

## CA's Consumer and Family Member Task Force Has Left Its Mark On State MH Care

When CA's Consumer and Family Task Force first met in Fall 1996, "we had no idea how important what we were doing was", declares task force member Darlene Prettyman. Prettyman, who has a mentally ill son, remains on the task force today and is able to observe the effects of the panel's work in operation at the county level. "It's a real partnering. I love collaboration," she says.

The ten member group began meeting a year before CA implemented its out patient MediCal Consolidation (managed care) Plan. In the beginning, Prettyman said, consumers sat on one side of the table and family members of both adult and juvenile consumers sat on the other. But it didn't take long for the two groups to discover that they had more in common than otherwise and that they shared the same goals. After that, the seating segregation ended and work began.

"We actually sat with state representatives and helped develop guidelines for the implementation plan," says Prettyman. The task force also insisted on and won some changes. Gains included choice of providers and therapists; second opinions in certain cases; and in instances where there were differences of opinion about payment between physical and MH providers, treatment would not stop, while the dispute was settled. The task force also formatted a template for the grievance process, including formation of a grievance panel, which has been adopted by some counties, including Prettyman's own, Kern County.

But the task force's work didn't end with implementation of managed care. Next came oversight reviews of county programs. Over the past three years the task force has trained more than 100 consumers and family members to conduct on-site reviews and concurrent consumer focus groups, along with state officials. The process improves MH treatment at the county level and also passes along

good ideas, according to Prettyman, who is part of an oversight review team. "Some counties are doing wonderful things. Word gets back to the state level through the oversight review team and can then be passed on to other counties," she says.

The oversight teams are learning from the programs they review. This year in response to a comment from MH directors the panel is trying to make its questionnaire more positive in tone.

What's next? "I see the task force continuing to work on implementation through oversight," says Prettyman, who also envisions it helping counties develop their own consumer/family member task forces. She believes every county ought to have one. In the meantime, CA's parity legislation, guaranteeing equal service for physical and MH, took effect last January and Prettyman finds a big role for the task force there. "If HMOs are going to treat MH patients equally they are going to need help and they'd do well to consult the task force," she says.

Prettyman attributes the existence of the task force and its success to leadership at the top, directly to State Director of Mental Health, Stephen Mayberg. Panel meetings, held every six weeks, are also attended by the President of CA Mental Health Directors, and the State Deputy Director of Training and Compliance. Included as goals are quality of care, continuity of care, easy access and clear grievance procedures.

To Prettyman, whose long standing involvement with CA MH is not only as the family member of a consumer but also as a professional psychiatric nurse, the task force is symbolic of a new era in MH. "It used to be MH professionals determined the course of treatment," she says. "Now the professionals ask the question, 'What is it we can do to service your needs?' It is amazing how well equipped the client and family members are to answer." ■

# From The Hill

By Sally McElroy, Associate Legislative Director, NACo

Let's take a quick look at some of the actions in the First Session that relate to mental health. Increased funding for the Mental Health Block Grant for FY 2000- Congress provided the largest increase in history for mental health programs under the Center for Mental Health Services (CMHS)/ SAMHSA. This block grant received an increase of \$67 million for a total of \$355 million, marking the first increase for this program in many years. The Mental Health Block Grant funding is a part of the Labor, Health and Human Services, and Education Appropriations bill, which this year was rolled into a larger end-of-the-year Omnibus Spending Bill. Work Incentives Improvement Act - S. 331/H.R. 1180, the Work Incentives Improvement Act, was approved by the Congress just prior to adjournment. This measure, which included a package of tax "extenders", as well, will make it easier for disabled persons to return to work without losing their health benefits. Under this new law, disabled individuals who return to work will be able to keep their Medicare benefits for eight and half years, an increase from the current four year limit. A disabled worker earning up to \$75,000 a year will be able to buy into the Medicaid program on a sliding fee scale. The legislation also sets up a pilot program that will allow states to provide Medicaid coverage, which includes prescription drugs, to persons with degenerative conditions, such as Parkinson's disease or HIV, so that these individuals will have access to preventative medicines that can keep them healthier and on the job.

OJJDP Directed to Conduct Comprehensive Mental Health Study - Report language added to the FY 2000 Commerce, Justice, State Appropriations bill by Rep. Rosa DeLauro (D-CT) directs the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to perform a comprehensive mental health study of juveniles in the juvenile justice system. While mental health and juvenile justice experts agree that the rate of mental disorders among youth in the juvenile justice system is substantially higher than among youth in the general population, no federal agency is required to collect and report this data.

The report language directs OJJDP to work in collaboration with the CMHS, within SAMHSA, and the National Institute of Mental Health (NIMH) to perform a comprehensive study that shall determine: 1) the mental health needs of all juveniles in the justice system; 2) the identification of government entities that have developed model screening, assessment of treatment programs that meet the needs of these juveniles; and 3) the availability of mental health services to youth at risk of participating in delinquent activities.

OJJDP is expected to submit the study to Congress by September 30, 2000. Hopefully, the results of the OJJDP mental health study will lead to appropriate mental health services for youth while they are incarcerated, and increase the availability of juvenile delinquency prevention programs. The report language was taken from a provision in the House-passed Juvenile Justice bill, H.R. 1501/H.R. 1150, which has stalled in conference committee over other issues. The National Mental Health Association worked with Rep. DeLauro to get the report language added to the appropriations bill.

Juvenile Justice Crime Legislation - H.R. 1150 (formerly H.R. 1501) and S. 254, the Juvenile Justice Crime bill, remains stalled in conference committee over controversial gun control provisions. Both measures contain several mental health provisions, which include the following: 1) allow states to utilize grant funds to develop and implement effective mental health treatment programs for juveniles who come in contact with the juvenile justice system; 2) make federal resources available for states to train justice system personnel on how to identify severely emotionally disturbed youth, and utilize appropriate community-based programs; and 3) require juvenile justice authorities to submit data on the delivery of mental health services as a requirement of receiving formula grant funds.

SAMHSA Reauthorization - The Senate approved S. 976, the SAMHSA reauthorization bill, by voice vote this fall, which caught many in the advocacy community by surprise. Apparently, Senate members and staff worked behind the scenes to reach agreement on the bill in order to avoid a potentially messy Senate floor

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# In Its Second Round Of Recovery Grants, OH Has Learned From The First

A national leader in recovery, Ohio issued its first recovery grants about five years ago, distributing four grants to various programs and in conjunction giving out four research grants. When that cycle ended this year, a new round of recovery with related research grants was issued, this time 15 grants in all.

Chief of Program Evaluation and Research Dee Roth says the first round of grants was very useful in showing what it takes for a consumer to recover. It can be summed up in one word: empowerment. Thus, even though consumers may not be symptom free, they come to feel they have control over their lives. For example, Roth relates the effects of one program, designed to train consumers to be board members. Not only did the trainees become able to serve on boards but they made such massive gains in empowerment that some went to college, while others got jobs. "It is," says Roth dryly, "very possible to affect this (empowerment)."

Empowerment is also cited as an effect of the Bridges Program, run by OH Advocates for MH and funded in some locations with recovery grants. Bridges - short for Building Recovery of Individual Dreams and Goals through Education and Support - is a program of recovery through training. The 15 week course, taught by consumers to consumers, teaches about facts, such as medication, insurance and public benefits; and feelings like emotional stages of recovery and spirituality. The course is followed with an ongoing support group. Developed by the TN MH Consumers' Association,

Bridges is now in eight states and British Columbia, Canada. Some 400 OH consumers are now taking the course at 20 different sites and in another year, when more teachers are trained, the number of individuals taking the course is expected to double.

Overwhelmingly, the biggest benefit to Bridges students, according to Program Coordinator Ellen Stukenberg, is the discovery that they're not alone. "They say it over and over again," says Stukenberg, who adds that Bridges' consumers also learn that they can be part of their own treatment team and to speak up for themselves. Frequently, they go on to become advocates for other people. In Lake County, OH, a group of Bridges teachers and students testified at a MH Board meeting in favor of a MH levy. Stukenberg could not say if their testimony was directly responsible but the measure is now on the ballot.

Over 2,000 OH consumers have now undergone the training to be Bridges teachers since the first 23 were trained in TN in 1998. Teachers, as well as students, find the experience empowering. "It has given me the tools I need to further my own recovery. It has brought me so much joy to watch the other teachers and class express themselves. It has increased my confidence and self-esteem and deepened my abilities and purpose in life" one teacher writes in a course evaluation.

Teacher training is paid for by the state but each individual site must find its own source of funding. Each 15 week course costs the local site \$1700.00. ■

## At the MH Summit, Preparing the Way for a National Consumer Organization

MH policy makers and consumers came together June 6 in Washington D.C. for the second annual MH Summit. The primary goal of the meeting was to lay the groundwork for a national network of consumers of MH services, which then would be able to affect MH policy.

Keynote speaker Sally Zinman, Executive Director of the CA Network of MH Clients, called for a MH system composed entirely of voluntary services. If that were the case, she said, there would no forced treatment, an issue

that came up repeatedly at the first MH Summit in Portland, OR, last August.

Zinman did note the progress of the consumer movement in MH, observing that that 25 or 30 years ago, consumers were outside the room where MH decisions were being made. Not so anymore, but, she said, the core issues haven't changed since then and it will take a national voice to address them.

### Alabama Council of Community Mental Health Boards Annual Conference

August 23-24th

Birmingham Jefferson Civic Center Birmingham, AL

The conference will feature over 40 workshops and plenary sessions with national speakers addressing issues on serious MI and issues examining, geriatric, substance abuse and children's behavioral health. Additional benefits include an exhibit hall, social hour, two luncheons and CEU's for social workers, counselors, nurses, and psychologists. Approximately 800 participants are expected. Please call Diane Dill at the Alabama Council: (205) 987-5274 or [acmhba@aol.com](mailto:acmhba@aol.com).

## From the Hill

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situation. S. 976 focuses a good deal on prevention and early intervention, in part as an attempt to address school shootings and other recent incidents of youth violence. Regarding co-occurring disorders, S. 976 directs the Secretary of Health and Human Services to report to the committees of jurisdiction on how services are currently being provided for co-occurring disorders, what improvements are needed, and a summary of best practices. In addition, the bill clarifies that both Substance Abuse Prevention and Treatment and Community Mental Health Service Block Grant funds may be used to provide services to those with co-occurring disorders as long as the funds are used for the purposes for which they were authorized. The Senate agreed to leave the controversy over the Synar penalties, which relate to states' laws on preventing youth access to tobacco, to the House to work out.

House activity/interest on a SAMHSA reauthorization bill has been rather slim until recently. The availability of a new drug for use in place of methodone without the addicting qualities associated with methodone has apparently sparked some interest on the House side in a reauthorization bill. It now appears that a House bill might be drafted over the recess with a committee mark-up possibly in late January or February.

Seclusion and Restraint - A hearing was held in the Senate Finance Committee on October 26th regarding S. 736, the Freedom From Restraint Act, sponsored by Senator Joe Lieberman (D-CT). H.R. 1313, a similar bill in the House sponsored by Rep. Diana DeGette (D-

CO), has not seen any action. These bills are designed to protect a patient's rights to freedom from restraint and other abuse while in a psychiatric hospital or other care facility or treatment center. The measures also require a service provider to report sentinel events (when a program beneficiary under psychiatric care dies unexpectedly or suffers serious injury unrelated to his or her illness or underlying condition) to appropriate oversight authorities.

Parity - Several bills have been introduced in both the House and the Senate that call for parity in mental health care coverage. Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) have sponsored S. 796 and continue to work on this issue in the Senate, while Representative Marge Roukema (R-NJ), among other House members, is supporting parity on that side of the Capitol and has introduced legislation, H.R. 1515, to that effect.

The recent report on mental health by Surgeon General David Satcher also addresses the need for parity for mental health care coverage. In addition, NACo's Legislative Priorities for 2000, which were adopted by the NACo Board of Directors in December, include a priority in support of universal mental health coverage for all, including prescription drugs.

As we prepare for the Second Session of the 106th Congress, I look forward to working toward another productive year for mental health issues. Also, I am pleased to note that David Wiebe, former NACBHD president, serves as the Vice Chair of NACo's Health Steering Committee's Behavioral Health Subcommittee for 2000 and Lynn Ferrell, also a NACBHD member, serves on the NACo Health Steering Committee. ■

## A Multi-Site Evaluation Of Consumer Operated Services Is Nearing The Halfway Point

The four-year Consumer Operated Services Program (COSP) will evaluate the effectiveness of consumer operated programs (COS) in treating adults with serious MI. The study is tracking the progress of consumers treated with COS and traditional MH services as well as consumers treated with traditional services alone.

Overseen by the Missouri Institute of Mental Health and funded by a \$20 million grant from SAMHSA, the program focuses on three COS models: drop-in centers, peer support groups and education/leadership/advocacy training. Each program has developed it's own protocol, making necessary adjustments to participate in a multi-site evaluation. There are eight selected sites:

- Self-help agencies (CA) are drop-in centers run by consumers who set their own goals and technologies.
- Peer Center (FL) is the state's largest consumer run service agency, offering over 100 people a day a variety of services.

- The Portland Coalition (ME), a consumer service provider, will be measured against two traditional service providers.
- GROW (IL) is a consumer-operated, mutual-help organization, providing consumers with a community.
- Peer Specialist Program (IA) gives consumer support services for consumers in traditional MH programs.
- Friends Connection (PA) provides peer counseling and support through the provisions of social and leisure skill development for dually diagnosed consumers.
- Advocacy Unlimited (CT) prepares people with MI to be effective advocates for themselves and others.
- Bridges (TN) (see story on OH Bridges) is a consumer to consumer education program. The Bridges study has been designed and will be evaluated by consumers.

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# Fragile Negotiations on Patients' Bill of Rights Continue; Early Action on Appropriations Expected

By Sally McElroy, Associate Legislative Director, NACo

A failed attempt to attach managed care reform provisions to the Department of Defense authorization bill during Senate floor consideration in early June did not signal the end to congressional negotiations on the Patients' Bill of Rights. Senate and House conferees continue to work toward reconciling the two bills, S. 1344 and H.R. 2990. However, major hurdles remain and progress is at a snail's pace.

The two major points at issue are scope and liability — how many people will be covered by the bill and will they be given the right to sue their insurance companies. H.R. 2990 would allow health plan participants to sue their health plans for damages while S. 1344 relies on internal and external appeals processes to resolve complaints. In addition, the House bill would apply to all persons enrolled in private health insurance plans - about 191 million people, whereas most of the provisions in the Senate measure would apply only to those persons enrolled in self-insured health plans - about 56 million people. However, the external and internal appeals process in the Senate bill would apply only to the 131 million people in group plans. Self-insured health plans are governed by the Employee Retirement and Security Income Act (ERISA) and, therefore, are exempt from state regulation.

Senate Republicans argue that covering all privately insured persons would interfere with the states' role as insurance regulators and, in addition, many states already have patient protection laws in place. In response to this concern, negotiators are discussing a possible state opt-out provision for states that have equal or better patient protection laws in place. There has also been much discussion about whether the liability provisions in the House bill would allow patients to sue their employers, as well.

Offers for compromises on several issues have gone

back and forth across the aisle, but with little movement forward. After several months of negotiations, the lack of progress finally prompted Senator Edward Kennedy (D-MA) to push for another vote on patient protections on the Senate floor in early June. Although Kennedy's amendment failed, he views the vote as adding new momentum to the managed care talks. However, the longer the talks go on, the more politics will come into play as Election Day draws near. All in all, the outlook is less than favorable for final passage this year.

In the meantime House and Senate leaders are pursuing an aggressive appropriations schedule this year, pushing the FY '01 Labor, Health and Human Services, and Education funding bill — notoriously an 11th hour, October frenzy — up to the front of the schedule. The early appropriations process is intended to give these programs a better chance at higher funding, as well as to give the Congress a stronger hand in year-end negotiations with the president. The president has already threatened to veto both the House and Senate Labor, HHS bills primarily because of funding cuts to Title XX, the Workforce Investment Act and education programs.

House and Senate appropriators had low allocations with which to craft these bills due to congressional budget resolution numbers. The general consensus on Capitol Hill is that, ultimately, the funding levels for this bill will be higher than the current numbers in the House and Senate legislation.

**The House of Representatives is scheduled to vote on final passage for the Labor, HHS appropriations bill on June 13th. The Senate will take up its version in the next couple of weeks. In the House bill, the Mental Health Block Grant is funded at \$416 million. The Senate funding for this program is set at \$366 million. FY 2000 Mental Health Block Grant funding was \$356 million. ■**

## NC Consumers Issue Another Report Card This Fall

Every six months consumers in North Carolina are asked to fill out a survey rating their satisfaction with area services. Based on a nationally recognized survey, the MH Consumer Oriented Report Card of the Center for MH Services and Statistics, it rates access to services, appropriateness of services, self assessment/outcomes and over all satisfaction.

Results are used for planning purposes at the division level and for area directors to evaluate their own programs. Area Director for MH Services in Catawba

County, John Hardy, says the survey has often resulted in measures to make consumers feel satisfied with their services. One adjustment he has made was to reduce waiting times.

NC's last survey (Dec.1999) was completed by 15,585 individuals. They gave area programs good marks. Overall satisfaction rated 92.7%; access to services, 91.9%; appropriateness of services, 91.9%; and self assessment/outcomes, 80.1%

Hardy says that for him overall survey numbers are

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## NC Report Card

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not as significant as where the differences fall between programs. Even then, the statistics have to be eyed with common sense. For instance, consumers in Catawba's court ordered sex offender program gave the program a low rating, which Hardy says is understandable because it is not a voluntary program. More surprisingly was

that consumers in the court-ordered SA program rated the program highly. Hardy thinks the difference is that SA consumers are more ready to admit that they have problems and to deal with them.

In Hardy's county, 560 questionnaires were filled out during the week of the last survey.

He feels that's a good sample, providing good information. Forty states conduct similar surveys. ■

## One Year after Olmstead: States Are Slow To Comply And The ADA May Be In Jeopardy

On June 22, 1999 the U.S. Supreme Court ruled in *Olmstead v. L.C.* that the unnecessary segregation of individuals in institutions may constitute discrimination based on disability. Under the Americans with Disabilities Act (ADA), the court said that states must provide community-based services rather than place disabled individuals in institutions.

One year later, only four states (KY, TX, DL and MO) have plans to comply with *Olmstead* and, of those, only Delaware has a plan that includes individuals with MI. The other three plans are solely for the developmentally disabled population. Many states did not get the idea that *Olmstead* imposed obligations on them and therefore have not moved to develop or implement a plan, according to Bazelon Center for MH Law Attorney Jennifer Mathis. She says states that have complied have done so because of local suits, rather than *Olmstead*.

Elizabeth Priaulx, Community Integration Specialist with the National Association of Protection and Advocacy Systems (NAPAS), agrees and adds that in those cases - MA, MI and LA for example - the states only address the case named in the suit so that de-institutionalization is far from complete.

Still other states may simply be waiting on the

outcome of a new challenge to the ADA. In October the Supreme Court will be hearing another disability discrimination case - *Garrett vs. University of Alabama* - that calls into question Congress' power to enact the ADA. If the court rules that Congress does not have that authority under the fourteenth amendment, the constitutionality of Title II under the ADA could be called into question.

*Garrett* is one of a series of states' rights cases heard by the high court. In the latest one, *Kimel v. Florida Board of Regents*, the court ruled that Congress did not have the authority to apply the Age Discrimination in Employment Act to the states. In *Garrett*, some states will be asking the court to reach the same conclusion about the ADA. Hawaii plans to file an amicus brief and will ask other states to sign on. Other states, like MN, will file briefs in support of the ADA.

According to NAPAS, a negative ruling would mean that states no longer have to comply with the ADA's integration mandate. Most state protection and advocacy agencies are already working on the issue and NAPAS suggests that they be queried for ways to help.

The court is expected to rule in *Garrett* early next year. ■

## Consumer Run Services, Services for Children Would Benefit From A Block Grant Increase

A new survey by the National Association of State Mental Health Program Directors (NASMHPD) shows that almost half of respondents would favor expanding or creating consumer run services for adults over other services, if additional money is made available through the proposed FY 2001 \$60 million block grant increase. The other half would expand new family support services for children.

Drawing responses from 35 states, one territory and the District of Columbia, NASMHPD's first ever block

grant survey showed that children are already the major target of block grant money. Thirty-six of 37 respondents (97%) said they are currently using block grant funds for children's services. Seventy percent channel the block grant into services for the homeless and 62% target people who have been in the criminal justice system or are at risk for being so.

Adult services being rendered with current block grant money include:

## Services

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Employment/vocational Rehabilitation	78%
Case Management	76%
Outpatient Services	73%
Psychosocial Rehabilitation	70%
Emergency Services	65%
Consumer-run Services and Partial Hospitalization	62%
Children and adolescents services include:	
Family Support Services	84%
Case Management	76%
In-Home Family Services	70%
School-Based Services	68%
Wrap-Around Services	68%
Emergency Services	60%
Outpatient Services	60%

Up until now, says NASMHPD Director of Government Relations Jenifer Urff, it has not been known how the block grant was spent and the survey will be a useful tool in working with lawmakers on Capitol Hill. In a letter accompanying the questionnaire, the Association says, "Future increases in the block grant may be contingent on our ability to address such fundamental questions as: How many people are served

by the block grant? What services are provided? Is the block grant effective?" For the first time, Urff says, the MH community is now united in making block grants a top priority.

Before 1999 the MH block grant had not been increased in eight years. In FY 1999 it went up \$13.5 million. An even bigger increase, \$67 million, was enacted for FY 2000. When called for information about allocation of the 2000 increase, SAMHSA said the information was not yet available and referred the NACBHD Bulletin to the NASMHPD survey.

The \$60 million dollar block grant increase for FY 2001, proposed in the President's budget has yet to be approved by Congress. According to the survey, if it passes, states would be able to provide the following median cost services:

- Employment support for 29,440 additional people; or
- Case management services for 24,316 additional people; or
- Assertive Community treatment (ACT) for 7,570 additional people. ■

## Multi-Site Evaluation

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Some 2500 consumers will take part in the research. Consumer outcomes under study include effects on empowerment, housing, employment, social inclusion

and satisfaction with services. Program and societal costs will also be measured, as well as partnerships among consumers, service providers and researchers. ■

## SAMSHA'S Consumer Panel is Up and Running

The Consumer Subcommittee of the CMHS The Consumer Subcommittee of the CMHS National Advisory Council will meet for the first time in September prior to the regularly scheduled meeting of the Council. Nine geographically and culturally diverse subcommittee members have been chosen from a pool of

100 consumers and are awaiting final approval by the agency. Representing a range of experiences and philosophical perspectives, subcommittee members will make recommendations to the council and report back to other consumers. Establishing the subcommittee has been a two-year process. ■

## Calendar of Events

Summer/Early Fall, 2000

**July 13 - 15:** National Association of County Behavioral Health Directors, **5th Annual Conference - Developing First-Class Leaders: Knowledge, Tools and Resources**, Adams Mark Hotel, Charlotte, NC, Contact: Lauren Wolfe, (202) 234-7543.

**July 15 - 19:** National Association of Counties, **Annual Conference**, Charlotte Convention Center, Charlotte, NC. Contact: Conference Dept., (202) 393-6226

**July 31-August 4:** New England Educational Institute. **17th Annual Summer Symposium: "Angry and Difficult Children and Adolescents - Promoting Hope, Motivation, Self-Discipline, and Resilience"**. Eastham, MA. Call 800-926-1232 or 413-499-1489. (source: Myron Pulier).

**July 31-August 4:** Professional Learning Network (PLN). **21st Cape Cod Institute: "Treating the Unmanageable Adolescent"**. Eastham, MA. Call 888-394-8900 (source: Myron Pulier).

**August 1-3:** American Association of University Affiliated Programs for Persons with Developmental Disabilities. **AAUAP Annual Meeting**. Seattle, WA. (Source: AAUAP web site).

**August 4-6:** Bridging Space and Time; Rural Mental Health in the New Age, Portland, OR. Contact: Cathy Britain, (541) 962-3430

**August 7-11:** Institute for Integral Development. **24th Annual Summer Institute on Behavioral Health and Addictions**. Colorado Springs, CO. Call 719-634-7943. (source: NCJRS web site).

**August 8-9:** Michigan Association of Community Mental Health Boards (MACMHB). **Pharmacological & Co-Occurring Disorders**. Lansing, MI. Contact Jessica Hewitt at 517-374-6848.

**August 11-13:** National Depressive and Manic-Depressive Association. **Annual Conference: Partnerships for Success**. Boston, MA. Call 800-826-3632. (Source: DMDA web site).

**August 21-24:** CDR Associates. **The Mediation Process**. Boulder, CO. Call -800-633-4283. (or [www.mediate.org/TrainingSchedule.html](http://www.mediate.org/TrainingSchedule.html)) (source: NCJRS web site).

**August 23-24:** AL Council of Community Mental Health Boards. **Annual Conference**. Birmingham Jefferson Civic Center. Call: Diane Dill at (205) 987-5274 or [acmnd@aol.com](mailto:acmnd@aol.com).

**September 9-12:** Prevent Child Abuse America and Healthy Families of America. **6th National Healthy Families Conference**. Atlanta, GA. Contact Sara Zuiderveen at 312-663-3520, Ext. 148. (source: NCJRS web site).

**September 22:** Philadelphia Child and Family Therapy Training Center. **Ethical/Legal Issues in Family Treatment**. Philadelphia, PA. Call 215-242-0949. (source: Myron Pulier).

**October 5-6:** Open Minds. **Information Technology Institute: How to Leverage Your Technology Investment**. San Francisco, CA. Call Open Minds. (Source: Open Minds web site).



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