

# 75 Years of Help, Hope, & Healing



National Association of Psychiatric Health Systems

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Opportunities For Individual Membership

NAPPH 1987 PRESIDENTIAL AWARDS

VISION for Behavioral Health 2003

Every 75 seconds, an American teenage AT-RISK suicide...

2005 Behavioral Healthcare Leadership in ACTION

Support of the Balanced Budget Act of 1997 on PPS's Largest Psychiatric Facilities

SUCCESS STRATEGIES IN QUALITY ACCOUNTABILITY IN THE '90s

NATIONAL EXPOSITION in conjunction with the 50th ANNUAL MEETING

CONVENTION NEWS Health Economist McNeerney Is Annual Meeting Keynote Speaker

TEENAGERS AT RISK: AN ADULT PERSPECTIVE

Quarterly News Letter

1997 Training Conference

THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

1998 Leadership in Behavioral Healthcare

Making the Case for BEHAVIORAL HEALTH

What's your company policy on Schizophrenia?

What Motorola knows about mental health coverage could fill a book.

ESSENTIAL LINKAGES 1997 ANNUAL MEETING NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

RISKS, RESPONSIBILITIES & REWARDS

napph roster 1981

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

1997 Training Conference

What Motorola knows about mental health coverage could fill a book.

GOOD CONNECTIONS FORMING ALLIANCES TO REFORM THE SYSTEM

CHALLENGES AND NEW REALITIES For the Private Psychiatric Hospital

MEETING THE FUTURE WITH STRATEGIC PLANNING

THE CHALLENGE OF CHANGE

INTERNATIONAL CONFERENCE PROGRAM

NEWS LETTER

NEW! IN RESPONSE TO THE NEW LEGISLATIVE BOARDS OF PSYCHIATRIC CARE THE PSYCHIATRIC HOSPITAL DIRECTORY

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

CONGRESS IN HARVARD

2001 Annual Membership and Board of Trustees Meeting

What Motorola knows about mental health coverage could fill a book.

MANAGING CHANGE, CHANGING MANAGEMENT STYLES

EDUCATIONAL CASSETTE PROGRAM

CHALLENGES AND NEW REALITIES For the Private Psychiatric Hospital

WELCOME TO PALM SPRINGS!

CHALLENGES AND NEW REALITIES For the Private Psychiatric Hospital

SUCCESS STRATEGIES IN QUALITY ACCOUNTABILITY IN THE '90s

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

1999 Annual Membership and Board of Trustees Meeting

PARTICIPANTS LIST BEYOND THE HOSPITAL BED

THE PRIVATE PSYCHIATRIC HOSPITAL OPPORTUNITIES AND RESPONSIBILITIES

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

MEETING THE FUTURE WITH STRATEGIC PLANNING

How to Avoid a Controversy

Opportunities For Individual Membership

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

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NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

PREPARING FOR THE FUTURE

NAPPH 54TH ANNUAL MEETING

PPS

75 years of Healthcare Leadership

Does your employee belong in a psychiatric hospital?

Using Inpatient Psychiatric Benefits Wisely

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

National Association of Psychiatric Health Systems

75 Years of Help, Hope, & Healing

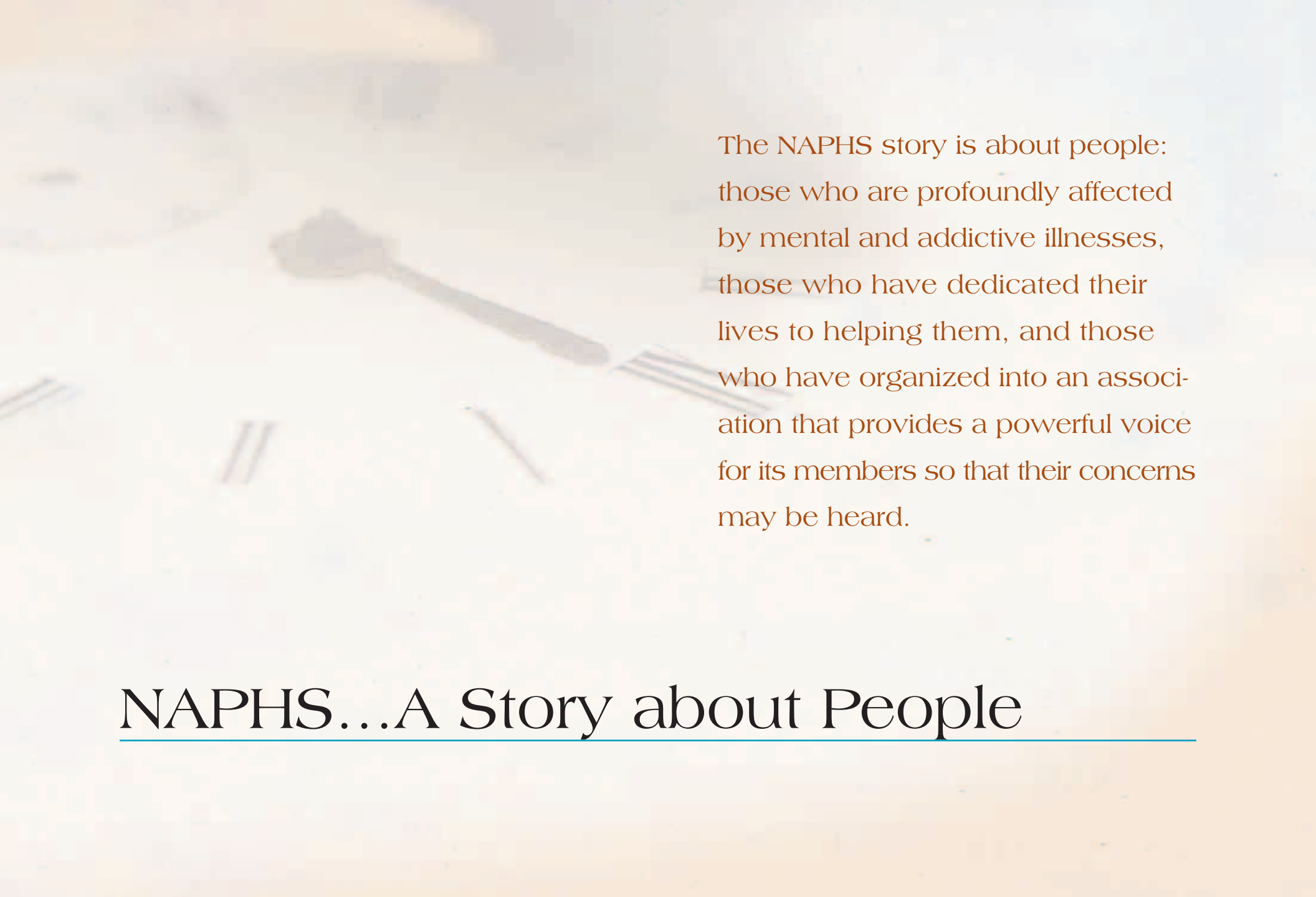


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The NAPHS story is about people: those who are profoundly affected by mental and addictive illnesses, those who have dedicated their lives to helping them, and those who have organized into an association that provides a powerful voice for its members so that their concerns may be heard.

## NAPHS...A Story about People

## NAPHS...A Story about People



**Mark Covall**  
Executive Director  
National Association of  
Psychiatric Health Systems,  
Washington, DC



**Jeff Borenstein, M.D.**  
2008 President  
National Association of  
Psychiatric Health Systems;  
CEO/Medical Director, Hollis-  
wood Hospital, Holliswood,  
NY; Senior Vice President and  
Corporate Medical Director,  
Liberty Behavioral Manage-  
ment Group, Inc.

NAPHS  
members  
are a source  
of help...  
of healing...  
of hope...  
  
every day...  
24 hours a day...  
in communities  
across America...

### NAPHS members exist because....

- serious mental illness affects about 6% of American adults (or 1 in 17), according to the National Institute of Mental Health.<sup>1</sup> About 1 in 4 adults suffer from a diagnosable mental disorder in a given year.
- research shows that "... mental disorders are the chronic disorders of young people in the U.S.," says NIMH Director Thomas Insel, M.D.<sup>2</sup>
- mental illnesses can be lethal. In 2004, 32,439 (approximately 11 per 100,000) people died by suicide in the U.S.—making it the 11th leading cause of death.<sup>3</sup> An estimated eight to 25 attempted suicides occur per every suicide death.<sup>4</sup>
- among children and young people, suicide was the third leading cause of death in 2004 for children ages 10–14 (1.3 per 100,000), adolescents 15–19 (8.2 per 100,000), and young adults ages 20–24 (12.5 per 100,000).<sup>5</sup>
- mental illness and substance abuse annually cost employers an estimated \$80 billion to \$100 billion in indirect costs.<sup>6</sup>
- mental disorders are the leading cause of disability in the U.S. for ages 15–44.<sup>7</sup>
- fifty percent of youth with serious emotional disorders drop out of high school.<sup>8</sup>
- an annual average of 8.2% full time workers aged 18 to 64 used illicit drugs in the past month, and 8.8% used alcohol heavily in the past month.<sup>9</sup>

—sources, page 9



## A Focus on Improving People's Lives

This is a story about people: those who are profoundly affected by mental and addictive illnesses, those who have dedicated their lives to helping them, and those who have organized into an association that provides a powerful voice so that their concerns may be heard.

As you read about the evolution of behavioral health care and of the correlated shaping of the National Association of Psychiatric Health Systems (NAPHS) over the last 75 years, one thing has remained fixed: the consistently devastating impact that untreated mental and addictive disorders have on the lives of all people who face them. And the impact of these illnesses expands to touch many others—families, friends, co-workers, classmates, and communities. The conditions can be severe, disabling, even fatal.

Private psychiatric providers in the United States recognized and began responding to the need for structured, targeted, compassionate care for those with the most severe

mental and addictive conditions as far back as the mid-1700s, when a few early and mostly independent psychiatric hospitals opened their doors. The caregivers in these hospitals began and continued a tradition—basically an ethic—of providing the around-the-clock, individualized, safe, and secure care that focuses on the needs of individuals with the most complex mental health needs.

It was the psychiatrists in these hospitals who founded our association in 1933 as a voice to make certain that the needs of these people with such serious illnesses would be heard. Over time, association membership has broadened to represent all levels of care—inpatient, residential, partial hospital, and outpatient—and been strengthened by engaging and blending the senior clinical and administrative leadership of member organizations. The men and women in these organizations, who have made help and healing their life's work, have created, molded, and led inpatient psychiatry into the future in profound ways. Through NAPHS,

NAPHS...

...is the voice of experts in behavioral healthcare delivery

...helps members *anticipate change*

...partners with others to produce *results* that improve peoples' lives

## NAPHS...A Story About People

**What Motorola  
knows about mental  
health coverage  
could fill a book.**

So what's to know? Right now, the National Association of Private Psychiatric Hospitals has available a limited number of copies of a study which analyzes this important employee benefit from all three perspectives: business, insurer, and health care provider.

It's packed with information on trends, and how all three sectors are reacting to them. It candidly compares mental health benefits to benefits like dental or eye care. It answers honestly, the question of mental health benefit costs. And it answers a whole lot more of the most "delicate questions" about this benefit.

If you think your company may be losing productivity due to employees under stress from work or family pressures...you owe it to your company and your employees to write today for a copy of this valuable report. It's been read by employee benefit managers at some of the nation's largest companies. Companies which currently include mental health benefits in their employee benefit package.


When it comes to mental health benefits...the NAPPH wrote the book. And now we'd like to share it with you.

**This Book.**

I want to know what Motorola knows about mental health coverage. Please send my confidential copy to:

Name \_\_\_\_\_  
Title \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The National Association of Private Psychiatric Hospitals  
1829 F ST. N.W. • Washington, DC 20004 • (202) 361-6700



NAPHS promotional ad campaign, 1985

these leaders in clinical organizations have come together to advocate for what it takes to deliver high-quality treatment that can make a difference in people's lives...and to ensure that those resources will be available when people need them.

Over the years, the structure of the hospitals and health systems that our members operate have evolved along with changing societal views and scientific understanding of the causes of mental illness, the role of the family, and the best treatment approaches. Private inpatient provider organizations have both helped to create and have incorporated the latest innovations—from new medications to evidence-based research—as they continuously work to meet patient needs. Having been on the cutting edge of improvements, of the expansion of knowledge, and in science, caregivers in NAPHS-member organizations have been able to adjust and lead—and are integral to the ongoing evolution of behavioral health.

## Power Through Advocacy

As the CEOs and chief medical officers of their organizations, members have stood up—often when issues were unpopular—to speak out based on real-life knowledge of what it takes to provide safe, secure, and hopeful treatment settings when lives are out of control and at risk.

Looking at the association's 75-year history, there are a number of lessons learned.

### There is strength in numbers.

No one person or organization alone can accomplish all that needs to happen. You need partners. You need the power of many individual voices working together at the grassroots level.

NAPHS has worked over the past decades to put these ideas into practice in support of innovation, quality, and responsive programming to meet the needs of those who need us most.

### **Advocacy is not a sometimes activity.**

You need to be there constantly so that when opportunities arise, you can act. Massive changes have occurred over the past 75 years (from the advent of managed care to the era of improved psychotropic medications). And change will continue unabated. Being able to anticipate and respond to change is essential and a key aspect of what the association does for its members.

### **You need to focus.**

Resources—even in the best of times—are limited, and a concentrated, results-oriented strategy is most effective.

### **Mental health is everyone's concern.**

While our members have worked hard over the years to overcome barriers to access, coverage, and many other issues, challenges remain. And many of those challenges—such as lingering stigma—are things that hospitals alone cannot fix. Meeting the needs of individuals with mental and


addictive conditions will take all of us—not just those in the mental health community. Mental health is integral to overall health. To continue to serve this patient population and meet their needs, this integration is something society as a whole—all of us—must work together to achieve. Inpatient caregivers have been leaders. They have made great progress with the resources they have had. More resources may be needed, but that's something that only can be achieved if everyone agrees and works toward making mental health part of overall health.

We want to—and have been—part of the solution. Working together, we all can make a difference.

### SOURCES

- 1 The Numbers Count: Mental Disorders in America. National Institute of Mental Health (NIMH). Accessed at [www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml](http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml). November 2007.
- 2 See NIMH news release at <http://www.nimh.nih.gov/press/mentalhealthstats.cfm> on the National Comorbidity Survey Replication. June 6, 2005.
- 3 NIMH. The Numbers Count.
- 4 Suicide in the U.S.: Statistics and Prevention. National Institute of Mental Health. Accessed at [www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml#CDC-Web-Tool#CDC-Web-Tool](http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml#CDC-Web-Tool#CDC-Web-Tool), November 2007.
- 5 NIMH. Suicide in the U.S.
- 6 An Employer's Guide to Behavioral Health Services: National Business Group on Health. December 2005. Also see Partnership for Workplace Mental Health at <http://www.workplacentalhealth.org/pdf/POPartnershipBrochure05.pdf>.
- 7 NIMH. The Numbers Count.
- 8 Helping America's Youth "Quick Facts" at [www.helpingamericasyouth.gov](http://www.helpingamericasyouth.gov). From the US Dept. of Education, Office of Special Education Programs (2001)
- 9 The NSDUH Report: Worker Substance Use by Industry Category. August 23, 2007. See <http://oas.samhsa.gov/2k7/industry/worker.cfm>.





Our thanks to our members,  
partners, and colleagues for  
helping to keep the needs of  
the millions of Americans with  
psychiatric and substance use  
conditions in front of policymakers...  
and for helping to shape the future.

# 75 Years of Behavioral Healthcare Advocacy

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NAPHS: 75 Years of Behavioral Healthcare Advocacy



NAPHS helped to form the Coalition for Fairness in Mental Illness Coverage, which has been an important voice in the fight for passage of parity legislation.

—*Sen. Pete Domenici (R-NM)*

NAPHS brings us the perspective of behavioral healthcare provider organizations.

—*Rep. Patrick J. Kennedy (D-RI)*





Our shared advocacy vision is for high-quality treatment, access, and coverage.

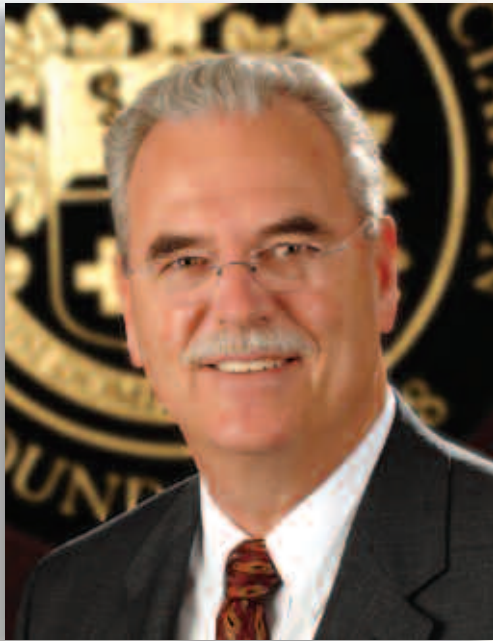
—*Michael J. Fitzpatrick, M.S.W.*  
*executive director*  
*National Alliance on Mental Illness*

The hospital-based inpatient psychiatric services (HBIPS) core measures set now under development puts the field on par with core measures initiatives developed for other medical conditions.

—*Paul M. Schyve, M.D.*  
*senior vice president*  
*The Joint Commission*



NAPHS: 75 Years of Behavioral Healthcare Advocacy



Mental health is integral to overall health, and we are pleased to work with NAPHS in the behavioral health arena.

—*Rich Umbdenstock*  
*president and CEO*  
*American Hospital Association*

Collaboration between the public and private sectors is critical.

—*Robert W. Glover, Ph.D.*  
*executive director*  
*National Association of State*  
*Mental Health Program Directors*







We are proud to note that psychiatrists founded NAPHS 75 years ago. Over the years, the American Psychiatric Association and NAPHS have worked closely together on policy issues that could affect the way our members help their patients. We wish NAPHS well and look forward to the next 75 years of collaboration.

—James H. Scully, Jr., M.D.  
*medical director/CEO*  
*American Psychiatric Association*

NAPHS and National Council members share a commitment to using advances in medicine and treatment to help those with mental illnesses and addiction recover and lead productive lives.

—Linda Rosenberg, M.S.W., *president and CEO*  
*National Council for Community*  
*Behavioral Healthcare*





All the noble goals that we each support will ultimately come to nothing without the ability to make our concerns heard.

NAPHS understands and has set behavioral health unity as a fundamental strategic goal.

# 75 Years of Behavioral Healthcare Leadership in Action

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## 75 Years of Behavioral Healthcare Leadership in Action

Among the **professionals who joined together** (at the close of the 1933 American Psychiatric Association meeting) to set objectives for the new National Association of Psychiatric Hospitals (NAPPH) were:



- John J. Kindred, M.D., Rivercrest Hospital
- Walter J. Otis, M.D., DePaul Hospital
- George Harding, M.D., Harding Sanitarium
- Emory John Brady, M.D., Brady Hospital
- James O'Neil, M.D., St. Vincents Hospital
- Howard R. Masters, M.D., Tucker Hospital
- G. Wilse Robinson, M.D., Neurological Hospital
- Rex Blankenship, M.D., Westbrook Sanitarium
- Carroll Turner, M.D., Carroll Turner Sanitarium

Recognizing that private psychiatric hospitals had a different foundation and interests than state hospitals (owned and funded by the government), owners of these private hospitals believed their interests would best be served by an organization independent of any other.

NAPHS  
History

### 1933

Behavioral  
Healthcare  
History



**Nation struggles through the economic devastation of The Great Depression.**

Originally, **NAPPH** members were individuals. By 1958, members were hospitals. Among **early hospital affiliates** (in addition to those listed above) were:

- Friends Hospital, Philadelphia, PA
- Hill Crest Sanitarium, Birmingham, AL
- Falkirk in the Ramapos, Central Valley, NY
- Compton Sanitarium, Compton, CA
- Fair Oaks Sanatorium, Summit, NJ
- Brunswick Hospital, Amityville, NY
- Elmcrest Manor, Portland, CT
- Brawner's Sanitarium, Smyrna, GA
- Broad Oaks Sanitarium, Morgantown, NC

**John J. Kindred, M.D.**

**association president**

**1934–36**

John J. Kindred, M.D. serves as the association's first president. For 43 years (through 1977), only physicians held the NAPPH presidency. Annual meetings and activities were held in conjunction with the American Psychiatric Association until 1961.

## 1934

Among the **oldest hospitals within the association membership** have been:

- Institute of Pennsylvania Hospital (opened in 1751)
- New Orleans Mental Health Institute, Inc. (DePaul Hospital & CMHC) (1861)
- New York Hospital-Cornell Medical Center/ Westchester Division (1771)
- Emerson A. North Hospital (1873)
- Friends Hospital (1813)
- St. Vincent's Hospital and Medical Center of New York, Westchester branch (1879)
- McLean Hospital (1818)
- South Oaks Hospital (1882)
- The Institute of Living (1822)
- Milwaukee Psychiatric Hospital (1884)
- Brattleboro Retreat (1834)
- Falkirk Hospital (1889)
- Butler Hospital (1844)
- Sheppard and Enoch Pratt Hospital (1891)
- Windsor Hospital, Inc. (1898)

**Glen Myers, M.D.**  
**association president**  
**1936–39**

NAPHS  
History

Behavioral  
Healthcare  
History

**1935**



**Alcoholics Anonymous (A.A.)** founded in New York by a New York stockbroker and an Ohio surgeon in an effort to help others who suffered from the disease of alcoholism and to stay sober themselves. A.A. grew with the formation of autonomous groups, first in the United States and then around the world.

**1936**

According to the American Hospital Association, “as of March 1, there are approximately 60 group **hospitalization plans** around the country, covering 300,000 lives. Some of the newer plans allow dependents to be enrolled.

“Six Canadian provinces also report the existence of hospitalization plans.”

**Clifford W. Mack, M.D.**

association president

1939–40

**1938**



B.F. Skinner publishes *The Behavior of Organisms* that describes operant conditioning.

**1939**



September 23—**Sigmund Freud** dies at the age of 83 in London.

75 Years of Behavioral Healthcare Leadership in Action

**James K. Hall, M.D.**  
association president  
1940–48

NAPHS  
History

Behavioral  
Healthcare  
History

**1940**



**World War II** (1941–45).

**1946**



President Truman signs the ***National Mental Health Act***, which called for the creation of a **National Institute of Mental Health**.





**John C. Kindred, M.D.**  
association president  
1948–50

**Walter J. Otis, M.D.**  
association president  
1950–51

**1948**

**1949**

**1950**



John Cade discovers that **lithium** is an effective treatment for bipolar disorder.

**National Institute of Mental Health** formally established. It was one of the first four NIH institutes.

## 75 Years of Behavioral Healthcare Leadership in Action

**G. Wilse Robinson, M.D.**  
association president  
1951–54

NAPPH President **G. Wilse Robinson, M.D.**, is appointed to the executive committee of the **Central Inspection Board (CIB) of the American Psychiatric Association (APA)**. APA also appointed NAPPH member **Harrison Evans, M.D.**, to its standards committee. Dr. Evans was the first “private hospital man” to sit on this committee.

**NAPPH dues** are \$10. **Individual memberships** are \$5.

NAPHS  
History

**1951**

Behavioral  
Healthcare  
History

**1952**

**Joint Commission on Accreditation of Hospitals (JCAH)** formed in collaboration with the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and Canadian Medical Association.

JCAH agrees to accredit psychiatric hospitals that passed APA's inspection. **APA established the Central Inspection Board (CIB)** to oversee the inspections, which began in 1956 when 66 hospitals applied (and paid for) their own inspections. In 1957, JCAH and APA ended their agreement—APA would continue to issue certificates to hospitals, but only JCAH could accredit them.

**Harrison S. Evans, M.D.**  
association president  
1954–56

**Phillip B. Reed, M.D.**  
association president  
1956–57

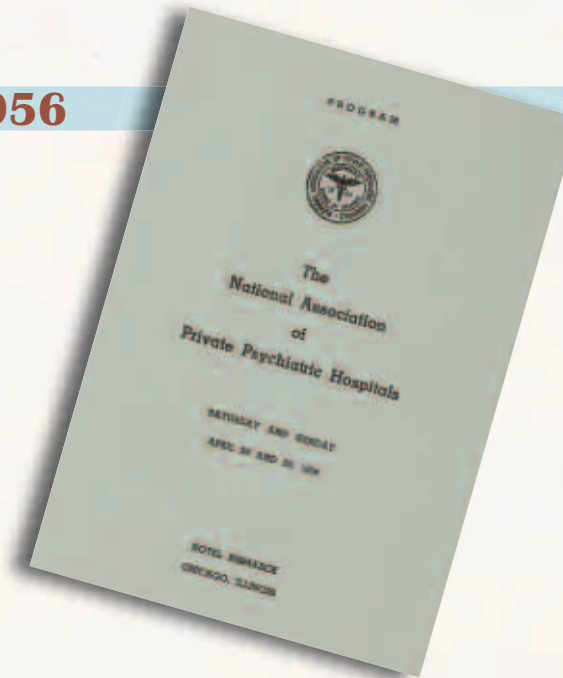
**Paul Hines, M.D.**  
association president  
1957–58

**1954**

First of the anti-psychotic phenothiazines (**Thorazine**) is sold in the United States.

**Diagnostic and Statistical Manual (DSM)** first published in 1954. The first printing was 132 pages.

**1956**



**1957**

American Medical Association recognizes **alcoholism** as a disease.

## 75 Years of Behavioral Healthcare Leadership in Action

**Mel Herman** first worked for the association as an assistant to two committees—the **Public Information Committee** and the **Pre-paid Hospitalization Committee**. Hospital members made voluntary contributions to employ Mr. Herman to develop a program to secure Blue Cross coverage for mental illnesses from all the Blue Cross plans in New York and neighboring areas.



**Mel Herman** selected as **first paid NAPPH executive director**. Headquarters were in his home in Leonia, NJ.

Two main goals were **continued improvement of quality of care** and greater involvement with the Joint Commission in **developing official organizational standards** and requirements for NAPPH membership.

NAPPH changes to **hospital membership** (vs. individual membership).

NAPHS  
History

1957

1958

Behavioral  
Healthcare  
History

“When the association began, nearly all the hospitals represented were owned by psychiatrists who ran the facilities and who became NAPPH members. During the 1950s, many of these facilities shifted from profit to non-profit status. The original owners ran the hospital but did not own it; the hospitals became public trusts with elected boards of trustees. Simultaneously, medical directors and hospital administrators began to take an active role in NAPPH and to attend annual meetings.”

—Mel Herman, NAPPH’s first executive director

**Benjamin Simon, M.D.**  
association president  
1958–59

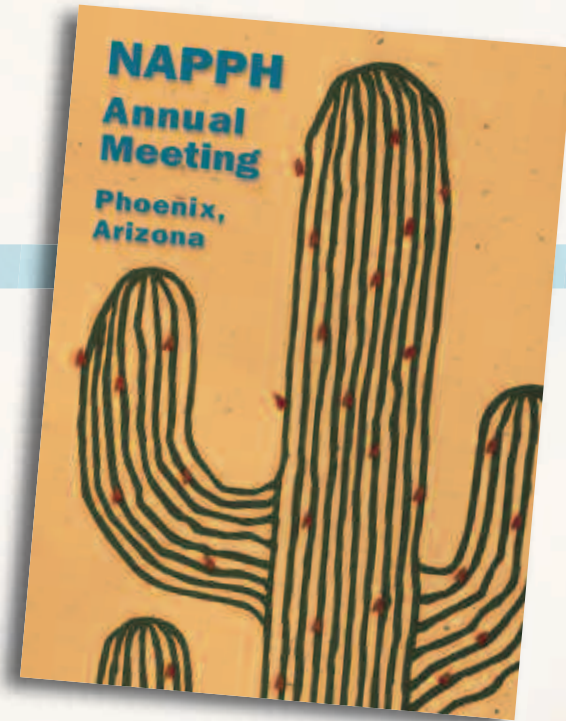
Regional meetings held to reach out to those who could not attend the annual meeting.

**1959**

**E. James Brady, M.D.**  
association president 1960

First **independent NAPPH annual meeting** held January 23 in Phoenix, AZ. Earlier meetings were held in conjunction with the American Psychiatric Association annual meeting.

**1960**



75 Years of Behavioral Healthcare Leadership in Action

**Edward G. Billings, M.D.**  
association president  
1961–62

**Samuel Liebman, M.D.**  
association president  
1963

A sum of \$600 was voted  
for the purchase of a  
**varitype machine.**

NAPHS  
History

**1961**

Behavioral  
Healthcare  
History

**1963**



President John F. Kennedy submits a special message to Congress on mental health issues, leading to ultimate passage of the ***Mental Retardation Facilities and Community Mental Health Centers Construction Act*** (P.L.88-164).

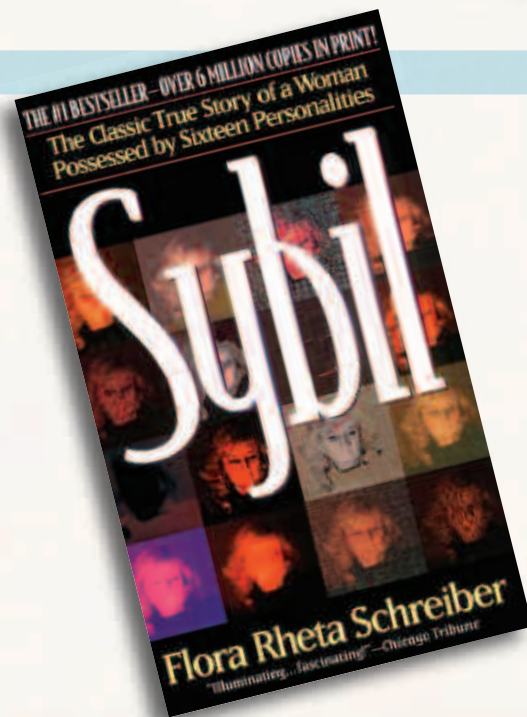
NAPPH elects **Cornelia B. Wilbur, M.D.**, as president—the **first female** to serve in this capacity. Since that time, five women have served as president (Jean P. Smith; Debra Osteen; Patricia R. Recupero, J.D., M.D.; and Diana Ramsay).

Published accounts name Dr. Wilbur as the New York psychoanalyst to “Sybil.” Dr. Wilbur is credited with asking Flora Schreiber to write the story of *Sybil*, published in 1973.

**Cornelia B. Wilbur, M.D.**  
**association president**  
**1964**

Annual meeting theme:  
“Adolescent Care.”

**1964**



NAPPH  
Annual Meeting  
1964

Adolescent  
Care

**Perry Talkington, M.D.**  
association president  
1965

...[responding to this first flexing of NAPPH’s political muscle related to the original Medicare legislation]:  
“The Association has ‘come of age.’”

—Perry Talkington, M.D.  
NAPPH president, 1965

NAPHS  
History

1965

Behavioral  
Healthcare  
History

## Medicare Medicaid

Between 1965 and 1990, the resident population of public mental hospitals dropped from approximately 500,000 to less than 100,000.

Medicare and Medicaid are established through passage of the **Social Security Amendments of 1965**.

When Medicaid was enacted, it excluded “institutions for mental diseases” (IMDs) from reimbursement. The IMD exclusion—affecting institutions of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases—was designed to prevent states from transferring financial responsibility for long-term-care patients in state mental hospitals to the Medicaid program. The exclusion applies only to persons between the ages of 22 and 64. IMD residents 65 and older have been exempted from the exclusion since Medicaid was enacted, and state Medicaid plans have had the option of exempting those under the age of 22 since 1972.

**The Joint Commission (JCAH)** begins charging for hospital accreditation inspections.

The **National Center for Prevention and Control of Alcoholism** was established as part of the **National Institute of Mental Health**.



G. Creswell Burns, M.D.  
association president  
1966

**The Joint Information Service of the American Psychiatric Association works with NAPPH to develop a working definition of a private psychiatric hospital:**

*... an active treatment institution that admits patients with a wide range of psychiatric diagnoses, provides continuous 24-hour service, and has an organized medical staff. It is operated under non-government auspices either on a nonprofit or proprietary basis and, if associated in some way with a larger institutional complex, it has enough administrative and/or physical independence to be recognized as a separate entity by its officers and the public.*

1966



75 Years of Behavioral Healthcare Leadership in Action

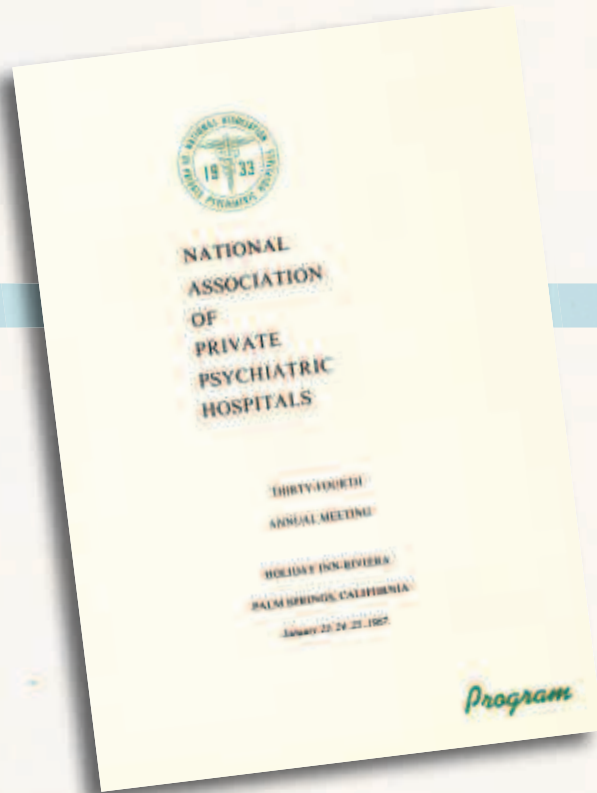
**Ralph S. Green, M.D.**  
association president  
1967

**John R. Saunders, M.D.**  
association president  
1968

NAPHS  
History

**1967**

Behavioral  
Healthcare  
History

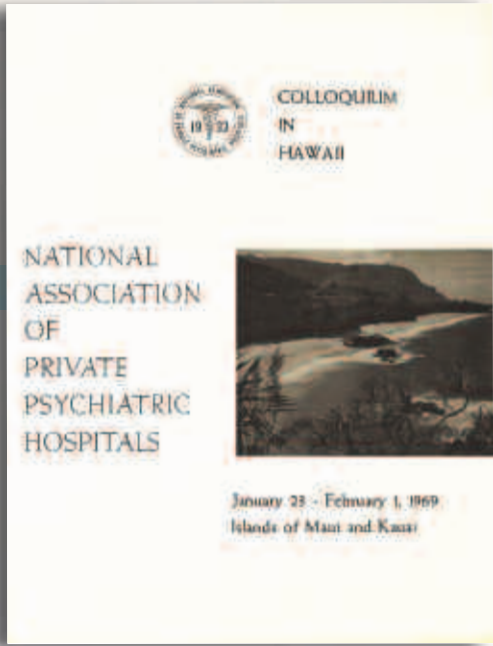


**1968**

**Ted Neumann, M.D.**  
association president  
1969

**Samuel Hibbs, M.D.**  
association president  
1970

**1969**



**1970**

Food and Drug Administration (FDA) approves **lithium carbonate to treat manic illness.**

*After rule changes in the early 1970s allowed Medicaid funds to be used for the care of children in psychiatric hospitals, many states decided to include this option in their state plans. This change created a new revenue stream for psychiatric hospitals that had generally been barred from receiving Medicaid dollars. Combined with expanding coverage for inpatient psychiatric services through commercial insurers, this change in Medicaid policy helped to fuel a significant expansion in the number of freestanding psychiatric hospitals. Between 1976 and 1992, approximately 300 new private (mostly for-profit) psychiatric hospitals were opened.*

—From “Shrinking Inpatient Psychiatric Capacity,”  
National Health Policy Forum, August 1, 2007, 8–9

75 Years of Behavioral Healthcare Leadership in Action

**Alexander Gralnick, M.D.  
& Robert W. Gibson, M.D.**  
association presidents  
1971

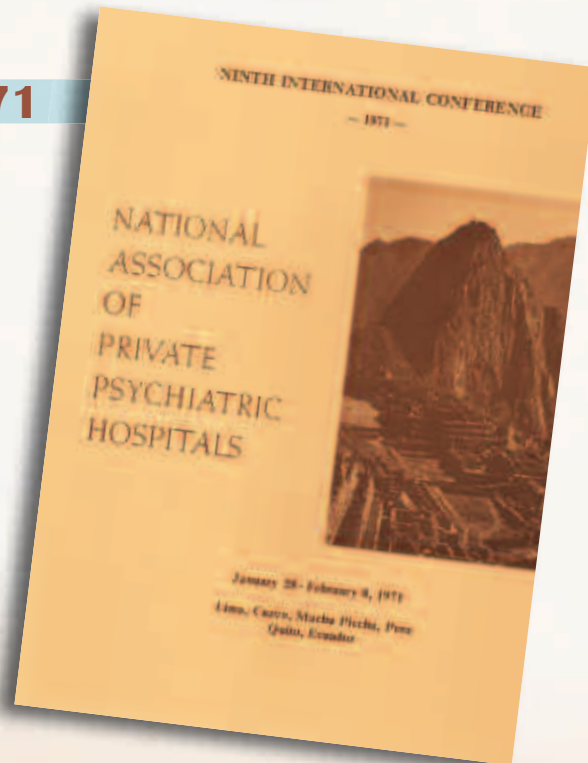
**Ninth International Conference** held in Lima, Cuzco, Peru; Quito, Ecuador. Sponsored by NAPPH, Peruvian Psychiatric Association, and Peruvian Private Hospital Association.

**Robert S. Garber, M.D.**  
association president  
1972

NAPHS  
History

1971

Behavioral  
Healthcare  
History



1972

**National Institute on Drug Abuse** established within NIMH.

State Medicaid plans are given the option of exempting those under the age of 22 from the "**Institutions for Mental Disease**" (IMD) exclusion.

**Social Security Amendments** also expand Medicare to cover individuals under 65 who are permanently disabled.

**Stuart M. Gould, M.D.**  
association president  
1973

**International Conference in Japan** jointly sponsored by  
**Japanese Association of Psychiatric Hospitals** and **NAPPH**.

American Hospital Association includes the  
**NAPPH Journal** in its "Hospital Literature Index."

**1973**

**Health Maintenance Organization (HMO) Act of 1973** (P.L. 93-222) specifies that employers who offer their employees health benefits must also offer them the choice of membership in a qualified HMO providing services in their area of residence



**J. Martin Myers, M.D.**  
association president  
1974

May—NAPPH headquarters moves to Washington, DC.

**Joy Midman** hired as the association's first legislative assistant.



**1974**

## 75 Years of Behavioral Healthcare Leadership in Action

**George Wayne, M.D.**

association president

1975

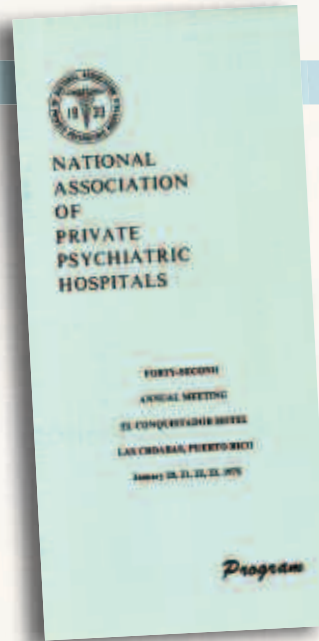
**Edward Lawlor** hired as **second executive director**.

Main concerns are **medical malpractice insurance** for member hospitals, JCAH **accreditation**, development of a strong **legislative network**, and **improved insurance coverage** for psychiatric care.

NAPHS  
History

1975

Behavioral  
Healthcare  
History



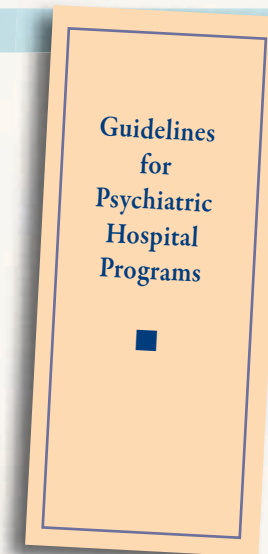
**Walter H. Wellborn, M.D.**

association president

1976

A **Utilization Review Committee** is appointed to write a model utilization review plan. Discussions continued throughout the next years, culminating in publication of a **Member's Handbook** (in 1978) related to utilization review... and **Guidelines for Psychiatric Hospital Programs** (in 1986).

1976



**John Donnelly, M.D.**  
association president  
1977

**Ralph M. Barnette, Jr.**  
association president  
1978

**First non-physician president**—Ralph Barnette—elected, beginning a **tradition of alternating administrators and clinicians** in this role.

President Ralph Barnette serves as **acting executive director while chairing a search committee** for a new executive director.

**1977**

**1978**



President Jimmy Carter creates the **first President’s Commission on Mental Health**.

The U.S. Department of Health, Education, and Welfare (HEW) establishes the **Health Care Financing Administration (HCFA)** to be responsible for the coordination of Medicare and Medicaid.

75 Years of Behavioral Healthcare Leadership in Action



**Robert L. Thomas named executive director**

Main concerns are with the assurance of **high-quality patient care**, establishment of a **strong and effective voice in Washington**, and **professional and public education** about mental health insurance benefits.

NAPHS History

**1978**

Behavioral Healthcare History

Joint Commission established the **Accreditation Program for Psychiatric Facilities**, with its own **Professional and Technical Advisory Committee (PTAC)**.

**Political Action Committee (PAC) formed.**

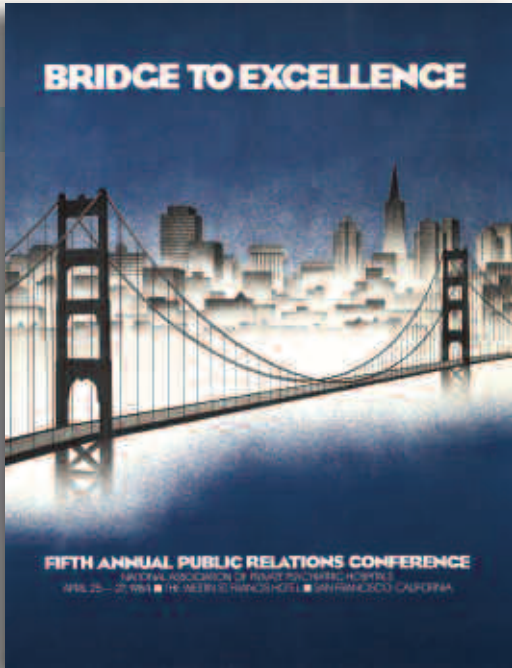


*The Psychiatric Hospital*, peer-reviewed journal, begins publication (and continues through 1991).





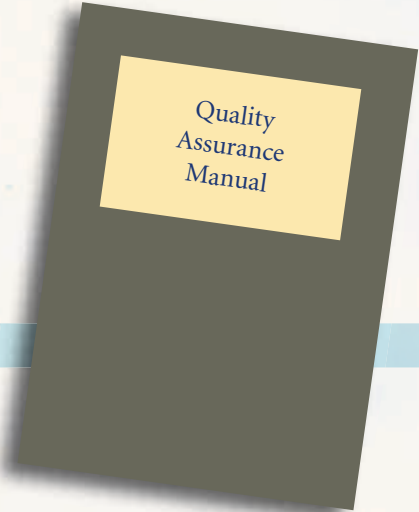
NAPPH sponsors an **annual marketing and public relations conference**— and an awards competition to highlight the best outreach efforts in member hospitals, which continued annually through 1992.



**Henry J. Langevin**  
association president  
1979

First Annual Survey data collected and analyzed.

**Quality Assurance Manual** published “to help hospitals deliver the highest quality care possible to patients.”



**1979**

The **National Alliance for the Mentally Ill** (NAMI) founded— ushering in an era of greater family and consumer involvement.



**Joint Commission** (JCAH) publishes the first **Consolidated Standards Manual** (CSM) for psychiatric facilities, establishing a separate set of standards for those hospitals covered by the **Accreditation Manual for Hospitals (AMH)**.

## 75 Years of Behavioral Healthcare Leadership in Action

**Lewis L. Robbins, M.D.**  
association president  
1980

**47th annual meeting** focuses on “**Assuring Quality Patient Care.**” Includes two special exhibits: “architectural display of renovation, new construction, and additions that stress the needs of the psychiatric patient and related environment” and “PR and community relations projects. . . showing different styles and techniques of presenting the hospital story.”



**Thomas Dolgoff**  
association president  
1981

Political commentator **Patrick Buchanan**, Harvard Law School professor **Alan Dershowitz**, and Rep. **Henry Waxman** (D-CA) are among the special guests at the **48th Annual Meeting.**

NAPHS  
History

1980

Behavioral  
Healthcare  
History

1981



The **Department of Health and Human Services (HHS)** is created when the Department of Health, Education, and Welfare (HEW) was divided into two agencies: the Department of Education and the Department of Health and Human Services (HHS). The Health Care Financing Administration (HCFA), founded in 1977, becomes an agency under HHS.

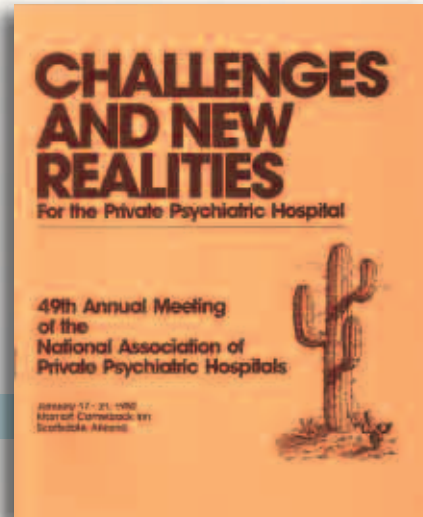
President Ronald Regan signs the ***Omnibus Budget Reconciliation Act of 1981***, which repeals the *Mental Health Systems Act* introduced by President Carter. This leads to the creation of 50 distinct state mental health systems and the transfer of community mental health center funding to a block grant system to states. The federal role in services to the mentally ill becomes one of providing technical assistance to increase the capacity of state and local providers of mental health services.

**Mark A. Gould, M.D.**  
association president  
1982

**Ann Landers**, nationally syndicated columnist and member of The Menninger Foundation Board, is among the special guests at the **49th NAPPH Annual Meeting**.



**1982**



NAPPH works to facilitate the transfer of its members from the Joint Commission's **Consolidated Standards Manual** to the **Accreditation Manual for Hospitals**.

**1982-83**

General hospitals move from a cost-based to a **prospective payment system** under Medicare (through the Social Security Amendments of 1983, P.L. 98-21), but...

The **Tax Equity and Fiscal Responsibility Act of 1982** (or TEFRA) exempts psychiatric hospitals and distinct-part psychiatric units in general hospitals from the hospital PPS system.

**Robert V. Sanders**  
association president  
1983

Association's first Annual Survey data collected and analyzed.

## 75 Years of Behavioral Healthcare Leadership in Action

Public education about psychiatric hospitals is provided by NAPPH through *Mental Illness: Its Myths and Truths*. Reprinted in 1986 and again in 1988, more than **50,000 copies of this document are distributed** through member facilities.

*Guidelines for Advertising* was first approved by the NAPPH **Committee on Public Relations** in 1982. The Board adopts the guidelines, which are again updated in 1989. In 2000, the guidelines are incorporated into *Principles of Organizational Practices in Behavioral Health Systems*.

NAPHS  
History

1983

Behavioral  
Healthcare  
History



History of NAPHS and Behavioral Health

First national advertising campaign launched by NAPPH to tell employers that insurance coverage for mental illness is “an employee benefit your company can’t afford to be without.” Ads appear in prestigious business journals such as *Dun’s Business Month*, *Business and Health*, and *Employee Benefit Plan Review*.

**Pasquale A. Carone, M.D.**  
 association president  
 1984

NAPPH wins a **seat on the Joint Commission’s HAP/ Professional and Technical Advisory Committee (PTAC)** and appointed Ken Gaver, M.D., as the first representative.

**1984**

**H. BRANDON, V. P.**

**DO NOT DISTURB**

**HOWARD BRANDON IS DISTURBED.**

Recognize Howard Brandon? Someone like him may be working in your organization. A person who can no longer get along with fellow employees. Who constantly complains about headaches, exhaustion and other physical problems. A person who must struggle to get through the simplest meeting. Who works harder and harder to get less and less done.

A person with the symptoms of mental illness. Symptoms that would cause many companies to fire Howard Brandon. But fortunately, other companies have a better solution. They have included hospitalization for mental illness in their employee health benefits packages. And they can get Howard the help he desperately needs so he can recover quickly and once again become a productive.

With the high stress of today's business environment, disability due to mental illness is affecting a growing segment of key employees. That's why you need mental health protection.

For your sake, and for the sake of the employees like Howard Brandon in your company.

Find out why insurance coverage for mental illness is important for your employees' health and your company's productivity. Write the National Association of Private Psychiatric Hospitals, P.O. Box 50724, 1319 F Street, N.W. Washington, D.C. 20004-0724 or call (202) 393-6700.

Insurance coverage for mental illness. It's an employee benefit your company can't afford to be without.

75 Years of Behavioral Healthcare Leadership in Action

**Anthony F. Santore**  
association president  
1985

NAPPH **direct mail campaign** aims to educate major employers about the importance of mental health coverage.

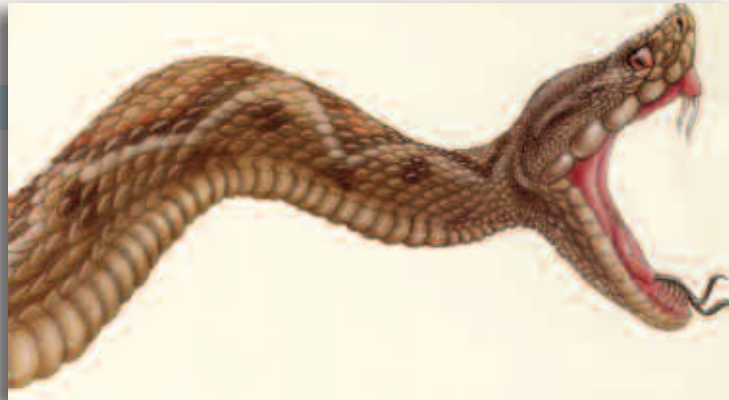
**Robert A. Moore, M.D.**  
association president  
1986

Study for NAPPH on the feasibility of prospective payment for psychiatric care published in the **November 1986** *New England Journal of Medicine*.

NAPHS  
History

1985

Behavioral  
Healthcare  
History



1986



Advertising targeted to employers addresses “Trends in Health Insurance Coverage for Mental Illness.”

# What Motorola knows about mental health coverage could fill a book.

So what's to know? Right now, the National Association of Private Psychiatric Hospitals has available a limited number of copies of a study which analyzes this important employee benefit from all three perspectives: business, insurer, and health care provider.

It's packed with information on trends, and how all three sectors are reacting to them. It candidly compares mental health benefits to benefits like dental or eye care. It answers honestly the question of mental health benefit costs. And it answers a whole lot more of the most "delicate questions" about this benefit.

If you think your company may be losing productivity due to employees under stress from work or family pressures... you owe it to your company and your employees to write us up for a copy of this valuable report. It's been read by employee benefit managers at some of the nation's largest companies.

Companies which currently include mental health benefits in their employee benefit package.

When it comes to mental health benefits...the NAPPH wrote the book. And now we'd like to share it with you.

**This Book.**  
I want to know what Motorola knows about mental health coverage. Please send me a complimentary copy to:

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The National Association of Private Psychiatric Hospitals  
 2149 P St. N.W. • Washington, DC 20036 • (202) 363-6700

The National Association of Private Psychiatric Hospitals



Prozac®, the first of a new class of anti-depressant drugs, is launched in Belgium by Eli Lilly; the U.S. launch follows in 1988.

**Malcolm Strickler**  
 association president  
 1987

NAPPH Task Force on Quality Indicators begins one of the first national efforts focused on providing a common language for facilities to address quality issues in the provision of care to psychiatric hospital patients. The committee reports yearly to the Board on the **Critical Indicator Project** — a precursor to later NAPHS performance measurement initiatives.

1987



75 Years of Behavioral Healthcare Leadership in Action

**Research monograph published** to summarize extensive research underway in private psychiatric hospitals.

**Long-range planning meeting** identifies “managed care systems” and “case management” as issues that “should be given top priority in the next two years.”

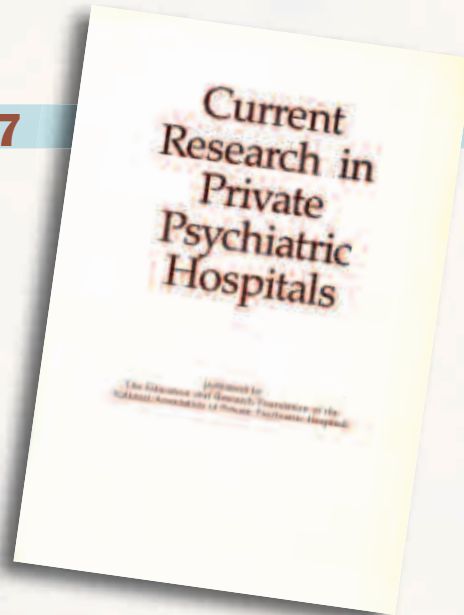
**Kenneth D. Gaver, M.D.**  
association president  
1988

Ad in *Washington Journalism Review* highlights role of NAPPH as a source of behavioral health information.

NAPHS  
History

1987

Behavioral  
Healthcare  
History



1988



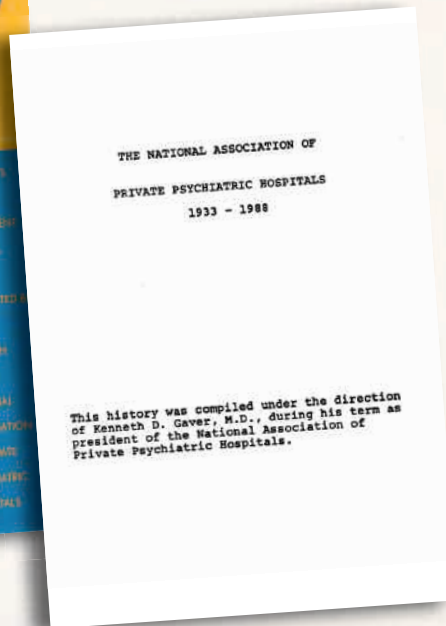
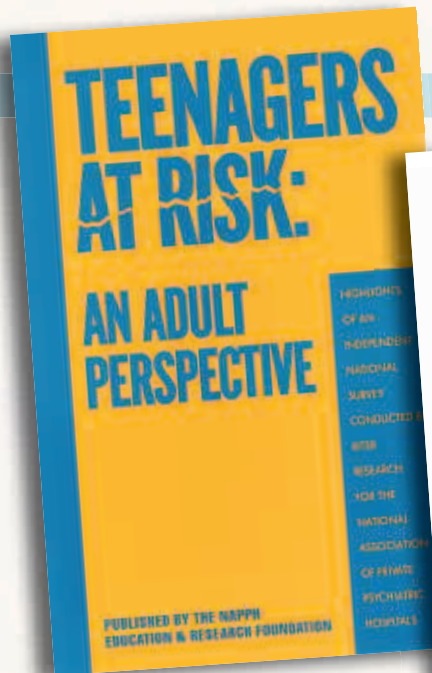


NAPPH releases **national opinion survey on Teenagers at Risk**, designed to provide a snapshot of adult perceptions of adolescent problems and barriers to seeking help. Widespread coverage results—for example, on the **CBS Evening News** and in **Associated Press** wires.

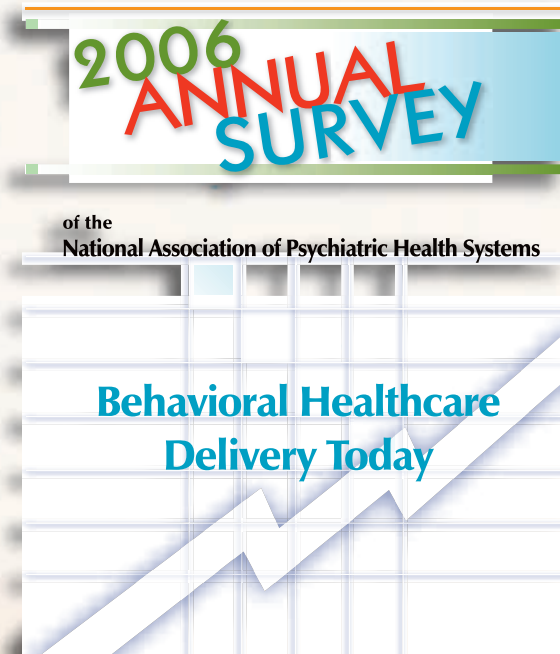
President Ken Gaver, M.D., oversees creation of a **written history** of the association (1933–1988)

**Loren Shook**  
association president  
1989

As part of its own annual survey process, NAPPH also begins gathering data for the federal government's bi-annual national data collection effort known as the **Survey of Mental Health Organizations** (as a subcontractor to Social & Scientific Systems, Inc.). This relationship continues for 17 years, through 2006. The association's own annual survey data-collection effort continues uninterrupted through today—and has become recognized as the nation's most comprehensive on behavioral health systems in the private sector.



## 1989



75 Years of Behavioral Healthcare Leadership in Action

**Doyle I. Carson, M.D.**  
 association president  
 1990

Board approves *Patient Bill of Rights and Responsibilities Guidelines*



NAPHS  
 History

1990

Behavioral  
 Healthcare  
 History



July 26—President George H.W. Bush signs the *Americans with Disabilities Act* in a ceremony on the White House lawn.

Fall issue of *The Psychiatric Hospital* is devoted to managed care (with papers by three healthcare consultants, a hospital administrator, two psychiatrist managers, and an outside psychiatrist). The issue was mailed to benefit managers, insurers, EAPs, and managed care firms inviting use of NAPPH as a resource.

An NAPPH-led coalition of 20 national health, military, and veterans organizations is **successful in delaying implementation and reducing the scope of proposed CHAMPUS mental health cuts** as the Gulf War continues to impact military families.

Gulf War I, 1990–91



**Frederick D. Raine**  
 association president  
 1991

Association launches a two-year, national advertising campaign focused on helping benefits decision-makers, policy-makers, the media, and consumers understand that psychiatric care is basic health care that must be included in any comprehensive benefits package.

1991

**Did you know that even when productivity is up, 20 percent of your staff can be down?**

FIRST IN A SERIES: HELPING WORKERS WORK IN THE NINETIES

**M**ental illness is a topic most employees feel uncomfortable talking about, much less admitting to. And that's unfortunate because, according to the National Institute of Mental Health, almost one-third of American adults will suffer from a mental or substance-abuse disorder at some time in their lives. What's more, approximately 20 percent of Americans display symptoms of mental illness in any six-month period. This not only affects their happiness and well-being, it ultimately can affect your bottom line.

So take a look around you. One out of every five of your employees could be suffering from mental illness. But instead of asking which one, ask yourself this: Can your employee health benefits program deliver the care that's needed?

**Learn more about trends in psychiatric benefits.**

The National Association of Private Psychiatric Hospitals has a booklet, *Trends in Mental Health Coverage*, that can help you evaluate your psychiatric benefits program. Its purpose is two-fold. It will arm you with the latest data on the cost-effectiveness of comprehensive mental health benefits. And it will help you protect your people and your bottom line.

To receive *Trends in Mental Health Coverage*, mail the coupon below. Or call (202) 293-6706.

**F R E E**

Please send me a free copy of *Trends in Mental Health Coverage*.  Yes

Name \_\_\_\_\_  
 Title \_\_\_\_\_  
 Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_

The National Association of Private Psychiatric Hospitals  
 1217 7th Ave., NW • Suite 1008 • Washington, DC 20001

**Minding America's  
 Mental Health**

**Jack W. Bonner, III, M.D.**  
 association president  
 1992

**Robert L. Trachtenberg** named NAPPH executive director.



1992

The National Institute on Drug Abuse becomes part of the National Institutes of Health



As a member of the **Coalition for Mental Health in Healthcare Reform**, NAPPH joins 33 mental health groups in issuing principles for any national health program. "Healthcare reform without equitable mental health benefits is no reform at all," says a Coalition ad in *Roll Call*.

**MENTAL DISORDERS ARE REAL.**

Healthcare reform without equitable mental health benefits is not reforms at all.

Coalition for Mental Health in Healthcare Reform  
 Sponsored by the  
 National Mental Health Leadership Forum Foundation  
 Representing more than one million members and  
 so million Americans with mental disorders

## 75 Years of Behavioral Healthcare Leadership in Action

**George Bone**  
association president  
1993

NAPPH begins a major strategic planning process to examine restructuring the association's governance, dues, and membership requirements.

NAPHS  
History

1993

Behavioral  
Healthcare  
History



NAPPH issues its own proposal for ***Healthcare Reform: A Comprehensive Mental Health Care Reform Proposal***. NAPPH was the first organization to present a mental healthcare reform plan to the White House Task Force Work Group on Mental Health, chaired by **Tipper Gore**.



NAPPH becomes a sponsor of **National Depression Screening Day**—a national outreach event that the association continues to support today. Many association members serve as screening sites in their own communities. Since that time, Screening for Mental Health has expanded its programs to include additional screening events (such as National Alcohol Screening Day) and year-round activities, such as workplace programs and outreach to the military.



NAPPH sponsors a special report in ***Business and Health*** magazine focused on the message that “Psychiatric care delivery is improving.”

**NAPPH** becomes the **National Association of Psychiatric Health Systems (NAPHS)**.

**George T. Harding, IV, M.D.**  
**association president**  
**1994**

A proposal to move to “**system**” memberships is presented to the membership.

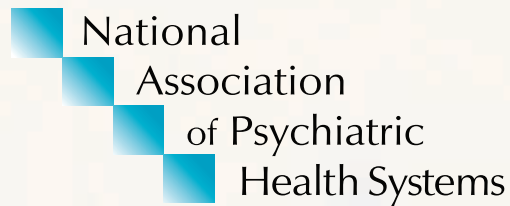
**E. Mac Crawford**  
**association president**  
**1995**

NAPHS switches from individual-facility memberships to **system membership** for all the behavioral health facilities and services of the member organization.

For the first time, behavioral healthcare provider organizations other than private psychiatric hospitals (such as psychiatric units, group practices, etc.) are eligible to join.

**1994**

**1995**



National  
Association  
of Psychiatric  
Health Systems

**American Managed  
Behavioral Healthcare  
Association** is founded.

## 75 Years of Behavioral Healthcare Leadership in Action



**Mark J. Covall** named  
NAPHS executive director.

Association focuses on:

- advocacy
- strategic alliances
- helping members anticipate and respond to change.



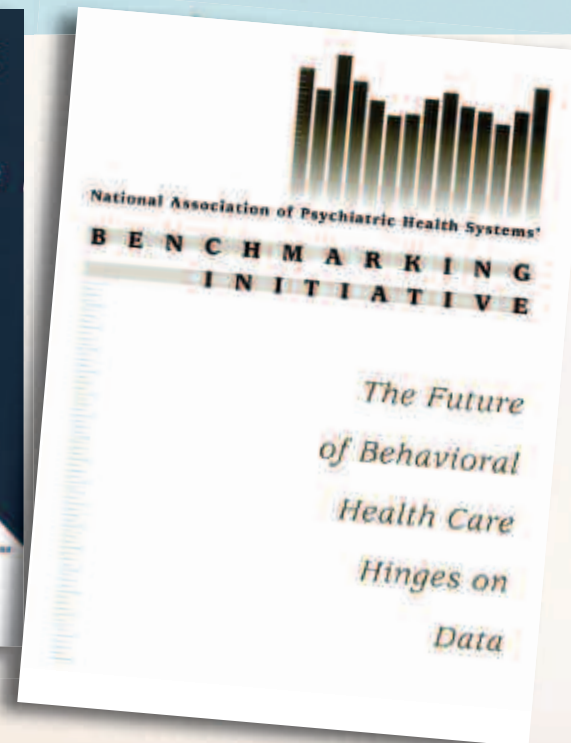
Washington insider  
**Mike Bromberg**  
becomes a lobbyist  
consultant for NAPHS.

NAPHS **Performance Measurement  
(Benchmarking) Initiative** begins.

NAPHS  
History

**1995**

Behavioral  
Healthcare  
History



**Paul J. Fink, M.D.**  
association president  
1996

NAPHS is a founding member of the **Coalition for Fairness in Mental Illness Coverage.**

Association installs a fax machine



June 20–22—NAPHS hosts a “second annual” joint Washington, D.C., conference with the American Hospital Association Section on Psychiatric and Substance Abuse Services on “**Successful Strategies for Behavioral Health Providers in the Public-sector Marketplace: Clinical, Administrative, and Political Solutions.**”

**1996**

This coalition today includes nine organizations, including **NAPHS** and the **American Hospital Association**, **American Medical Association**, **American Psychiatric Association**, **American Psychological Association**, **Association for Behavioral Health and Wellness**, **Federation of American Hospitals**, **Mental Health America**, and **National Alliance on Mental Illness.**



Congress takes the first step to help end discriminatory insurance practices through enactment of legislation (the **Mental Health Parity Act of 1996**) requiring equal lifetime and annual limits for physical and mental illnesses.

## 75 Years of Behavioral Healthcare Leadership in Action

June 29—Association moves to 1317 F Street, NW, Washington, DC.

NAPHS participates in a national “**Outcomes Roundtable**” effort spearheaded by the National Alliance for the Mentally Ill (NAMI).



**NAPHS Committee on Accreditation**, chaired by **Lloyd I. Sederer, M.D.**, is charged with a top-to-bottom review of current JCAHO standards and an assessment of where we need to be in the future.

“Our guiding principle: NAPHS supports the development of accreditation processes that are integrated, minimally prescriptive, cost effective, and that improve patient care.”

NAPHS  
History

**1996**

Behavioral  
Healthcare  
History

“Collaboration is to be valued over competition...a united voice for the organizations that provide behavioral health care is essential, wherever those organizations fall along the continuum of care. We’ve worked to ensure that our Board represents all levels of care—from outpatient centers to partial hospitals to inpatient providers (both freestanding and units in general hospitals). In 1996, we’ve proved the strength and value of an association that can harness the creative energies of all segments of the behavioral health field.”

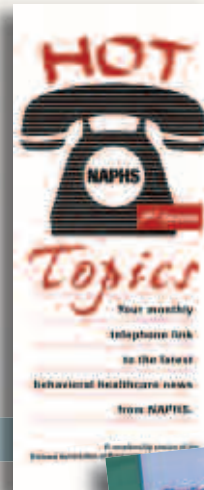
—Paul J. Fink, M.D., NAPHS president, 1996



Jean P. Smith  
association president  
1997

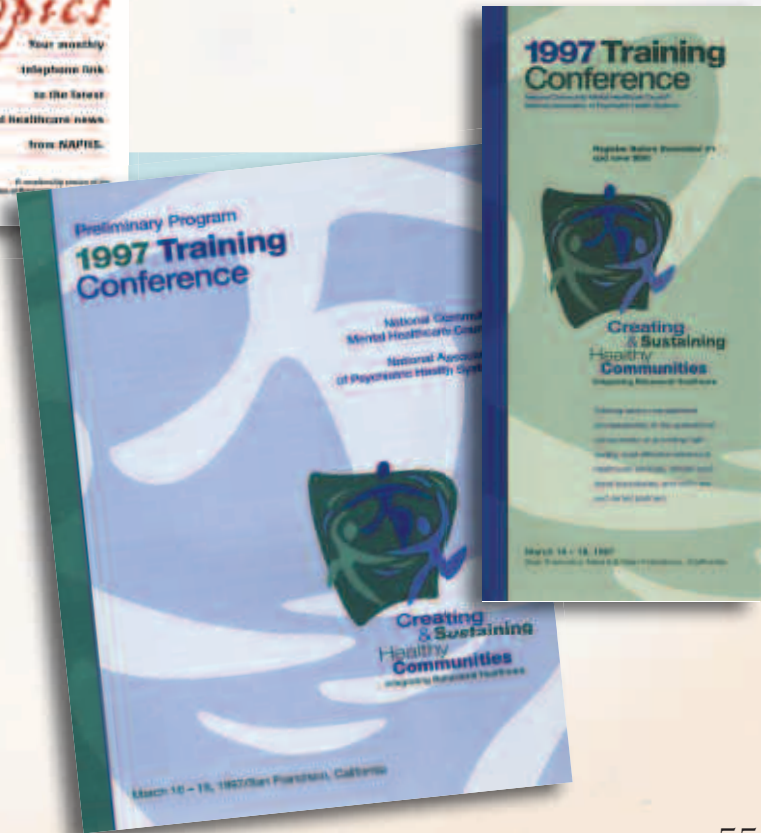
NAPHS launches Web site,  
[www.naphs.org](http://www.naphs.org).

February—NAPHS  
hosts the first “**Hot  
Topics**” telephone  
call for members.



March 16–18—NAPHS and the National Community Mental Health Council jointly host an annual meeting in San Francisco on “**Creating & Sustaining Healthy Communities: Integrating Behavioral Healthcare.**”

1997



## 75 Years of Behavioral Healthcare Leadership in Action

Board establishes the **NAPHS Committee on Behavioral Health Services within General Healthcare Systems** to better serve this growing constituency within the membership.

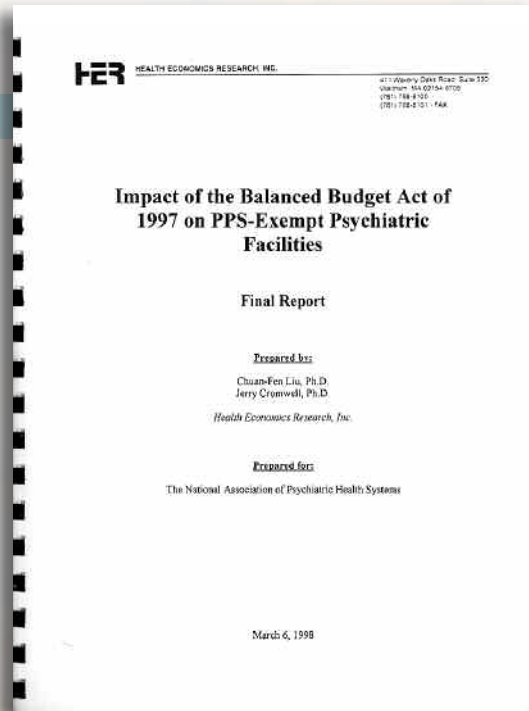
NAPHS forms a **TEFRA Task Force Committee** to oversee Medicare payment reform and to begin looking at the policy and technical issues involved in assessing the feasibility of a PPS system.

NAPHS commissions study by Health Economics Research to **fight provisions of the *Balanced Budget Act of 1997*** (BBA) that would compound negative Medicare margins of many psychiatric hospitals and psychiatric units of general hospitals exempted from the Medicare prospective payment system. The study definitively demonstrates the severity of the cuts members would face under the then-current TEFRA system.

NAPHS  
History

1997

Behavioral  
Healthcare  
History



NAPHS wins a **delay in implementation of the Joint Commission's ORYX project for psychiatric hospitals**. Armed with information on the woefully inadequate performance measures for behavioral health, NAPHS was able to hold off a hasty rush to implementation of new—and costly—regulations.

**William D. Zieverink, M.D.**  
association president  
1998

NAPHS-commissioned **Hay Group** study documents a decade of diminished resources for behavioral health care.

Annual Meeting reformatted to zero-in on advocacy concerns—a strategy that continues through today. The 1998 theme was “**Advancing Behavioral Health: Advocacy in Action.**” Speakers included Rep. **Jim McCrery** (R-LA) on the legislative landscape for behavioral health; **Mike Bromberg** on operationalizing change using legislative and economic forecasts; and HCFA Center for Health Plans and Providers Deputy Director **Kathleen Buto** on Medicare/Medicaid restructuring, among others.

NAPHS Board establishes the **Youth Services Committee** as a way of elevating youth service issues on the association’s overall agenda.

**1998**

**The Hay Group Study  
on  
Health Care Plan Design  
and Cost Trends**

1988–1997

We made some tough decisions, but ones that have paid off and have culminated in this exceptional year. NAPHS has solidified its standing as a strong and effective advocacy force in Washington....”

—William Zieverink, M.D.,  
NAPHS president, 1998



75 Years of Behavioral Healthcare Leadership in Action

**Thomas Bender**  
association president  
1999

NAPHS works throughout 1998 to win **both House and Senate support for Medicare payment system change.**

February 8—**NAPHS and the American Hospital Association (AHA)** sign a Memorandum of Understanding to partner on initiatives to help address the issue of behavioral health as an integral part of a person’s overall health.

February 25—NAPHS and AHA issue **“Guiding Principles on Restraint and Seclusion for Behavioral Health Services.”**

NAPHS History

1998

1999

Behavioral Healthcare History

Reps. **Jim McCrery** (R-LA) and **Benjamin Cardin** (D-MD) jointly introduce H.R.3780, the **Medicare Psychiatric Hospital Prospective Payment System Act of 1998**. This bill would provide short-term relief from the Balanced Budget Act reductions as a transition to a prospective payment system.

With the help of both members and an outside grassroots consultant firm, NAPHS wins the support of Sens. **John Breaux** (D-LA) and **Connie Mack** (R-FL), who introduced S.258.



**American Hospital Association**

National Association of Psychiatric Health Systems

**NAPHS takes the federal government to court over lack of economic analysis prior to release of proposed restraint/seclusion regulation.**



**Association of Behavioral Group Practices** merges with the **National Association of Psychiatric Health Systems**.



August—**Medicare outpatient prospective payment system** affecting partial hospitalization and outpatient behavioral health services takes effect.

***The Balanced Budget Refinement Act of 1999*** requires the secretary of Health and Human Services (HHS) to implement a Medicare prospective payment system (PPS) to replace the TEFRA payment system. (Projected implementation was early 2004.)

Medicare issues **“Conditions of Participation on Patients’ Rights”** (including restraint/seclusion regulations).

December—Surgeon General David Satcher, M.D., Ph.D., releases a landmark report on mental health and mental illness—the first such report ever issued by a Surgeon General. ***Mental Health: A Report of the Surgeon General*** challenges the nation to focus on mental health as a public health issue and as an integral part of overall health.

## 75 Years of Behavioral Healthcare Leadership in Action

**Association moves to 325 Seventh Street, NW...within sight of the Capitol...** and within the same building that housed the American Hospital Association (AHA). This is one result of the groundbreaking Memorandum of Understanding signed by AHA and NAPHS in February to collaborate on advocacy and quality issues.

The **NAPHS Benchmarking Indicators** survey identifies a variety of performance measures widely used by the field that may hold promise for future benchmarking. The NAPHS Board makes a commitment to pilot testing several indicators that may be valuable to the field.

**Peter Panzarino, M.D.**  
**association president**  
**2000**

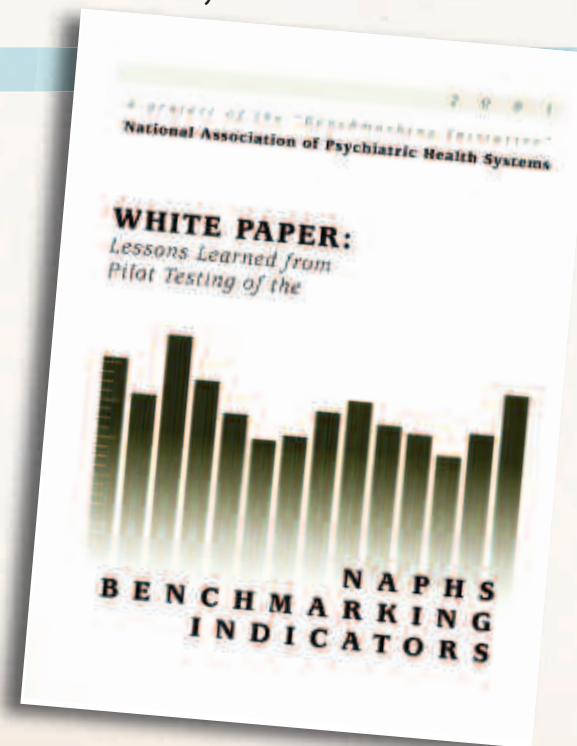
NAPHS President Peter Panzarino, M.D., appointed to serve on the Joint Commission's **Task Force on Restraints Use**.

February—NAPHS launches national campaign, **Make Behavioral Health for Youth a Priority**.

NAPHS  
History

Behavioral  
Healthcare  
History

**1999**



**2000**



History of NAPHS and Behavioral Health

NAPHS works to **anticipate new restraint/seclusion standards for Medicaid’s under-21 population** (set to be released in 2001). Association works not only with the federal government, but with a variety of children’s groups to build a common language around “time outs” and “therapeutic holds”—essential if policies are to reflect unique issues related to this population.

NAPHS works with the **American Academy of Pediatrics** and other organizations to develop a consortium statement calling for better coverage for children with mental disorders. NAPHS also participates in a number of coalitions, including the **National Consortium for Child and Adolescent Mental Health Services** as well as a broader-based **Children’s Coalition**.

NAPHS is an early and strong supporter of the **Family Opportunity Act**—a measure aimed at allowing states to offer Medicaid coverage to children with severe disabilities, so parents would not be forced to give up their custodial rights to obtain necessary treatment services.

August 2000—Medicare launches hospital **outpatient prospective payment system (OPPS)**, which changes reimbursement policy for partial hospitalization and other outpatient behavioral health services.



September 14—**Court agrees with NAPHS** that the federal government failed to do an economic impact analysis required by law when issuing hospital Medicare Conditions of Participation on restraint/seclusion and **requires CMS to look at the real-world impact** of their provision.

## 75 Years of Behavioral Healthcare Leadership in Action

NAPHS is successful in getting some **financial relief from the 1997 *Balanced Budget Act (BBA)* cuts.** In the final days of the 106th lame-duck session, Congress approves a large Medicare “give-back” measure, which includes a 1% increase in bonus payments to **TEFRA psychiatric hospitals** and units. NAPHS members also benefit from other provisions in the relief package, including a provision that increases hospital bad debt relief from 55% to 70%.

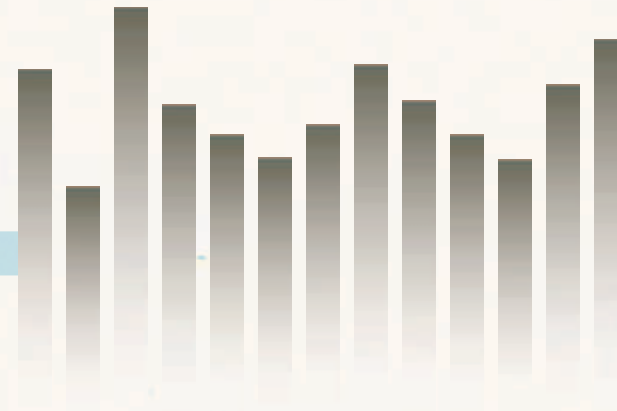
NAPHS  
History

Behavioral  
Healthcare  
History

2000

**TEFRA**

NAPHS completes a **pilot test** of its **Benchmarking Initiative.** Data in the 2000 pilot test alone represents 637,241 days of inpatient care; 601,595 days of residential care; and 161,993 days of partial hospital care.



“As part of a two-year campaign (including a major study on the impact of the *Balanced Budget Act*), NAPHS was able to get Congress to recognize that psychiatric hospitals and units were severely hurt by BBA cuts. NAPHS was also able to get some financial relief through increased Continuous Improvement bonus payments in FY2001 and FY2002. Although not as much as needed, these dollars are an important step in the right direction. In addition, Congress passed NAPHS-backed legislation to establish a prospective payment system for psychiatric hospitals and units. Prospective payment has great potential to significantly improve the Medicare payment system for inpatient psychiatric providers. With implementation set for October 1, 2002, there is much work to be done between now and then to develop an implementation plan. This will be a top association priority to ensure that the payment system that evolves is fair and equitable.

—Tom Bender, NAPHS president, 1999



NAPHS publishes and promotes a fact sheet demonstrating that **Behavioral Health Is an Integral Part of Overall Health.**



NAPHS takes providers' concerns about the need to create an **expedited credentialing process** for preferred group models and to eliminate micromanagement to National Committee for Quality Assurance (NCQA) leaders. **A series of discussions leads to NCQA seeking more active provider involvement in the standard-setting process.**

## 75 Years of Behavioral Healthcare Leadership in Action

**Anil Godbole, M.D.**  
association president  
2001–2002

Through year-long participation by Peter Panzarino, M.D., (NAPHS president in 2000) in the **Joint Commission's Task Force on Restraints Use**, NAPHS is able to play a leadership role with consumers, families, payers, and other constituencies advising JCAHO as they work to develop **new restraint/seclusion standards** (effective January 2001). This role helps to bring balance to a sensitive quality issue with which providers have first-hand clinical experience.

February—First **"Hot Topics"** call to be jointly offered to both NAPHS and American Hospital Association members. These joint calls continued through 2007.

February—NAPHS prepares and distributes the first monthly **Behavioral Health Update** newsletter for members of both NAPHS and the American Hospital Association. These e-mail newsletters continue to this day.

NAPHS  
History

2001

Behavioral  
Healthcare  
History



January 1, 2001—All health plans in the **Federal Employees Health Benefits Program (FEHBP)**, under the **Office of Personnel Management**, begin **parity coverage for mental illness**. President Bill Clinton first ordered the move to parity coverage for federal employees at the June 1999 White House Conference on Mental Health.

January 2001—**New Joint Commission standards on restraint/seclusion become effective.**





NAPHS members—both in the affected cities and around the nation—offer services to support their communities through the **emotional impact of the events of 9/11**—both in the short and long term.



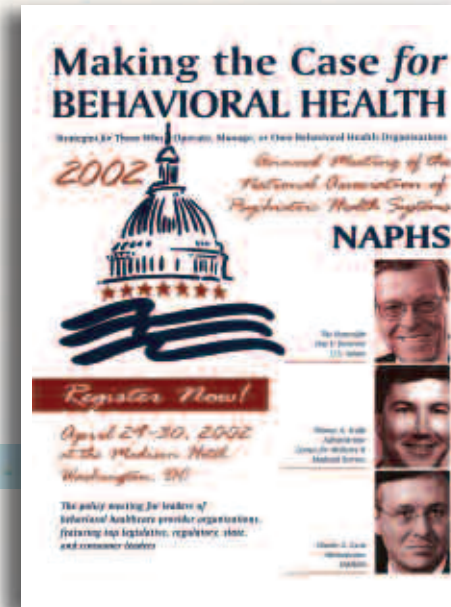
July 2001—HCFA is renamed the **Centers for Medicare & Medicaid Services (CMS)**.

**9/11** September 11, 2001—The nation is stunned as more than 2,900 people die when terrorists crash hijacked planes into the World Trade Center, the Pentagon, and a field in Pennsylvania (as passengers force the plane down). **The long-term mental health effects of the terrorist attacks are felt to this day.** For example, according to a study from researchers at NewYork-Presbyterian Hospital/Weill Cornell Medical Center published in the April 2007 *Biological Psychiatry*, the **rate of psychiatric illness among children who lost a parent in the 9/11 World Trade Center attack doubled**—from about 32% to nearly 72%—in the years following the event. More than half (56.8%) of the young children studied suffered from some sort of anxiety disorder, including post-traumatic stress disorder, which affected nearly three in 10 bereaved children.

## 75 Years of Behavioral Healthcare Leadership in Action

April—**NAPHS President Anil Godbole, M.D.,** is appointed by President George W. Bush as one of 15 commissioners on the **President's New Freedom Commission on Mental Health.**

October—Unique public-private collaboration on performance measurement launched with a **Teaming Agreement between NAPHS, the National Association of State Mental Health Program Directors, and the NASMHPD Research Institute, Inc.**



NAPHS  
History

2002

Behavioral  
Healthcare  
History



April—President George W. Bush establishes the **President's New Freedom Commission on Mental Health.**

October—Providers must meet privacy/confidentiality standards of the **Health Insurance Portability and Accountability Act (HIPAA).**



**Institute of Medicine (IOM)** highlights three mental health issues [children with special healthcare needs (including those at-risk or with chronic developmental, behavioral, or emotional conditions), major depression, and severe and persistent mental illness] among 20 priority areas [e.g., asthma, hypertension, and medication management] to serve as a starting point to help transform the entire healthcare system.

**Dennis P. King**  
association president  
2003

NAPHS purchases first  
Blackberry for executive  
director.

**Pilot testing of performance measures**  
underway through the NAPHS/NASMHPD/NRI  
public/private initiative.

NAPHS holds the first annual **NAPHS Youth  
Services Leadership Forum** for members  
of the NAPHS Youth Services Committee.

2003

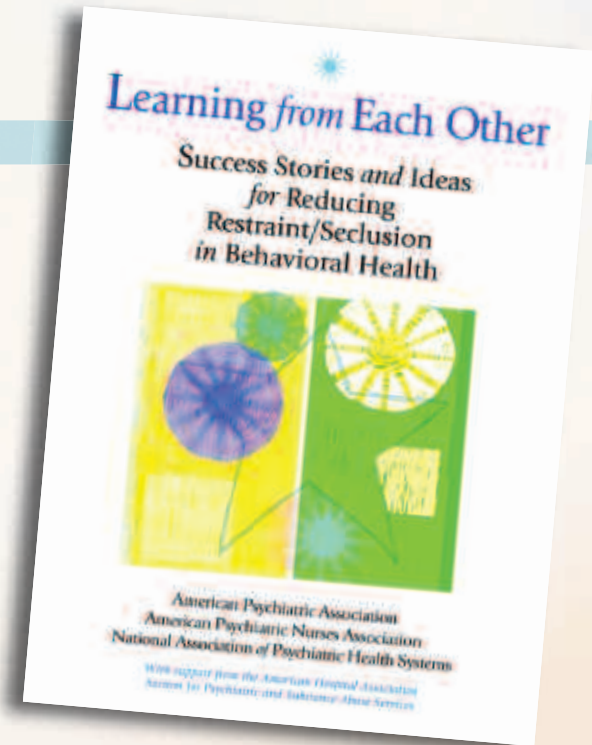


November 2003—A **prescription drug benefit is added to Medicare**—the most significant change since Medicare’s creation in 1965 (an important win for patients facing the high cost of psychotropic medications).

November 28, 2003—Proposed rule on development of a **Medicare inpatient psychiatric prospective payment system** published in the *Federal Register*.

History of NAPHS and Behavioral Health

***Learning from Each Other: Success Stories and Ideas on Reducing Restraint/Seclusion in Behavioral Health*** published by NAPHS, American Psychiatric Association, and American Psychiatric Nurses Association, with support from the American Hospital Association’s Section for Psychiatric and Substance Abuse Services.





NAPHS joins the **Partnership for Prescription Assistance** ([www.pparx.org](http://www.pparx.org)) to help qualifying patients who lack prescription coverage get the medicines they need through the public or private program that's right for them. The program helped 4 million uninsured patients across the U.S. in its first two years.

NAPHS  
History

2003

Behavioral  
Healthcare  
History



NAPHS-supported legislation to address **IMD/EMTALA** concerns is first introduced as the **Medicaid Psychiatric Hospital Fairness Act of 2003** (H.R.3663 and S.1771).

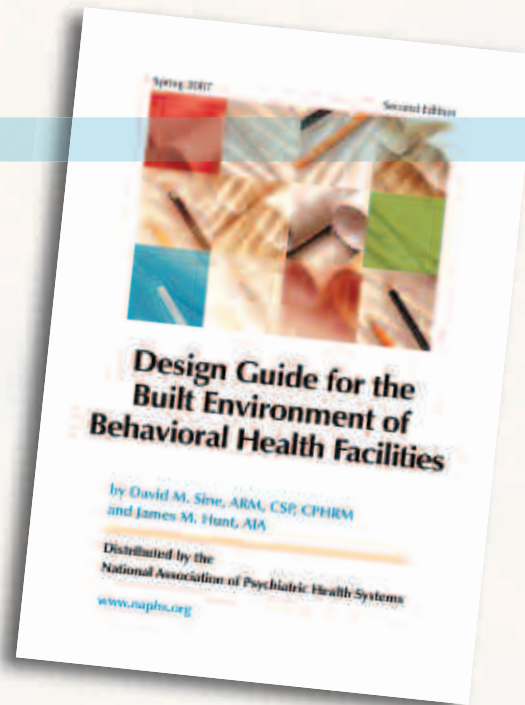
The measure is supported by a broad coalition, including NAPHS, the American Hospital Association, National Alliance for the Mentally Ill, American Psychiatric Association, and National Association of County Behavioral Health Directors.

NAPHS publishes white paper, **Challenges Facing Behavioral Health Care: The Pressures on Essential Behavioral Healthcare Services**, documenting access problems, emergency room backlogs, and other challenges.



First **local coverage determinations** for inpatient psychiatric services introduced by Medicare fiscal intermediaries.

On its Web site, NAPHS provides the field with a white paper, ***Guidelines for the Built Environment of Behavioral Health Facilities***, written by David M. Sine, ARM, CSP, CPHRM, and James M. Hunt, AIA. This one-of-a-kind safety resource was designed to help providers think through the many aspects of the environment that can have a significant impact on patient safety. An updated second edition was published in 2007 as the ***Design Guide for the Built Environment of Behavioral Health Facilities***.



**Debra Osteen**  
**association president**  
**2004**

April 22, 2004—Joint Commission teams with NAPHS, NASMHPD, and NRI to launch hospital-based inpatient psychiatric services (HBIPS) core measures initiative.

# HBIPS

## 2004

The process being used to develop psychiatric core measures has been parallel to—and as rigorous as—that used to develop core measures for heart failure and other specialties. The project included input from 24 stakeholder organizations, including consumers, families, providers, researchers, and others. While the initial core measures focus on inpatient hospital care, the entire process has been designed with the expectation that many of the concepts may ultimately be useful to other levels of care.

## 75 Years of Behavioral Healthcare Leadership in Action



August 16—Association moves to **701 13<sup>th</sup> Street, NW, Washington, DC** (in a building over the Metro Center subway stop).

NAPHS  
History

**2004**

Behavioral  
Healthcare  
History

October 15, 2004—Food and Drug Administration (FDA) issues a Public Health Advisory to warn the public about the **increased risk of suicidal thoughts and behavior in children and adolescents being treated with antidepressant medications**. FDA requires manufacturers to place black-box warnings on antidepressants.

November 15—Final rule on **Medicare inpatient psychiatric prospective payment system (IPPPS)** published in *Federal Register*.

**NAPHS was the lead organization that helped shape and implement the inpatient psychiatric prospective payment system.** The association provides members with an immediate briefing and written analyses on the implementation of the IPPPS. NAPHS also develops cost-effective telephone trainings for both members and non-members.

The screenshot shows the GPO Access website interface. At the top, there are search filters for 'Resources by Topic' and 'No Search History'. Below the search bar, there are navigation tabs for 'LEGISLATIVE', 'EXECUTIVE', 'JUDICIAL', 'FISCAL', and 'ACTION'. The main content area is titled 'GPO Access Resources by Topic: Health & Safety'. It includes a search bar and a list of frequently requested information. The list includes:

- 2005 Health Rule Affecting Medicare Competitive Acquisition of Outpatient Drugs and Biologics (100 pages)
- PART B: Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Part 414, Medicare Program, competitive Acquisition of Outpatient Drugs and Biologics Under part B; interim Rule (100 pages)
- 2005 Final Rules Affecting Medicare Programs – The U.S. Department of Health and Human Services has published an interim Rule affecting 42 CFR Part 414, Medicare Program, Competitive Acquisition of Outpatient Drugs and Biologics Under part B in the July 8, 2005 issue of the Federal Register. The part of July 8, 2005 Federal Register affecting the Medicare Program is available in text and PDF format directly below.
- 2005 Final Rules Affecting Medicare Programs – The U.S. Department of Health and Human Services has published an interim Rule affecting 42 CFR Part 414, Medicare Program, Competitive Acquisition of Outpatient Drugs and Biologics Under part B in the July 8, 2005 issue of the Federal Register. The part of July 8, 2005 Federal Register affecting the Medicare Program is available in text and PDF format directly below.
- 2005 Relative Value Units (RVUs) – Also known as Unique Physician Fee Schedule RVUs are released once a year, usually during November. The latest RVUs were released by the Centers for Medicare & Medicaid Services on November 15, 2004 and can be found in the Federal Register by either using the [browse](#) or search features. To open:
  - A. Go to the [Federal Register](#) advanced search page.
  - B. Select Volume 09 (2004).
  - C. Check "Final Rules and Regulations".
  - D. Enter "Physician Fee schedule" (it auto-fills in the search box and hit Submit).



**Patricia R. Recupero, J.D., M.D.**  
association president  
2005

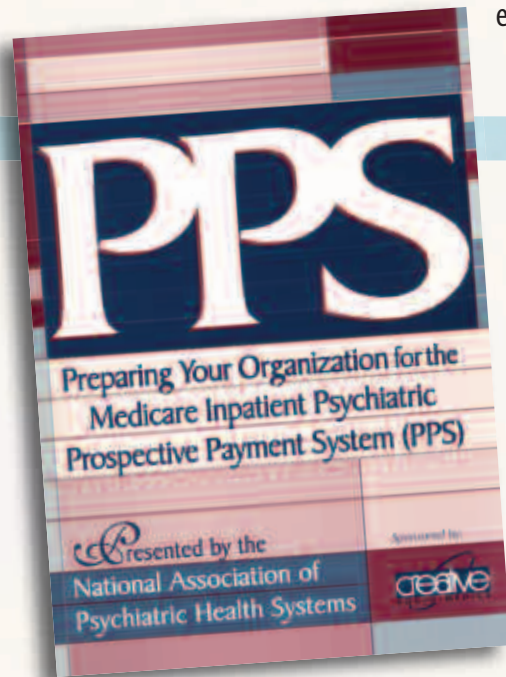
Face-to-face training offered to members  
on new IPPS.

April 2005—NAPHS Performance Measurement Committee **Chairman Frank Ghinassi, Ph.D.**, chosen to chair the Technical Expert Panel for the **hospital-based inpatient psychiatric services (HBIPS) core measures initiative**. His leadership continues throughout the years of development and implementation.

June 2005—NAPHS invited to testify at **Medicare's Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG)** about the impact of EMTALA on psychiatric care.

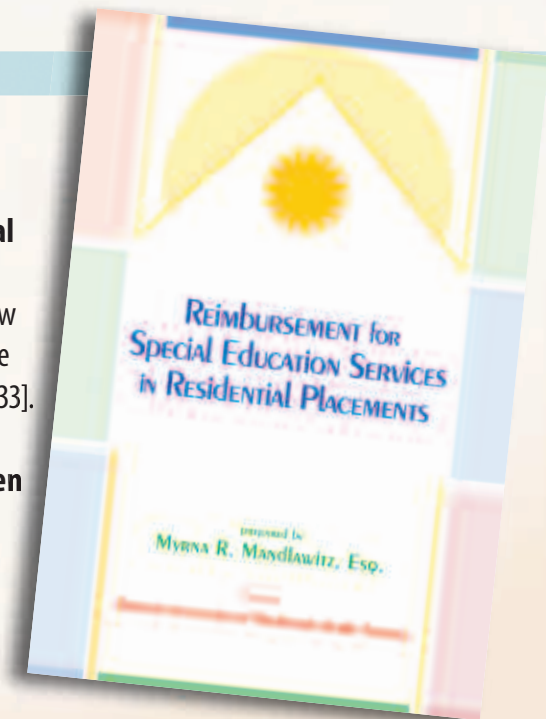
**Reimbursement for Special Education Services in Residential Placements** by special education expert Myra Mandlawitz, Esq., published.

2005



March 2005—An online study in *Health Affairs* of the years 1991–2001 reports that **Medicaid increased to be the largest payer of mental health care, with prescription drugs the fastest-growing spending component**. View “U.S. Spending for Mental Health and Substance Abuse Treatment, 1991–2001” [10.1377/hlthaff.w5.133].

April 2005—**Technical Expert Panel chosen** for the hospital-based inpatient psychiatric services (HBIPS) core measures initiative.



## 75 Years of Behavioral Healthcare Leadership in Action



Responding to Hurricane Katrina, **NAPHS joins with the American Hospital Association (AHA) and other major DC-based national organizations** (including the Federation of American Hospitals, National Association of Children's Hospitals and Related Institutions, Catholic Healthcare Association, Premiere, VHA, and others) in a **national hospital response to hurricane relief requested by the Department of Health and Human Services (HHS)**. NAPHS is the only behavioral health-care association in the coalition, which worked directly with HHS to get volunteers mobilized, to assess hospital needs, and to get clarification on Medicare/Medicaid issues.

NAPHS begins working with the **American Public Human Services Association (APHSA)**, which serves as the secretariat for rewriting the Interstate Compact on the Placement of Children (ICPC). Among unresolved issues in the rewrite is pre-approved placement in residential treatment facilities.

NAPHS  
History

**2005**

Behavioral  
Healthcare  
History



August 2005—**Hurricane Katrina**, the costliest and one of the deadliest hurricanes in U.S. history, hits the Gulf Coast.

October 2005—Joint Commission issues **call for stakeholder/public comment on Performance Measures for Hospital-Based, Inpatient Psychiatric Services (HBIPS)**.

**Edward C. Irby**  
association president  
2006



March 2006—NAPHS collaborates with the **National Association for Children’s Behavioral Health** to jointly release *Medicaid: Principles for Treatment of Children and Youth with Emotional and Substance Use Disorders*. The principles serve as part of an advocacy campaign to Congress.

April—NAPHS launches a threaded-message **NAPHS Networking** forum within the password-protected, members-only section of [www.naphs.org](http://www.naphs.org). Here members can exchange ideas or offer their contact information for further follow up on topics ranging from staffing to visitor searches.

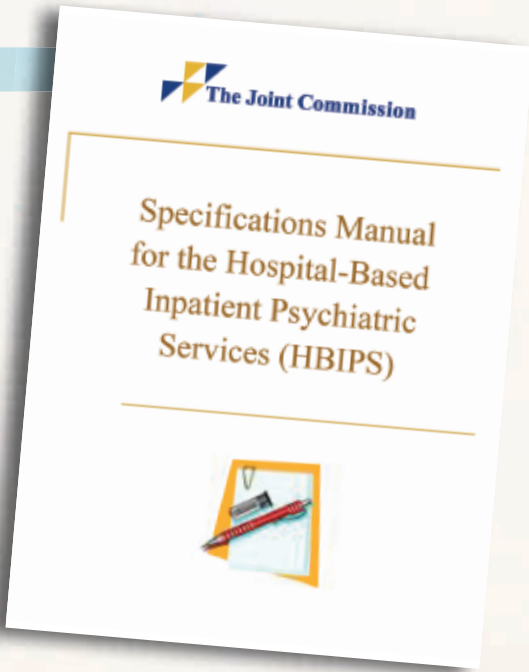
NAPHS leads an effort to seek continued funding for the **HBIPS initiative**.

NAPHS hosts the first annual **Leadership Forum for the NAPHS Committee on Behavioral Health Services within General Healthcare Systems**.

**2006**

July 2006—Joint Commission announces its intent to **test the initial inpatient psychiatric services core measures set** in 2007.

**The Substance Abuse and Mental Health Services Administration (SAMHSA)** awards close to \$100,000 to help support the **Hospital-Based Inpatient Psychiatric Services (HBIPS)** core measures project.



August 14, 2006—Final regulations on the **Individuals with Disabilities Education Act (IDEA)** are published in the **Federal Register**.

NAPHS works to help members understand the changes. NAPHS also worked with the Department of Education to seek clarifications. In December, NAPHS received a letter from the **Office of Special Education and Rehabilitation (OSEP)** with a formal response to members’ questions about who is responsible for payment of special education services for children publicly placed in residential treatment programs.

## 75 Years of Behavioral Healthcare Leadership in Action

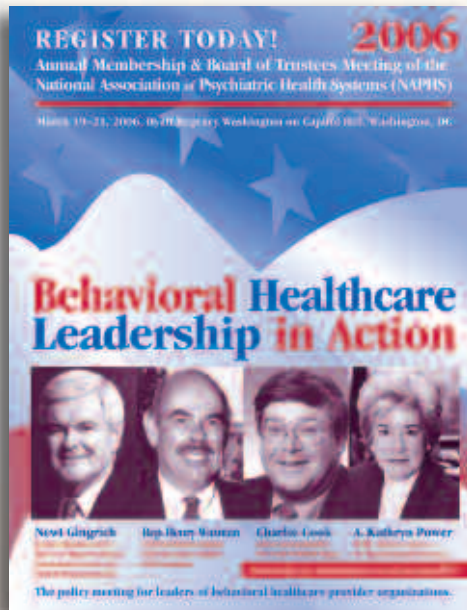
Information Technology (IT) Committee issues **NAPHS Information Technology Principles** to help Congress understand and address the issues impacting IT within behavioral healthcare organizations.

December 8, 2006—After seven years of operating under an interim final rule requiring a physician to conduct a face-to-face assessment of a patient within one hour of initiation of restraint or seclusion, the **Centers for Medicare and Medicaid Services (CMS)** published a final rule revising the “one-hour rule.” The change (proposed by NAPHS, many other professional organizations, hospital groups, and other allied healthcare organizations) is part of the final rule.

NAPHS  
History

2006

Behavioral  
Healthcare  
History



Institute of Medicine (IOM) report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, says that **patient-centered care and more emphasis on the mind-body connection are necessary** to changing care for the better.

December 8, 2006 —Final rule on the hospital **Conditions of Participation (CoP) for Patients' Rights** (including regulations on restraint/seclusion) published in the *Federal Register*.

**Diana L. Ramsay**  
association president  
2007

April 2007—Journalist **Jane Pauley**, presidential candidate and former Health and Human Services Secretary **Tommy Thompson**, Rep. **Patrick Kennedy** (D-RI), and others speak at NAPHS Annual Meeting.



## 2007

January 1, 2007—More than **190 hospitals begin pilot-testing through the Hospital-Based Inpatient Psychiatric Services (HBIPS) Performance Measurement Initiative.**

April 16, 2007—A **shooting on the campus of Virginia Tech** stuns the nation. Thirty-two people are killed and many more wounded before the gunman commits suicide. The incident sparks immediate and ongoing national debate about **gaps in the mental healthcare system, confidentiality, gun control, and commitment laws.**



September 2007—S.558, the **Mental Health Parity Act**, is passed by the U.S. Senate.

75 Years of Behavioral Healthcare Leadership in Action

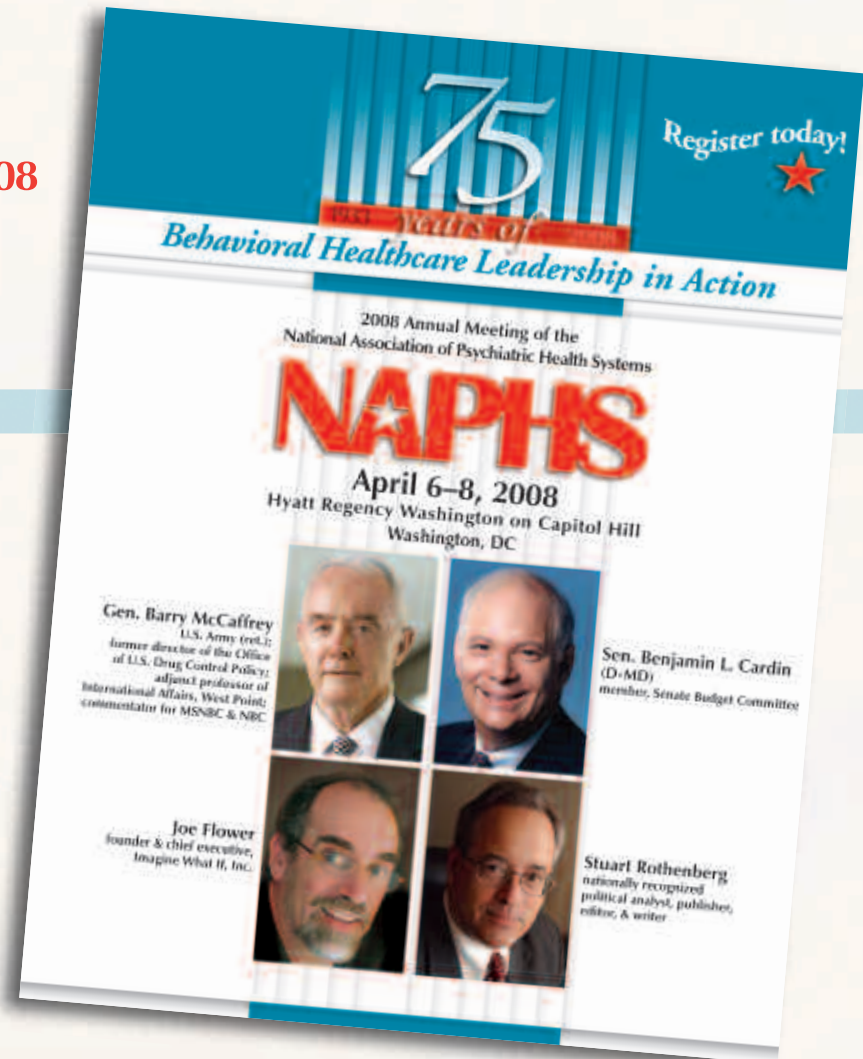
**Jeff Borenstein, M.D.**  
association president  
2008

1933 ANNIVERSARY 2008

NAPHS  
History

2008

Behavioral  
Healthcare  
History

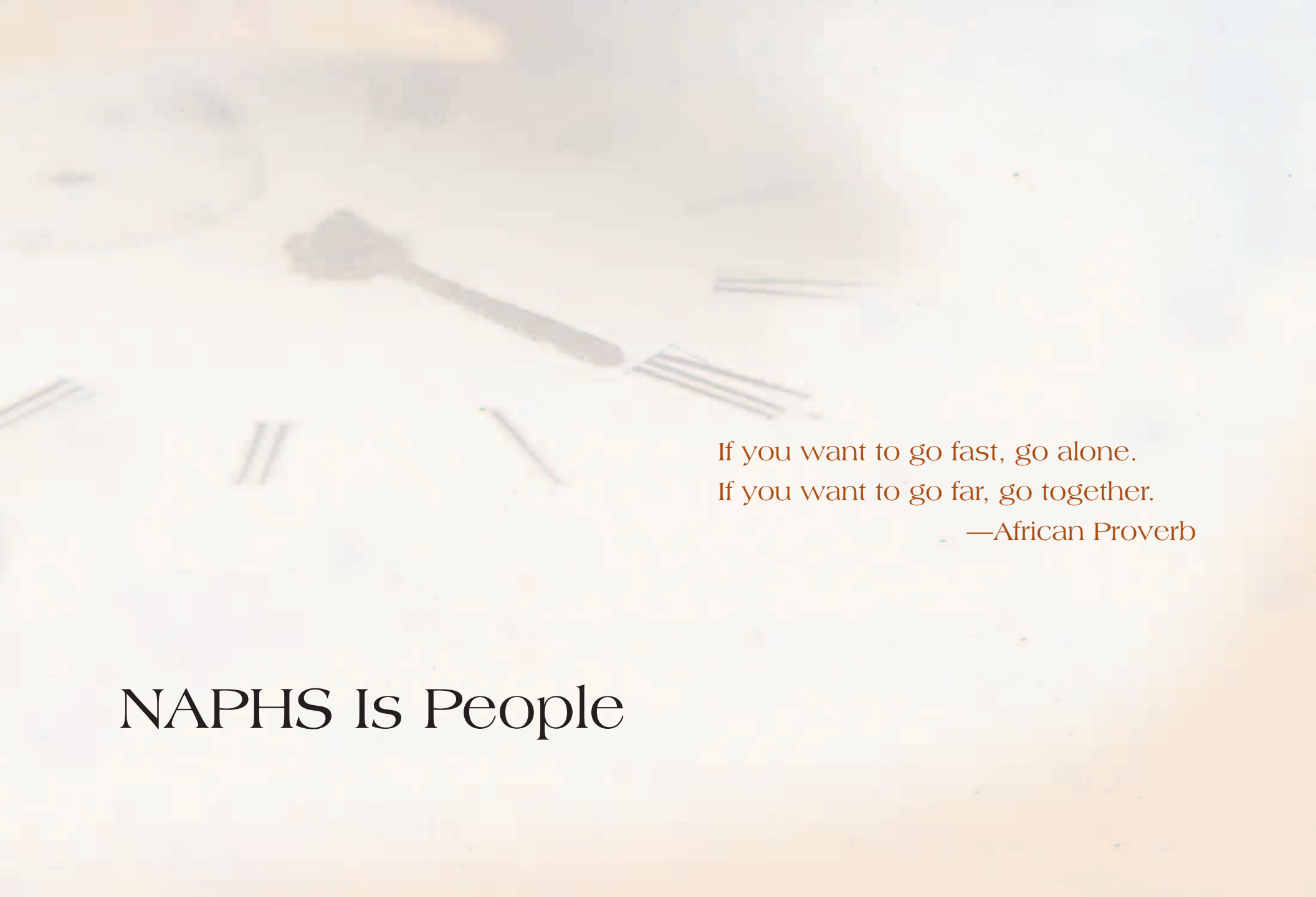


“As we head into the...election year, the critical role of behavioral health advocacy—and of NAPHS leadership—is once again in the spotlight. The election process is a reminder...of how we need to continually keep the needs of our patients and communities in front of an ever-changing cast of characters at both the federal and state levels...of how forcefully we must make our case to be heard among the many voices...of the positive impact our efforts can ultimately have on improving care and improving lives.”

—*Dennis P. King, NAPHS president, 2003*







If you want to go fast, go alone.  
If you want to go far, go together.

—African Proverb

NAPHS Is People

The National Association of Psychiatric Health Systems (NAPHS) honors the people who have made it possible for the association to support its members in meeting the needs of patients and families for quality psychiatric and substance use services.

## NAPHS PRESIDENTS

1934–36:	John J. Kindred, M.D.	1964:	Cornelia B. Wilbur, M.D.
1936–39:	Glen Myers, M.D.	1965:	Perry Talkington, M.D.
1939–40:	Clifford W. Mack, M.D.	1966:	G. Creswell Burns, M.D.
1940–48:	James K. Hall, M.D.	1967:	Ralph S. Green, M.D.
1948–50:	John C. Kindred, M.D.	1968:	John R. Saunders, M.D.
1950–51:	Walter J. Otis, M.D.	1969:	Ted Neumann, M.D.
1951–54:	G. Wilse Robinson, M.D.	1970:	Samuel Hibbs, M.D.
1954–55:	Harrison S. Evans, M.D.	1971:	Alexander Galnick, M.D. and Robert W. Gibson, M.D.
1955–56:	Rex Blankenship, M.D.	1972:	Robert S. Garber, M.D.
1956–57:	Phillip B. Reed, M.D.	1973:	Stuart M. Gould, M.D.
1957–58:	Paul Hines, M.D.	1974:	J. Martin Myers, M.D.
1958–59:	Benjamin Simon, M.D.	1975:	George Wayne, M.D.
1960:	E. James Brady, M.D.	1976:	Walter H. Wellborn, M.D.
1961:	Edward G. Billings, M.D.	1977:	John Donnelly, M.D.
1962:	Carroll C. Turner, M.D.	1978:	Ralph M. Barnette, Jr.
1963:	Samuel Liebman, M.D.		

1979:	Henry J. Langevin	1995:	E. Mac Crawford
1980:	Lewis L. Robbins, M.D.	1996:	Paul J. Fink, M.D.
1981:	Thomas Dolgoff	1997:	Jean P. Smith
1982:	Mark A. Gould, M.D.	1998:	William D. Zieverink, M.D.
1983:	Robert V. Sanders	1999:	Thomas Bender
1984:	Pasquale A. Carone, M.D.	2000:	Peter Panzarino, M.D.
1985:	Anthony F. Santore	2001–02:	Anil Godbole, M.D.
1986:	Robert A. Moore, M.D.	2003:	Dennis P. King
1987:	Malcolm Strickler	2004:	Debra Osteen
1988:	Kenneth D. Gaver, M.D.	2005:	Patricia R. Recupero, J.D., M.D.
1989:	Loren Shook	2006:	Edward C. Irby
1990:	Doyle I. Carson, M.D.	2007:	Diana L. Ramsay
1991:	Frederick D. Raine	2008:	Jeff Borenstein, M.D.
1992:	Jack W. Bonner, III, M.D.		
1993:	George Bone		
1994:	George T. Harding, IV, M.D.		

“Consumers and families are our customers and our allies in advocating for resources necessary to deliver quality behavioral health care. Their opinions and perceptions about treatment—and how well we deliver it—will have a profound impact in the coming decades. ”

—Tom Bender  
NAPHS president,  
2000

We also wish to recognize and applaud the hundreds of individuals who have served throughout the years as members of the NAPHS/NAPPH Board of Trustees and Executive Committee.

## PRESIDENTIAL AWARD RECIPIENTS

### Leadership in Psychiatry

- Francis de Marneffe, M.D., Holly Hill Hospital, NC (1991)
- Robert S. Garber, M.D., Carrier Foundation, NJ (1981)
- Robert Gibson, M.D., Sheppard and Enoch Pratt Hospital, MD (1984)
- Otto F. Kernberg, M.D., New York Hospital-Cornell Medical Center, Westchester Division, NY (1993)
- Jerry M. Lewis, M.D., Timberlawn Psychiatric Hospital, TX (1989)
- Karl A. Menninger, M.D., The Menninger Foundation, KS (1987)
- Robert A. Moore, M.D., Vista Hill Foundation, CA (1993)
- Walter H. Wellborn, Jr., M.D., The Manors, FL (1991)

### Mental Health Administration

- Rosalie Aberman, Hall-Brooke Foundation, CT (1992)
- James W. Conte, Community Psychiatric Centers, CA (1990)
- Frank J. Dunning, Camelback Hospitals, AZ (1981)
- Elmer M. Ediger, Prairie View Hospital, KS (1983)
- Arthur Jost, Kings View Foundation, CA (1988)
- Sydney Koret, Ph.D., Convalescent Hospital for Children, NY (1983)
- G. Robert Owens, Watauga Mental Health Services, Woodridge Hospital, TN (1986)

### Psychiatric Research

- John P. Docherty, M.D., Nashua Brookside Hospital, NH (1990)
- Mark S. Gold, M.D., Fair Oaks Hospital, NJ (1981)
- John T. Gossett, Ph.D., Timberlawn Hospital, TX (1992)
- John M. Kane, M.D., Hillside Hospital/Long Island Jewish Medical Center, NY (1989)
- Jeffrey A. Lieberman, M.D., Hillside Hospital, NY (1993)
- Thomas H. McGlashan, M.D., Chestnut Lodge Hospital, MD (1988)
- Steven M. Mirin, M.D., McLean Hospital, MA (1991)
- Steven D. Targum, M.D., Sarasota Palms Hospital, FL (1985)

### Volunteer Trustee

- Eric Barradale, D.D.S., Brattleboro Retreat, VT (1984)
- Norton Clapp, The Menninger Foundation, KS (1991)
- James L. Hagle, Harding Hospital, OH (1989)
- Ruth I. Kaufman, Emma Pendleton Bradley Hospital, RI (1990)
- Marvin Levitties, Philadelphia Psychiatric Center, PA (1987)
- John A. Luetkemeyer, Sheppard and Enoch Pratt Hospital, MD (1986)
- George Putnam, McLean Hospital, MA (1992)
- Jonathan Rhoads, M.D., Friends Hospital, PA (1993)
- Miles G. Seeley, The Menninger Foundation, KS (1985)
- William Bradley Turner, The Bradley Center, GA (1988)
- Walter C. Young, M.D., Mount Airy Foundation, CO (1983)

### The Gralnick Foundation-High Point Hospital Award

- Samuel J. Keith, M.D., University of New Mexico School of Medicine, NM (1993)
- Nina Schooler, Ph.D., The Western Psychiatric Institute and Clinic, PA (1993)

### Special Humanitarian Award

- Jonas Salk, M.D., The Salk Institute, CA (1993)

Historic documents reference the following association staff members over the last several decades.

We thank everyone for helping the association to evolve and grow over the past 75 years, and we regret any omissions.

**Bold indicates current staff. Italic indicates executive directors.**

## STAFF

- **Lester Altschul**
- Mary C. Anderson
- Mark Baechtcl
- Debbie Baladad
- Kim Bender
- Sharon L. Bernier, R.N., Ph.D.
- Kathy Dunn Bjercknes
- **Tia Boyd**
- Terry Boyle
- Lisa A. Brawley
- David Brown
- Bonnie Bryan, R.N., M.H.A.
- Lana Buck
- Charles Campisi
- Dora Cholakian
- Nancy Clay
- Joan Connolly
- Monica Cornish
- Tamarah Costas
- **Mark Covall**
- Linda Corcoran, R.N., A.C.S.W.
- Lucia D'Avella
- Elizabeth Darby
- Christy Davis
- Eileen Dutka Demko
- Stephanie Dent
- Irene B. Devin
- Hugh Diamond
- Melanie Donohue
- Paula Dubrow
- **Frieda Eastmann**
- Kai Elken
- Fran Feikin
- Michael Feinstein
- Barbara Fernandez
- Melody Gordy
- Terry Gorman
- Jacqueline Grant
- Kimberly Graeff
- Patricia B. Habansky, R.N.
- Diane L. Hart
- *Melvin Herman*
- Debbie Jacobsen
- Edward L. Kelly
- Rosette Koorajian
- Robin L. Kropf
- Lisa Kubeck
- Anne Lamont
- *Edward F.X. Lawlor, Jr.*
- Kristin LeBlanc
- Ron McBee
- **Kathleen McCann, R.N., Ph.D.**

- Margaret C. McDonald, M.F.A.
- Lesley McGoughran
- Joan Macken
- Alice Mansfield
- Allison Marsh
- Nina Merendino
- **Maria Merlie**
- Joy Midman
- Katherine Millard
- M. Jo Namerow
- Paige Pawlak
- Cidette Perrin
- Mary Peters
- Mimi Phillips
- Susan Piarulli
- Roberta Rhodes
- Jan Ridgley
- Patricia Ryan
- Connie Schantz
- Kathleen M. Sheehan
- Tracey Shover
- Bonnie B. Sites, R.N.
- Jacqueline Smith
- Suzie Smith
- **Carole Szpak**
- Linda H. Thomas
- *Robert L. Thomas*
- Wendy Thorpe
- *Robert Trachtenberg, J.D.*
- **Nancy Trenti, J.D.**
- William B. Wassum
- Jeanne Whalen
- Melvon White
- Cynthia Wood, MSN
- Aisha Williams
- Brenna Zwanzig



“Quality can exist only in an environment in which behavioral health is recognized, respected, and allocated resources with fairness and equity...that allows for innovation and creativity...Each and every one of us who is working in behavioral health care today has an opportunity—and a responsibility—to speak out. NAPHS makes it possible.”

—Patricia R. Recupero, J.D., M.D.

NAPHS president, 2005

Our thanks to the hundreds of thousands of individuals who work in communities around the country to improve the lives of children, adolescents, adults, and older adults who are experiencing psychiatric and substance use disorders.

The following provides a listing of NAPHS systems and the facilities they operate as of January 1, 2008.

## MEMBER ORGANIZATIONS

Academy at Canyon Creek, UT  
Academy at Swift River, MA  
Academy of the Sierras, CA  
Academy of the Sierras, North Carolina, NC  
Acadia Abilene, TX  
Acadia Hawaii, HI  
Acadia Healthcare Company, LLC, GA  
The Acadia Hospital, ME  
Acadia Montana, MT  
Acadia Pathways, TX  
Acadia Vermilion Hospital, LA  
Addison Gilbert Hospital, MA  
Adirondack Leadership Academy, NY  
Advocate Behavioral Health Council, IL  
Advocate Christ Hospital & Medical Center, IL  
Advocate Family Care Network, IL  
Advocate Good Samaritan Hospital, IL  
Advocate Good Shepherd Hospital, IL  
Advocate Illinois Masonic Medical Center, IL  
Advocate Lutheran General Hospital, IL  
Alabama Clinical Schools, AL  
Alegent Health Behavioral Services, NE  
Alexandria Wellness Center, LA  
Alexian Brothers Behavioral Health Hospital, IL  
Alhambra Hospital, CA  
Allenwood–WDR, PA  
Alliance Health Center, MS  
Amesbury Child Unit, Anna Jaques Hospital, MA  
Anchor Hospital, GA  
Apex Behavioral Health–Ann Arbor, MI  
Apex Behavioral Health–Brownstown, MI  
Apex Behavioral Health–Dearborn, MI  
Apex Behavioral Health–Detroit, MI  
Apex Behavioral Health–Plymouth, MI  
Apex Behavioral Health, PLLC, MI  
Arbour Health System, MA  
Arbour–Fuller Hospital, MA  
Arbour–HRI Hospital, MA  
Arms Acres, NY  
Ascend Health Corporation, NY  
Ascent, ID  
Ascent Childrens Health Services, AR  
Aspen Achievement Academy, UT



## History of NAPHS and Behavioral Health

Aspen Institute for Behavioral Assessment, UT Aspen Ranch, UT	Avera McKennan Behavioral Health Assessment Program, SD	Behavioral Centers of America, LLC, TN
Atlantic Shores Hospital, FL	Avera McKennan Behavioral Health Outpatient/EAP, SD	Behavioral Health Center–CMC Randolph, NC
AtlantiCare Behavioral Health, NJ	Avera McKennan Behavioral Health Partial Hospitalization Program, SD	Behavioral Health Center–First Step at CMC-Union, NC
AtlantiCare Regional Medical Center, City Campus, NJ	Avera McKennan Behavioral Health Services, SD	Behavioral Health Center–Kings Mountain Hospital, NC
AtlantiCare Regional Medical Center, Mainland Campus, NJ	Avera McKennan Behavioral Health Services–Inpatient Programs, SD	Behavioral Health Center–Mercy Horizons, NC
Augusta Alcohol & Drug Treatment Program, GA	Azure Acres, CA	Behavioral Health Concepts, Inc., CA
Auldern Academy Boarding School, NC	Banner Behavioral Health Hospital, AZ	Behavioral Health of Forsyth Medical Center, NC
Aurora Behavioral Health Services, WI	Banner Behavioral Health Mesa Clinic, AZ	Behavioral Health Partners, MD
Aurora Behavioral Health System, AZ	Banner Good Samaritan Medical Center Behavioral Health Services, AZ	Behavioral Health Partners at Patrick Street, MD
Aurora Charter Oak, CA	Banner Health, AZ	Behavioral Health Services of the Greenville Hospital System, SC
Aurora Chicago Lakeshore, IL	Banner Health–Helpline, AZ	Bell Therapy, Inc., WI
Aurora Las Encinas Hospital, CA	Banner Mesa Medical Center Generations, Geropsychiatric Program, AZ	Belmont Center For Comprehensive Treatment, PA
Aurora Psychiatric Hospital, Inc., WI	Banner Thunderbird Medical Center Behavioral Health Services, AZ	Belmont Pines Hospital, OH
Aurora San Diego, CA	BayRidge Hospital, MA	Benchmark Behavioral Health System, UT
Aurora Vista del Mar, CA	Baystate Health, MA	Beverly Hospital, MA
Austen Riggs Center, MA		
Austin Lakes Hospital, TX		
Avera McKennan Behavioral Health Addiction Recovery Program, SD		

## NAPHS Is People

Blue Mountain–WDR, PA  
Bon Secours Hampton Roads Behavioral  
Medicine Services–Maryview  
Behavioral Medicine Center, VA  
Boulder Creek Academy, ID  
Bournewood Hospital, MA  
Bournewood–Caulfield Center, MA  
Bowling Green Brandywine, PA  
Boys Town National Research  
Hospital, NE  
Brentwood Behavioral Healthcare of  
Mississippi, MS  
Brentwood Hospital, LA  
BridgeWay Hospital, AR  
Bridgeway Psychiatric Center, LA  
Bromley Brook Academy, VT  
Brooke Glen Behavioral Hospital, PA  
Brynn Marr Hospital, NC  
Butler Hospital, RI  
Calvary Center, AZ  
Camp, CA  
Camp Huntington, NY  
Canyon Ridge Hospital, CA  
Care Plus, CT  
Carilion Health System, VA  
Carilion New River Valley Med. Ctr./Carilion  
Saint Albans Behavioral Health, VA  
Carilion Roanoke Memorial Hospital, VA  
The Carolina Center for Behavioral  
Health, SC  
Carolina Treatment Raleigh House, NC  
Carolinas HealthCare System, NC  
Carrier Clinic, NJ  
The Cawley Johnson Group, GA  
Cedar Crest Clinic–Killeen, TX  
Cedar Crest Hospital & Clinic, TX  
Cedar Crest RTC, TX  
Cedar Grove, TN  
Cedar Ridge, OK  
Cedar Springs Behavioral Health System,  
CO  
Cedars Academy, DE  
Centegra Health System, IL  
Centegra Horizons Behavioral Health, IL  
Centegra Memorial Medical Center–  
Inpatient Services, IL  
Centegra Memorial Medical Center–  
Outpatient Services, IL  
Center for Behavioral Health, CA  
Center for Change, UT  
Center for Hope of the Sierras, NV  
Center for Recovery, SC  
Chad Youth Enhancement Center, TN  
Christian Health Care Center, NJ  
Christian Health Care Counseling  
Center, NJ  
Clarion Psychiatric Center, PA  
Clinical Day Treatment–Windham, CT  
Coastal Harbor Treatment Center, GA  
College Health Enterprises, CA  
College Hospital Cerritos, CA  
College Hospital Costa Mesa, CA  
Columbia Presbyterian Hospital, NY  
Columbus Behavioral Center for Children  
and Adolescents, IN  
Community Hospital of Monterey  
Peninsula, CA  
Compass Behavioral Center of Crowley, LA  
Compass Health, LA  
Compass Hospital, TX  
Compass Intervention Center, TN  
Compass Psychiatric Specialties, LA  
Conifer Park, NY  
Copper Canyon Academy, AZ  
Copper Hills Youth Center, UT

## History of NAPHS and Behavioral Health

Cottonwood Treatment Center, UT	The Devereux Florida Treatment Network, FL	Family Services Agency, Inc. of Montgomery County, MD
The Counseling Center, SC	The Devereux Foundation, PA	First Home Care, VA
The Counseling Center of Lutheran General Hospital, IL	The Devereux Georgia Treatment Network, GA	First Hospital Wyoming Valley, PA
Cove Forge Behavioral Health System, PA	The Devereux Institute of Clinical Training & Research, PA	Florida Civil Commitment Center, FL
Cove Prep, PA	The Devereux Kanner, PA	Florida Hospital Center for Behavioral Health, FL
Crawford First Education, VA	The Devereux Massachusetts, MA	Focus by the Sea, GA
CRC Health Group, CA	The Devereux New Jersey Treatment Network, NJ	Focus Healthcare of Florida, FL
Cumberland Hall, KY	The Devereux New York, NY	Focus Healthcare of Ohio, OH
Cumberland Hall of Chattanooga, TN	The Devereux Pocono Center, PA	Forbush School, MD
Cumberland Hospital, VA	The Devereux Texas Treatment Network, TX	Forest View Hospital, MI
Cypress Creek Hospital, TX	The Devereux Whitlock, PA	Fort Bayard Medical Center, NM
Daytona Residential Treatment Center, FL	Diamond Grove Center, MS	Fort Lauderdale Hospital, FL
Deaconess Cross Pointe Center, LLC, IN	Dominion Hospital, VA	Foundations Behavioral Health System, PA
Del Amo Hospital, CA	Dover Behavioral Health System, DE	Foundations For Living, OH
DePaul Health Center, MO	Elliot Hospital, NH	Four Winds Hospitals, NY
Desert Hills-New Mexico, NM	Excel Academy, TX	Four Winds Hospital–Saratoga, NY
Detroit Behavioral Institute, MI	Fairbanks Memorial Hospital Behavioral Health Unit, AK	Four Winds Hospital–Westchester, NY
The Devereux Arizona, AZ	Fairfax Hospital, WA	Fox Run Hospital, OH
The Devereux Beneto, PA	Fairmount Behavioral Health System, PA	Franciscan Missionaries of Our Lady Health System, LA
The Devereux California Treatment Network, CA		Franklin House Crisis Residential Center, ID
The Devereux Cleo Wallace, CO		Fremont Hospital, CA
The Devereux Connecticut–Glenholme, CT		Friends Hospital, PA

## NAPHS Is People

The Frost School, MD  
Galax, VA  
GEO Care, Inc., FL  
Girls and Boys Town Behavioral Health  
Division, NE  
Glen Oaks Hospital, TX  
Good Samaritan Counseling Center, AK  
Granite House, MD  
Gulf Coast Treatment Center, FL  
Hall-Brooke Behavioral Health Services, CT  
Hall-Brooke The Center at Bridgeport, CT  
Hall-Brooke, Outpatient Services, CT  
Hall-Brooke, Seton Academy, CT  
Hampton Hospital, NJ  
Harbor Oaks Hospital, MI  
Harmony Healthcare, NV  
Hartgrove Hospital, IL  
Haven Behavioral Healthcare, Inc., TN  
Haven Behavioral Senior Care, CO  
Havenwyck Hospital, MI  
HCA, Inc., TN  
Health Partners New England, Inc., MA  
Heartland Behavioral Health Services, MO  
Heritage Oaks Hospital, CA  
Hermitage Hall, TN  
Hickory Trail Hospital, TX  
Highland Ridge Hospital, UT  
Highlands Behavioral Health System, CO  
Hill Crest Behavioral Health Services, AL  
Holliswood Hospital, NY  
Holly Hill Hospital, NC  
The Horsham Clinic, PA  
Immanuel Medical Center, NE  
The Institute of Living: Hartford Hospital,  
CT  
INTEGRIS Mental Health, Inc., OK  
Intermountain Hospital, ID  
Island View, UT  
JBH Sulphur Center, LA  
Jefferson School, MD  
Jennings Behavioral Health, LLC, LA  
Jennings Senior Care Hospital, LA  
Joshua Center, CT  
Joshua Center–Brooklyn, CT  
Joshua Center–Enfield, CT  
Joshua Center–Montville, CT  
Keys of Carolina, NC  
Keystone, SD  
KeyStone Center, PA  
Keystone Newport News, VA  
KidsPeace, PA  
KidsPeace Children's Hospital, PA  
KidsPeace National Centers, PA  
KidsPeace National Centers of GA, GA  
KidsPeace National Centers of New  
England, ME  
King George School, VT  
Kingwood Pines Hospital, TX  
La Amistad Residential Treatment Center, FL  
Lakeland Regional Hospital, MO  
Lakeside Behavioral Health System, TN  
Lancaster–WDR, PA  
Langley Porter Psychiatric Hospital &  
Clinics, CA  
Laureate Psychiatric Clinic & Hospital, OK  
Laurel Heights Hospital, GA  
Laurel Oaks Behavioral Health Center, AL  
Laurel Ridge Treatment Center, TX  
Laurelwood Hospital, OH  
Lee Memorial Hospital, FL  
Levindale Hebrew Geriatric Center and  
Hospital, MD  
Liberty Behavioral Management Group,  
Inc., NJ  
Liberty Point Healthcare, VA

## History of NAPHS and Behavioral Health

Life Bridge Health, MD  
Life Healing Center, NM  
Lighthouse Care Center of Augusta, GA  
Lighthouse Care Center of Conway, SC  
Lighthouse Care Center of Oconee, SC  
Lincoln Trail Behavioral Health System, KY  
Linden Oaks at Edward, IL  
Lindner Center of HOPE, OH  
Loma Linda Behavioral Medicine Center, CA  
Lone Star Expeditions, TX  
LRG Healthcare, NH  
Macon Behavioral Health Treatment  
Center, GA  
Maine Medical Center, ME  
MaineHealth, ME  
Manatee Palms Youth Services, FL  
Mann RTC, MD  
Marion Juvenile Correctional Facility, FL  
Marion Youth Center, VA  
Mayo Clinic, MN  
McDowell Center for Children, TN  
McLean Ambulatory Treatment Center at  
Naukeag, MA  
McLean Hospital, MA  
McLean SouthEast, MA

Meadows Hospital, IN  
The Meadows Psychiatric Center, PA  
MeadowWood Behavioral Health System,  
DE  
Memorial Behavioral Health at Gulfport,  
MS  
Mental Health Services for Clark and  
Madison Counties, Inc., OH  
Mental Health Services for Clark County–  
Community Support, OH  
Mental Health Services for Clark  
County–CARE Counseling, OH  
Mental Health Services for Clark County–  
Child, Adolescent, Family Center, OH  
Mental Health Services for Clark  
County–Mental Health, Alcohol & Drug  
Services for Madison County, OH  
Mental Health Services for Clark County–  
Western Counseling Services, OH  
Mental Health Services for Clark  
County–Youth Challenges, OH  
Meridell Achievement Center, TX  
Meridian Services Corp., IN  
Mesabi Academy of KidsPeace, MN  
Mesilla Valley Hospital, NM

Michiana Behavioral Health Center, IN  
The Midwest Center for Youth and  
Families, IN  
Millcreek ICFMR & PRTE, MS  
Millcreek Management Corp., MS  
Millcreek of Pontotoc, MS  
Millcreek Rehab of Arkansas, AR  
Millwood Hospital, TX  
Mission Hospitals, NC  
Mission Vista Behavioral Health Center, TX  
Moccasin Bend Ranch, OK  
Montecatini, CA  
Montecatini II, CA  
Montevista Hospital, NV  
Mosaic Community Services, MD  
Mount Bachelor Academy, OR  
Mount Regis Center, VA  
Mountain Home Residential Treatment  
Center, ID  
Mountain Youth Academy, TN  
MUSC Institute of Psychiatry, SC  
Nashville Rehabilitation Hospital, TN  
Natchaug Hospital, Inc., CT  
Natchez Trace Youth Academy, TN  
National Deaf Academy, FL

## NAPHS Is People

New Beginnings Residential Treatment Center, AL  
New Directions–WDR, PA  
New Directions Transitional Living Program, AL  
New Dominion Maryland Residential Treatment Program, MD  
New Dominion Virginia Residential Treatment Program Boys, VA  
New Dominion Virginia School Residential Treatment Program Girls, VA  
New Leaf Academy, OR  
New Leaf Academy of North Carolina, NC  
New Life Lodge, TN  
New Perspectives–WDR, PA  
New York Presbyterian Hospital, NY  
Newport Bay Hospital, CA  
The North Baltimore Center, MD  
North Colorado Medical Center Behavioral Health Services, CO  
North Oaks Health System–North Oaks Rehabilitation Center, LA  
North Shore/Long Island Jewish Health System, NY  
North Spring Behavioral Healthcare, VA  
North Star Behavioral Health System, AK  
North Star Center, OR  
Northeast Hospital Corp., Inc., MA  
Northwest Academy, ID  
Northwest Hospital Center, MD  
Norwalk Hospital, CT  
Norwich School System, CT  
Oakley School, UT  
The Oaks Treatment Center, TX  
Ohio Hospital for Child & Adolescent Psychiatry, OH  
Old Vineyard Youth Services, NC  
Options Treatment Center, IN  
Orlando Regional Behavioral Health Services, FL  
Osceola Residential Treatment Center, FL  
Our Lady of Peace, KY  
Our Lady of the Lake Regional Medical Center–Tau Center, LA  
Outback Expeditions, UT  
Paint Rock Valley Residential Treatment Program Boys, AL  
Paint Rock Valley Residential Treatment Program Choices, AL  
Paint Rock Valley Residential Treatment Program Girls, AL  
Palm Beach County Detention Center, FL  
Palmetto Baptist Medical Center, SC  
Palmetto Health Behavioral Care, SC  
Palmetto Lowcountry Behavioral Health, SC  
Palmetto Pee Dee Behavioral Health, SC  
Palmetto Pines Behavioral Health, SC  
Panamericano, PR  
Parc Place, AZ  
Parc Place–Casa Grande, AZ  
Parkside, Inc., OK  
Parkwest Medical Center, TN  
Parkwood Behavioral Health System, MS  
Parthenon Pavilion at Centennial Medical Center, TN  
Passages to Recovery, UT  
Pathways Partial Hospitalization Program, NJ  
The Pavilion, IL  
Payne Whitney Manhattan, NY  
Payne Whitney Westchester, NY  
Peachford Behavioral Health System, GA  
Peak Behavioral Health Services, NM  
Pembroke Hospital, MA  
Peninsula Hospital, TN

## History of NAPHS and Behavioral Health

Peninsula Outpatient, TN  
Peninsula Village, TN  
Pennsylvania Clinical Schools, PA  
Phoenix Care Systems, Inc., WI  
Phoenix Outdoor, NC  
Piedmont Medical Center, SC  
Pine Grove Behavioral Health and  
Addiction Services, MS  
Pine Rest Christian Mental Health  
Services, MI  
Pines–Charleston, SC  
The Pines Residential Treatment Center, VA  
Pinnacle Pointe Hospital, AR  
Pioneer Behavioral Health, MA  
Pioneer Counseling Centers, MI  
Pivotal Research Centers, Inc., AZ  
Poplar Springs Hospital, VA  
Potomac Ridge Anne Arundel, MD  
Potomac Ridge at Washington Adventist  
Hospital, MD  
Potomac Ridge Behavioral Health  
System, MD  
Potomac Ridge Eastern Shore, MD  
Potomac Ridge Rockville, MD  
Prairie St. John's, ND  
Prairie St. John's–Adult Partial Program, MN  
Prairie St. John's Clinic–Woodbury, MN  
Prairie St. John's Clinic–Fargo, ND  
Prairie St. John's Clinic–Minnetonka, MN  
Prairie St. John's Clinic–Moorhead, MN  
Prairie St. John's Clinic–Wahpeton, ND  
Premiere Care, Inc., TX  
Pride Institute, MN  
Princeton House Behavioral Health, NJ  
Provo Canyon School, UT  
Psychiatric Institute of Washington, DC  
Psychiatric Solutions, Inc., TN  
PsychSolutions, Inc., FL  
Quincy Medical Center, MA  
Quinebaug Day Treatment Center, CT  
Ramapo Ridge Partial Program, NJ  
Ramapo Ridge Psychiatric Hospital, NJ  
Red Rock Behavioral Health Hospital, NV  
Reginald S. Lourie Center for Infants and  
Young Children, MD  
Reliant Healthcare, LLC, AL  
Renewal Center at Cove Forge, PA  
Residential Treatment Center of Ohio, OH  
Resolute Treatment Facility, IN  
Resource Residential Treatment Center, IN  
The Retreat at Sheppard Pratt, MD  
Retreat Healthcare, VT  
Richard H. Young Hospital, NE  
Richland Springs, SC  
Ridge Behavioral Health System, KY  
Ridgeview Institute, GA  
Rivendell Behavioral Health Services, AR  
Rivendell Behavioral Health Services, KY  
River Crest Hospital, TX  
River Oaks Psychiatric Hospital, LA  
River Park Hospital, WV  
RiverEast Day Hospital and Treatment  
Center, CT  
Riveredge Hospital, IL  
Riverside Behavioral Health Centers, Inc., VA  
Rockford Center, DE  
Rogers Behavioral Health System, Inc., WI  
Rogers Memorial Hospital– Brown Deer, WI  
Rogers Memorial Hospital–Kenosha, WI  
Rogers Memorial Hospital–Milwaukee, WI  
Rogers Memorial Hospital, Inc., WI  
Rolling Hills Hospital, OK  
Roxbury Treatment Center, PA  
Rye Hospital Center, NY  
Sachem House, CT

## NAPHS Is People

Sage Walk “The Wilderness School,” OR  
Saint Joseph Regional Medical Center, ID  
San Juan Capestrano Hospital, PR  
San Marcos Treatment Center, TX  
Sandy Pines Hospital, FL  
Satilla Reliant Psychiatric Hospital, GA  
Scripps Mercy Behavioral Health, CA  
Seasons, NC  
Seven Hills Behavioral Institute, NV  
Shadow Mountain Behavioral Health System, OK  
Shaker Clinic, OH  
Shands Vista, FL  
SHARP Mesa Vista Hospital, CA  
SHARP Vista Pacifica, CA  
Sheboygan Memorial Medical Center, WI  
Sheppard and Enoch Pratt Hospital, MD  
Sheppard Pratt at Ellicott City, MD  
Sheppard Pratt at Howard County, MD  
Sheppard Pratt Health System, MD  
Sierra Tucson, AZ  
Sierra Vista Hospital, CA  
Signature Healthcare Services, CA  
Silver Hill Hospital, CT  
Sinai Hospital, MD  
Sisters of Charity Health System, ME  
Sober Living By The Sea, CA  
Sonora Behavioral Healthcare, AZ  
South Florida Evaluation and Treatment Center, FL  
South Florida State Hospital, FL  
South Oaks Hospital, NY  
Southwest Washington Medical Center, WA  
Southwood Psychiatric Hospital, Inc., PA  
Spring Harbor Hospital, ME  
Spring Mountain Sahara, NV  
Spring Mountain Treatment Center, NV  
SSM Health Care–St. Louis, MO  
St. Alphonsus Addiction Recovery Center, ID  
St. Alphonsus Psychiatric Center, ID  
St. Alphonsus Regional Medical Center Behavioral Health, ID  
St. Dominic–Jackson Memorial Hospital, MS  
St. Elizabeth Medical Center Behavioral Program, LA  
St. Helena Hospital, CA  
St. Johns Juvenile Correctional Facility, FL  
St. Joseph Health Center, MO  
St. Louis Behavioral Medicine Institute, MO  
St. Luke’s South Shore, WI  
St. Mary’s Health Center, MO  
St. Patrick’s Out Patient Services, LA  
St. Patrick’s Psychiatric Hospital, Inc., LA  
Starlite Recovery Center, TX  
Stone Mountain School, NC  
Stonington Institute, CT  
Streamwood Hospital, IL  
Success Group Home, IN  
Summit Oaks Hospital, NJ  
Sunhawk Academy, UT  
SUWS Adolescent and Youth Program, ID  
SUWS of The Carolinas, NC  
Talbott Recovery Campus, GA  
Talisman Summer Camps, NC  
Tampa Bay Academy, FL  
Ten Broeck Hospital Dupont, KY  
Ten Broeck Hospital Jacksonville, FL  
Ten Broeck Hospital KMI, KY  
Ten Broeck Ocala, FL  
Ten Lakes Center, OH  
Texas NeuroRehab Center, TX  
Thames Valley School, CT  
Three Rivers Behavioral Health, SC  
Three Rivers Residential Treatment Services/ Midlands Campus, SC



## History of NAPHS and Behavioral Health

Three Springs Englishton Park, IN	Vermilion Behavioral Health Center, LA	Whisper Ridge Behavioral Health System, VA
Three Springs of Courtland, AL	Virgin Islands Behavioral Services, VI	Williamsport–WDR, PA
Three Springs of Duck River Residential Treatment Program, TN	Virginia Beach Psychiatric Center (VBPC), VA	Willow Crest Hospital, Inc., OK
Three Springs of North Carolina Residential Treatment Program, NC	Vista Care Traditions–St. Michaels, AZ	Willow Springs Center, NV
Three Springs of Sierra Vista, AZ	Vista Care Traditions–Tuba City, AZ	Willowglen Academy–Illinois, Inc., IL
Three Springs School of Madison, AL	Vista Care Traditions–Chinle, AZ	Willowglen Academy–Indiana, Inc., IN
Three Springs School of Tuskegee, AL	Way Station, Inc., MD	Willowglen Academy–New Jersey, Inc., NJ
Three Springs, Inc., AL	Wekiva Springs, FL	Willowglen Academy–South Carolina, Inc., SC
Timberlawn Mental Health System, TX	Wellness Residential, LA	Willowglen Academy–Wisconsin, Inc., WI
Timberline Knolls, IL	Wellness Resource Center, FL	Wilmington Treatment Center, NC
Tucker Pavilion of Chippenham Medical Center, VA	Wellplace, MI, MI	Windmoor Healthcare, FL
Turn-About Ranch, UT	Wellplace, UT	Windsor Hospital, OH
Turning Point Care Center, GA	Wellspring Adventure Camp, NC	Wyoming Behavioral Institute, WY
Turning Point Youth Center, MI	Wellspring Family Camp, MI	YFCS Indiana and Ohio Midwest Regional Office, IN
Twelve Oaks Treatment Center, FL	Wellspring Hawaii, HI	Youth and Family Centered Services, Inc., TX
Two Rivers Psychiatric Hospital, MO	Wellspring New York, NY	Youthcare, UT
Union Juvenile Residential Facility, FL	Wellspring Texas, TX	
United Medical Corporation, FL	Wellstone Regional Hospital, IN	
Universal Health Services, Inc., PA	West Hills Hospital, NV	
University Behavioral Health, FL	West Oaks Hospital, TX	
University Behavioral Health of Denton, TX	Western Psychiatric Institute and Clinic/ University of Pittsburgh Medical Center, PA	
Valle Vista Hospital, IN	Western Wellspring Adventure Camp, CA	
	Westwood Lodge Hospital, MA	



I have been impressed by the respect and the impact that NAPHS has as an advocate on Capitol Hill, within regulatory and accrediting agencies, and with critical constituency groups representing consumers, state leaders, and others.”

—Anil Godbole, M.D.  
NAPHS president, 2001–2002

## In Our Own Words

Quotes and Perspective from NAPHS members throughout the years

## ABOUT THE MEMBERSHIP

“When the association began, nearly all the hospitals represented were owned by psychiatrists who ran the facilities and who became NAPPH members. During the 1950s, many of these facilities shifted from profit to non-profit status. The original owners ran the hospital but did not own it; the hospitals became public trusts with elected boards of trustees. Simultaneously, medical directors and hospital administrators began to take an active role in NAPPH and to attend annual meetings.”

—Mel Herman

*NAPPH's first executive director*

“[Historically] why did the owners of private psychiatric hospitals think their institutions were different from state psychiatric hospitals and general hospitals with psychiatric beds? Leonard Krinsky, PhD, in “History of Mental Health and Industry,” cited several reasons. First, the freestanding psychiatric hospital’s only purpose is treatment of the mentally ill. If the hospital does not meet the patient’s needs, the hospital fails. Second, private hospitals can respond quickly to the marketplace because they lack a cumbersome bureaucracy. Third, operating costs are more controllable and

length of stay is often shorter, leading to lower costs to the patient.”

—From *History: The National Association of Private Psychiatric Hospitals, 1933–1988*

“A thoughtful, multi-year strategic planning initiative involving a number of committees and work groups culminated in 1995 with a unanimous membership endorsement of ‘system memberships.’ For the first time in our association’s 62-year history, our members are now behavioral health systems—including all behavioral health services that come under one organizational umbrella. This is good news for members who are developing and planning an ever-wider continuum of services to meet community needs. As an association representing the full range of behavioral health care providers—not-for-profit and for-profit as well as all the components of service offered, NAPHS has strengthened its advocacy voice on your behalf.”

—E. Mac Crawford  
*NAPHS president, 1995*

“Our association has accomplished some remarkable, groundbreaking, and even historic things in 1996. And it has set an impressive agenda for 1997. NAPHS has done all of this in a year when dues for the vast majority of members actually decreased dramatically. As a result of proactive management and a clear vision of the future, NAPHS is maximizing your association investment not only for the good of your facilities, but for the good of behavioral health.

I am proud of the statesmanship NAPHS has demonstrated. And, as a psychiatrist who has seen the dramatic changes sweeping our industry, I applaud the forward-thinking foundation set by the Strategic Planning Committee and Board of Trustees that has positioned NAPHS as the advocate for what is right and necessary if high-quality care is to continue to be available for those who struggle with psychiatric and addictive disorders.”

—*Paul J. Fink, M.D.*  
*NAPHS president, 1996*

“As a result of a major reevaluation of our strategic direction in 1996, the Strategic Planning Committee and Board reaffirmed NAPHS’ emphasis on:

- collaboration
- advocacy
- delivery system restructuring.

We’ve said that collaboration is to be valued over competition. We’ve said that having a united voice for the organizations that provide behavioral health care is essential, wherever those organizations fall along the continuum of care. We’ve worked to ensure that our Board represents all levels of care—from outpatient centers to partial hospitals to inpatient providers (both freestanding and units in general hospitals). We’ve worked to include both allies and partners (including consumers, families, employers, and general healthcare organizations) in advocacy. And in 1996, we’ve proved the strength and value of an association that can harness the creative energies of all segments of the behavioral health field.”

—*Paul J. Fink, M.D.*  
*NAPHS president, 1996*

## Quotes and Perspective from NAPHS members throughout the years

“Everyone’s job is tougher these days. Behavioral health is in the throes of a major restructuring. That means that everything—from the way care is paid for to the way we deliver care—is subject to tough scrutiny and constant reevaluation. Budgets are tight. Legislative and regulatory policies are multiplying—and often change overnight. Mergers, joint ventures, and other partnerships are being evaluated and formed at a dizzying pace. Yet as life become more complex, there is one constant that helps make sense of the chaos: association membership.

The National Association of Psychiatric Health Systems (NAPHS) has set its sights on being your voice—the provider’s voice—in this increasingly complex world. It has been my privilege to serve as your president, and I am proud to present this wrap-up on what, quite honestly, has been a tough, but groundbreaking year that has helped to solidify the NAPHS role as the voice of our industry.

—*Jean P. Smith*  
NAPHS president, 1997

“As a result of a forward-thinking planning process, NAPHS was able to make—and carry out—strategic decisions about what differentiates our organization. The Board and membership agreed on a clear vision of who we are (behavioral healthcare provider organizations) and what we do (advocacy for behavioral health). We walked away from some projects that we could have done, but that others were doing well—such as training and general education. We made some tough decisions, but ones that have paid off and have culminated in this exceptional year. NAPHS has solidified its standing as a strong and effective advocacy force in Washington—a position that will pay dividends for you as members over the next few years.”

—*William Zieverink, M.D.*  
NAPHS president, 1998

“Every day decisions are being made that affect the future of behavioral health care. And every day the pace of change quickens. Whether the voice of behavioral healthcare providers will be heard as policy is decided will be determined by the commitment of organizational leaders to stand up today—united—to deliver a clear and consistent message about what we know works....what is in our patients’ best interests...and what is best for our communities. As those on the frontlines, we know only too well the day-to-day realities of staffing, operating, and financing behavioral health facilities within a tough economic and regulatory environment. A host of practical—and sometimes even unpopular—issues requires us to speak out....or risk the loss of valuable and irreplaceable community services. Every day the National Association of Psychiatric Health Systems (NAPHS) is our advocacy voice and our early-warning system—helping us anticipate, impact, understand, and respond to change.”

—*Peter Panzarino, M.D.*  
*NAPHS president, 2000*

“Several years ago when I was evaluating associations, I was impressed by the knowledge and experience that CEO-level medical directors and administrators brought to the association's agenda. Having had the opportunity to serve as your association's President over the course of the past two years, I continue to be in awe of the commitment that our membership brings to improving patient care—the ultimate goal in all we do. And I have been impressed by the respect and the impact that NAPHS has as an advocate on Capitol Hill, within regulatory and accrediting agencies, and with critical constituency groups representing consumers, state leaders, and others.”

—*Anil Godbole, M.D.*  
*NAPHS president, 2001–2002*

Quotes and Perspective from NAPHS members throughout the years

## ABOUT ADVOCACY

“The last 25 years have yielded more legislation that directly or indirectly affects the psychiatric hospital industry than did the 50 years preceding them. The community mental health movement, Medicare and Medicaid, the evolution of various payment systems, and the passage of a sometimes bewildering variety of regulations—NAPPH has had to deal with these and many other challenges in quick succession.”

—From *History: The National Association of Private Psychiatric Hospitals, 1933–1988*

“When I took over the Legislative Committee, I asked ‘What will I have to do?’ ‘Not much,’ they said. ‘Just report to the Board on a few pieces of legislation.’ Then along came Medicare....In the original there was a blanket statement that said that Medicare would apply to all institutions ‘except mental or tubercular institutions.’ Psychiatric hospitals were to be excluded from the system. This, of course, caused a huge uproar....I spent a lot of 1965 involved in this fight...trying to put together some sort of battle plan. The folks over at the American Psychiatric Association were

not geared up to do anything. I quickly became the most knowledgeable psychiatrist in the country about Medicare because when the bill came out, no one knew anything about it.” [Dr. Gibson visited many legislators and gave extensive testimony before Congress during the hearing process.] “At one point, a Congressman said, ‘Well, anyone older and mentally ill is hopeless, so why should we fund treatment for them?’ I got our medical records department to dig up prognosis and outcome data for 65-plus patients and found good outcome and cited that to Congress. And I got some other hospitals to look at their data, too. This data is still sometimes quoted.” [Eventually, the legislation passed and—excepting the 190-day lifetime limit, which NAPHS continues to fight—it was pretty close to the NAPPH recommendations.]

—*Robert Gibson, M.D.*  
*president & CEO, Sheppard and Enoch Pratt Hospital in Baltimore*  
—*who was the newly selected chairman of the NAPPH Legislative Committee in 1965*



...[responding to this first flexing of NAPPH's political muscle related to the original Medicare legislation]..."The Association has 'come of age.'"

—*Perry Talkington, M.D.*  
*NAPPH president, 1965*

[On landmark passage of the first mental health parity legislation in 1996]: "Not only did NAPHS help to bring together key behavioral health organizations (including the American Managed Behavioral Healthcare Association, American Psychiatric Association, American Psychological Association, National Alliance for the Mentally Ill, National Mental Health Association), but for the first time a behavioral health coalition was able to enlist the support of important players from general health care (including the Federation of American Health Systems and the American Medical Association). Through the Coalition, NAPHS and its partners secured public endorsement of mental illness coverage by small business leaders that countered misperceptions held by many on Capitol Hill that coverage would be too costly or not valued by employers. The Coalition gathered the actu-

arial evidence that made the case for the affordability of parity."

—*Paul J. Fink, M.D.*  
*NAPHS president, 1996*

"In the space of a single year, our alliance with the American Hospital Association has added the considerable clout of the [American Hospital Association's] AHA's voice to a variety of priority NAPHS issues, such as Medicare reform and restraint/seclusion....We have also created a formal exchange of representatives between the AHA's Section for Psychiatric and Substance Abuse Services (SPSAS) and our Board of Trustees. The NAPHS/AHA partnership also bodes well for powerful discussions on the interface between behavioral and general healthcare—a critical topic for the millennium.

—*Tom Bender*  
*NAPHS president, 1999*

"As part of a two-year campaign (including a major study on the impact of the Balanced Budget Act), NAPHS was able to get Congress to recognize that psychiatric hospitals and units were severely hurt by BBA cuts. NAPHS

## Quotes and Perspective from NAPHS members throughout the years

was also able to get some financial relief through increased Continuous Improvement bonus payments in FY2001 and FY2002. Although not as much as needed, these dollars are an important step in the right direction. In addition, Congress passed NAPHS-backed legislation to establish a prospective payment system for psychiatric hospitals and units. This has been my top advocacy priority as NAPHS President. Prospective payment has great potential to significantly improve the Medicare payment system for inpatient psychiatric providers. With implementation set for October 1, 2002, there is much work to be done between now and then to develop an implementation plan. This will be a top association priority to ensure that the payment system that evolves is fair and equitable.

—*Tom Bender*  
*NAPHS president, 1999*

“Throughout the multi-year process of developing the [Medicare inpatient psychiatric prospective payment system] PPS, NAPHS has been a leader both out front and behind the scenes representing your concerns as behavioral healthcare providers. The development,

implementation, and ongoing refinement of PPS provide a model of the importance of NAPHS—and the importance of the grassroots involvement of every behavioral healthcare provider organization in NAPHS around issues that matter to them. In the years leading up to the final rule, NAPHS was able to articulate what it would take to create—and to build coalitions to win—a workable system. From the beginning, NAPHS was able to identify core principles necessary for any PPS that rang true with our partners (including the American Psychiatric Association, American Hospital Association, and Federation of American Hospitals). As a result, we have had a consistent message urging a simple-to-use system that takes into account the wide variations in the types of patients served. This principle-based logic has enabled NAPHS and its coalition partners to fight off attempts to superimpose a complex patient-classification system. These principles will continue to provide a solid framework for evaluating any future system refinements—particularly as CMS continues to study the feasibility of patient classification. In the final rule, CMS recognized and took action on all of the major

changes NAPHS and its partners had recommended (including an emergency room adjustment, recognition of additional comorbid conditions, and a separate adjuster for ECT). This success is due in large part to the grassroots advocacy of our members. From written comments on the proposed rule to personal lobbying with members of Congress, our members have provided the real-life examples to help explain how providers are impacted by regulatory decisions. Throughout this process, we have had the able support of the extremely knowledgeable NAPHS staff as well as our lobbyist consultant Mike Bromberg. NAPHS has known when—and how—to gather the data, studies, and case examples to demonstrate how payment-system reform impacts patient care.”

—*Debra Osteen*  
*NAPHS president, 2004*

“Working to ensure that people receive the right care, in the right setting, at the right time, providers know that partial hospitalization is an important part of a continuum of services. But access to partial hospitalization for Medicare recipients was severely threatened when the Centers for Medicare and Medicaid Services (CMS) proposed a 15% cut in the partial hospitalization per diem rate for 2007. NAPHS hired a consulting firm to analyze the CMS data used to determine the PHP payment rates. That analysis distinctly raised some specific points about the accuracy of the CMS cost calculation. In response to the study and major concerns raised by NAPHS and other organizations, CMS decided to substantially rescind partial hospitalization payment cuts in the final rule on the update on payment rates for the Hospital Outpatient Prospective Payment System (OPPS) issued in November 2006. The final rule reduces the per diem by only 5%. This change in a proposed regulation won back an estimated \$6 million to \$10 million for NAPHS members alone.”

—*Mark Covall*  
*NAPHS executive director*  
*2006 year-end report*

Quotes and Perspective from NAPHS members throughout the years

## ABOUT QUALITY/ STANDARDS

“I think during my term we effectively moved our relationship with JCAH (The Joint Commission) to another level. There was a lot of turmoil at the time, but our ability to influence the process of change [from the Consolidated Standards Manual to the Accreditation Manual for Hospitals] was good. As a first step in development of a long-range plan for how to deal with coming changes, we also had to grapple with some of the needs within the NAPPH for reorganization. We met with member hospital CEOs and began to realize how we would deal with membership on other than a case-by-case basis. It was the beginning of a transition from the old to the current structure.”

—*Mark A. Gould, M.D.*  
*NAPPH president, 1982*

“As a psychiatrist and a hospital CEO, quality issues have always been first and foremost in my thoughts. Quality—care that changes people’s lives for the better—is our ultimate mission as providers. And in 2005 there have been remarkable advances in the science of behavioral health that make it possible for us to offer more hope, more progress than at any time in history. As I’ve talked with NAPHS members

throughout the country, I know that each one of us wants to provide the best possible care for the children, adolescents, adults, and older adults who come to us for help. But I also know that it is sometimes frustrating to manage a hospital or other clinical service these days. The unintended consequences of conflicting or unfunded regulations and accreditation standards, the scarce dollars available for behavioral health care, the lack of access to alternative placements once people leave the hospital, lingering stigma, and a shrinking workforce are just some of the many system challenges we all face. Quality can exist only in an environment in which behavioral health is recognized, respected, and allocated resources with fairness and equity...and in an environment that allows for innovation and creativity. That’s why advocacy for behavioral health is so important both at the national level through organizations like NAPHS and at the grassroots level. Each and every one of us who is working in behavioral health care today has an opportunity—and a responsibility—to speak out. NAPHS makes it possible.”

—*Patricia R. Recupero, J.D., M.D.*  
*NAPHS president, 2005*

“The credibility of behavioral health has been elevated through our commitment to developing core measures. Our ability to carry out our commitment to developing useful measures has the potential to impact not only quality of care, but reimbursement and accreditation standards in the long run. Our work—and our members’ participation throughout the testing and implementation phases of the project—have positioned behavioral health to enter the era of outcomes discussions on the solid footing of consensus building between the public and private sectors and among all the various stakeholders.”

—*Mark Covall*  
*NAPHS executive director*  
*2006 year-end report*

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“Consumers and families are our customers—and our allies—in advocating for the resources that will be necessary to deliver quality behavioral health care. Their opinions and perceptions about treatment—and how well we deliver it—will have a profound

impact in the coming decades. The NAPHS Board recognizes the importance of listening to and working with consumers and families, and we will continue in the coming year to work with critical organizations—including the National Alliance for the Mentally Ill, the National Mental Health Association, and others toward our common goals.”

—*Tom Bender*  
*NAPHS president, 2000*

“As we head into the 2004 election year, the critical role of behavioral health advocacy—and of NAPHS leadership—is once again in the spotlight. The election process is a reminder...of how we need to continually keep the needs of our patients and communities in front of an ever-changing cast of characters at both the federal and state levels...of how forcefully we must make our case to be heard among the many voices...of the positive impact our efforts can ultimately have on improving care and improving lives.”

—*Dennis P. King*  
*NAPHS president, 2003*

## ABOUT CONSUMERS

Quotes and Perspective from NAPHS members throughout the years

## ABOUT CHANGE

In the midst of change, we must never forget:

*We are in the business of helping people.* People with psychiatric and addictive disorders face some of the toughest challenges imaginable. Their illnesses put them at risk for family crises, financial hardship, and turmoil at work or school. They are coming to us at a time when they are most vulnerable, and most in need of professional help. As providers, we must fight for adequate access, coverage, and funding to ensure that the help they need is there for them when they need it.

*There is strength in numbers.* All the noble goals that we each support will ultimately come to nothing without the ability to make our concerns heard. NAPHS understands and has set behavioral health unity as a fundamental strategic goal.

*Behavioral healthcare professionals MUST be at the table whenever change is considered.* No one organization alone can have the impact that a strong, effective, and credible industry voice can have.

*When you are an NAPHS member, you are not alone.* NAPHS is your industry voice. As a member myself, I know from experience that NAPHS is a unique source of information, networking, and advocacy savvy. I encourage you to become actively involved in the NAPHS agenda—which is your agenda.

—Jean P. Smith  
NAPHS president, 1997









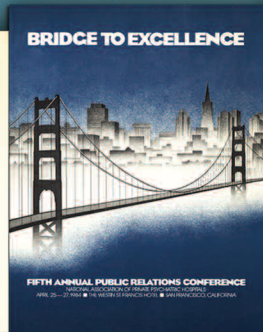
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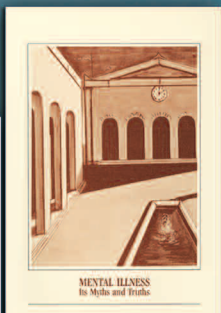
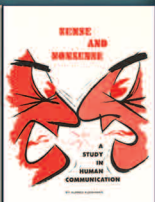
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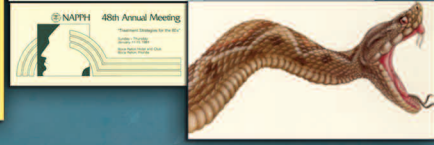
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