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Essential information for decision-makers

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The community behavioral health clinics in states selected to become part of a federal demonstration program in October will have opportunities to partner with other organizations to provide services such as primary care screening and monitoring and wraparound services for veterans. National Council for Behavioral Health conference attendees learned about Certified Community Behavioral Health Clinics working with Designated Collaborating Organizations during a session last week in Las Vegas. . . . See bottom story, this page

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Senate HELP committee jumps into fray of MH reform with new legislation

Senate health committee lawmakers on March 7 unveiled bipartisan draft legislation to address this country's mental health crisis that, among other provisions, aims to promote the use of evidence-based practices within states and strengthens the enforcement of existing mental health parity protections.

Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-Tenn.) and Sens. Bill Cassidy (R-La.), Chris Murphy (D-Conn.) and Patty Murray (D-Wash.) introduced the Mental

Health Reform Act of 2016.

The legislation appoints a chief medical officer (CMO) at the Substance Abuse and Mental Health Services Administration (SAMHSA) to advise the administrator and promote evidence-based and promising best practices. The CMO would serve as the liaison between the administration and providers of mental health, substance use disorder prevention, and treatment and recovery services, according to the legislation.

Other provisions would include:

- Strengthens the enforcement of mental health parity protections by issuing new guidance to health plans with respect to how they disclose information to patients, including how they establish and apply nonquantitative

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Bottom Line...

Advocates are working with Senate lawmakers and staff to make priorities known in advance of the markup scheduled for March 16.

Untraditional community partnerships will become part of CCBHC process

As states awarded planning grants to integrate behavioral health with physical health care gear up to potentially become one of eight Certified Community Behavioral Health Clinics (CCBHCs) this fall, they may find opportunities to partner with other organizations to provide specialty required services.

Attendees of a March 7 session during the National Council for Behavioral Health Conference in Las

Vegas learned about these untraditional partnerships involving the CCBHC demonstration program.

Many of the behavioral health organizations selected to become CCBHCs in October may not provide all nine of the services that will be required of them, said Susannah Vance Gopalan, a partner with Washington, D.C.-based Feldesman Tucker Leifer Fidell LLP, and presenter of the session, "Becoming Best Friends: CCBHCs and Designated Collaborating Organizations."

According to Gopalan, some of the following services, if not available directly through the CCBHC, are provided or referred through

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Bottom Line...

The CCBHC demonstration program will enable participating organizations to leverage existing partnerships and develop new ones.

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tative treatment limitations on mental health and substance use disorder coverage.

- Modernizes the block grant for mental health services and promotes the use of evidence-based practices within states, including early intervention programs for individuals with serious mental illness.
- Improves access to mental health care for children by providing grants to promote behavioral health integration in pediatric primary care through the development of and improvement of statewide child psychiatry access programs.

The Mental Health Reform Act of 2016 is an important development on the Senate side, said Mark Covall, president and CEO of the National Association of Psychiatric Health Systems (NAPHS). “We see this as another very important step forward to reach the ultimate goal, which is to pass mental health reform legislation,” Covall told *MHW*.

Covall noted that three provisions of the legislation do stand out that are important to NAPHS:

1. **Mental health and addiction parity.** Covall said NAPHS is pleased about the additional clarification in the legislation that issues new guidance

to health plans regarding how they disclose information to patients, including how they establish and apply nonquantitative treatment limitations on mental health coverage.

2. **Taking steps to resolve the mental health workforce shortage.** “We’re short of all kinds of mental health positions,” Covall said. It’s very difficult to find psychiatrists, particularly psychiatrists who provide inpatient care, he said. The bill would provide some financial resources toward training and educational opportunities for psychiatrists and other mental health professionals, he said. Now that broader health care coverage is available, courtesy of the Affordable Care Act and the federal parity law, more people can get the coverage they need; however, there currently aren’t enough providers to fulfill that need throughout the country, he said.
3. **Establishment of a CMO at SAMHSA.** “We need a focal point within the federal government, in addition to NIMH [the National Institute of Mental Health],” Covall said. The legislation would ensure a focus on treatment and re-

covery, Covall said.

“We have to break down the barriers to treatment and recovery,” especially in the public mental health system, he said. Covall said he hopes for discussion about changes needed regarding parity in Medicaid and Medicare before the legislation goes to the Senate floor.

Clarifications regarding the Institutions for Mental Disease (IMD) exclusion that prevents state psychiatric hospitals from receiving federal Medicaid funds for its patients and the health information privacy laws are still needed in the Senate bill, Covall said.

Advocates weigh in

James K. Finley, associate executive director and director of public policy of the American Mental Health Counselors Association (AMHCA), said he hopes the legislation would ultimately include the Seniors Mental Health Access Improvement Act (S. 1830), introduced last summer by Sens. John Barrasso (R-Wyo.) and Debbie Stabenow (D-Mich.). The bill would expand the number of mental health providers available to Medicare beneficiaries by allowing them access to mental health counselor services and marriage and family therapists through Medicare.

“AMHCA supports the HELP bill, but we are asking the Senate to ex-

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‘We see this as another very important step forward to reach the ultimate goal, which is to pass mental health reform legislation.’

Mark Covall

pand the initiative in the Finance Committee by adding our Medicare provider status bill, S. 1830,” Finley told *MHW*. “We will then urge the Senate to consider this broader bill when it reaches floor consideration.”

Finley said he hopes the identical House version, H.R. 2759, would be given the same consideration. “We’ve continued to press various offices to add it to Tim Murphy’s bill [the Helping Families in Mental Health Crisis Act], when and if it receives further consideration,” said Finley. The Mental Health Access Improvement Act of 2015 was introduced by Reps. Chris Gibson (R-N.Y.) and Mike Thompson (D-Calif.).

Brian Hepburn, M.D., executive director of the National Association of State Mental Health Program Directors (NASMHPD), said NASMHPD commends the efforts of the HELP committee and its bipartisan mental health bill. “The committee has worked hard to put together a bill

that will improve the lives of persons with mental illness,” Hepburn told *MHW*. “We do have some concerns that there are new criteria for state plans included in the HELP draft. The new criteria may make writing the state plan more burdensome.”

Hepburn also noted a change in 42 U.S.C. 300x-4(b) on maintenance of effort (MOE), from “maintaining *material* compliance” to “complying.” “This appears to tighten the language and decrease SAMHSA’s flexibility on MOE,” he said. “These changes may increase the burden on states. The states value the [mental health] block grant. However, it is generally less than 1 percent of the funding under the mental health authority in each state.”

The Senate bipartisan bill still does not address the needs of people with serious mental illness, said DJ Jaffe, founder of Mental Illness Policy Org. Sponsors of the bill should add provisions to fund as-

sisted outpatient treatment, he said. “[AOT] is the only program known to reduce homelessness, hospitalization, arrest and incarceration in the 70 percent range,” Jaffe told *MHW*. The creation of expanded hospital beds for serious mental illness is also needed.

The legislation should also require SAMHSA to focus on people with serious mental illness, noted Jaffe. Legislation sponsors should also add provisions to “prevent Protection and Advocacy programs from lobbying against treatment,” he stated.

The Health Insurance Portability and Accountability Act privacy law should also be changed “so that families that provide care out of love can get the same information paid providers get,” noted Jaffe, who said he met with HELP committee members and other Senate staff to raise concerns by Mental Illness Policy Org.

The HELP bill is a good start, said NAPHS’s Covall. However, more needs to be done, he said. “If we stop here, we’re not really reaching meaningful reform,” Covall said. Meanwhile, NAPHS is working with the Senate Finance Committee to ensure changes are made to Medicaid and Medicare, he said. What remains paramount is getting people access to treatment when they need it and where they need it, said Covall. •

Pediatricians not inquiring enough about maternal MH

Fewer than half of pediatricians inquire of and screen patients to identify maternal depression, suggesting a missed opportunity to identify depression and refer women to treatment, according to researchers of a new study published in the February/March issue of the *Journal of Developmental & Behavioral Pediatrics*.

The research is timely. The U.S. Preventive Services Task Force (USPSTF) in January released final recommendations that all adults, especially pregnant and postpartum women, be screened for depression

(see *MHW*, Feb. 1).

According to the study, “Identifying Maternal Depression in Pediatric Primary Care: Changes Over a Decade,” maternal depression affects between 10 percent and 40 percent of mothers with young children, and can have negative consequences for women and their children.

Maternal depression has been linked to insecure attachment, reduced time breastfeeding, increased likelihood of placing infants to sleep in the prone position and increased use of emergency department care, Bonnie Kerker, Ph.D., MPH, lead au-

thor and associate professor of child and adolescent psychiatry at NYU Langone Medical Center’s Child Study Center, told *MHW*. It has also been linked to decreased use of preventive services and even poor cognitive outcomes in children, she said.

Most parents report that infants receive well-child visits and the American Academy of Pediatrics (AAP) recommends seven well-child visits for children during the first year of life, said Kerker, a research scientist at Nathan Kline Institute. “As a result, pediatric offices may be

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a promising venue for identifying and managing maternal depression," she said.

Study method/findings

The AAP conducted a Periodic Survey of pediatricians three or four times each year to inform policy, to develop new initiatives and/or to evaluate current projects.

Researchers analyzed the most recent periodic surveys, which included 321 nontrainee, general practice pediatricians who answered questions about maternal mental health, access to services and training in mental health in 2013. They compared survey results to a similar sample (457 pediatricians) who answered the same questions in 2004.

of the pediatrician was associated with inquiring/screening in 2013.

'Missed opportunity'

Although the finding is promising, less than half of pediatricians attempted to identify maternal depression in 2013, said Kerker. "Given how much we know about parent characteristics as risk factors for poor child development, these data represent a missed opportunity," she said.

"Without understanding the entire family context, pediatricians cannot provide appropriate care for their patients," Kerker noted. "In fact, we found that physicians who usually ask about child/adolescent depression, and those who believe that family screening is within the scope of the pediatrician, were more likely

Kerker added, "Making off-site referrals in this population has not been shown to be effective, so we need to better understand alternative models (including on-site care) that will help women and families get the help they need."

Clinical implications

The study noted much debate about whether maternal depression screening can be effectively performed in pediatric practices, but several studies have shown that implementing universal maternal depression screening in busy pediatric practices is possible. Recent research suggests that both professionals and women are willing to discuss mental health topics at pediatric visits, the study noted.

"Our study suggests that many pediatricians are not addressing their patients' family risk factors in their practices," Kerker said. "This might be more likely to happen if mental health clinicians and pediatricians worked more closely together to ensure that the whole child, which includes his or her family, is being treated." Ideally, mental health care for both mothers and children would be co-located on site with pediatricians, so that all the needs of the family could be addressed in one place, she added.

Several factors put women at risk of developing postpartum depression (PPD) — identifying women who are at greatest risk and having preventive interventions available to them is key, noted Kerker. "There are some effective skill-based interventions for at-risk women geared towards managing stress during pregnancy and reducing symptoms after birth," she said.

"Mental health practitioners have an opportunity to provide their patients with these skills during pregnancy, as previous mental health issues is one of the risk factors for PPD, and to make sure their patients know the signs and symptoms of PPD, as well as how and when to get help," said Kerker. •

'This might be more likely to happen if mental health clinicians and pediatricians worked more closely together to ensure that the whole child, which includes his or her family, is being treated.'

Bonnie Kerker, Ph.D., MPH

Between 2004 and 2013, the percentage of pediatricians who usually ask about maternal depression increased from 33 to 44 percent.

In both years, pediatricians who usually inquired about child/adolescent depression had increased odds of usually inquiring/screening to identify maternal depression, said researchers. Patient race/ethnicity and training in adult *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria for depression were associated with inquiring/screening in 2004 and believing that family screening is within the scope

to ask about maternal depression."

Training that emphasizes the importance of this larger context would benefit children and families greatly, she said. Kerker noted that the recent USPSTF depression screening recommendations are important. "Hopefully, this wide recognition of the importance of identifying women with depression will lead to more women and families getting the help they deserve," she said.

While screening pregnant and postpartum women for depression is essential, it is not enough, Kerker said. "We must focus resources and research on identifying and providing effective mental health treatments that are feasible for pregnant women and new mothers to access and complete," she said.

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MHA developing first national certification program for peers

Recognizing that peer support is well-established in the public mental health system, while making very little headway entering into the commercial/private sector, Mental Health America (MHA) is currently developing a national, accredited certification for whole health peer specialists that will set new standards in the field, say advocates.

MHA, in partnership with the Florida Certification Board, is developing the Nationally Certified Peer Specialist credential. The fully accredited certification program recognizes peer specialists qualified to work in both public and private whole health practices.

As part of the process, MHA has developed the Nationally Certified Peer Specialists Draft Core Competencies, currently available for public comment. Core competencies are job tasks that credentialed individuals must be able to perform on the job regardless of employers or service delivery model. The deadline for public comment is March 31.

MHA anticipates that nationally certified peer specialists will be employed in a variety of clinical settings, including emergency departments and inpatient settings, and with private practitioners, such as primary care physicians (PCPs), according to the draft core competencies report.

“The public will have an opportunity to review the core competencies and let us know ways to improve it,” Patrick Hendry, vice president of peer advocacy, supports and services at Mental Health America, told *MHW*. “When trained individuals with lived experiences with a mental health diagnosis step up to provide support, education, mentoring and motivation, the effects are powerful and positive.”

Peer support services are pretty strong in the public sector but not in the private sector, said Hendry. MHA did conduct a series of pilot programs that placed peer specialists

with enhanced trainings as providers of peer support at Kaiser Permanente as a way to bring peer support into the national health maintenance organization’s system, noted Hendry.

“PCPs provide a huge amount of behavioral health care services in this country,” he said. “We want them to have access to peer support. People receiving psychiatric [support services] need support beyond medication.”

Enhancing traditional training

This credential is not designed to qualify a peer to work in clinical roles; it is designed to build upon

‘We are currently working with several national training organizations to develop training that will meet our standards.’

Patrick Hendry

and enhance traditional peer specialist training and core competencies upheld by current programs and add the additional competencies necessary to enable peers to work alongside any other health care team(s), according to MHA.

While individuals holding the MHA Nationally Certified Peer Specialist credential will be qualified to work in both traditional, public peer settings and private/commercial settings, this program is not intended to replace existing peer support specialists credentialing or certification programs at the state and local levels within the public health care space, nor should it be a require-

ment for Medicaid/Managed Care reimbursement, according to the Nationally Certified Peer Specialist Draft Core Competencies.

Currently, there are about 35 states that have some type of certification, said Hendry. “Some of those are statewide and some regional or local,” he said. “California does not have a certification at this point; they are in the process of developing one. Our certification will be the first national one and will set the highest standards of knowledge and experience in the country.”

In June, Virginia will begin to certify new peer specialists through their training and examination, he said. “Currently they are still ‘grandfathering in’ people who have been working in the state with local or regional credentials,” Hendry said.

Hendry added, “We are currently working with several national training organizations to develop training that will meet our standards.” MHA plans to unveil all of the standards and requirements for its certification program during a preconference workshop (June 7) at MHA’s annual conference, “Media, Messaging and Mental Health,” June 8–10 in Alexandria, Virginia. •

For more information about the Nationally Certified Peer Specialist credential, visit <http://bit.ly/1QMHHK7> and <http://bit.ly/1P4OUkI>.

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formal relationships with other providers:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization.
- Screening, assessment and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes,

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including risk assessment and crisis planning.

- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

Gopalan noted that the following CCBHC services can be contracted out to the Designated Collaborating Organization (DCO): primary care screening and monitoring, psychiatric rehabilitation, targeted case management, peer support services, and the special wraparound services for veterans and members of the armed forces.

SAMHSA and the Centers for Medicare & Medicaid Services (CMS) developed the DCOs. “SAMHSA has said that under the demo every CCBHC must be able to directly provide both mental health and substance use disorder services, at least to some degree,” Gopalan told *MHW*.

If providers are unable to provide services directly, they cannot just refer a patient to a certain provider, said Gopalan. The DCOs, would provide the services under contract to the CCBHC, she said.

Gopalan added, “Each provider must prepare a cost report documenting all nine services. The reimbursement rate will be provided for

the entire bundle of services.”

The process of making staffing or operational changes, whether or not states learn they will be selected, does involve some risk, noted Gopalan.

Addressing concerns

Some of the concerns raised by session attendees were related to the fact that the CCBHCs would be financially responsible for the DCO, Gopalan said. “Some risks are involved,” she said. The CCBHCs have to make sure to choose a partner clinically and operationally to carry out the services and to do so in a way required by the CCBHC, she said.

“We recommend that CCBHCs lay out very clear protocols for DCOs as to how the services need to be provided,” Gopalan said.

‘Those linkages may already be in place. The CCBHC process requires taking it to the next level.’

Susannah Vance Gopalan

Community mental health centers and behavioral health organizations have ways to connect their patients with more specialized services that they don’t already provide, said Gopalan. “That’s typically done on a more informal basis,” she said. “Those linkages may already be in place. The CCBHC process requires taking it to the next level.”

Services provided under the demonstration will be reviewed by federal and state agencies, including SAMHSA and the CMS, said Gopalan. Session attendees, she noted, “brought a lot of positive energy and excitement about the demonstration project and about partnering in a new way with other providers in the community, despite the complexity and the challenges of the project.”

Managing chronic illness

Altogether, there were about six separate presentations on CCBHCs alone, said Rebecca Farley, director of policy and advocacy for the National Council. Attendees learned, for example, how behavioral health organizations in designated states can work together with primary care on screening and management of a patient’s chronic illness, she told *MHW*.

Another session on the CCBHCs involved psychiatrists presenting on helping to reduce the mortality gap for people with serious mental illness, she said. “Attendees were interested in learning about strategies beyond screening and beyond monitoring and what else they can do to improve patients’ physical health,” Farley said.

People are trying to grapple with how to file cost reports, what is expected of the services they have to add and what are the costs of meeting the requirements, she said.

Netsmart hosted a breakfast session on CCBHCs to address some of the questions conference attendees might have regarding the new demonstration project. Ian Chuang, M.D., M.S., F.C.F.P., senior vice president of health care informatics and chief medical officer at Netsmart, was one of the panelists.

Some providers from one of the states receiving planning grants seem to embrace the process of becoming a CCBHC, said Chuang. One respondent said that even if their state is not selected, what they will learn will have value, and that the approach is the right one, he said.

Under the care model, patients would be recipients of holistic care, he noted. Value-based care is the goal, he said. “You as a physician would pay attention and help individuals get the right care even if it wasn’t your specialty,” Chuang told *MHW*. Providers have to be accountable, he said.

It’s important that the right structure be in place to help individuals receive appropriate care, he said. Treating behavioral health con-

ditions along with chronic illnesses will ensure patients will now receive mind and body care, said Chuang. •

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APA annual stress report finds discrimination a major cause

The American Psychological Association (APA) on March 10 released its annual stress survey, which found that nearly half of U.S. adults report they have experienced a major form of unfair treatment or discrimination prompting stress and lifestyle challenges.

Regardless of the cause, experiencing discrimination is associated with higher reported stress and poorer reported health, according to the report, "Stress in America: The Impact of Discrimination." The 2015 Stress in America survey was conducted online within the United States by Harris Poll on behalf of the APA between August 3 and 31, 2015, among 3,361 adults aged 18 and over who reside in the United States.

There's a growing body of research that shows discrimination can increase stress, James S. Jackson, Ph.D., APA consultant and director of the Institute for Social Research at the University of Michigan, said during an APA webinar to announce the findings. "Discrimination knows no boundaries," he said. "This report identifies several groups dealing with discrimination and [its resulting] stress on a daily basis."

Of the adults polled, nearly seven in 10 experience having any discrimination, he said. Three in five adults polled report day-to-day discrimination, such as being treated with less courtesy or respect, receiving poorer service than others and being threatened or harassed, Jackson said.

While average reported stress levels in the United States have seen a slight increase in the past two years (5.1 in 2015 and 4.9 in 2014 on a 10-point scale, where 1 is "little or no stress" and 10 is "a great deal of stress"), some segments of the population are more likely to report experi-

encing higher average stress levels.

In general, the top two stressors are work and money, Jaime Diaz-Granados, Ph.D., the APA's executive director for education, told webinar attendees. However, family responsibility is emerging as the third most consistent stressor for all adults, he said.

Stress triggers

For many adults, dealing with discrimination results in a state of heightened vigilance and changes in behavior, which in itself can trigger stress responses — that is, even the anticipation of discrimination is sufficient to cause people to become stressed, the survey stated.

American Indians and Alaskan Natives are careful about what they

Average stress levels of those reporting discrimination (6.1 on a 10-point scale for Hispanics, 5.5 for blacks and 5.4 for whites) were higher than for those not reporting it (5.1 for Hispanics, 3.8 for blacks and 4.0 for whites).

Other findings

Almost half of all adults (47 percent) report experiencing major forms of discrimination, which include police unfairly stopping, searching, questioning, physically threatening or abusing them; neighbors making life difficult for them or their family upon moving into a neighborhood; a teacher or advisor discouraging them from continuing their education; or experiencing unfair treatment when receiving health care.

'Discrimination knows no boundaries.'

James S. Jackson, Ph.D.

say and how they say it in order to cope with day-to-day discrimination, said Jackson. "The survey also suggests that stress is significantly a health disparity in and of itself," he said.

Hispanic and black adults (31 percent and 29 percent, respectively) are more likely to say they feel a need to take care of their appearance to get good service or avoid harassment, according to the survey.

LGBT (lesbian, gay, bisexual or transgender) adults who have experienced discrimination have average stress levels of 6.4, compared to 6.0 for LGBT adults overall. Among adults who are non-LGBT, stress levels are 5.5 for those who have experienced discrimination and 5.0 for non-LGBT adults overall.

According to the survey, adults who live with a disability report higher stress levels and are almost twice as likely as those without a disability to report a stress level in the "extreme" category. In addition, individuals with disabilities are more likely than those without to cite money, work and health as sources of stress.

The report found a "sharp spike" in younger adults saying their stress levels have increased in the past year (45 percent of millennials and 39 percent of Gen Xers in 2015, compared to 36 percent and 30 percent, respectively, in 2014). These percentages represent a return to levels seen in 2013, when 45 percent of millennials and 36 percent of Gen Xers said the same.

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Emotional support

Despite their stress, the majority of adults (59 percent) who report experiencing discrimination feel they have dealt quite well or very well with it and any resulting changes or problems.

In addition, many adults report having a positive outlook, and survey findings point to the strong impact of emotional support. Having someone they can ask for emotional support if they need it, such as talking about problems or helping them make a difficult decision, appears to improve the way individuals view their ability to cope with discrimination.

Adults who experienced discrimination and had emotional support are twice as likely to say that they coped quite or very well compared with those adults who experienced discrimination but did not have emotional support (65 percent vs. 37 percent of those who report not having emotional support).

“For people feeling overwhelmed and experiencing difficulty coping with stress, they should consider getting help from mental health professionals, such as a psychologist,” Diaz-Granados said. Policymakers and people in the health care system should do more to address health disparities and ensure health services, including mental health services, are accessible to more people, he said. •

For a copy of the “Stress in America: The Impact of Discrimination” survey, visit www.stressinamerica.org.

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STATE NEWS

California bill could give counties flexibility with Prop. 63 funding

State Sen. John Moorlach (R-Costa Mesa) announced a bill February 25 that would give counties

Coming up...

The **New Jersey Association of Mental Health and Addiction Agencies** will host its 2016 annual conference, “Innovating for Progress, Partnering for Solutions,” **April 13–14 in Iselin, N.J.** For more information, visit www.njamhaa.org/events.

The 169th annual meeting of the **American Psychiatric Association** will be held **May 14–18 in Atlanta, Ga.** Visit www.psychiatry.org for more information.

The **US Psychiatric Rehabilitation Association** 2016 Recovery Workforce Summit, “The State of Recovery in the World of Psych Rehab: Our Collective Vision Put Into Action,” will be held **May 22–25 in Boston.** Visit www.uspra.org for more information.

Mental Health America will host its annual conference, “Media, Messaging and Mental Health,” **June 8–10 in Alexandria, Va.** For more information, visit www.mentalhealthamerica.net/annualconference.

The **National Alliance on Mental Illness** will hold its national convention, “Act. Advocate. Achieve,” **July 6–9 in Denver.** Visit www.nami.org/convention for more information.

more flexibility when spending funds earmarked for mental health services, *mynewsLA.com* reported February 26. “Prop. 63 is very limited in the way it can be spent and so our county is getting its emergency rooms clogged up and they don’t have enough psychiatric beds,” Moorlach told City News Service. “Our county doesn’t even have a designated place for psychiatric beds.” Moorlach hopes the county can use its share of the Proposition 63 money to build a psychiatric

ward that would function as an emergency room for patients “with a mental health crisis,” the senator said. “It’s just a way to change the state code just a little bit so the county of Orange and others can feel comfortable reallocating funding,” he said. Because the funding is restricted to “new services,” sometimes the money is spent on things such as coloring books, he said. “I expect a lot of support from Dems once it’s heard in committee,” said Moorlach.

In case you haven’t heard...

A new study reveals that individuals in their 60s who give advice to a broad range of people tend to see their lives as especially meaningful. At the same time, this happens to be the age when opportunities for dispensing advice become increasingly scarce, say researchers in the March issue of *Social Psychology Quarterly*. According to the study, individuals in their 60s who report giving advice to a wide variety of people — to family members, friends, neighbors and strangers — see their lives as highly meaningful, while adults in that age group who dispense advice to fewer types of people are much less likely to report high life meaning. “This association between advice giving and life meaning is not evident for other age groups,” Markus H. Schafer, an assistant professor of sociology at the University of Toronto and the lead author of the study, said in a press release. “Overall, we interpret these findings to suggest that the developmental demands of late midlife — particularly the desire to contribute to others’ welfare and the fear of feeling ‘stagnant’ — fit poorly with the social and demographic [realities] for this segment of the life course. Just when giving advice seems to be most important, opportunities for doing so seem to wane.”