Tracking Wellness Measures to Increase Life Expectancy Among People with Mental Health and Substance Use Disorders

OCTOBER 26, 2010

10×10 Wellness CAMPAIGN
SAMHSA

Disclaimer

The views expressed in this training event do not necessarily represent the views, policies, and positions of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Food and Drug Administration (FDA), or the U.S. Department of Health and Human Services (DHHS).

Archive

- This training teleconference is being recorded.
- The PowerPoint presentation, PDF version, audio recording of the teleconference, and the written transcript will be posted to the SAMHSA 10x10 Campaign Web site at *http://www.10x10.samhsa.gov* under the “10x10 Training” section.

Questions and Answers

At the end of the speaker presentations, you will be able to ask questions. You may submit your question by pressing “*1” on your telephone keypad. You will enter a queue and be allowed to ask your question in the order in which it is received. On hearing the conference operator announce your first name, you may proceed with your question.

The Role of Surveillance in Improving the Health Status of Consumers of Mental Health Care

Elsie Freeman, M.D., M.P.H.

Director for Integrated Care Projects

Office of Quality Improvement

Maine Department of Health and Human Services

Connecting Mental and Physical Health

- Compared to the general population, people with serious mental illness on average lose 25 years of normal life span.
- People are dying from treatable medical illnesses, such as diabetes or heart disease, that result, in part, because of preventable health risks, such as obesity or smoking.
- People with serious mental illness have a greater prevalence of medical conditions than people in the general population.

SOURCE: Colton, C.W. and Manderscheid, R.W. Preventing Chronic Disease 2006 Apr. http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

Preventing and Reducing the Impact of Medical Conditions

- Health improvement starts with surveillance and data collection.
  - Brings attention to a particular health issue
  - Promotes root cause understanding to focus interventions
  - Directs and informs actions and interventions
  - Permits evaluation of interventions' efficacy
- The mental health system–federal and state agencies, providers and consumers–can't go it alone.
  - Optimal health care for people with complex medical conditions requires sophisticated, high-quality healthcare delivery systems.
  - Programs confined to the mental health and related systems may unintentionally foster community exclusion.

We Need Partners in the Healthcare Delivery and Public Health Systems

Healthcare providers and public health practitioners care deeply about the conditions that lead to early death.

These two systems have well-developed programs that

- Track health data and identify evidence-based practices
- Educate the workforce and general population
- Prevent and reduce health risks
- Deliver high-quality preventive care for chronic medical conditions
- Ensure patient safety

Data from Public Health Partners

Behavioral Risk Factor Surveillance System (BRFSS)

Data on social determinants, health risk, chronic disease, and mental illness in the general population

- One in thirteen Mainers has current symptoms of clinically significant depression.
- One in five Mainers has had a diagnosis of depression in his or her lifetime. Everyone has a loved one, colleague, or friend touched by depression.
- Depression is associated with higher rates of health risk, such as smoking, obesity, poor nutrition, and physical inactivity.
- Depression is associated with higher rates of chronic disease, such as asthma, diabetes, arthritis, and heart disease.
- The effects of mental illness persist when controlling for age, gender, income, and education.

Integrated Analysis of Maine BRFSS Data

- Greater partnerships with public health at state and local level
  - Depression screen included in statewide Web-based health screen and depression awareness campaign launched by state and local public health systems
- Mental health issues addressed in state health plan, Healthy Maine 2020, Maine Medical home pilot
- Broader acceptance of concepts
  - There is no health without mental health.
  - Mental illness affects not just “them,” but almost all of “us” (destigmatization).
- Shared public health resources to support consumers with serious mental illness, e.g., diabetes self-education program, Living Well with Chronic Disease

Partnerships with Maine BRFSS

Partnerships with Maine BRFSS have led to adding BRFSS questions to SAMHSA Consumer Satisfaction Survey.

- What is your height and weight as translated into body mass index (BMI)?
- Have you ever been told by a doctor or health professional that you have coronary artery disease, heart attack, diabetes, high blood pressure, or high cholesterol?
- Do you smoke cigarettes?
- Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?
- Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?
- During the past 30 days, about how many days did poor physical or mental health keep you from doing usual activities, such as self care, school, or recreation?
- Would you say that your general health is excellent, very good, good, fair, or poor?

Results of BRFSS Health Questions in Consumer Survey

- Rates of health risks (smoking, obesity, physical inactivity) are two to three times that of the general population.
- Rates of heart disease and diabetes are two to six times that of the general population.
- People with serious mental illness and high degrees of physical ill health are less satisfied and have poorer outcomes with their psychiatric services.

Data from Health System Partners: Medicaid

As the major payer of mental health care, Medicaid can identify people with serious mental illness and/or substance use disorders and describe their health status.

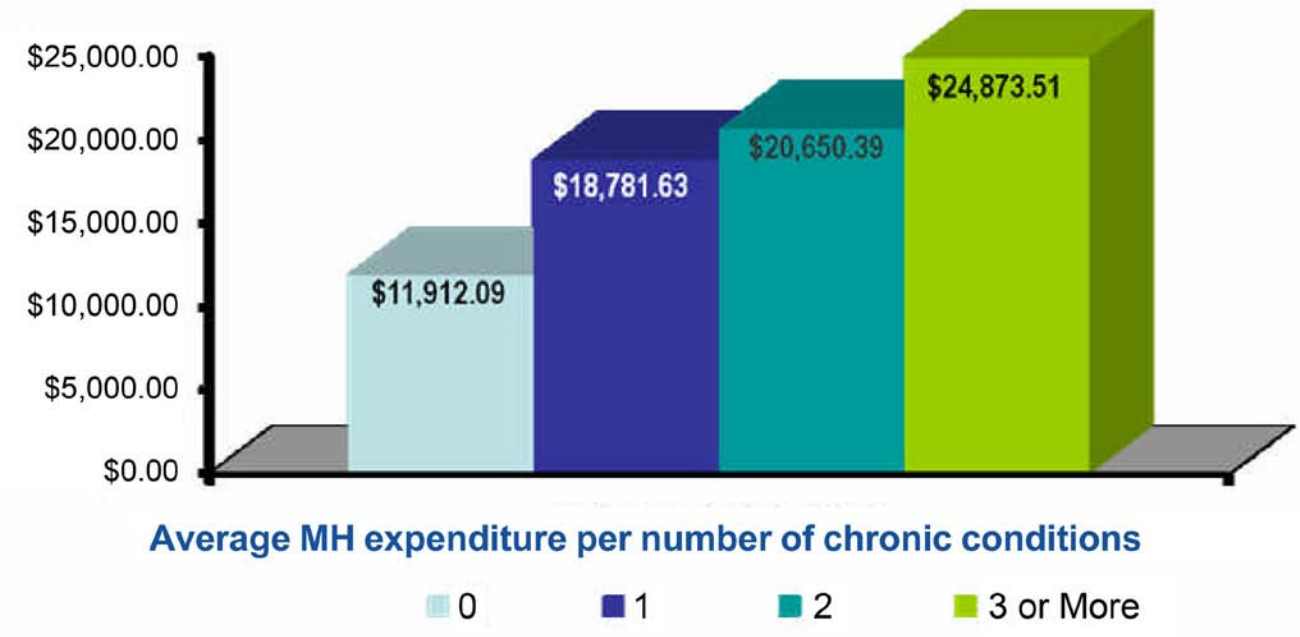
- Prevalence of chronic medical conditions and multiple medical co-morbidities.
- Adherence to national quality-of-care measures for specific diseases.
- Outcome measures, e.g., emergency room use, hospitalization, or number of different providers.
- Quality pharmacy measures including polypharmacy, discontinuities in adherence, or metabolic screening tests.

What Maine Medicaid Data Has Shown Us About People with Serious Mental Illness Compared to General Maine Care

- They have higher rates of many chronic diseases.
- They are less likely to receive quality interventions for diabetes, such as tests for Hemoglobin A1C and lipids and eye exams.
- They have higher rates of short- and long-term complications of diabetes.
- They are two to three times as likely to use emergency services for medical issues and less likely to use primary care.
- Those on antipsychotic medications receive recommended monitoring less than half the time.
- They saw increased costs across both health and mental health systems of care.

Mental Health Expenditures for People with Serious Mental Illness and Chronic Health Conditions

Having more medical conditions increases expenditures for mental health services for people with serious mental illness.



Maine DHHS Medicaid Data

Maine Action Steps Leveraging Existing Systems of Care

- Sustainable systems for integrated analyses of Medicaid data on health status, health care utilization, and quality for persons with mental illness
- Development of regular reports from Medicaid to mental health agencies about the health status of consumers they serve
- Direct assessment of health risk and metabolic indicators as routine practice in mental health agencies, integrated with medication management, treatment planning, and recovery goals
- Inclusion of health questions in consumer satisfaction surveys and in roll-out of Maine's consumer-specific Outcome Measurement System
- Development of systems for mental health care management to support consumers in interactions with healthcare system
- Education programs about health, quality of care, and chronic disease self management for both mental health staff and consumers
- Linkage of each consumer to a welcoming medical home
- Improved coordination of care between mental health and health systems of care
- Greater access to community public health resources for health and wellness

Maine's Integrated Analysis of BRFSS, Medicaid, and Health Data Collected in Mental Health System

Maine's integrated analysis of BRFSS, Medicaid, and health data collected in mental health system has also supported the following:

- Expansion to other states, including the National Association of State Mental Health Program Directors Research Institute, Inc., (NRI) work group on inclusion of BRFSS health questions in consumer surveys in other states (optional Uniform Reporting Service [URS] indicator–get your state to participate)
- Ongoing support for mental health modules in BRFSS (get your state to run these modules)
- Participation with other states in multi-state Medicaid projects to improve quality of prescribing for psychiatric drugs
- Access to funding, including award of an Agency for Healthcare Research and Quality (AHRQ) grant to study outcomes across both mental and physical health for persons with multiple complex conditions; awards from local healthcare foundation to integrate health into mental health systems of care, and integration of mental health into public health systems of care

Consumer-Survivor Activism for Quality of Life, Longevity, and Well-Being

Meghan Caughey, M.A., M.F.A.
Peer Wellness Coordinator
Benton County Health Services
Oregon

Oregon Report

- Men and women with both substance abuse and mental disorders had the highest rate of loss regardless of sex or race.
- They experienced between 32.8 years and 37.4 years per life lost.

SOURCE: Oregon Department of Human Services: Addiction and Mental Health Division (2008). Measuring Premature Mortality Among Oregonians.

Oregon Report Follow-up Questions

- How do we create a “culture of wellness” in the consumer/survivor community and for all stakeholders based on our strengths, our unique talents, and all that we bring to the healing partnership?
- Let us be mindful about how language helps to shape our reality. How we define ourselves can either support the healing process or distract us from it.

Trauma-informed Care

- We know the value of **trauma-informed care.**
- Trauma-informed care is when a caregiver seeks to help, with sensitivity and without creating trauma-induced treatment, clients who have experienced traumatic events.
- The core elements of trauma-informed care include the following:
  - Safety (physical and emotional)
  - Trustworthiness
  - Choice
  - Collaboration
  - Empowerment

SOURCE: Fallot, R.D. and Harris, M. (2001). A Trauma-informed Approach to Screening and Assessment. *New Directions for Mental Health Services*, 23–31.

Wellness-informed Care

- We must also create **wellness-informed care.**
- Wellness-informed care is when a caregiver seeks to help clients, recognizing that health and wellness are vital to mental health. In addition, the caregiver actively acknowledges that treatment must address mental AND physical components of recovery and well-being.
- Elements of wellness-informed care include the following:
  - Acknowledgement of the holistic nature of persons
  - Treatment of the whole person, including physical, mental, spiritual, and environmental
  - Treatment that is strength based and focused on what a person can do and what he or she excels in that creates a positive outcome for the individual
  - Treatment that relates to how a person's choices can create well-being
  - Support, encouragement, education, and tools for making choices that will lead to well-being and a healthful lifestyle
  - Belief that people can change their lives and situations through wise choices

Lifestyles Overcoming Trouble Utilizing Support (LOTUS) Wellness Support Group

- LOTUS is a support group created in 2007 for consumer/survivors at Pathways Program at Laurel Hill Community Mental Health in Eugene, Oregon.
- LOTUS was created to have an impact in preventing sickness and promoting longevity through peer-facilitated groups.
- LOTUS provides mindfulness and cardiovascular benefit to participants.

SOURCE: Joan E. Fox, Lerner Institute for Molecular Cardiology, Cleveland Clinic.

LOTUS Wellness Support Group

- **Mindfulness Practice** is shown by medical studies to have positive cardiovascular benefits, i.e., it makes our hearts healthier and can also help with chronic pain.
- **Person-driven Wellness Action Plan** for each group participant
- **Kindness Practice** to bring closure at the end of the group
  - The wishing of safety, improved physical and mental health, freedom from fear, and well-being for all beings and ourselves

SOURCES: Ditto, B., Eclache, M., and Goldman, N. (2006). Short-term Autonomic and Cardiovascular Effects of Mindfulness Body Scan. *Annals of Behavioral Medicine, 32* (3): 227–234. Kabat-Zinn, J. (1993) Psychosocial Factors in Coronary Heart Disease: Their Importance and Management. In Ockene, I.S. and Ockene, J. (Eds.), *Prevention of Coronary Heart Disease*, 299–333. Kabat-Zinn, J., Lipworth, L., and Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioral Medicine*, 163–190.

Person-Driven Wellness Action Plan

- What are your personal strengths?
- What things (hobbies/activities) do you like to do?
- What are the areas that you would like to be different?
- What do you really want to be doing right now?
- What are your short-term and long-term goals?
- What is an action step that can help you reach these goals?
- When will you do this?
- Who do you need to be involved to help you get there?
- How will you know that you have completed this?

Kindness Practice: Clarifying Our Intentions

- May we dwell in safety.
- May we know physical happiness.
- May we know mental happiness.
- May we be free from fear.
- May we have ease of being.
- May all beings dwell in safety.
- May all beings know physical happiness.
- May all beings know mental happiness.
- May all beings be free from fear.
- May all beings have ease of being.

Peer Wellness Program in Benton County, Oregon

- Health promotions in public health
- Certified peer specialist program
- Peer wellness coaching program
- Mindfulness and movement
- Holistic view of health
- Federally Qualified Health Center

Integrating Mental Health with Primary Care at Peer Delivered Services Level

- Peer delivered services use a “sideways” versus “top down” approach.
- “Sideways” means instead of using the “top down” approach, information is exchanged by persons who are not in a hierarchical structure and are therefore on an equal level. Peer support work is non-hierarchical. The relationship that a patient has with his or her doctor is from the “top down.”
- Both are necessary!
- We spend many more hours of the day outside the doctor’s office than with our doctor. We need to have ways of support and to find ways to cope with the other 23.5 hours of the day when making lifestyle choices.
- Integrating care is one of the recommendations found in the National Association of State Mental Health Program Directors (NASMHPD) 2006 report, “Morbidity and Mortality in People with Serious Mental Illness,” as a way to help reduce sickness and early death of people with serious mental illness.

SOURCE: NASMHPD (2006). Morbidity and Mortality in People with Serious Mental Illness. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

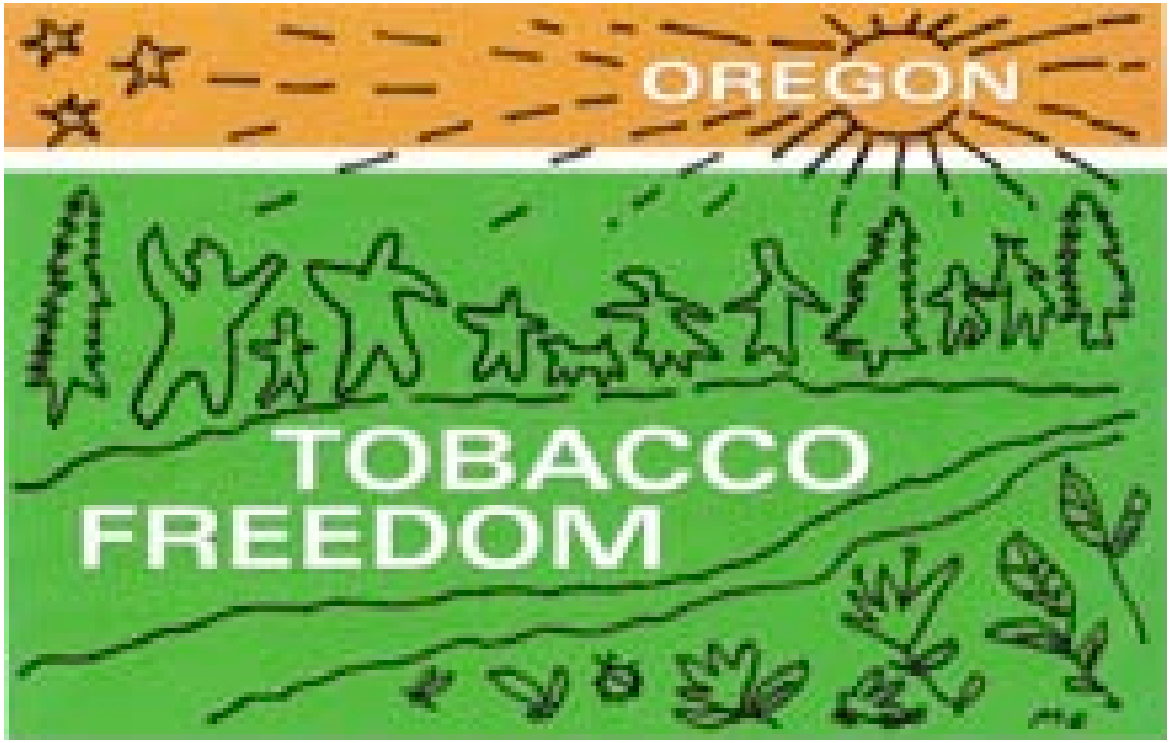
Outcome Tools for Peer Wellness Program

- **Wellness Survey**
  - The survey is self-administered by peer clients. The results of 13 variables help measure mental and physical well-being.
- **Workforce Weekly Survey**
  - The survey results help peer specialists track job satisfaction, stress levels, and if the work is supporting the recovery of peer specialists.
- **Electronic medical records (EMRs)**
  - The EMR can provide hard data on health indicators.

Well-Being Groups, Classes, and Tools Offered

- Peer wellness coaching
- Living Well with Chronic Conditions class
- Mindfulness Practice group
- Dual Diagnosis Anonymous support group
- LOTUS Group
- Veteran’s support group

Oregon Tobacco Freedom Initiative



Oregon Tobacco Freedom Initiative

- The initiative is a peer-initiated campaign.
- The initiative would like to see state-funded residential facilities tobacco free by 2012.
- Tobacco use by mental health consumers is 44 percent of market, and among consumers, 70–90 percent use tobacco products.*
- Tobacco use contributes to many chronic conditions, sickness, and death.*
- The initiative is finding ways to make this transition a winning change.

SOURCES: *Smoking Leadership Cessation Center, San Francisco, California. Lasser et al., 2000.

Governor's Proclamation

STATE OF OREGON

PROCLAMATION

OFFICE OF THE GOVERNOR

WHEREAS: Persons with serious mental health challenges served by the public mental health system die on average of 25 years earlier than the general population; and

WHEREAS: The causes of death are largely due to conditions that are modifiable by behavioral and situational changes and therefore preventable; and

WHEREAS: The population of persons with serious mental health challenges is a health disparity population and needs care from our citizens and communities; and

WHEREAS: It is important that we find and realize solutions to the conditions that make our citizens with mental health and addiction challenges get sick and die earlier than our general population; and

WHEREAS: It is important to set goals to reduce the number of years that persons with mental health and addiction challenges die early by at least 10 years in the next 10 years of time and such goals are established in the "10 by 10 Campaign."

NOW, THEREFORE: I, Theodore R. Kulongoski, Governor of the State of Oregon, hereby proclaim October 2010 to be

THE 10 BY 10 CAMPAIGN FOR MENTAL AND PHYSICAL WELLNESS MONTH

In Oregon and encourage all Oregonians to join in this observance.

IN WITNESS WHEREOF, I hereunto set my hand and cause the Great Seal of the State of Oregon to be affixed. Done at the Capitol in the City of Salem in the State of Oregon on this day, October 1, 2010.

Theodore R. Kulongoski, Governor

Kate Brown, Secretary of State

Whereas: persons with serious mental health challenges served by the public mental health system die on average of 25 years earlier than the general population; and

Whereas: the causes of death are largely due to conditions that are modifiable by behavioral and situational changes and therefore preventable; and

Whereas: the population of persons with serious mental health challenges is a health disparity population and needs care from our citizens and communities; and

Whereas: it is important that we find and realize solutions to the conditions that make our citizens with mental health and addiction challenges get sick and die earlier than our general population; and

Whereas: it important to set goals to reduce the number of years that persons with mental health and addiction challenges die early by at least 10 years of time and such goals are established in the "10 by 10 Campaign."

Now, therefore: I, Theodore R. Kulongoski, Governor of the State of Oregon, hereby proclaim October 2010 to be

The 10 by 10 Campaign for Mental and Physical Wellness Month in Oregon and encourage all Oregonians to join in this observance.

10×10 Wellness CAMPAIGN SAMHSA

Resources

- Benton County Health Department (2010) Personal Wellness Survey.
- Caughey, M. (2008). The Wellness Model, *Psychiatric Services, 59* (10): 1218.
- Ditto, B., Eclache, M., and Goldman, N. (2006). Short-term Autonomic and Cardiovascular Effects of Mindfulness Body Scan. *Annals of Behavioral Medicine, 32* (3): 227–234.
- Fallot, R.D. and Harris, M. (2001). A Trauma-informed Approach to Screening and Assessment. *New Directions for Mental Health Services*, 23–31.
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- Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D., McCormick, D., and Bor, D. (2000). Smoking and Mental Illness: A Population-Based Prevalence Study. *Journal of the American Medical Society 284*, 2602–2610.
- NASMHPD (2006). Morbidity and Mortality in People with Serious Mental Illness. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.
- Oregon Consumer/Survivor Council, Statement, Freedom from Tobacco & Freedom to Choose. http://www.oregon.gov/DHS/mentalhealth/wellness/resource-reports/oregon-tobacco-freedom-campaign.pdf.
- Oregon Department of Human Services: Addiction and Mental Health Division (2008). Measuring Premature Mortality Among Oregonians.
- The Guided Meditation Site. http://www.the-guided-meditation-site.com/how-to-practice-mindfulness.html.

The Mortality Crisis: What Needs To Be Done?

Ron Manderscheid, Ph.D.
Executive Director
National Association of County Behavioral Health and Developmental Disability Directors
Washington, D.C.

Need for Data

- Actions taken and reviewed data needs in 2007 (Manderscheid, Druss, & Freeman) include the following:
  - Annual data on premature deaths for all state mental health agencies
  - Better data on the co-occurrence of mental health, substance use, and primary care conditions
  - Development of effective working relationships between SAMHSA, the National Institutes of Mental Health (NIMH), the National Center for Health Statistics (NCHS), and the Centers for Disease Control and Prevention (CDC)

Need for Data

- Status: Mainly unfulfilled. Needs strong field advocacy.
  - Recommendations remain mainly unfulfilled today.

Develop an Effective Intervention Approach

- Actions taken
  - Reviewed practice needs that include the following:
    - Evidence-based practices (EBPs) that link psychopharmacology and wellness approaches
    - Better information on the effects of psychopharmacology, e.g., a comparative table showing metabolic effects, which is available through NIMH's Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE)

Develop an Effective Intervention Approach

- Status: Mainly unfulfilled. Needs strong field advocacy.
  - EBP development remains mainly unfulfilled today.
  - Consumers have taken major steps to develop self-help wellness approaches. More needs to be done to coordinate and disseminate these. Our hats are off to the consumer community for taking strong initiative in this area.

Develop a Population Approach

- Actions taken
  - Developed a model of the social and physical determinants of health to identify changeable determinants (Healthy People 2020 [HP2020] Secretary's Advisory Group)

Develop a Population Approach

- Status: Partially fulfilled. Needs to be coordinated with the consumer community.
  - A model of social and physical determinants of health has been developed but not yet applied nationally. This will be done as part of the implementation of HP2020.
  - This model will need to be applied to the determinants of premature death.

Role of National Health Reform

- Actions taken
  - Identified major healthcare disparities across population groups
  - Noted little current focus on improving health education
  - Noted little effort to organize local health/public health advocates
  - Noted little effort to identify the role of institutional factors in health conditions, e.g., high fructose foods

Role of National Health Reform

- Status: Started. Get involved!
  - Implementation of national health reform will accelerate these developments.

Role of Frames

- Actions taken
  - We reviewed the frames people use to understand “mental illness” and “mental health.”
  - This is a fundamental issue in how we will be able to discuss and promote positive mental health outside of the mental health community.

Role of Frames

- Status: Started. Get involved!
  - Implementation of national health reform will accelerate these developments.

A Call to Action

- Bottom line
  - This is an *urgent* call for data and much more aggressive national action.
  - We commend CMHS for undertaking and sustaining the 10x10 Initiative and Pledge.

Vision

What is your vision?

Elsie Freeman's Vision

- It should be recognized that health is part of mental health and mental health is part of health at all levels: surveillance, programming, quality improvement, policy, research, regulation, and perception.
- A holistic focus should be automatic, and collaboration should be seamless across behavioral health, primary care, and public health at the Federal, State, and local levels.

Meghan Caughey's Vision

- Every state and county should have independent sustainable funding for mental health consumer-run recovery and wellness education centers that are fully integrated into a holistically focused mind/body/spirit local, county and State healthcare system.
- Consumer/survivors should play a central role in the development of health and fiscal policy and the service delivery systems at all levels.

Ron Manderscheid's Vision

- Annual national data should document this urgent problem and its effects.
- There should be an urgent development of effective clinical EBPs and population approaches.
- There should be an urgent movement to implement national health reform.
- There should be an urgent empowerment of consumers to take charge of their own lives.

Contact Information

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Additional Resources

- Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis 2006 Apr. http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.
- Foti, M.E., Parks, J., Svendsen, D., Singer, P. (Eds.). Morbidity and Mortality in People with Serious Mental Illness. 13th in a Series of Technical Reports. NASMHPD Medical Directors Council. October 2006. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.
- Mazade, N.A., Parks, J., Radke, A.Q. (Eds.). Measurement of Health Status for People with Serious Mental Illness. 16th in a Series of Technical Reports. NASMHPD Medical Directors Council. October 2008. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf.
- Recommendations to Foster System Reform for Adults with Serious Mental Illness, July 2010. http://www.nacbhdd.org/content/Fostering%20System%20Reform.pdf.
- Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal, 29*, (4) 311–314.

Speaker Biography

Elsie J. Freeman, M.D., **M.P.H.,** is the director for Integrated Care Projects for the Maine Department of Health and Human Services (DHHS), where she focuses her energy on healthcare quality improvement, public health program development, policy and planning for publicly funded healthcare systems, implementing the principles of the Institute of Medicine's report on quality within mental health and health systems, and integrating mental and physical health and public health in services research. She is a member of several DHHS work groups on evidence-based practices, psychopharmacology quality improvement, and integrated health care.

Dr. Freeman also serves on an advisory group for integrated care sponsored by the Maine Health Access Foundation, Maine's largest health philanthropy, and has served on the Board of Directors of the Maine Center for Public Health. She served for two decades as the director of multidisciplinary neuropsychiatry evaluation clinics in the Harvard Department of Psychiatry and has concentrated her clinical work on the overlap between psychiatry, neurology, developmental disorders, and chronic health conditions. Dr. Freeman is board certified in pediatrics and completed training in both adult and child psychiatry within the Harvard system at Massachusetts Mental Health Center and at McLean Hospital. She received her master's in public health from Harvard.

Speaker Biography

Meghan Caughey, M.A., M.F.A., consults to public and private organizations throughout the State of Oregon, including the Benton County Health Services and the Addictions and Mental Health Division of the Oregon Department of Human Services, where she serves as the peer wellness coordinator. Caughey has pioneered the application of mindfulness and movement in peer support programming. She also created the first peer specialist training program in Oregon to receive state approval for certification. Caughey has also developed outcome measurement tools for peer support services, co-chaired the Consumers Legislative Committee in the State's most recent legislative session, and is actively involved in the process of reforming the Oregon State Hospital system.

A national speaker and writer on mental health reform, wellness, art, and healing, Caughey is also a visual artist whose paintings and drawings have been featured in numerous medical journals and books. Her work is informed by her experience of having more than one hundred psychiatric hospitalizations that included shock treatments, seclusion, and restraint. She is vice president of Mental Health America of Oregon and the founder of VISIONS—Art for Resilience and Transformation (ART), an organization that strives to use art for activism and social justice in transforming mental health systems. A certified peer specialist, she has a bachelor's degree in psychology, a master of arts in visual art, and a master of fine arts in pictorial arts.

Speaker Biography

Ron Manderscheid, Ph.D., has emphasized consumer and family concerns throughout his diverse career. Currently executive director of the National Association of County Behavioral Health and Developmental Disability Directors, an organization that represents county and local authorities in Washington, D.C., Dr. Manderscheid is also an adjunct professor at the Johns Hopkins University's Bloomberg School of Public Health Department of Mental Health. He is a member of the Secretary of Health and Human Services Advisory Committee on Healthy People 2020, president-elect of ACMHA–The College for Behavioral Health Leadership, and serves on several boards.

He also writes the Manderscheid Report, a monthly commentary for *Behavioral Healthcare*. A former branch chief of the Survey and Analysis Branch of CMHS, SAMHSA, Dr. Manderscheid was a senior policy advisor on national healthcare reform in the office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services. He also held a variety of positions within the National Institutes of Mental Health, including chief of the Statistical Research Branch. Principal editor for eight editions of *Mental Health, United States*, Dr. Manderscheid has authored numerous scientific and professional publications on services to persons with mental illnesses. He has received countless Federal and professional awards.

Questions and Answers

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Survey

We value your suggestions. Within 24 hours of this teleconference, you will receive an e-mail request to participate in a short, anonymous online survey about today's training material. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately five minutes to complete.

Survey participation requests will be sent to all registered event participants who provided e-mail addresses at the time of their registration. Each request message will contain a Web link to our survey tool. Thank you for your feedback and cooperation.

Written comments may be sent to the Substance Abuse and Mental Health Services Administration 10x10 Wellness Campaign via e-mail at 10x10@samhsa.hhs.gov.