

Becoming a Player on the National Stage, Developing Future Leaders, New President Jim Stewart Charts NACBHD's Course

If you sense that enthusiasm at NACBHD is booming, it has a lot to do with new President James (Jim) W. Stewart, III, whose energy and zeal are irresistible. During his five years with NACBHD Stewart has come to value the organization for two primary reasons. One is its potential to influence federal legislation and regulation. The other is meeting other county directors in other states. Executive Director of Henrico Area Mental Health & Retardation Services, which manages and provides behavioral health services in three Virginia counties, Stewart has benefited from the experience of other NACBHD members particularly in the areas of managed care implementation and Medicaid.

During his term as president Stewart hopes to build on NACBHD's strengths, both as a national player and as a local facilitator. First on his list is Medicaid. He wants to clarify Medicaid issues that are of concern to members and then make a concerted effort to influence federal thinking on the subject. "A Medicaid Committee has been established, chaired by David Wiebe from Kansas," says Stewart in an elegant upper South accent, earned possibly from his years of working in mental health programs in

Tennessee and Virginia. "The Committee will develop issue papers with the involvement of the membership and formulate strategies to approach CHMS and legislators."

Next on the agenda is filling the void in future leadership in the behavioral health field. This effort will be guided by a distinguished steering committee composed of NACBHD past presidents and the jewel in their crown will be NACBHD's new leadership institute. It will be funded by drug companies and several reputable educational institutions have expressed interest in hosting it.

When the leadership institute gets going, it will train about 30 senior executives a year. More immediately, says Stewart, there will be a half-day mini-leadership institute at next July's

"What I like best about NACBHD is I can pick up the phone and call people in other states."

NACBHD President Jim Stewart

annual meeting.

Increasing opportunities for members to interact about issues of mutual concern, Stewart is "exploring the idea of regional forums and the possibility of a gathering that will bring together state leaders from all states to discuss county-based systems of community mental health, mental retardation and substance abuse services."

He also wants to expand NACBHD's membership from the current 310 to four or five hundred. This, he says, will enhance NACBHD's visibility and give it greater clout in the national arena.

Stronger membership services are just one piece of evidence that it's a new day at NACBHD. Look also for an increased emphasis on the work of committees, greater cooperation with state associations and higher visibility. Moving NACBHD down all these various paths at a brisk pace, Stewart has increased the number of executive committee meetings. "I'm excited," he tells the newsletter over the phone and in that short statement can be heard the pulse of activity.

NACBHD WEB SITE

We have renovated our web site! It is clearer, more attractive and better designed with you in mind. Many new features will be added in the coming months, but check it out now at www.nacbhd.org. Let us know what you think. Have a web site that you would like to link to ours? Email it to the NACBHD office at Lauren@nacbhd.org.

bulletin

President Elect Barbara Droher Wants to Establish NACBHD State Affiliates

MN has no county behavioral or mental health association at the state level and therein Barbara Droher, who is Director of Adult Services for Hennepin County, sees a lack. An affiliate group could both feed information about local issues up and about happenings at NACBHD down. Although the affiliate group is still an idea, Droher has established an informational e-mail tree, to share information on a more regular basis and so she can learn “what they would like me to look at for next three years.”

Already a three veteran of the NACBHD executive committee, Droher has observed that many members have never attended a conference, all on the east coast to date and the next one planned for the west coast. The answer: regional conferences that “would draw a lot more people and target local needs.”

In the meantime she’s collecting a roster of issues, both endemic to MN and more universal, that give specific clues as to what’s on her mind and what she’d like to see NACBHD grapple with. An issue that affects her state specifically is the auto-closing of current SSI cases every six months that then require considerable paperwork to renew and often result in consumer stress, service interruption and uncompensated care. Another is overlap in TANF funding where recipients often have undiagnosed and untreated behavioral health issues.

Broader issues include: identifying developmentally

disabled consumers who could benefit from new mental health medications; diagnosing consumers with organic cognitive issues from physical injuries or chronic drug abuse through neurological exams using MRI’s; taking a public health approach to identifying and educating high risk consumers before they become seriously mentally ill; taking a public health approach to treat medication resistant consumers before they are court committed or jailed; and improving correctional data.

“We get the conversation started and discover another state has a mutual concern,” says this thoughtful future leader of NACBHD, adding, “I’m hoping to get stronger alliances with state mental health associations to get some of these discussions at a broader level which will start to make a difference at the public policy level.” Droher would also like to see NACBHD do more orange books like two already produced that provide research information. “I can barely keep enough of them, I give them out to so many people,” she says.

Finally, Droher would like to include the consumer perspective in NACBHD’s national conference. While she admits it gets overdone and that she doesn’t see the need for consumer input on everything, she believes that hearing from consumers is revitalizing. “That’s what keeps you going in a field that is so difficult you wonder why you even come to work every day.”

NACBHD in the National News, Foresees Treasurer Jeffrey Davis

“I predict that in the next five years NACBHD will in the media in some significant way, either quoted or asked to present views,” says Marion County (OR) Health Department Administrator Jeffrey Davis, who believes the association is gaining significant credibility. As NACBHD’s new treasurer, Davis defines his role as offering “to support the other members of the executive committee.”

He makes a great cheerleader. A member of NACBHD since its inception about 7 years ago, he remembers when there only ten members. The organization’s 3000 percent growth is one of its biggest changes but he has seen others. For instance there has been a significant improvement in the relationship between county directors and state program leaders, who thanks to NACBHD, have become more

knowledgeable about the county system. Davis also applauds the staff presence in Washington, citing Tom Bryant’s leadership and ability to make NACBHD visible and he’s thrilled that the increase in membership provides planning money for projects like the leadership institute (see Stewart above).

Looking into the future he prophesizes that NACBHD’s leadership institute “will take off” and that it “will be good for behavioral health across the country.” He sees more partnerships between NACBHD and state organizations like NASMHPD and NASADAD and that projects they promote will have increasing visibility. Finally Davis believes that “in the next three to five years significant projects will be coming out of NACBHD committees.”

Meet NACBHD's Board of Directors

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NACBHD 2002 MEMBERSHIP CAMPAIGN

The campaign will be launched by October 19th with the mailing of renewal notices. Some new benefits have been added this year. Look for the notices and respond promptly. We are growing and changing because of the investment that each one of you makes to the association. Thank you in advance for your commitment and support. We look forward to working with you in 2002!

New County-Friendly SAMHSA Director: “A Date on the Weekends” for the Mentally Ill

When Charles Curie addresses various PA groups in his capacity as Deputy Secretary of Public Welfare’s Office of Mental Health and Substance Abuse, he always concludes with his personal mission statement to the effect that those afflicted with mental illness have a right to work, to have a home and family, and, he winds up, to a date on the weekends.

Presumably he has taken that mantra to Washington where he is already on the job, although not allowed to make decisions or give interviews until Congress confirms him, probably around Christmas, sighs a SAMHSA spokesperson. But Curie’s six years in PA government speak for him in many ways, the most relevant being his openness to counties.

Executive Director of PA Mental Health and Mental Retardation Program Administrators, Michael Chambers, considers Curie a friend, having met with him at least monthly during the time Curie was in Harrisburg and spoken to him on the phone regularly. But Curie’s accessibility was widespread. “He has been willing to listen to views from all corners and consider them carefully in his decision making,” says Chambers.

Tim Boyde has been Centre County Mental Health/Mental Retardation Administrator for 15 years and he’s seen a few deputy secretaries come and go. But he says he’ll miss Curie, who always knew what was going on in Centre County, particularly around the implementation of Health Choices, PA’s managed behavioral health care plan. What Curie took from meetings with consumers and local administrators, he used on behalf of counties. “He was willing to advocate with Department of Public Welfare to allow the county programs to have first right of opportunity to implement Health Choices,” says Kathleen Kelly, Northampton County Administrator of behavioral health programs, adding that Curie’s stance came under intense pressure from the for-profit managed care companies. As a proponent of universal health care, she differs from Curie philosophically but can “appreciate his openness to county oversight and control.”

In the end counties were granted the right to try and manage their own behavioral health plans. All but one have chosen to do so and all except Philadelphia County have contracted with private managed care companies. Here, Kelly is critical, saying the state should have done more by capping administrative costs charged by the private companies. Instead, negotiations were left to the individual counties. “Because there are so few companies now nationally that’s left us with little negotiating power,” says Kelly, adding that she wishes Curie’s office could have addressed this.

Chambers, Boyde and Kelly give Curie high marks for his openness to consumers and families. “He’s genuinely sensitive,” says Kelly. One example, she cites, is that every health choices program must have a consumer/family satisfaction component, mandated by the state but not in such detail that counties can’t configure their own systems. Boyde notes Curie’s efforts to empty the state hospitals and return consumers to the community. Last year his department won the national Harvard/Ford Foundation Innovations in American Government award for its program to reduce use of restraints and seclusion in state hospitals, down 74% since 1997. According to Chambers, “Charley often says ‘seclusion and restraint are not treatment.’”

Curie’s attempts to meld mental health and alcohol and drug abuse services also win him praise. Beginning with the reorganization of his own office to include both mental health and substance abuse services, Curie has spearheaded a statewide effort to integrate services based on the work of Dr. Kenneth Minkoff. He’s “forward thinking”, says Kelly, who nevertheless laments that the process has taken such a long time. But in Pennsylvania substance abuse services are divided between the departments of welfare and health so Curie has only controlled those services that are funded with Department of Welfare money. “I wish they’d seal the deal and eliminate the Department of Health,” grumbles Boyde, who thinks the department is a “nightmare”.

In the mid 1980’s Curie moved to PA from another strong county state, OH, to run a community mental health center. Thus, he began in PA as a provider and worked his way up to deputy secretary. Along the way he was active in the Community Providers Association and worked for the private sector, providing insurance to providers. With that background Curie did nothing less than “change the direction of mental health services in our state,” says Chambers, adding that Curie will be taking the values he held in PA to Washington.

Once there Kelly believes Curie will promote managed care for the public system on a national level, maybe even use a PA model. “I think the Philadelphia model is worthy of replication,” she says but adds that she does not think Curie will take a cookie cutter approach but will acknowledge county differences. Boyde anticipates a new federal emphasis on empowerment and deinstitutionalization.

Kelly also anticipates that Curie will take time in Washington to practice what he preaches. Every year she sees him at Music Fest in Bethlehem where they both live, having a date on the weekend with his wife, Candace.

NACBHD 2002 CONFERENCE SCHEDULE

LEGISLATIVE CONFERENCE
February 27 - March 1st
Madison Hotel, Washington, DC

ANNUAL CONFERENCE
July 25 - 27th
Clarion Bayview Hotel
San Diego, CA

The Legislative Conference registration brochure will be out by mid-November.
Look for the Annual Conference Call for Proposals on NACBHD's web site by mid-October and in the mail in November. Turn your ideas into presentations.

NACBHD 2001 Annual Conference: A Great Success

By Lauren Wolfe, MS, NACBHD Deputy Executive Director

NACBHD recently completed a successful Annual Conference held in Philadelphia in July. We would like to review the highlights of the conference and continue the discussion that we began.

We are grateful to Estelle Richman, Director of Social Services for the City of Philadelphia, for her wonderful keynote address. She spoke eloquently and passionately about the challenges of managing a large metropolitan county system, and encouraged us to be mindful of the rewards.

The first day continued with an examination of workforce issues. This is a difficult topic with no easy solutions. From recruitment to retention, we explored how county directors can position themselves in a more proactive way. Michael Shirley, a seasoned recruiter, talked about how behavioral health boards can better understand the county directors positions for which they are recruiting. Phil Rosenberg, the H.R. Doctor, and a NACo favorite speaker, spoke with great humor about creating a "compelling work environment". Both men know the local public system and what it takes to attract and keep the best people invested.

We heard about the challenge of keeping social workers in the system and the kinds of partnerships with academic institutions that are necessary to recruit and retain, when we know that we are in competition with the private sector for the most qualified professionals. We heard from two models: the CA Workforce Summit and Henrico Area Community Services Board (VA)'s management diversity improvement project. They provided good examples of county directors coming together to solve a very difficult problem and shaping a program that is more responsive to the need and requests of the community.

We engaged in a brainstorming session facilitated by Bill Benton that gave participants the opportunity to share their thoughts, experiences and opinions. The session culminated in a series of

recommendations that NACBHD can move forward into its policy agenda for Yr. 2002. (see separate article below).

Maximizing our professional network in this way has always been a hallmark of our organization. We learned the in-depth story about the state of behavioral health care in Pennsylvania from those at the state association level, Philadelphia County and the impact of the Medicaid waiver on one county. This session gave our hosts and local directors the chance to tell their story. The Pennsyl-

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NACBHD 2001 Conference...

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vania State Report provided attendees the information and insights they welcome. So did the update session on the Michigan Medicaid waiver. We topped off this discussion, with a presentation by Dr. Jeffrey Buck of the Center for Mental Health Services/SAMHSA, who spoke about the National Spending Trends Research Project and its implications for public policy.

Sessions examined such critical issues for county directors as: information technology, juvenile justice and several aspects of children's behavioral health: school-based mental health programs and the best practice model - WrapAround Milwaukee.

The new Display Area gave participants a chance to sample product and service information from 17 organizations serving local behavioral health care systems. Judging from the response, it was a worthwhile addition. With close to 80 directors attending, we believe that the NACBHD Annual Conference is now the place to network and obtain vital information and materials pertaining the county/local

behavioral health directors. No other venue is so specifically designed with the county director in mind.

The Awards Luncheon has become a standard feature of the conference. This year's Thomas Wernert Award was Santa Clara County Department of Corrections for its ARTEMIS program.. We are grateful to the Technical Assistance Collaborative and The David and Lura Lovell Foundation for their effort throughout the year to make this program a reality and a meaningful contribution to our professional lives. In 2002, we will be in San Diego from July 25 - 27th. Don't miss the opportunity to attend NACBHD's annual conference. Look for the Call for Proposals on our web site in early October and in print in November. Submit a proposal for a session. It is a great way to get involved, let others know what you are doing and contribute to the program. Check NACBHD's web site for more conference information: <http://www.nacbhd.org/>.

NACBHD Moves Towards Workforce Policy

In a particularly productive session at July's conference NACBHD members discussed workforce recruitment and retention, problems that may direct the future of country behavioral health departments. The result of the session was a number of resolutions to be advanced at the national level by NACBHD. They include:

- Providing stipends for mental health professionals
- Making workforce issues a priority of the proposed Mental Health Commission
- Contacting the Center for Social Work Education, American Counseling Association and American Psychological Association to move the discussion to the federal policy level
- Working with partners such as NAMI and American Public Human Services Association, to develop crisis related policy
- Opening up Title IV-E
- Meeting with SAMHSA and HRSA to raise issues to a higher priority

Workshop participants agreed that the greatest need was for staff to work with severely

emotionally disturbed children, that relationships with graduate schools are difficult and that departments need to pay more attention to their own internal processes, providing better training for clinicians to move into administrative positions. Perhaps most ominously, participants lamented the devaluation of public service in society in general, saying that the work is not invested with the same spirit that it has been in previous years.

UPCOMING CONFERENCES:

Sept. 29 - Oct. 1st: HIPAA Road Map. San Francisco Marriott, San Francisco, CA. Presented by CMHC Systems, Dublin, OH. For more information contact: 1-888-848-8111 or hipaaroadmap@cmhc.com.

Oct. 19 - 21st: Consensus Conference on The Behavioral Issues Involved in Bioterrorism. Bethesda Marriott, Bethesda, MD. Contact: Robert Ursano, MD at (301) 295-2469 or rursano@usuhs.mil.

Congress, After The Summer Recess

By Sally McElroy, NACO Associate Legislative Director

Congress will consider a number of mental health and substance abuse measures this fall. Here are the highlights:

Health Insurance Portability and Accountability Act (HIPAA) of 1996 - Legislation (S. 836 and H.R. 1975) has been introduced that would delay the compliance date for HIPAA by two years. HIPAA calls for the administra-

tive standardization of the processing and handling of health care information and data by all entities that deal with such information, including county government. The goal of the law is to achieve cost and time efficiencies through administrative simplification. For example, a national, uniform medical code system will replace the

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thousands of codes that are used regionally and locally to process reimbursement forms and in record keeping. However, implementation and compliance requirements of the law have been released in a piece-meal fashion and compliance is time-consuming and costly. County governments can expect no federal financial assistance in this effort, making this issue an unfunded mandate. Hearings have been held on HIPAA. The likely strategy for these bills is to get them attached to the Labor, Health and Human Services Appropriations bill or other year-end omnibus legislation.

Parity - Before Congress adjourned for the August recess, the Senate Health, Education, Labor, and Pensions (HELP) Committee approved the Mental Health Parity Act (S. 543), equalizing mental and physical health insurance coverage. Committee members voted unanimously for the bill after agreeing to expand the small business exemption from 25 to 50 employees out of concern that increased costs might cause some employers to drop insurance coverage. An amendment nullifying the parity requirement if it raises health care costs by more than one percent may be offered during full Senate consideration. The current parity law expires September 30. At recess time no action had been scheduled on the House mental health and substance abuse parity legislation (H.R.162).

Patients' Bill of Rights - The House has passed its version of the Patients' Bill of Rights legislation, setting

the stage for a difficult conference with the Senate. Unlike previous years, the Senate approved a bill that contains greater rights for patients to sue health plans, while the House adopted the more limited version, after a compromise was reached between President Bush and Rep. Charlie Norwood (R-GA). However, the result could still be no new law. Conference negotiations are expected to be slow and contentious, just as they were last year, when no deal was reached. Senate Democrats oppose the Norwood amendment and have warned that they will move the Patients' Rights legislation onto another moving bill if progress stalls in conference. Rep. Norwood insists the amendment is crucial because without it the President will veto the measure. The House has now acted on three Patients' Bill of Rights bills in three years.

Medicare Prescription Drug Coverage - Until late July, House and Senate health care leaders were still working to produce a bipartisan Medicare prescription drug coverage bill that could be considered in committee before the August recess. This proved elusive as discussions stalled over how to reduce the cost of a premium that the Medicare beneficiary would have to pay for the prescription drug benefit. The new goal is to consider legislation before Congress adjourns for the year. The general belief on Capitol Hill is that if action is to occur on this issue in the 107th Congress, it must happen before this session adjourns because 2002 is an election year.

Faith-based Initiatives: Hot Air Or Is There Fire?

When the U-S House of Representatives passed the "Community Solutions Act" (H.R.7) on July 19th, there was little fuss, possibly because it is hard to know what effect the measure will have. It allows cabinet secretaries to convert up to \$47 billion worth of social spending into vouchers so that participants can shop around for secular or religious programs. While behavioral health treatment is not included in the voucher program, peripheral services are, including juvenile justice, housing, elderly services, child abuse and domestic violence.

"It's a lot of hot air," says NACBHD Treasurer and Administrator of the Marion County Oregon Health Department Jeffrey Davis. "The irony is that a lot of faith based organizations already deliver social services with government money."

Exactly, says Director of Government Relations for the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) John Avery, but he says the law isn't aimed at organizations like Catholic Charities or Lutheran Services. He calls the measure "a stealth thing" for the benefit of small congregations that don't have the ability or resources to comply with government requirements. Because the vouchers allow for consumer choice, H.R. 7 permits religious groups to operate without restrictions. Says Representative Bobby Scott (D-VA),

"(Supporters) figure they can get money passed around through the back door they couldn't get through the front door."

What raises the hackles of the American Civil Liberties Union is that tax dollars might be used to fund discrimination in both hiring and delivery of services. Avery, who used to be a service provider himself, also sees a danger to existing programs. Most current service providers, he says, are dependent on guaranteed government grants. If cabinet secretaries are allowed to change how money is distributed at whim, how can those organizations establish operating budgets? "If they can't count on that solid base contract, they can't do it," says Avery.

"That's the piece that I think is negative," agrees Davis, who foresees that long time service providers may get their budgets cut and that in turn "cracks in the infrastructure" could develop as money shifts between programs.

H.R. 7 now goes to the Senate where Senator Joe Lieberman (D-CT) is going to develop a draft to make the bill "more acceptable", Avery says but isn't clear about what that means. He's pessimistic about the Community Solutions Act: "There is no need for new law unless what you're trying to do is create a loophole whereby churches can take federal dollars and use them for proselytizing or discrimination or so forth."

Bioterrorism, Developing A Behavioral Response

After the 1995 gas attack on the Japanese subway that killed ten people, four thousand others showed up in local hospital emergency rooms with symptoms deemed to be anxiety related. Would your county be able to handle a situation like that? Would you know what to do?

Don't feel bad. The mental health response to bioterrorism and other bio-events, such as the hoof and mouth contagion, has been largely overlooked. Journal articles on the subject seem to be largely limited to two,

a 1997 JAMA article and one in the American Journal of Psychiatry in 1999, which concludes that chemical and biological weapon agents can cause behavioral and cognitive disturbances. Based on a literature review, the article also shows that a bio terrorist incident would have wide ranging psychological effects on individuals and the community, some acute, some prolonged, requiring a broad range of responses and that behavioral health experts should train for such a possibility along with other health care professionals.

Responding to bioterrorist attacks in other ways seems to have been on almost everybody's mind this summer. In late July a Congressional committee heard testimony about a simulated smallpox outbreak, 'Dark Winter', that showed authorities were woefully unprepared. Two weeks earlier HHS had announced the appointment of a special assistant for bioterrorism. Scott Lillibridge will work to improve public health and medical response; expand research and stockpiles of pharmaceuticals, if needed; and regulate shipment of hazardous biological agents. The nations' governors, when they met in June, conducted a tabletop exercise designed to gauge state problems and response.

Colonel Molly Hall with the Uniformed Services University of Health Sciences (USUHS) Department of Psychiatry has been collecting data from states on psychological and behavioral preparedness. After contacting interviews with 20 regionally diverse states she has found that in about half mental health has not been involved in the planning at all. No specific plans for psychological and behavioral consequence management had been drawn up for bioterrorism at all. "A lot of questions I was asking were very new to folks at state level," Hall says, "A lot of them hadn't thought of it."

Those that have mostly formulated responses along the lines of those for traditional natural disasters. But Hall says a bioterrorism incident would be different and would require its own set of responses. According to Hall it would more hidden, more ongoing. There would be no identifiable beginning or end, nor would the source of infection necessarily be known. Bioterrorism would appeal more darkly to people's fears and bring up all sorts of troubling questions like who is responsible and why were certain victims chosen. "Some of the states I interviewed referred to experiences they'd had with school shootings and the kind of anxiety, fear that ensues in a community after something like that," Hall notes.

Hall is also interested in the county response to bio event planning. She wants to know if concerns have begun to trickle down to the county level, although in

BIOTERRORISM QUESTIONNAIRE

Describe your county in terms of: rural, urban, coastal, interior_____

1. Is there a response plan/ or planning to manage the behavioral/ psychological responses to a Bioterrorism(BT) event or a naturally occurring infectious disease outbreak (large scale such as epidemic)?

If yes: Are there communication plans or information programs developed to inform the public in a BT scenario

- has this been broken down for specific agents of BT?
 - are there plans or policies to communicate strategies of evacuation, quarantine and immunization?
 - is there a risk communication program?
2. Have you had training exercises that included a BT scenario or been involved in planning for outbreaks of animal disease such as Hoof and Mouth?
3. Have you worked with local public health officials in managing the public/community response
- to an epidemic outbreak of illness? (i.e. meningitis in Ohio)
 - to an outbreak of food poisoning?
4. Have you had experience managing the behavioral, psychological and mental health impact of a natural disaster-forest fires, earthquakes
- how different or similar do you think this experience would be to that seen in a BT event
5. How do you perceive your need for behavioral and mental health response preparedness in anticipation of bioterrorism and infectious disease outbreaks?

Send responses to: Col. Molly Hall, Dept of Psychiatry, USUHS, 4301 Jones Bridge Rd., Bethesda, MD 20814-4799, mhall@usuhs.mil

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one state questions about bio terrorism seem to be trickling up. “The state level agency is getting concern from the county level about what should be in a disaster response plan”. See the box for Hall’s questionnaire, if you would like to provide some county input.

The data collected by Hall will be put to use in October when USUHS, which has a history of trauma and disaster response, and CMHS co-sponsor a conference to examine psychological and behavioral response to bioterrorism and other bio events. Funded by SAMHSA the conference will bring together state mental health officials, representatives of state government, FEMA and the FBI, among others. “We hope to talk very specifically about how to plan and address a response to a bio event. Mental health tends to be thought of later rather than sooner in most things, but we feel it’s going to be a larger piece of the management

requirements than many people have thought of,” Hall says.

Among issues she anticipates being discussed at the conference are the protection of first responders. “When I spoke to mental health participants (in simulation exercises) they said it hadn’t been worked out how mental health people were going to report to work and feel protected.” In addition there were tensions between various levels of government and a lot of confusion about what to say to the media and when. Hall expects the conference to endorse the need for prepared media messages. Another problem is what to do about people who are behaviorally affected, who don’t really need to be treated in a medical facility but present there anyway. Then there is the whole difficulty of special populations and how to protect and care for them.

NEWS IN BRIEF

New Developmental Disabilities Administration Commissioner Patricia A. Morrissey began work in late August. A Ph.D. in special education, Morrissey has been helping federal agencies make their electronic and information technology accessible to individuals with disabilities. She has also worked with both Senate and House, and for President Reagan during her 26 years in Washington. The ARC credits her with “a long and distinguished Washington career in disability policy.”

Surgeon General’s report, *Mental Health: Culture, Race and Ethnicity*, documents the role culture and society play in mental health treatment. Not surprisingly the August 26th report finds that racial and ethnic minorities are less likely to receive quality care than the rest of the nation and are more likely to need it. The report makes broad recommendations including improving the science base, making treatment more accessible and supporting culturally relevant capacity development. A full copy is available at <http://www.surgeongeneral.gov/>.

Surgeon General convenes national mental retardation meeting this fall. A teleconference is schedule for late October and the conference is set for December 5 & 6th. Topics include: improving health provider education; diagnosing a range of conditions that often go undetected; overcoming stigma and improving access to care. You can provide input at <http://www.surgeongeneral.gov/topics/mentalretardation>.

Screening for Mental Health (SMH) is distributing a new kit for screening mood disorders. Designed to be used by public sector sites including local or county hospitals, clinics and service providers, the kits include easy-to-use guidelines, an educational talk, a video with Spanish subtitles, screening forms in both English and Spanish, a new bipolar diagnostic kit and other materials. Kits can be used in daily contact with consumers or as part of National Depression Screening Day, October 11. They can be obtained by calling 781-239-0071 or online at <http://www.mentalhealthscreening.org/reg>.

Working on Measures of Cultural Competence, the Evaluation Center@HSRI and Cambridge Health Alliance’s Department of Psychiatry are developing a standardized set of cultural competence measures at three levels: organizational, provider, and consumer. The measures will be based on CMHS cultural competence standards in managed mental health care services as well as interviews with providers and focus groups. Funded by SAMHSA, the Evaluation Center@HSRI provides technical assistance to county, state and non-profit public and private entities to improve mental health services. For more information on the cultural competence measurement project call Terry Camacho-Gonsalves at (617) 876-0426, ext. 32 or visit the Evaluation Center website at <http://www.eval.hsri.org>. Thank you to Kathy Eilers, NACBHD Board member and Director, Milwaukee County Mental Health Department for serving as NACBHD’s liaison to HSRI.

Job Announcements

MH Program Administrator #D1300

The City of Virginia Beach is seeking an individual to manage a staff of 200 and direct the mental health and substance abuse service delivery system including program planning, monitoring and evaluation; work effectively with staff, colleagues, other City departments, consumer/family advocacy groups and state agency liaisons; assure programs meet licensure, accreditation, and compliance requirements; oversee complex budget, staff productivity and program outcomes; remain current with changing health care environment, including managed care technologies. Requires education and/or experience equivalent to 11 years associated with such positions as director of a major community mental health center or clinical supervisor/administrator of a major local/state mental health program unit or any combination of education and training which provides the required knowledge, skills and abilities. Preferences: Master's degree in behavioral health specialty; experience in public behavioral health sector; and strong managerial skills. Salary range: \$62,688-\$94,033. Submit City application, copies of certifications and college transcripts by 9/26/01 to: Department of Human Resources. 2424

Courthouse Drive, Virginia Beach, VA 23456. Application forms may be downloaded from our web site at www.VBgov.com/careers.

Executive Director

Our Client is a Behavioral Health Authority serving the needs of the people in one of Virginia's largest cities. The Executive Director is directly accountable to the Board of Directors. He or she is the principal professional in the organization and is directly responsible for all operations, facilities and administration. The successful candidate must possess a Master's Degree in psychology, counseling, business, public administration or related field. Candidates should have five or more years of experience as Executive Director or equivalent in a major social services organization with demonstrated leadership, Board participation and successful development activity. Experience in the development and implementation of policies and procedures related to Board, staff and facilities is necessary. Extensive knowledge of the principles of community-based behavioral health services and delivery systems is needed along with demonstrated skill in assessing, relating and coordinating various activities of department staffs and groups of individuals in serving behavioral health populations. Send current resume with cover letter to: Dean Bare at mbsearch@mulling.com or fax to 770-395-3148. Equal Opportunity Employer.



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