NAMI Concho Valley

National Alliance on Mental Illness

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July 2014
NAMI Concho Valley

*NO MEETINGS IN JULY**

*The first Thursday in July (our regular meeting time) is on July 3. Fourth of July events take place in San Angelo on both July 3 & 4.

Our next meeting is on August 7, 2014.

NAMI Concho Valley Appoints New Board Member

The NAMI Concho Valley Board of Directors met on June 16 for a regular board planning meeting. Lori Smithwick was appointed to the Board of Directors to fill a vacant position.

Sunset Commission Issues Brutal Report on Dept. of State Health Services

--by Emily DePrang, ***The Texas Observer****, June 18, 2014*

Next week, the Sunset Advisory Commission will meet to hear testimony regarding its scathing report on the Department of State Health Services (DSHS), one of the largest and most important state agencies. "Scathing" is a term that gets thrown around a lot but really ought to be reserved for dispatches like this one, released in May, which saves special condemnation for the department's many failures in running the state's public mental health system. "This experiment was well-intentioned," the report says, referring to the department as a whole, but DSHS "has struggled to address longstanding concerns, despite clear and repeated direction." Because of this, most of the Sunset staff recommendations don't break new ground but "reflect a need for the agency to simply do its job better."

While the report specifies nine areas for improvement, its authors note that this list is constrained by the resources of their review, not by any limit to the department's problems. They even suggest that by the time the Sunset review concludes next fall, future reports may question "continuation of DSHS as a standalone agency." The report goes beyond critical and gets existential.

Some of the recommendations are specific, like calls to combat fraud in the EMS industry, to better protect vital statistics information, and to reduce the department's regulatory role. But some are just damning pronouncements: "DSHS Has Not Provided the Leadership Needed to Best Manage the State's Public Health System;" and "DSHS' Numerous Advisory Committees Lack Strategic Purpose, Limiting Their Effectiveness and Wasting Resources."

Perhaps the broadest and most troubling part of the report is its wholesale indictment of the state public mental health system. That system has two parts: outpatient community-based treatment, and inpatient treatment through the state mental health hospitals. According to the report, both are broken.

The mental health hospital system, finds the Sunset Commission, is in a crisis that "Requires Action, Starting Now" because of understaffing, inadequate capacity, and aging, remote facilities that need more that $200 million in upgrades. These aren't new problems, the report notes: "Numerous plans and studies attempting to correct pervasive state hospital system issues have yielded few results, and the success of future plans is questionable… The State essentially operates the same mental health hospital system as during the last Sunset Advisory Commission review 15 years ago, despite years of planning and discussion."

At least one thing has changed in that period, but it hasn't helped matters. In recent years, Texas judges have sent more and more psychiatric patients to the hospitals for "competency restoration"—that is, to receive psychiatric treatment until they're mentally competent to stand trial—exacerbating bed shortages. The special challenge of these so-called "forensic commitments" is that if state hospitals are full, a person charged with a crime who needs inpatient treatment can be held in jail, untried and often untreated, until space opens up. Long waits have led to lawsuits. Under pressure from the courts, the Department of State Health Services has reduced the wait time for forensic patients from an average of 77 days to 17 days over the last few years, but at a price. More forensic beds means fewer civilian beds, and this year, forensic commitments exceeded civil ones for the first time. In other words, if you need treatment from a state mental health hospital, your odds of getting it are now better if you've committed a crime than if you haven't.

The outpatient mental health system is hardly better. The department "has not seized obvious opportunities to integrate… mental health and substance abuse services," the report found. Half a million Texans suffer from a severe mental illness, two million have a substance abuse problem, and there's plenty of overlap between those populations. But

screening, assessment and treatment systems for the two groups remain separate, which "allows people with complex, co-occurring mental health and substance abuse issues to more easily fall through the cracks." The department's funding structure for community mental health providers is "irrational," "byzantine," and "disconnected from performance," and despite collecting hundreds of data points, the department knows little about what programs work and why. These systems need "a complete re-evaluation and overhaul."

In short, the Department of State Health Services fails to plan strategically or address structural problems because it's "constantly operating in crisis management mode," says the Sunset staff report. Mercifully, the report's authors blame this on the department's overly ambitious mission rather than the department itself. "[F]ew, if any, state agencies have the breadth and scope of DSHS' responsibilities," they write. "...[I]n many ways DSHS was set up to be a 'jack of all trades, and a master of none.'" But this may be cold comfort if a future report recommends, as this one suggests, that state legislators dismantle the Department of State Health Services altogether.

Mental Health: Texas' Department of State Health Services is in a state of crisis and needs attention.

---Opinion, Houston Chronicle | June 13, 2014

Mental health care is on the tip of everyone's tongue after a recent spate of public shootings, but the conversation often seems to end at headlines and cable news chyrons. People across the nation need better access to affordable mental health care, but Texas specifically is in a state of crisis. A report on the Texas Department of State Health Services by the Sunset Advisory Commission has painted a picture of a department that is unfocused, underfunded and simply unable to do its job. Fixing this department should be at the top of the agenda for the state Legislature in 2015.

The Sunset Commission describes the DSHS as a "jack of all trades, and a master of none," but the statistics make it look more like a joker. While Texas' population has been booming, state mental health hospitals have seen their capacity decline by 19 percent between 2001 and 2013. These mental health hospitals suffer from a chronic shortage of qualified personnel. Meanwhile, the state has been unable to track performance at either state-operated or private contract facilities.

It is difficult to state exactly how DSHS needs to be changed when, as the Sunset report puts it, "several of the recommendations in this report simply reflect a need for the agency to simply do its job."

However, the Sunset report does offer some specific recommendations for improving the department, each of which should demand the attention of our state legislators.

Notably, the DSHS, which was created as an amalgam of several other departments, has yet to fully integrate all of its services. Meanwhile, the department is still burdened with regulatory functions that would fit better under the Texas Department of Licensing and Regulation. Is it really the DSHS's duty to regulate meat packing plants and massage therapists?

Yet while services suffer, more patients than ever are being referred from the criminal justice system. Our state is stuck in a cycle where people who don't receive needed mental health care end up in courts, which then in turn try to send them back to receive the mental health care that they couldn't get in the first place.

The Sunset report recommends better communication between our criminal courts and mental health service providers, but this conundrum would not exist if Texas simply had more capacity for mental health treatments. Without additional beds and qualified personnel, places like the Harris County jail end up serving as de facto mental health facilities. Jails are not hospitals, and staff simply aren't trained or equipped to treat mental health. Passing the mental health buck to the criminal justice system is an inefficient and ineffective use of taxpayer dollars.

Texas needs to spend those dollars where they can do the most good - and we likely need to spend more of them. Our state spends less than a third of the US average per capita on mental health, at $39 per person. In contrast, Louisiana spends $62, Alabama spends $78 and Mississippi spends $115.

We need to invest in what works rather than add another patch to a failing system. This means ensuring that people can get care where they live. Right now, there are no state mental health hospitals anywhere in the Houston area. Texas needs more capacity, and we need it near our big cities.

Our state can also do a better job of attracting qualified mental health personnel. We've raised salaries for psychiatric nursing assistants, but money isn't the option on the table. Creating more internship sites accredited by the American Psychological Association would bring more students to Texas. And allowing psychologists to write prescriptions, as they can in New Mexico and Louisiana, would make a better business climate for professionals.

If Texas doesn't invest in mental health services, we will end up paying for it in public safety costs and a suffering workforce. Mental health needs a bigger place on the legislative agenda, so that it takes up less space in newspaper headlines.

ADVOCATES FOR CHANGE

NAMI NATIONAL CONVENTION

Washington, DC----September 2-5, 2014

How to rebuild America's mental health system, in 5 big steps

---by Paul S Appelbaum, ***The Guardian***, May 29, 2014

A checklist of real, tangible ideas for President Obama to kick-start an integrated healthcare system that works. We've tried it before, and it is long past time to try again. (Yes, there will have to be a website.)

No genuine system of mental health care exists in the United States. This country's diagnosis and treatment of mental health problems are fragmented across a variety of providers and payers – and they are all too often unaffordable. If you think about it, the list of complications is almost endless:

- Families of loved ones with mental illness recount horror stories.
- Patients transitioning from inpatient to outpatient treatment often fall between the cracks.
- Mental health and general medical treatment are rarely coordinated.
- Substance abuse treatment usually takes place in an entirely different system altogether, with little coordination.
- Auxiliary interventions that are so essential to so many people with serious mental illnesses – supported housing, employment training, social skills training – are offered through a different set of agencies altogether ... if they are available at all.

Our mental health system is a non-system – and a dysfunctional non-system at that.

The evidence is everywhere that things have been getting worse – more and more Americans with mental illness are stranded in emergency rooms, for example, and simply for want of hospital beds. And that is in no small part because nobody has tried, in more than 50 years, to design a comprehensive mental health system for all Americans.

It's time to try again.

The last major rethinking of the system's flaws began, in 1955, with an act of Congress that resulted in the appointment of something called the Joint Commission on Mental Illness and Health. The commission's report, ***Action for Mental Health***, offered a vision of community-based mental health treatment: a new clinic would be created for every 50,000 persons – for prevention and early intervention services. People who once had to wait for their symptoms to become bad enough to go to the hospital before anything could be done? They would receive prompt care in their own communities and return quickly to life as usual – back at work, living with their families, seeing their friends.

Soon came the downsizing of large state hospitals and, in 1963, the passage of the Community Mental Health Act.

That legislation envisioned the creation of a network of mental health centers spanning the country, so that every citizen would have a single point of access. A person experiencing early symptoms of mental disorder could receive emergency, inpatient, partial hospitalization and outpatient care – all in the same place – while her family was educated about her disorder and how best they could help.

Unfortunately, fewer than half of the centers were ever built, and adequate support for their operation was never provided. As federal funding ceased, many of the existing centers shifted away from caring for the most seriously ill ... to serving paying customers. The promise of an effective community-based system of care remains unfulfilled.

Yet we are, half a century later, in a different world for which a different vision may be required – a vision of comprehensive care aimed at helping people with mental illness continue to be functioning members of society. But the essential notion of having an integrated system of healthcare – a system that recognizes the spectrum of needs associated with mental disorders, from family therapy to medication to supported housing – is too important to relinquish.

President Obama can kick-start planning for a genuine system of mental health care, by establishing a presidential commission to suggest realistic, re-inventive steps forward.

It could be a landmark moment, right now, today.

Here's what it might take:

1. **Create single points of access**
   - 24-hour hotline for patient evaluation
   - 24-hour hotline for patient treatment
   - 24-hour hotline for family information
   - A federal website for referral to resources---that works.

   --No one struggling with depression or trying to find help for a troubled child should have to spend weeks figuring out whom to call. In every area of the country, a single point of contact should be created to respond to questions and triage people in need of help to appropriate services. Today, much of this information can be provided online – think of the live chat boxes on many business and banking websites, or even the pop-up video for customer support on Amazon's Kindle Fire tablet.

2. **Coordinate services for patients and families**
   - Broad offerings for patients with mental disorders.
   - Facilitators for quick access to integrated care.

   --Today people are too often left to their own devices when it comes to assembling and monitoring the package of services they need. Too often people can't find what they're looking for. These services can range from medication to family therapy to rehabilitation services. Care coordinators should be available to shoulder those burdens – not patients and families.

3. **Develop an array of community-based services**
   - Individual and group psychotherapy
   - Marital and family therapy
   - Substance abuse treatment
   - Medication
   - Rehab and supported housing options.

   --People with mental disorders need more than just a pill – but that's often all that's available to them. Psychotherapy can help them understand and deal with the problems they face. Substance abuse commonly accompanies mental disorders – and must be addressed equally seriously. Many people with serious mental illnesses need assistance with job training and housing as critical parts of their recovery.

4. **Provide accessible crisis and inpatient services**
   - Today: the ER—and even jail
   - Tomorrow: timely crisis services, stability and outpatient treatment
   - Plus: inpatient care → quicker access to beds

   --Most mental health problems can be dealt with inside a community, but when emergencies arise it becomes essential to have access to crisis services, short-term respite beds and inpatient care. Low payments from insurers for mental health treatment have led to the closure of many inpatient units, resulting in a backlog of people in crisis being held in emergency rooms – sometimes for days or weeks.

5. **Build a stable funding stream**
   - Long term state budget commitments
   - Aggressive oversight of insurers' coverage decisions
   - Federal dollars to fill the gaps

   --Today, paying for mental health care is nobody's responsibility. Insurers pay as little as possible, often denying claims on flimsy grounds. States have cut more than $4bn from their mental health budgets in the last six years. The federal government directly contributes only a tiny amount to supporting mental health treatment beyond the coverage it provides through Medicare and Medicaid. A joint federal-state commitment is needed to funding the infrastructure of a care system, while insurers' feet are held to fire to make certain they live up their obligations under the Mental Health Parity Act.

In the 21st century, with our instantaneous electronic communications, it may be less important to house these kinds of services in a single site – but it's no less important to insure that they are all available.

A half-century of patchwork efforts to improve one or another aspect of the mental health system has resulted in abject failure. Unless we take a comprehensive approach, and mend the safety net that protects us all, we will fail again.

Let's get to work.

---Paul S Appelbaum is the Dollard Professor of Psychiatry, Medicine and Law at Columbia University, and a former president of the American Psychiatric Association.

Mental Health Reform Should Also Help Families

--by Kenneth Dudek, President and Executive Director, ***Fountain House***, in ***Huffington Post***, June 16, 2014.

Mental health reform has been in the air since the tragic 2012 mass shooting in Newtown, Connecticut. In that time, the nation has witnessed 74 more school shootings, including one last week. Justified or not, these crimes continue to fuel public discourse about our present mental health system. Many of these instances, including last month's mass killing in Isla Vista, California, highlight one glaring inadequacy: how difficult it is for families to get help for their loved ones experiencing a mental health crisis.

Two separate mental health reform bills are now on the table, and both have fallen prey to the same old mental health politics. The limited and inconclusive research on the efficacy of various proposed treatment approaches always brings the issue back to questions of ideology.

- Helping Families in Mental Health Crisis Act of 2013 was introduced by Congressman Tim Murphy (R-PA). Among its endorsers is the Treatment Advocacy Center, which most notably advocates for the expansion of court-ordered assisted outpatient treatment (in New York State, known as Kendra's Law) as the most humane and best solution to the social problems associated with serious mental illness.
- Strengthening Mental Health in our Communities Act of 2014, sponsored by Congressman Ron Barber (D-AZ), emphasizes ***Mental Health First Aid***, an educational program that teaches mental health response skills, and the expansion of community-based services, such as those funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Mental health advocates who embrace the second approach prize the right of an individual to make his or her own choices above all. But what if those choices result in the murder of innocent people? Continually repeating that the vast majority of people with serious mental illness don't commit violent crimes doesn't alleviate the suffering of the families of the victims or the perpetrators. These philosophical discussions, usually led by mental health policy makers, academics, or inside-the-Beltway advocates, are divorced from the real-life experience of many families with adult children with mental illness. Like the two Congressional bills, the families are stuck - helplessly watching their children follow a path of self-destruction.

The rights-first approach evolved from a very real need. By

the mid-20th century, more than 500,000 people with mental illness were languishing in state hospitals where they were isolated from their communities, often abused, neglected, and subjected to barbaric treatments or surgical procedures. Rights advocates fought for and won deinstitutionalization, a sweeping policy that came with the promise of the support and resources necessary for former patients to pursue fulfilling lives of their own choosing.

The Fountain House community works together to achieve that goal every day, but we do it from a position of respect-first, rather than rights-first. Respect doesn't mean leaving people to waste away and die in the street for the sake of preserving their right to do so. It means creating opportunities for people to build lives that matter to them and developing treatment plans beyond a one-size-fits-all approach. Some may think this is too nuanced to legislate, but as the president of an organization in which my life and the lives of all my staff workers are intertwined with hundreds of people living with serious mental illness every day, I'm telling you that we have to try harder.

Families deserve a better answer than the one mental health advocates are giving right now. More than 30 years ago, the National Alliance for Mental Illness (NAMI) was formed because families of people with serious mental illness were not getting the help they needed.

Today, little has changed. Why is that so?

Three innovative ways to address mental health issues

--by Valerie Strauss, ***Washington Post***, June 3, 2014

With every new traumatic shooting that rivets the nation's attention, mental health becomes a hot topic for debate for a short while before dying down until the next disaster. In an attempt to move the dialogue into action, the National Alliance on Mental Illness, or NAMI, and the Cigna Foundation hosted an all-day forum on Wednesday, June 4, at George Washington University titled "It's Time to Take Action: Innovative Community Approaches to Children's Mental Health." You can read the following post, which details steps that will move the mental health debate from dialogue to action. It was written by Mary Giliberti and Stuart Lustig. Giliberti is the executive director of the National Alliance on Mental Illness, and Lustig is the lead medical director for child and adolescent care for Cigna Behavioral Health and associate clinical professor at the University of California San Francisco in the Department of Psychiatry.

---By Mary Giliberti and Stuart Lustig:

Our nation has just witnessed another tragedy involving a young adult, with young adult victims. Facts often emerge slowly and it is important not to speculate about diagnoses through the news media; however, it seems clear in this case that mental illness is a factor—even though few people living with mental illness are violent.

To avoid tragedies, solutions are needed. One area of real promise is early intervention—before crises occur. Mental illnesses are diseases that strike early: the symptoms for approximately 50 percent of lifetime cases appear by age 14 and 75 percent by age 24. It can take as long as eight to 10 years to get people with mental health issues to get the treatment they need.

One in five children struggle with mental health conditions and suicide is the third leading cause of death for people ages 10 to 24. It's critical that we focus on children and youth who are vulnerable and may face delayed access to mental health treatment.

Despite the increase in public awareness of childhood mental health issues, stigma continues to exist as a barrier to care. During this delayed access, children are missing critical developmental milestones, experiencing school failures, social isolation, family distress, or, in particularly tragic cases, attempting or completing suicide. Families confronting mental illness often do not know where to turn for advice or struggle to find an appropriate and available mental health care provider.

However, amidst the turmoil, there is hope. Many successful, innovative approaches have emerged in pockets of local communities across the country. NAMI and Cigna have identified three key, no-nonsense, cost-effective innovations that should be examined for replication nationwide.

First, we need to ensure that mental health services are available to young people where they are every day – in schools. *B*ringing mental health prevention and early intervention into schools makes perfect sense. School-linked mental health programs make it possible for children and families to receive help in a familiar, non-stigmatized setting where professionals have an opportunity to really know and understand the children they serve. In addition, schools must know how to recognize signs and symptoms early and assist youth and families in getting appropriate help.

Second, addressing the mental health of children in primary care, including screenings, is key to ensuring that children with mental health needs are identified and linked with services. There are many barriers to early identification, intervention and care for young people with mental health conditions including a shortage of mental health services and providers. With the majority of children and youth in the regular care of pediatricians, conversations, as well as effective early identification and treatment should routinely take place in primary care settings with referral to specialty care.

Third, we need to promote intensive, youth-friendly mental health services that effectively engage young people. The National Institute of Mental Health has researched a package of services for youth focusing on employment and education along with family support and treatment. These intensive services get young people with serious mental health conditions on the right track. Mental health crisis services are also needed for those with the most serious conditions.

These solutions leverage what matters most to youth – relationships, school and work—while also recognizing the important role that families and schools play in the lives of children. It's time to take action to ensure a better future.

Mental Illness Is No Kentucky Derby

---By Dawn Brown, NAMI HelpLine Content and Development Specialist, May, 2014

The Kentucky Derby is called "The Most Exciting Two Minutes in Sports." It's attended and watched by over one hundred thousand people each year, and even if you weren't watching this past Saturday when it was run, you probably know at least a few facts about the derby. You almost certainly know it's a horse race and that there's a starting line and a finish line. You'd know that the race is run on a track. Everyone likely knows that the fastest horse and jockey crossing the finish line is the winner, and that there's a fair amount of betting on who will be the winner.

That's about all I know about the Kentucky Derby, but I do know a lot about mental illness and it's no Kentucky Derby. There is, however, a starting line. Sometimes the start is hard and fast when psychosis hits. Sometimes it starts like a slow moving fog that fills the brain. But, when mental illness starts everything changes and you're left running for your life.

Unlike the derby's racetrack at Churchill Downs, our track is never flat or level. The race cannot be run fast. There is no fast way to recover. It is a slow grind on an uneven ups and downs track with curves and blind spots. There are often multiple hospitalizations. Some people have periods of homelessness or are wrongfully jailed. Some of us lose friends to violence or suicide. Any one of these common catastrophes could derail a person's life.

Still every day, people living with mental illness and those that love them are winning. There is resilience. There is purpose and a future because we're not in it alone. It takes love and support from people like friends and family. It takes commitment from mental healthcare providers, non-profit and faith-based organizations. It takes support and resources from community mental health centers, supported housing, employment opportunities and politicians.

These things make us winners. Our wins and successful recoveries have a ripple effect which reaches far beyond our individual lives. Families are made whole. Communities benefit from another engaged person. Wellness wins. My son is a winner, so I'm a winner.

NAMI has an important role to play in recovery. NAMI is people, like you and me, willing to use our experience with mental illness to make a difference. Become involved with NAMI in your community through your NAMI Affiliate and NAMI State Organization. Locate yours at Find Your Local NAMI. Advocate for people affected by mental illness by becoming involved with NAMI Advocacy. Participate in NAMI education and support programs. NAMI provides opportunities and training so that we can come along beside people with encouragement and engage them in ways that transform lives. You can be part of the NAMI movement by becoming a member and NAMI leader yourself.

No, recovery's not a horse race. You don't win it alone, but when you join the efforts of thousands of others moving towards wellness you always win.

Why Asking Texas Drivers About Mental Illness is Dumb

--by Emily DePrang, ***The Texas Observer****, January 17, 2014*

Yesterday (January 16), the *Houston Chronicle* reported that the Texas driver's license application asks drivers whether they've been diagnosed with a psychiatric disorder. The question isn't new—the Department of Public Safety has asked since the 1970s. Nor has it gone unnoticed; state Rep. Garnet Coleman has been trying to have it removed for the last few legislative sessions. But it's an important story because, in several ways, it's about what happens when government and reality collide. (Spoiler: reality loses.)

First, the question is overly broad. It asks, specifically, whether an applicant has in the last two years been diagnosed with, hospitalized for, or is currently receiving treatment for a psychiatric disorder. It doesn't ask whether the disorder interferes with a person's ability to safely drive, which is a component of another question about medical conditions in general. By asking separately about medical conditions and psychiatric conditions, the question implies that psychiatric illnesses are not medical, which is a funny distinction to make about a problem effectively treated by a wide array of drugs. And by including all psychiatric disorders in the question's scope instead of conditions that might affect driving, it's uselessly inclusive.

Have you ever felt grumpy from caffeine withdrawal? According to the most recent Diagnostic and Statistical Manual of Mental Disorders, that's a diagnosable psychiatric problem. So are binge eating, sleepwalking and restless leg syndrome. Considering that a quarter of Americans will suffer a mental illness in a given year, the question assumes most drivers will lie.

Second, the question is illogical. A psychiatric condition that's being treated will usually be less symptomatic than an untreated one. For greater relevance, the question would ask whether a driver has been diagnosed with but declined treatment for a disorder. Or better, it would ask if someone has a mental illness of which they're unaware. While inquiring about that, Dateline Houston suggests the Department of Public Safety ask if an applicant texts while driving, tends to make terrible decisions, or has ever played Grand Theft Auto.

Third, the enforcement mechanism appears to rely on applicants to lie. Answering “yes” doesn’t disqualify a person, but it leads to more questions to determine whether someone’s psychiatric record should be examined by the Medical Advisory Board of the Department of State Health Services. That board comprises 13 doctors, none of whom are psychiatrists. Texas has about 18 million licensed drivers. And yet, after all the questions about medical history, a shaded box reminds applicants, “False information could also lead to criminal charges with penalties of a fine up to $4,000.00 and/or jail.”

To Disclose or Not to Disclose: Mental Illness at Work

--by David Sack, M.D., Psych Central, June 18, 2014

About half of the roughly 58 million Americans with mental illness are active in the workforce. Looking at the average company, you wouldn’t know it. Unless you work for an open-minded boss or a company that actively encourages people to come forward and get help, many workers keep their struggles with depression, anxiety, substance abuse and other issues silent for fear of losing their job, their credibility or opportunities to advance. Although nondisclosure is certainly understandable, there are risks and benefits to consider on both sides.

Safety in Silence

The majority of employees with mental illness exercise their right to remain silent (a right that ceases if you cannot safely and competently perform the basic requirements of your job). Why? In spite of growing awareness and anti-discrimination laws, the stigma of mental illness persists.

Most employers, like much of the public, still believe people with mental illness are dangerous, incompetent and untreatable, and become blind to their positive skills and attributes once a diagnosis is made public. Though they wouldn’t hesitate to accommodate a physical disability, such as confinement to a wheelchair or visual impairment, a survey by Shaw Trust showed that more than half of employers wouldn’t hire someone with a known mental disorder.

Although patently unfair and uninformed, the reality is you may face penalties for disclosure. In polls, people have reported being demoted, passed over for promotions and having job offers rescinded after disclosing a mental health disorder. Given these harsh realities, Bob Carolla, director of media relations for the National Alliance on Mental Illness, advises against disclosure to a manager whenever possible.

Rewards for the Brave of Heart

Just as some people feel empowered by keeping their mental health private, others find it liberating to be open with an employer. They take proactive steps to improve the situation for themselves and others and, in so doing, deliver a tough blow to the secrecy and shame that are prevalent among those with mental health issues. If they are rewarded with an employer who is supportive, disclosure can be highly therapeutic.

Another benefit of opening up: If you want to protect your legal right to any accommodations you might need under the Americans with Disabilities Act (ADA), you must disclose. The ADA requires employers to make reasonable accommodations for employees with disabilities. By staying silent, you run the risk of poor job performance being attributed to laziness or incompetence rather than a mental illness that can improve with treatment. If your employer terminates you, you have no redress. While only 14 percent of all charges filed under the ADA involve mental illness, you lose the possibility of protection if you choose not to disclose.

While many employers hold fast to old notions of mental illness, others recognize the incentives to encourage disclosure. Studies from the National Institute of Mental Health have shown that employers save money when they help valued employees get treatment. In addition to getting a more productive and loyal worker, they boost morale, reduce turnover and minimize their exposure to lawsuits. Most accommodations under the ADA, such as alterations in work schedules or job descriptions, allowing leave to see a therapist and training for supervisors, are inexpensive to implement (68 percent of all accommodations cost less than $500). Only by creating a supportive environment in which workers can be honest and get prompt treatment can disclosure be a win-win.

A Personal Choice

So should you tell your employer about your mental illness? The choice is yours, and should depend on the company you work for, the severity of your illness and your personal comfort level in sharing this information. Ask yourself: Does the company encourage flex time or offer employee assistance programs? Do other people in the company need similar accommodations? What is the personal toll of keeping your illness a secret?

If you decide to disclose, plan in advance what you will say and partner with your human resources department or an employee assistance program, if available, to negotiate any necessary accommodations. Ideally, you should disclose before serious problems arise that warrant termination. Be prepared to describe the skills and attributes that continue to qualify you for the job, as well as the limitations that may impact your performance. Have on hand a few resources your employer can refer to for more information about your condition.

If you decide not to disclose, make sure you get support elsewhere, whether through family, friends, a therapist or a support group. Monitor your symptoms, especially in times of stress, and follow through with your therapist’s recommendations for medications and other treatments.

Whether you disclose or not – and whether or not your employer supports you in managing your condition – it’s important to know that mental illness does not preclude career success. In fact, work can be central to restoring a sense of self-worth and stability to daily life. Many of the nation’s best and brightest have struggled with mental

illness and gone on to enjoy rewarding and productive lives. With the right supports in place, you can, too.

---David Sack, M.D., is board certified in psychiatry, addiction psychiatry and addiction medicine. He is CEO of Elements Behavioral Health, a network of mental health and addiction treatment centers.

Remembering Francis D. Bachman Jr.

January 15, 1921 - March 31, 2014

Francis D. Bachman Jr. died on Monday, March 31, 2014 after a brief illness. He was born on Jan. 25, 1921 in Mer Rouge, La., to Francis D. Bachman Sr. and Vera Bachman.

After serving in the U.S. Army during World War II, he met the love of his life, Bessie (Becky) E. Shepard, and they were married on Oct. 20, 1946, in Monroe, La. In 1950, Francis and Becky moved to San Angelo, Texas, where he was employed by a local accounting firm. He became a licensed CPA and served as a partner in the firm until his retirement in the mid 1990's. He was a deacon at First Baptist Church and was very devoted to his faithful following of Christ. He sang in the church choir and led the singing in his own Sunday school class for many years.

He was known by his family and friends for his sometimes amicable humor and antics. Francis was devoted to his own family and his wife's family and was considerate of other families as well. He will be dearly missed by his family and friends.

Francis is survived by his wife of 67 years, Becky, of San Angelo; his children, Ron and Margaret Bachman of Hurst, Dianne and Sam Robbins of Richardson, Rick and Deb Bachman of Fort Stockton and Rob Bachman of San Angelo; six grandchildren; and eight great-grandchildren.

Francis and Becky Bachman were charter members of NAMI Concho Valley; Francis was the long time Treasurer of the organization. He will be missed.

Family and friends may sign the online register book at www.johnsons-funeralhome.com

Mental Health and Crisis Services in the Concho Valley

Mobile Crisis Intervention Services – Suicide prevention & crisis intervention (24 hour hotline) **653-5933**

Mental Health Services (non-crisis)......................**658-7750**

Tom Green Co. M. H. Deputies.............................**655-8111**

Emergency-Police-Fire..**911**

West Texas Guidance & Counseling Center..........**944-2561**

NAMI Concho Valley

NEW MEMBERSHIP or RENEWAL FORM

All dues and donations are tax deductible (NAMI Concho Valley is a 501 c3 organization.) Membership includes annual dues to NAMI Concho Valley, NAMI Texas, and NAMI National, plus newsletters.

Date: ____________, 2014

Name: ____

____

Address: ____

________________________, State: ___________

Zip Code: ____________________-_________

Home Phone: (______) _______-__________

Work Phone: (______) _______-__________

Email: ________________________________

[ ] NEW [ ] RENEWAL

- ❑ Individual Dues.............................. **$35.00**
- ❑ Open Door Dues (Limited Income)............**3.00**

Donations:

- ❑ Contributor.................................. ... **50.00**
- ❑ Supporter..................................... **100.00**
- ❑ Other Donation ...._________
- ❑ Donation In Memory/Honor of __________________

____

Thanks! **TOTAL $**_____________

Make Checks payable to **NAMI Concho Valley**

Mail to: **Jackie Shannon, Membership Coordinator**
NAMI Concho Valley
6002 Equestrian Blvd.
San Angelo, TX 76904-9363

This newsletter is published by: ***NAMI Concho Valley, P. O. Box 62791, San Angelo, TX. 76906-2791***
Phone*: contact Alfred Hernandez at* ***(325) 949-7767***

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We are grateful to the MHMR Services for the Concho Valley for their ongoing support in the printing and mailing of our newsletters! We appreciate you!