MENTAL HEALTH WEEKLY
Essential information for decision-makers

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Highlights...

North Carolina's provider community has **experienced** a number of **recent developments**, most notably, a **reduction** in their **hourly rate. Providers** subsequently **convinced state officials** to **expedite more detailed reviews** of **community support billing. Provider concerns** also **include** the **lack of new funding** for **MH services**. *See story, top of this page.*

Mental health and children's advocates applauded the **introduction** of a **new bill** last week that **seeks to ensure** that the **State's Children's Health Insurance Program (SCHIP) provides** equitable **coverage** of **mental health services** for **low-income children**. The bill, introduced by **Sen. John Kerry (D-Mass.)**, would **end discriminatory limits** on **mental health care** that currently exist in **SCHIP plans**. *See story, bottom of this page.*

Inside This Issue...

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North Carolina providers and advocates gird for changes in public services

State continues to examine community support services

North Carolina's community mental health provider community has recently experienced the rollercoaster of emotions that can accompany a reliance on public sources of funding. Providers learned on the day before last month's Easter holiday weekend that they would see an immediate one-third reduction in the Medicaid rate for case management services, only to find more than half of that amount restored in an amended action by the state three weeks later.

More changes may be in store in how the state administers community support services for people with behavioral illness, as state officials continue to try to encourage innovative service provision under enhanced benefit categories that were introduced in March 2006 (see *MHW*, Feb. 26). State officials have been concerned for some time that some providers may be using less-intensive community support too often as a stand-alone service in lieu of innovative, recovery-promoting services such as Assertive Community Treatment or Multi-Systemic Therapy.

Members of the state's provider community believe the rate discussions and other potential changes reflect predictable challenges in providers' adjusting to a dramatically transformed public service system in the state.

"We crosswalked from the old

See **North Carolina** on page 2

Senators introduce SCHIP bill to provide mental health parity for children

Legislation would end discriminatory treatment of mental health care

While congressional efforts are still underway to reauthorize the State Children's Health Insurance Program (SCHIP), Senate lawmakers last week introduced new legislation that would end discriminatory treatment of mental health care under SCHIP. The new legislation would make the coverage of mental health services equal with any other medical service.

SCHIP is a partnership between the federal government and the states to fund and provide health insurance for children in mostly working families with incomes too high to qualify for Medicaid but too low to afford private coverage. Created in 1997, the program gave states three options as they devised plans to cover uninsured low-income children. Under the SCHIP program, states can elect to expand their existing Medicaid program to cover uninsured low-income children or they can opt to establish a separate insurance program.

Mental health advocates have urged lawmakers to consider insurance equity issues in the SCHIP reauthorization discussion. Several groups have been working to ensure that all SCHIP plans provide mental health coverage equivalent to the coverage provided for general

See **SCHIP** on page 6

NORTH CAROLINA from page 1

to the new, and [providers] borrowed from some of the old in what was done," Bob Hedrick, executive director of the North Carolina Providers Council, told *MHW*. "I don't think we adequately trained providers and told them what the expectation set was. We need to have clear criteria for use of these services."

Rate changes

The state Medicaid system in March 2006 began to pay for community support services at an hourly rate of $60.96. But based on concerns that the service mix providers were offering to Medicaid-eligible clients was not in line with what had been projected in designing the new service mix, the state Department of Health and Human Services began to review billing patterns from a group of 167 providers.

According to media reports, department Secretary Carmen Hooker Odom last month informed Gov. Mike Easley that these reviews uncovered not only a higher-than-expected volume of billing for community support services, but also inappropriate billing in some cases. While community support is designed to help identify clients' clinical and skills-based needs for living successfully in the community, some providers were inappropriately billing for functions such as taking children to recreational activities, according to the department.

The state announced on April 5 that the $60.96 rate that had been in effect for a year would be reduced to $40, with the lower rate also applying retroactively to the period when the $60.96 rate had been in place.

'This is one of the most insulting budgets we've ever seen, especially in a time of relative prosperity here.'

John Tote

"That reduction was made based on the best available data we had at the time, which showed that those 167 providers were billing for services that were almost totally provided by people with high school degrees or less," Odom said in a statement. "The original rate was set up with the idea that a quarter of the services would be provided by professional staff with master's degrees."

The unexpected announcement of a significant rate change, issued on the day before Good Friday, stunned mental health providers and advocates. "By Monday morning hundreds of people in provider agencies were getting pink slips," John Tote, executive director of the Mental Health Association in North Carolina, told *MHW*.

Hedrick said reactions from providers were instrumental in convincing state officials to expedite more detailed site reviews of community support billing, with an eye toward basing the hourly rate on actual cost data. On April 26, the department issued a new announcement stating that the final Medicaid rate for community support services would be $51.28, with that retroactive to April 5 and not to the one-year period when the higher $60.96 rate was in effect. The department states that this rate "reflects the actual cost of service provision."

Hedrick said, "We felt that the Division of Medical Assistance was fair in the way it handled the rate review process. [Odom] included us in the process."

According to the April 26 statement from the health and human services agency, more changes are being initiated or contemplated in the oversight of community support services. Post-payment reviews will be conducted for all community support clients who receive more

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than 12 hours of service a week, and any findings of improper service provision resulting from these reviews could lead to legal action.

In addition, the state is currently seeking comments on a number of other potential changes to community support, including measures to require prior approval for all community support services and to cap the amount of services for an individual adult at 15 hours per week.

Budget, staffing developments

A number of other developments have North Carolina's mental health provider and advocacy communities in a vigilant state at present. The House version of the proposed state budget for the fiscal year that begins July 1 includes virtually no new funding for mental health services, at a time when analyses of mental health reform efforts in the state have pointed to a grossly underfunded service system in general (see *MHW*, Jan. 22).

"This is one of the most insulting budgets we've ever seen, especially in a time of relative prosperity here," Tote said. He said that state Senate leaders already have expressed concern about how the House budget process is unfolding, which could mean that a lengthy budget debate among leaders in the two chambers is on the horizon for this year's legislative session.

In addition, mental health system stakeholders learned earlier this month that Odom is leaving her post as secretary of health and human services at the end of this legislative session. She will become president of the Milbank Memorial Fund, a New York-based health policy research organization for which she has served as a board member for several years.

Tote said the mental health community has had mixed feelings about Odom's performance at the helm of the health and human services department. Yet he added that her understanding of mental health issues during recent reform efforts was probably instrumental in the establishment of some of the newly funded services in the public system.

Tote added that while some advocates are looking forward to a leadership change because they have considered Odom's approach too confrontational, he believes that anyone in that post will simply reflect the priorities of the administration for which he or she works. •

Illinois juvenile justice initiative provides MH services for youth

An Illinois-based initiative to diagnose and treat mental illness among youth who have been in contact with the justice system revealed a significant decrease in future contact with law enforcement, according to program officials, who unveiled findings from the program last week.

The Juvenile Justice Mental Health Initiative was coordinated by the Illinois Collaboration on Youth/Youth Network Council and operated by more than 22 community-based youth services agencies throughout the state.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provided $1.2 million in grant funding for the 16-month initiative. The program, which ran from September 1, 2005 through December 30, 2006, treated approximately 698 youths, whose ages ranged from 11 to 17, with mental illness who had been in contact with law enforcement and the juvenile justice system.

The program grew out of a series of discussions with community-based youth service providers who voiced the need for comprehensive mental health services for youth in their care. The providers noted that it was becoming more difficult for them to provide care for youth with mental health concerns, said C. Gary Leofanti, M.S.W., president of the Illinois Collaboration on Youth.

"The youth agencies had a hard time accessing the local mental health system because they have a lot to do," Leofanti told *MHW*. "The youth services system is not funded to provide mental health services; it is more [geared] towards family mediation, counseling, after-school programs and intensive case management."

The youth who participated in the program showed a high-to-moderate risk of re-offending or further involvement with the juvenile justice system, said Leofanti. The youth received screening, assessment, diagnosis and counseling and therapy by licensed clinicians and access

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Juvenile Justice Mental Health Initiative

Some of the program's goals, based on discussion among providers, included:

- Higher utilization rate for existing community-based mental health services for the target population.
- Client ownership of the recovery process through family, youth and significant community stakeholders collaborating on the plan.
- Increased use of evidence-based methodologies, as well as gender- and cultural-specific approaches.
- Increased service integration for targeted youth.

Continued from previous page
to psychiatrists, he said.

The participating youth agencies used the Youth Assessment and Screening Instrument (YASI) as the major inclusion criterion of the project. Youth who were rated at moderate-to-high risk of re-offending and moderate-to-high risk in the physical/mental health domain of the YASI were included in the population.

"The overarching goal of the initiative was three-fold: to increase local capacity to service juvenile justice youth with mental health problems; to increase access and use of community-based services; and to provide a way for youth service providers, including mental health, law enforcement and the courts to collaboratively work together," said Gary B. Beringer, Dr. P.H., senior researcher of the Abbate Group, Ltd., and lead evaluator of the initiative.

Various youth agencies realized sufficient mental health efforts were not devoted to youth, he said. The direct service goal of the program is treating youth, he added.

"We're seeking to talk to people in the state and federal government to try and extend the program," Beringer said. Meanwhile, although the program is completed, 16 of the 22 agency participants have volunteered to provide program officials with more data until more funding can be provided, he said.

Program findings

The report noted that diagnostic services were provided and finalized in 632 of 698 clients (90.54 percent). During the initiative, 505 (89.23 percent) did not re-offend while 61 (10.77 percent) did re-offend.

According to the report, after the initial evaluation, 195 referrals were made by the psychiatrists or the Qualified Mental Health Professionals (QMHPs). They referred to other psychiatrists 92 times and mental health facilities accounted for another 103 referrals.

More than three-quarters (79.94 percent) of these youth were covered by some form of health insurance, either privately supplied or through the state of Illinois. Almost one-third (29.22 percent) were privately insured while more than one-half (50.72 percent) were covered by Medicaid/'Kid Care with nearly another one-tenth (9.74 percent) eligible.

The program reported that 130 youth (18.62 percent) had suicidal thoughts, and 7.88 percent had one or more suicide attempts. About 11.37 percent experienced homicidal ideation. The report found that 60.31 percent had indications of violence.

Program officials noted that the greatest strength of the initiative was to develop a statewide program for an unrecognized special population in Illinois. Access to comprehensive mental health care for a critical need, such as those exhibited by youth, has not been supported by traditional funding streams in the past, they said.

The program's success was due to a "timely response," said Leofanti. "We identified mental health problems immediately and zeroed in on [their needs]." Leofanti said he was pleased that more than 500 of the participants did not re-offend during the duration of the program. Meanwhile, discussions are continuing with the Juvenile Justice Commission to have the program included in their funding plan for next year, he said. Technical consultants are currently working with some of the community-based youth service agencies to help them develop Medicaid/mental health programs for their respective sites, he said.

For further information, contact Gary B. Beringer at (312) 558-1456 or e-mail: gbberinger@sbglobal.net. •

National survey links depression, first time use of drugs, alcohol

Results from the new National Survey on Drug Use and Health (NSDUH), released this month by the Substance Abuse and Mental Health Services Administration (SAMHSA), revealed that youths who faced depression in the past year were twice as likely as those who did not have depression to take their first drink or use drugs for the first time.

The NSDUH Report: *Depression and the Initiation of Alcohol and Other Drug Use among Youths Aged 12 to 17* examines past year major depressive episode (MDE), past year initiation of alcohol and illicit drug use, and the association between MDE and the initiation of alcohol or other drug use in the past year among youths ages 12 to 17.

MDE is defined using the diagnostic criteria set forth in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, which specifies a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.

The report found that in 2005, 8.8 percent of youths ages 12 to 17 (2.2. million persons) experienced at least one major depressive episode (MDE) in the past year. Among youths ages 12 to 17 who were at risk for alcohol initiation (i.e., those who had never used alcohol previously), those who experienced a past year MDE were twice as likely to have initiated alcohol use in the past year as those who did not have a past year MDE (29.2 vs. 14.5).

Among youths who were at risk for illicit drug initiation, those who experienced a past year MDE were over twice as likely to have initiated use of an illicit drug as those who

Continues on page 6

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FROM THE FIELD...

Self-directed behavioral health care: Where is it directed?

by Richard H. Dougherty, Ph.D.

In the three years since the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2004 Consumer Direction Initiative Summit, the transformation of behavioral healthcare through self-direction has been slow. The promise of truly self-directed care for people with mental illness is an elusive goal so far. So where has progress occurred? Are we still headed in the right direction?

In the commercial sector, America's Health Insurance Plans reports more than 10M enrollees in account-based HSAs (health savings account) and HRAs (health reimbursement arrangement) consumer-directed health care plans. About 75 percent of Medicare enrollees now have access to one or more "HSA-like" plans. The growth of commercial plans has been slowed partly because many consumer-driven health plans have been poorly designed and "consumer"-oriented features often mask real reductions in benefits. Such was my experience in a consumer-directed plan! Second, price transparency is virtually non-existent in the healthcare system and though simpler, behavioral health is no exception to this. Try asking what the cost of a medical procedure or prescription is!

In the public sector, there have been several consumer-and family-directed projects implemented in the last three years. There has been significant expansion of the Family Directed Care project in Hillsborough County, Fla., serving more than a 1,000 children and families since inception. There is the promise that WellPoint will continue efforts to incorporate self-direction into its health plans in Florida. Other new projects include a small initiative in Oregon and another in Massachusetts as a part of a Medicaid Real Choice System Change grants. Finally, Magellan has developed a promising self-direction program in Iowa and has plans to expand this to most of their public sites. We hope that is successful.

It may come as a surprise that Medicaid has been the primary driver of self-direction to date. The Centers for Medicare and Medicaid Services (CMS) understands the efficacy and cost effectiveness of self-direction through the experience with Cash and Counseling demonstrations and through Home and Community-Based Waivers for people with developmental disabilities. Real Choice grants support self-direction efforts. The Deficit Reduction Act (DRA) strongly supports efforts for self direction through two options in the Act: Home and Community-Based Services (HCBS) and Money Follows the Person. To date however most of the efforts under these options have been with the physically and developmentally disabled. State Medicaid programs need to understand the importance.

Self-directed care has been slow in mental health because of several factors:

- There is limited use of HCBS waivers (1915c) for people with mental illness, primarily because of Medicaid's IMD (Institutions for Mental Disease) exclusion. There is some hope for expansion with the DRA option (which waives the cost neutrality requirement). Iowa has recently expanded under this option for people with mental illness.
- There has always been and continues to be significant provider resistance to advancing self direction. Given the shifts in funding and the payment methods often used, this is understandable but policy makers must seek to enhance consumer choice.
- Another major challenge lies in redesigning service plans to be truly person-centered and to include personal budgets. We don't have accepted ways to quantify needs like Activities of Daily Living are used for people with Developmental Disabilities. As a result, most efforts to date have used a flat budget for everyone. In Michigan, however, individuals can request to see the costs of the current services they receive and then can choose to redirect the funds for more valued services.
- Finally, the stigma of mental illness prevails and many professionals lack the vision needed to understand the significance of the shift to self-direction. The article recently published in *Psychiatric Services* (March 2007) by Richard Labrie and colleagues is a notable example of the effects of widespread stigma. Rather than presuming that a variety of consumer characteristics (such as "poor self-efficacy") will limit self-direction, a system structured around consumer choice and self-direction allows professionals to provide support to overcome these barriers to effective care!

We have a long way to go and there are certainly practical and economic challenges for professionals and providers from the proposed changes. The pace is slow so far but the direction is clear. Increasing self-

Continues on next page

Continued from previous page

direction and person-centered care is central to recovery and also to the cost-effectiveness of services.

Richard H. Dougherty, Ph.D., is chief executive of DMA Health Strategies, a Lexington, Mass.-based consulting firm. DMA Health Strategies has worked with federal, state and local health and human service clients on projects involving strategic planning, change management and quality improvement with public and private organizations across the country.

Continued from page 4

had not experienced an MDE in the past year (16.1 vs. 6.9 percent).

This pattern was relatively consistent across drugs, the report noted. Among youths who had not previously used marijuana, those with a past year MDE were more than twice as likely as their counterparts with no past year MDE to initiate use of marijuana in 2005.

SAMHSA released the NSDUH report on May 3, just days before National Children's Mental Health Awareness Day on May 8. "It's important to remember that depression is real and painful for youths," said Terry Cline, Ph.D., SAMHSA Administrator. "Recognizing depression early and helping youths receive appropriate help may prevent substance use."

Gender differences

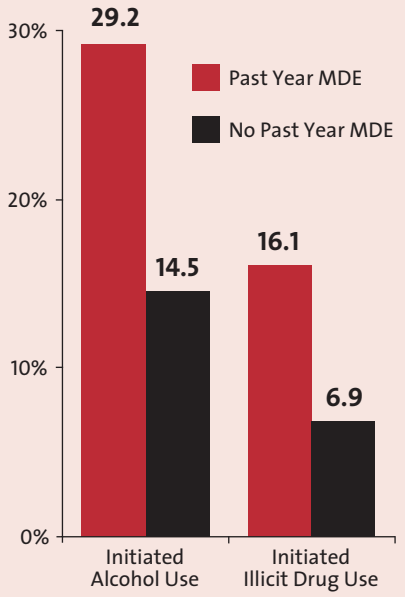
The report also found that females were three times as likely as males to have a past year MDE (13.3 vs. 4.5 percent). Rates of past year MDE varied by age, with youths ages 17 having the highest rate of past year MDE (11.9 percent) and those aged 12 having the lowest rate (4.3 percent). Rates of past year MDE were relatively similar across racial/ethnic groups.

The 2005 NSDUH survey indicates that 2.7 million youths ages 12 to 17 were past year initiates of alcohol use, representing 15.4 percent of youths who were at risk for initiation of alcohol use. An estimated 1.5 million youths were past year initiates of illicit drug use, which represents 7.6 percent of youths at risk for initiation of illicit drug use.

The NSDUH is an annual survey sponsored by SAMHSA. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

The NSDUH report is available on the web at http://oas.samhsa.gov/2k7/newUserDepression/newUserDepression.cfm. •

Past year substance use initiation among persons ages 12 to 17 at risk for initiation, by past year major depressive episode (MDE)



Source: SAMHSA, 2005 NSDUH

SCHIP from page 1

health care. (See *MHW*, March 12).

The Children's Mental Health Parity Act would prohibit discriminatory limits on mental health care in SCHIP plans by directing that any financial requirements or treatment restrictions that apply to mental health or substance abuse services must be no more restrictive than the financial requirements or treatment restrictions that apply to other medical services.

The Children's Mental Health Parity Act was introduced last week by Senators John Kerry (D-Mass.) and Gordon H. Smith (R-Ore.). The co-sponsors of the bill are Sen. Pete Domenici (R-N.M.) and Edward M. Kennedy (D-Mass.).

The broader issue is reauthorization of SCHIP in general, said Kimberly Collins, spokesperson for Sen. Gordon Smith. "This legislation is one part of a larger issue, which is mental health parity across the board," Collins told *MHW*. "The federal government should be setting the standard. SCHIP is the first place to look. This bill will be a part of that discussion."

Sen. Smith co-sponsored the Mental Health Parity Act of 2007 (S. 558) introduced in February, which would require health insurance plans that offer mental health coverage to provide that coverage on par with financial and treatment coverage for other physical illnesses (see *MHW*, Feb. 19).

Discriminatory limits

Currently, discriminatory limits on mental health care are one of the main reasons that low-income children are unable to receive necessary mental health services. Many states impose restrictive limits on mental health care that do not apply to the coverage offered for traditional medical and surgical care. Consequently,

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children who need to see a psychiatrist weekly, for example, are only allowed one visit per month.

The Children's Mental Health Parity Act would eliminate the provision in the current law that authorizes states to lower the amount of mental health coverage they provide to children in SCHIP down to 75 percent of allowable benchmark plans.

Advocates encouraged

"Many state SCHIP plans impose restrictive limits on mental health services — not based on children's medical needs or on practitioners' best practice guidelines," said David Shern, Ph.D., president and chief executive of Mental Health America. "In fact, low-income children have much higher rates of mental health disorder, but only about 40 states offer full coverage of necessary services for children with complex mental health needs."

Shern added, "This legislation would end the inequality by improving access to appropriate mental health services for the many low-income children at risk."

"Research shows that children in Medicaid and in SCHIP have a higher prevalence of mental health disorders than insured children or even uninsured children," Kirsten Beronio, senior director of government affairs at Mental Health America, told *MHW*. "Low-income [kids] have higher mental health disorders than other populations."

"We really want this bill enacted as part of SCHIP reauthorization," she said. "That's our goal. The bill addresses problems with discriminatory limits in inpatient and outpatient care under SCHIP."

MHA and other advocacy groups are working with a number of House lawmakers to get similar legislation introduced, Beronio noted. "We're hopeful that we will get a House bill introduced," she said.

While there are several SCHIP-related bills on lawmakers' plates these days, the Children's Mental Health Parity Act goes further to ensure equivalent benefits with respect to cost sharing and benefit limits across mental health and physical care, Chris Koyanagi, policy director for the Judge David L. Bazelon Center for Mental Health Law told *MHW*.

"The Children's Mental Health Parity Act is the most comprehensive bill in terms of mental health provisions," said Koyanagi. "We're very thrilled. We'll be working to see those provisions get into the final bill," she said.

"This is the first step in moving toward kids getting individualized, appropriate services on a timely basis," Joy Midman, executive director of the National Association for Children's Behavioral Health, told *MHW*.

Advocates are pleased that this is the first freestanding bill to address child parity for mental health, Midman said. "We're pleased that Sen. Kerry took this up and was able to get Sen. Smith as a co-sponsor," she noted. "Parity begins to address some of these inequities. We need equity for the kids in our care."

Midman added, "Mental health needs to be a preventive, ongoing and developmental issue on par with physical health."

As for the reauthorization of SCHIP, Senate Finance Committee Chair Max Baucus is expected to mark up the SCHIP reauthorization bill by Memorial Day, and the House is expected to do likewise later in the summer, said Midman. •

Briefly Noted

DOD task force highlights failings of military MH system

As the Pentagon continues to insist that adequate services are in place to address mental health issues among combat troops, a Department of Defense (DOD) task force recently released a draft report that found "significant gaps" in the continuum of care for troops and their families, reported the Hartford Courant on May 4. The task force, which is comprised of behavioral health experts, half of them also military doctors and officials, will release their full finding s to the Secretary of Defense in June.

Among their findings: Stigma surrounding mental health issues continues to be pervasive and leaders are not adequately trained to assist troops in seeking services. Also, there is insufficient mental health screening for troops both deploying and returning from war. "The single findings that underpins all others," reads a summary of the report, is that the system lacks adequate resources to fully support psychological health in peacetime and during conflict.

Cannabis found to worsen psychotic symptoms

Yale University researchers were recently surprised to find that marijuana exacerbates psychotic symptoms in schizophrenic patients, rather than inducing the calming effect that patients tend to describe, reported the Associated Press on May 1. Tetrahydrocannabinol (THC) also elicited psychotic symptoms in nearly half of the study's healthy volunteers. This confirms the findings of another recent study, in which British researchers used MRI scans of the healthy brains to confirm that cannabis is linked to psychosis. While one active ingredient, cannabidiol, tended to have a calming effect, THC elicited reactions like hallucinations and paranoia in some subjects. The results of both studies were presented at the Second Annual Cannabis and Mental Health Conference at Kings College on May 1-2.

Genetic study is first of its kind in bipolar disorder

It's estimated that 5.7 million American adults have bipolar disor-

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der, also called manic-depressive illness, and not all patients respond to treatment with lithium or other mood-stabilizing medications. The National Institutes of Health reported on May 8 that newly published genetic research by National Institute of Mental Health (NIMH) scientists could lead to more pharmacological treatment options. This was the first study to scan virtually all of the variations in human genes to find those associated with bipolar disorder, and NIH Director Elias Zerhouni, M.D., calls it "an example of how advances in genetics research feed into practical applications." The study suggests that targeting an enzyme produced by one of the genes involved in bipolar disorder could lead to the development of more effective medications. The findings were reported online last week in *Molecular Psychiatry*.

Coming up...

The **National Alliance on Mental Illness (NAMI)** will hold its 2007 Annual Convention, "Building our Movement, Building our Future," on **June 20-24** in **San Diego**. For more information or to register, visit www.nami.org.

The **American Mental Health Counselor Association (AMHCA)** will hold it 2007 Annual Conference, "Growth out of Adversity," on **July 26-28** in **New Orleans**. For more information and to register, visit www.amhca.org.

The **International Brain Research Organization** will hold its 7th World Congress of Neuroscience on **July 12-17** in **Melbourne, Australia**. Registration closes on May 31. For more information, visit www.ibro2007.org.

State Watch

Texas considers submitting MH data for background checks

Although federal law requires states to notify the National Instant Criminal Background Check System of individuals convicted of felonies or domestic violence, Texas is one of 28 states that do not submit information regarding mental health commitment. National debate about background checks prior to gun purchase was stirred following the Virginia Tech shootings, reported the Austin-American Statesman on April 27. Texas Sen. Rodney Ellis (D-Houston) has submitted legislation (SB 1755) under which the state would report people who have been committed to inpatient psychiatric services or institutions for mental retardation. Supporters of the measure say that National Rifle Association opposition stumped the bill last session. The bill, submitted to the Senate Criminal Justice Committee, must pass in the Senate and be received by the House by May 18.

Resources

Guide: Designing behavioral healthcare facilities

The National Association of Psychiatric Health Systems (NAPHS) has released a newly updated publication: The Design Guide for the Built Environment of Behavioral Health Facilities: Second Edition. Two national leaders, David Sine, ARM, CSP, CPHRM and James M. Hunt, AIA, share their practical experience to assist behavioral healthcare facilities in meeting accreditation and regulatory requirements in their built spaces. The guide was first published in 2003. Visit the NAPHS website (www.naphs.org) to access the guide free of charge.

Names in the News

Tommy G. Thompson, former secretary of the U.S. Department of Health and Human Services (2001-2005), has been honored by the National Association of Psychiatric Health Systems (NAPHS) for his "commitment to a fair and comprehensive system of care for those with serious mental illnesses." The award was announced at the NAPHS Annual Meeting earlier this month. In addition to announcing his candidacy for the presidency in 2008, Thompson is chairman of the Deloitte Center for Health Solutions and a partner at the law firm of Akin Gump Strauss Hauer & Field.

In case you haven't heard...

In the first study to examine how meditation impacts attention, published online last week in the journal PloS Biology, three months of rigorous meditative training appeared to change how the brain assigns attention, in effect allowing study participants to take in information more rapidly. The New York Times reported that according to lead study author Richard Davidson, professor of psychology at University of Wisconsin, expert meditators are better at detecting things such as subtle changes in facial expressions. Ron Mangun, Ph.D., a professor of psychology and neurology at UC Davis, said the study "provides neuroscience evidence for changes in the workings of the brain with mental training." Mangun was not involved in the study.

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