



SUMMER 1999

networks

practical tools for a changing environment

Seclusion & Restraint

DEBATE GAINS MOMENTUM

For Cathy Bustin Baker, director of the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services' office of consumer affairs, the current debate about the use of seclusion and restraint in psychiatric facilities goes much deeper than simple considerations of policy, technique or strategy.

The debate brings back the unforgettable experience of her involuntary hospitalization at age 25. Ms. Bustin Baker found herself standing in the middle of a noisy psychiatric hospital unit among staff and patients, too terrified to speak. Wanting someone to reach out to her and show kindness and concern, she faced instead hospital staff who simply observed her "as though I were a disease," she says.

Panicking, she began to walk toward what she thought was her room. She remembers immediately being tackled by five hospital aides. One of them, a young man, pulled down her slacks and injected her with a tranquilizer. The terror of that experience has never left her. The event both reawakened old traumas and added a new one that remains a constant presence—and a motivator to ensure that it isn't repeated with other helpless individuals.

The debate over seclusion and restraint reverberates as well with Dr. Rupert Goetz, Medical Director of the Oregon Mental Health and Developmental Disabilities Services Division. A psychiatrist specializing in emergency mental health, Dr. Goetz clearly recalls an incident that occurred when he was a physician at a Portland, Oregon, hospital. A female patient disappeared into a bathroom; some time later, she had yet to emerge.

Following hospital policy, a security officer went to check on her. Moments later, the woman exited the bathroom, heading straight for Dr. Goetz's examining room. Before he grasped what was happening, the woman stood in front of him, the pistol in her hand pointed directly at him and the security officer. The officer quickly pushed Dr. Goetz out of the way and helped police disarm and subdue the woman, who was placed in restraints. He still thinks about that incident—and how unexpectedly people and events can spiral out of control in an inpatient psychiatric facility.

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MESSAGE FROM NTAC'S DIRECTOR

This issue of *networks* addresses one of the most significant challenges facing the mental health field today: the use of seclusion and restraints in psychiatric settings. Recent media attention has virtually ensured that legislators, decision-makers and the general public will now join in the close examination of how publicly-funded facilities are using seclusion and restraints.

In May, the Center for Mental Health Services initiated a comprehensive analysis of seclusion and procedures in psychiatric facilities. The initiative recognizes that seclusion and restraint should only be used in rare circumstances.

Even more recently, the White House weighed in by issuing a new regulation designed to prevent use of inappropriate chemical and physical restraint. The regulation was developed in direct response to media reports of injury and deaths. While the new rule applies only to federally-funded hospitals, it contributes to the trend toward serious questioning of the use of seclusion and restraints.

Although generally spoken of in the same phrase, seclusion and restraint differ from one another both in their definition and use. Further attention needs to be paid to better understanding those differences. For our purposes in this issue of *networks*, however, we simply attempt to frame the debate in a way that makes the most critical issues more understandable. As a better informed reader, you will then be able to contribute more effectively to the ongoing dialogue.

A February 1999 meeting in Atlanta of the NASMHPD Medical Directors Council represented an important step forward in better understanding the complexity of the concerns and the personal experiences of those involved. Many of the ideas which were discussed at that meeting are reflected in this issue.

We also include an excerpt from the NASMHPD Position Statement on the Use of Seclusion and Restraint which will be discussed at the Summer Commissioners meeting later this month in Pittsburgh. Current efforts of the State of Pennsylvania to reduce the use of seclusion and restraint in its psychiatric hospitals are described. They provide an outstanding example of the difference that leadership and training can make in changing a system's entire approach to this difficult issue.

Your involvement is needed. The use of seclusion and restraint concerns us all, as citizens with an interest in balancing the needs of the individual with the needs of society. Since a lasting and appropriate resolution to the problem can occur only after a candid debate has been encouraged and engaged in by all interested parties, we hope this issue of *networks* will contribute to your ability to do just that.

Please let us hear from you about further work that NTAC and NASMHPD might do in the future in the area of seclusion and restraint or in any other topic area. Your comments, as always, make a real difference.

—Bruce D. Emery, M.S.W.

Emerging Issues

These two distinct experiences help define and illuminate the fierce debate now occurring in the mental health community, Congress and the general public about the use of seclusion and restraint in psychiatric settings. A key feature of that debate is the emerging consensus that seclusion and restraint can no longer be regarded as mental health treatments. In fact, they are increasingly viewed as emergency safety measures to be avoided whenever possible and used only as a last resort.

For a growing number of consumers, family members and mental health officials at state and local levels, the continued widespread use of seclusion and restraint is a sign of treatment failure that highlights serious problems with the nation's mental health system. State mental health agencies in Pennsylvania, Massachusetts and Minnesota, among others, have recently implemented policies designed to dramatically reduce the use of seclusion and restraint in their psychiatric facilities. [*See Focus on the States on page 4.*]

Increased Media Attention

Sparked by a series of articles published last year by the *Hartford Courant* newspaper and a "60 Minutes" segment that aired in April 1999, deaths and injuries resulting from the use of seclusion and restraint have raised new questions about quality of care in the nation's inpatient psychiatric facilities. Allegations that staff in many inpatient psychiatric hospitals receive little or no training in de-escalating potential problems and in appropriate use of seclusion and restraint have drawn attention to the concern that some facilities operate with few or no guidelines for determining how and when to use such safety measures and how to avoid their use entirely.

These media revelations and a growing public concern have prompted Congress to consider legislation that would limit the use of seclusion and restraint in psychiatric facilities and require reporting of all incidents of injury and death to the state Protection and Advocacy office for investigation. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the private, not-for-profit organization that accredits most of the nation's inpatient psychiatric facilities, held hearings in April 1999 to reevaluate its standards on seclusion and restraint. On June 25, the U.S. Department of Health and Human Services issued new national regulations placing strict limits on the use of seclusion and restraint in psychiatric facilities.¹

Making a Difference

The National Association of State Mental Health Program Directors (NASMHPD) has joined the National Alliance for the Mentally Ill and the National Mental Health Association in recently calling for reductions in the use of seclusion and restraint and stricter oversight of these practices in psychiatric facilities. "This is one of those areas where we can make a real difference in people's lives," maintains Robert W. Glover, Ph.D., Executive Director of NASMHPD. "We can stop people from dying and from being injured or traumatized. Hard evidence now exists that people who have been physically or sexually abused at earlier times in their lives can be retraumatized as a result of being restrained in inpatient psychiatric settings. That victimizes individuals all over again."

NASMHPD's membership is set to vote in July on a proposed position statement regarding the use of seclusion and restraint at the association's summer meeting in Pittsburgh, PA. The position statements calls for a major reduction in its use. [*See page 6 for more information on the NASMHPD position statement.*] In October 1999, NASMHPD members will address the issue of seclusion and restraint, among other topics, at the first national meeting of public psychiatric hospital superintendents to be held in Washington, D.C.

Changing Culture

Despite the growing momentum to reduce or entirely avoid the use of seclusion and restraint, some mental health providers and organizations caution against a wholesale prohibition. "It is very important not to overuse seclusion and restraint, but it is also unrealistic to say that we should never use them," asserts Paul Jay Fink, M.D., Senior Consultant to Charter Behavioral Health Systems and Professor of Psychiatry at Temple University School of Medicine in Philadelphia, PA. "The reality is that we get very sick people in psychiatric hospitals, and they are sometimes out of control. Seclusion and restraint should not be used as therapy, and certainly not as punishment. These interventions are needed primarily when there is an element of danger."

However, Ira Burnim, staff attorney with the Judge David L. Bazelon Center for Mental Health Law in Washington, D.C., contends that seclusion and restraint are too often used as a substitute for more appropriate interventions. He points to a

¹U.S. Department of Health and Human Services. (June 25, 1999). "Medicaid and Medicare; Hospital Conditions of Participation: Patients' Rights."

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Focus on the States

Pennsylvania Leads the Way in Reducing the Use of Seclusion and Restraint

During a time when national attention has been sharply focused on the potential dangers of using seclusion and restraint in psychiatric facilities, Pennsylvania is one of several states leading the way in exploring strategies to reduce or eliminate the use of these coercive measures in the mental health arena.

Since his appointment three and a half years ago, Charles G. Curie, Pennsylvania's Deputy Secretary for Mental Health and Substance Abuse, has pursued a policy aimed at dramatically reducing the use of seclusion and restraint in the state's nine psychiatric hospitals. This initiative has resulted in substantial reductions in both incidents and hours of seclusion and restraint.

Between 1994 and 1998, according to data from the Pennsylvania Performance Measurement System, the number of hours of seclusion in the state's psychiatric hospitals dropped by 91 percent (from 32.5 hours to 2.9 hours per thousand patient hours), and the number of incidents of seclusion fell by 60 percent (from 3.2 to 1.3 per thousand patient hours). During the same period, hours of restraint fell by 52 percent (from 40 hours to 19 hours per thousand patient hours), and the number of restraint incidents dropped by 42 percent (from 3.8 to 2.2 per thousand patient hours).

In Curie's view, Pennsylvania's experience demonstrates that it is "quite feasible for any state mental health system" to make a major reduction in its use of seclusion and restraint.

Curie emphasizes that Pennsylvania's initiative to reduce the use of seclusion and restraint is part of a broader effort to reorient the state mental health system toward a consumer-focused philosophy that emphasizes recovery and independence. "Seclusion and restraint were symptoms of a whole approach to caring for patients," he asserts. "We felt that it was important to make it clear that these practices are not treatment interventions but treatment failures to be used only as a last resort."

Since 1997, each of the state's psychiatric hospitals has reported regularly on the number and duration of incidents of seclusion and restraint. These data, in addition to being closely monitored by SMHA officials, are made available to consumer and family

organizations and the state's mental health planning and advisory council. "This has introduced accountability and a healthy competition among hospitals," Curie notes.

The SMHA also initiated comprehensive staff training that addresses strategies for preventing or "de-escalating" confrontations between consumers and staff. Curie acknowledges that, initially, some staff members had concerns about discipline and safety as a result of the new policy. However, he says staff now realize that they can provide the necessary oversight without resorting to physical measures. He notes that preliminary data indicate that both the numbers of consumer and staff injuries have decreased since the new policy was implemented.

For the relatively few cases where seclusion and/or restraint are still considered necessary, Curie says, the SMHA has established guidelines for their use, including the following:

- ◆ Under most circumstances only a doctor can order seclusion or restraint and only for "up to one hour."
- ◆ In an emergency, a nurse may provide the order; however, a doctor must be notified immediately and perform a "face-to-face" assessment of the individual who is being secluded or restrained within 30 minutes.
- ◆ To extend seclusion or restraint beyond one hour, a doctor must perform a new assessment and provide a new order each hour.
- ◆ After every incident of seclusion or restraint, a debriefing must take place involving the consumer, staff, doctors and others to examine what precipitated the incident and discuss how to avoid similar occurrences.

In Curie's view, Pennsylvania's experience demonstrates that it is "quite feasible for any state mental health system" to make a major reduction in its use of seclusion and restraint. He cautions, however, that to make real progress SMHAs must look beyond particular strategies or techniques to the broader goal of helping consumers prepare to return to their communities and live independently. "If a state embarks on a quest to reduce the use of seclusion and restraint solely from the narrow perspective of teaching de-escalation techniques or appropriate holds, it will undercut the scope of what can be accomplished," he emphasizes.

www.seclusion.restraint

American Academy of Child and Adolescent Psychiatry (AACAP): Presents issue briefs on the use of seclusion and restraint with children and adolescents and summarizes proposed legislation on seclusion and restraint. Describes a variety of publications that address the use of coercion in the psychiatric treatment of children and adolescents. <http://www.aacap.org>

Judge David L. Bazelon Center for Mental Health Law: Provides current information on legislation and court decisions affecting the use of seclusion and restraint in psychiatric facilities. Includes an in-depth discussion of the use of Advance Directives in stating a consumer's preferences during times of incapacity, including a series of Advance Directive templates. Also contains information on the proposed Patients= Bill of Rights, Americans with Disabilities Act (ADA) and *Olmstead v L.C.* <http://www.bazelon.org>

MacArthur Research Network on Mental Health and the Law: Provides basic information on mental health issues such as competence for treatment, coercion, risk of violence and adjudicative competence. Describes study instruments and manuals. <http://ness.sys.virginia.edu/macarthur>

National Association of Protection and Advocacy Systems (NAPAS): Offers information on federally mandated Protection

and Advocacy (P&A) programs that protect the rights of persons with disabilities, including psychiatric disabilities. Contains a centralized repository of training and technical assistance information, legal research assistance and links to related organizations. <http://www.protectionandadvocacy.com>

National Association of Psychiatric Health Systems (NAPHS): Offers guidelines on the use of seclusion and restraint in psychiatric facilities. Provides information on advocacy projects, news releases, upcoming events and links to related web sites. <http://www.naphs.org>

National Mental Health Consumers= Self-Help Clearinghouse: Includes testimony by Joseph Rogers, the Clearinghouse's Executive Director, at the April 13 congressional hearings on restraint and seclusion. Provides consumer-oriented materials on a range of mental health issues. <http://www.mhselfhelp.org/index2.html>

People Working Together for Social Justice and Human Rights in Mental Health: Discusses a range of issues related to involuntary treatment and social justice for mental health consumers. Includes a chat room, discussion boards, responses to frequently asked questions, an online magazine, a search engine and links to similar organizations. <http://www.madnation.org>

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study by Robert Okin, M.D., a former commissioner of mental health in Massachusetts and Vermont and now a professor of clinical psychiatry at the University of California at San Francisco and chief of psychiatry at San Francisco General Hospital. The study found wide variation in the use of seclusion and restraint among inpatient psychiatric facilities serving patients with similar needs.

"The only factor that seemed to explain the difference was the attitude of the hospital administration toward use of seclusion and restraint," Mr. Burnim says. "That, to me, stops the argument. The hospital's culture dictates whether, in what circumstances and how often seclusion and restraint interventions are used."

Advocates, providers and consumers all appear to agree on one point: hospital leadership is critical in developing the

atmosphere of respect and concern for patients that is necessary to minimize use of seclusion and restraint. Staff trained to recognize and diffuse situations that might otherwise escalate and result in its use are key to ensuring that seclusion and restraint are used only when absolutely essential, and then as appropriately as possible.

The current debate regarding seclusion and restraint offers an important opportunity for mental health stakeholders, legislators and members of the public to explore a core therapeutic challenge to the mental health field. Mental health consumers are expressing a resurgence of hope because of the newly emerging national discussion of the issue. "I'm very optimistic," says Ms. Bustin Baker. "As painful as the subject is, there is incredible excitement that this issue is finally breaking through to the mainstream media, legislators and the public. Lasting change may truly be on the way." ♦

CALENDAR OF EVENTS

July 11-12: National Association of State Mental Health Program Directors (NASMHPD). **NASMHPD's 1999 Summer Commissioners Meeting and Older Persons Division Annual Meeting.** Pittsburgh, PA. Call 703-739-9333.

July 19: National Association of Social Workers (NASW). **The Invisible Client: Working with Lesbian, Gay, Bisexual, and Transgender Youth.** Indianapolis, IN. Contact Denny Sparks at 317-923-9878.

August 4-6: Institute on Disability (Affiliated with the University of New Hampshire). **Institute on Abuse and Neglect of Persons with Disabilities.** Durham, NH. Contact Debbie Wilkinson at 603-228-2084.

August 25-29: National Mental Health Consumers' Self-Help Clearinghouse. **National Summit.** Philadelphia, PA. Call 800-553-4539, ext. 297.

August 29-September 1: **NASMHPD Legal Division 20th Annual Meeting/Interstate Compact Coordinators for Mental Health Annual Meeting.** Seattle, WA. Call 703-739-9333.

September 15-17: **ATSP's Annual International Conference: Telemedicine-Rebuilding the Business of Health Care.** Albuquerque, NM. Contact Pat Wittenberg at 503-222-2406.

October 3-8: **NASMHPD's Forensic Division 20th Annual Conference/NASMHPD's Children, Youth & Families Division 1999 Annual Meeting.** Tarrytown, NY. Call 703-739-9333.

October 14-17: American Academy of Psychiatry and the Law. **1999 Annual Meeting.** Baltimore, MD. Contact Wanda Brat at 800-331-1389.

October 27-November 1: American Academy of Child and Adolescent Psychiatry. **46th Annual Meeting.** Chicago, IL. Contact Anita Wiler at 202-966-7300.

November 18-21: National Association for Rights Protection and Advocacy (NARPA) 19th Annual Rights Conference. **A New NARPA for a New Millennium.** Louisville, KY. Contact Colleen Fry at 605-399-9713.

NASMHPD Members To Consider Statement on Seclusion and Restraint

Members of the National Association of State Mental Health Program Directors (NASMHPD) will vote at their semi-annual meeting in July on a proposed position statement calling for "preventing, reducing, and eliminating" the use of seclusion and restraint in public inpatient psychiatric settings.

"Seclusion and restraint, including the use of involuntary medications for purposes other than stabilizing an individual, are safety interventions of last resort and are not treatment interventions," asserts the draft position statement, which was developed by a NASMHPD work group convened by the NASMHPD Medical Directors Council. "Seclusion and restraint should never be used for the purposes of discipline, coercion or staff convenience, or as a replacement for adequate levels of staff or active treatment."

In addition to pointing out that the use of seclusion and restraint poses risks of serious injury or death, the draft position statement emphasizes that persons who have a history of trauma such as physical or sexual abuse may be retraumatized by such measures. "In light of these potentially serious consequences, seclusion and restraint should be used only when there exists an immediate risk of danger to the individual or others and no other safe and effective intervention is possible," the draft position statement asserts.

In situations where seclusion and restraint are still considered necessary, the draft position statement says they "should be administered in as safe and humane a manner as possible by appropriate personnel." It also calls on inpatient psychiatric facilities to report all injuries and deaths related to the use of seclusion and restraint to an independent external authority while conducting thorough internal reviews to assess the incident and prevent future incidents that result in harm to patients or staff members.

The draft position statement urges the leadership and staff of inpatient psychiatric facilities to "maintain an environment and culture of caring that prevents the need for seclusion and restraint from arising" through:

- ◆ early identification and assessment of individuals who may be at risk of receiving those interventions;
- ◆ high quality, active treatment programs that include peer-delivered services;

- ◆ trained, competent staff who effectively employ individualized alternative strategies to defuse escalating situations; and
- ◆ policies and procedures that state clearly that seclusion and restraint will be used only as emergency safety measures.

The draft position statement goes on to say that NASMHPD is “committed to achieving its goals of safely preventing, reducing, and eliminating the use of seclusion and restraint by: (1) encouraging the development of state mental health agency policies and facility guidelines on the use of seclusion and restraint; (2) continuing to involve consumers, families, treatment professionals, facility staff, and advocacy groups in collaborative efforts; (3) supporting technical assistance, staff training, and consumer/peer-delivered training and involvement to effectively improve and/or implement policies and guidelines; (4) promoting and facilitating research regarding seclusion and restraint; and (5) identifying and disseminating information on ‘best practices’ and model programs.”

Robert W. Glover, Ph.D., NASMHPD Executive Director, said that one of the primary messages of the proposed position statement is that seclusion and restraint should no longer be viewed as routine practices in inpatient psychiatric facilities but should be used only under certain circumstances and as a last resort. Noting that several states, including Massachusetts, Minnesota and Pennsylvania, have already embarked on successful efforts to dramatically reduce the use of such measures, he said that it is realistic to expect a major reduction in the use of seclusion and restraint nationwide.

Dr. Glover noted that in addition to the position statement, the NASMHPD Medical Directors Council has developed a technical report that addresses effective policies and strategies for reducing the use of seclusion and restraint and establishing an environment in which these measures are seldom if ever needed.

Robert Bernstein, Ph.D., Executive Director of the Judge David L. Bazelon Center for Mental Health Law, praised NASMHPD’s leadership on this issue, noting that public mental health systems have been among the leaders in efforts to reduce the use of seclusion and restraint and ensure other rights for consumers.

To obtain a copy of the position statement or the technical assistance report, please contact NASMHPD at (703) 739-9333.

SUGGESTED READING

NASMHPD Medical Directors Council. (March 1999). *Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations* (Technical Assistance Report). Alexandria, VA: National Association of State Mental Health Program Directors. (Contact NASMHPD at 703-739-9333).

Massachusetts Department of Mental Health, Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused. (1996). *Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused: Report and Recommendations*. Boston, MA. (No cost; contact the Department at 617-727-5500.)

New York State Commission on Quality of Care for the Mentally Disabled. (1994). *Restraint and Seclusion Practices in New York State Psychiatric Facilities*. Albany, NY. (Cost: \$10; Contact the Commission at 518-473-7538).

New York State (NYS) Commission on Quality of Care for the Mentally Disabled. (1995). *Governance of Restraint and Seclusion Practices by NYS Law, Regulation, and Policy*. Albany, NY. (Cost: \$10; contact the Commission at 518-473-7538.)

Petrila, J. (1998). *Ethical Issues for Behavioral Health Care Practitioners and Organizations in a Managed Care Environment*. Rockville, MD: Substance Abuse and Mental Health Services Administration. (Cost: \$5; contact the Florida Mental Health Institute at 813-974-4471.)

Ray, N., Myers, K., and Rappaport, M. (1996). *Patient Perspectives on Restraint and Seclusion Experiences: A Survey of Former Patients of New York Psychiatric Facilities*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Ridgely, M., and Van den Berg, P. (1997). *Women and Coercion: Commitment, Involuntary Treatment and Restraint*. Tampa, FL: Florida Mental Health Institute (FMHI), Department of Mental Health Law and Policy. (Cost: \$5; contact the FMHI at 813-974-4471.)

Employment Tool Kit available this summer

Final edits are now being made to a one-of-a-kind, 300-page *Technical Assistance Tool Kit for Employment of People with Psychiatric Disabilities* to be available in August. This is the second tool kit developed by NTAC and its collaborators, and it closely follows the format used for the Housing Tool Kit published in fall 1996. Building upon the successful Senior Executive Training Institute on Employment held in Alexandria, Va., March 11-12, 1999, the Employment Tool Kit contains background briefing papers, innovative program descriptions, comprehensive state model documents and other resource materials of interest to all those with a concern about employment issues for persons with psychiatric disabilities.

A broad audience of clinicians, consumers, family members, employment specialists, advocates and technical assistance providers will find the Employment Tool Kit essential in designing, financing and advocating for employment services for all people with psychiatric disabilities. Copies of the Employment Tool Kit will be available from NTAC for \$25.00. To place an order, please call (703)739-9333.

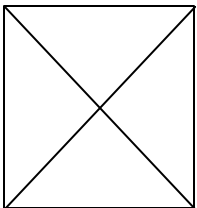


Technical Assistance Tool Kit for Employment of People with Psychiatric Disabilities is published by the National Technical Assistance Center for State Mental Health Planning (NTAC) and is supported under a Cooperative Agreement between the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (CMHS/SAMHSA), and the National Association of State Mental Health Program Directors (NASMHPD). Cited reproductions, comments and suggestions are encouraged.

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