to support investment, said Rosenberg.

Attendees were encouraged to write e-mails and letters (templates were available) to their local elected officials. Information was also available in the room to enable them to conduct local advocacy following the Town Hall presentation. The National Council will hold its annual Hill Day on September 16–17. •

STATE NEWS

N.H. Medicaid commission created to address managed care

Gov. Maggie Hassan announced the creation of the Governor's Commission on Medicaid Care Management to address concerns from the mental health, developmentally disabled and elderly communities about the state's managed care program, the New Hampshire Union

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Leader reported April 10. "Moving forward with implementing Medicaid managed care is critical to ensuring that we are able to effectively expand Medicaid coverage and maximize our health care dollars," Hassan said. Commission members include Kenneth Norton, executive director of the National Alliance for Mental Illness-New Hampshire.

Mass. nurses oppose plans to close psychiatric beds for children

In the wake of an announcement by Cambridge Health Alliance (CHA) of a plan to close eleven child psychiatric beds, the Massachusetts Nurses Association/National Nurses United believes it represents an abandonment of children who need the care provided by the program, News Blaze reported April 4. The CHA plan is to consolidate a 13-bed Child Assessment Unit (CAU) for children ages 3–12; and a separate 14-bed Adolescent Assessment Unit for children 12–19, reducing the 27 beds currently available to children to just 16 beds. The new combined unit will serve children from 9–18, which means children aged 3-8 will no longer have access to care at the facility. Currently, 45 percent of the children seen on the CAU are between the ages of 4–8.

Coming up...

The **New Jersey Association of Mental Health and Addiction Agencies** will hold its Annual Conference, "A View from the Top: Putting the Big Picture into Focus in Everyday Operations," **April 24–25** in **Edison, N.J.** Visit **www.njamhaa.org** for more information.

The **American Association of Suicidology** will hold its 46th Annual Conference **April 24–27** in **Austin, Texas**. For more information, visit **www.suicidology.org/education-and-training/annual-conference**.

The **New York Association of Psychiatric Rehabilitation Services (NYAPRS)** 9th Annual Executive Seminar, "Mastering the Opportunities in Healthcare, Olmstead and Budget Reforms," will be held **April 25–26** at the Albany Hilton in **New York City**. See program and registration details at **www.nyaprs.org/conferences/executive-seminars/index.cfm**.

The 166th Annual Meeting of the **American Psychiatric Association** will be held **May 18–22** in **San Francisco, Calif.** Visit **www.psych.org/AnnualMeeting** for more information.

Mental Health America (MHA) will host its 2013 Annual Conference, "Why Wellness Works: Breakthroughs and Pathways to Whole Health," **June 5–8** in **National Harbor, Md.** For more information, visit **www.mentalhealthamerica.net/go/annualconference/speakers**.

The **US Psychiatric Rehabilitation Association (USPRA)** will host its annual conference **June 9–12** in **Atlanta, Ga.** Visit **https://netforum.avectra.com/eWeb/StartPage.aspx?Site=USPRA** for more information.

The **Depression and Bipolar Support Alliance (DBSA)** 2013 National Conference will be held **June 14–16** in **Miami, Fla.** For more information, visit **www.dbsalliance.org/Conference2013/Conference2013_4pg_brochure.pdf**.

U.S. to retain control of California's prisons

A federal judge on April 5 rejected California's motion to regain control of mental health care in its prisons, ruling that the quality of care failed to meet standards required by the Constitution, the New York Times reported. The move dealt a blow to Gov. Jerry Brown's broader efforts to bring the prisons back under the state's authority. The ruling was handed down about 90 days after the state first argued that enough improvements had been made to mental health care after 18 years of outside control. In a statement, Deborah Hoffman, a spokeswoman for the California Department of Corrections and Rehabilitation, said that the judge had not given enough weight to experts and evidence showing that mental health care in the prisons was "a model for the nation." Hoffman said that the state will appeal.

In case you haven't heard...

Rep. William G. Batchelder, speaker of the Ohio House of Representatives, when speaking about removing Medicaid expansion from the House budget, "estimated that he had about 20 members of his caucus who wanted to do something, 20 were unsure and 20 who 'might shoot themselves before they voted for it,'" according to the April 10 Columbus Dispatch. The National Alliance on Mental Illness issued an action alert in response saying, "NAMI-Ohio has thousands of members who have lost loved ones to suicide. Although maybe unintentional — words hurt. Linking this statement to the demise of services that could prevent people from wanting to take their own life is unconscionable. We currently live in a world that discriminates against and stigmatizes those with this terrible illness. We expect more from our elected leaders."