The Concho Valley’s Voice on Mental Illness

March 2015
NAMI Concho Valley

DATE: Thursday March 5, 2014
TIME: 6:30 P.M. Support Group
7:30 P.M. – Program Meeting

PROGRAM: Depression, Bipolar Disorder, and Trauma

PLACE: MHMR Services for the Concho Valley
1501 W. Beauregard St. in Jack Ray Auditorium

6:30 P.M. SUPPORT GROUP

NAMI Concho Valley
March Meeting

NAMI Concho Valley will feature a program at 7:30 p.m.,
March 5, presented by Karen Horner, M.Ed, who will discuss
depression, bipolar disorder, and trauma situations

Mentally Ill?
Drink a Smoothie

The federal agencies supposed to help the mentally ill
are more concerned with the worried well.

–By E. FULLER TORREY And DORIS A. FULLER,

The nonpartisan Government Accountability Office this
week released a scathing report on the lack of leadership in
the Department of Health and Human Services for
coordinating federal efforts related to serious mental illness.
It described 112 separate programs in eight federal agencies
with little coordination. “The absence of high-level
coordination,” the GAO concluded, “hinders the federal
government’s ability to develop an overarching perspective
of its programs supporting and targeting individuals with
serious mental illness.” The report was especially critical of
the lack of any formal evaluation mechanism for the
majority of the programs, so there is no way to tell whether
they are working.

The main target of the report was the Substance Abuse
and Mental Health Services Administration, or SAMHSA, an
HHS agency that is required by its enabling legislation “to
promote coordination of programs relating to mental illness
throughout the federal government.” In 2003 President
George W. Bush’s Commission on Mental Health noted the
lack of coordination among federal programs. In response, a
Federal Executive Steering Committee for Mental Health,
led by HHS, was formed. This produced some improvement
in program coordination, as noted by the GAO in 2008. But,
astonishingly, the Steering Committee hasn’t met since
2009.

Not coincidentally, the new director of SAMHSA, Pam Hyde,
assumed her position in November 2009. A lawyer by
training, Ms. Hyde has made clear that SAMHSA’s mission
is to be mental health, not mental illness. Incredibly,
“Leading Change: A Plan for SAMHSA’s Roles and
Actions 2011-2014” didn’t include a single mention of
schizophrenia or bipolar disorder, despite running more
than 41,800 words.

Ms. Hyde promoted a social worker to be the director of the
agency’s Center for Mental Health Services, a center that
doesn’t include a single psychiatrist. There is only one
psychiatrist among all of SAMHSA’s 570 employees and her
expertise is in substance abuse, not serious mental illness.
Thus it is not surprising that the GAO notes that
“coordination related to serious mental illness has been
largely absent across the federal government.”

Meanwhile, problems related to serious mental illness have
continued to get worse. Such individuals comprise at least
one-third of the homeless population. And according to our
analysis of data from the Justice Department, American
Correctional Association and the American Jail Association,
there are now 10 times more people with serious mental
illness in U.S. jails and prisons than in state mental
hospitals. Individuals with untreated serious mental illness
are responsible for 10% of all homicides in the U.S. and
approximately half of all mass killings.

And what has been SAMHSA’s response? In September the
agency sponsored a “National Wellness Week” during which
it suggested that drinking fruit smoothies and line dancing
would achieve wellness. And during last month’s “historic”
East Coast snowstorm, SAMHSA opened four hotlines for
individuals worried about the storm.

The GAO report was prepared after congressional hearings
that culminated with Pennsylvania Rep. Tim Murphy’s
**New GAO Report on Mental Health Calls for Better Federal Coordination on Serious Mental Illness: NAMI Agrees**

The Government Accountability Office (GAO), a nonpartisan agency that reviews and provides oversight over federal programs, has issued a report emphasizing lack of coordination at the leadership level in the administration of federal programs for children, youth and adults with serious mental illness. The report was conducted at the request of Representatives Tim Murphy, R-Pa., and Diane DeGette, D-Colo., the Chair and Ranking Member of the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce. NAMI is grateful to Representatives Murphy and DeGette for their leadership and commitment to improving the lives of people with serious mental illness and their families.

The GAO’s report concludes that there has been poor coordination among the eight agencies and 112 federal programs that provide services to people with mental illness. The report also documents shortcomings in the evaluation of programs serving people with serious mental illness, contributing to the overall lack of information about who these programs serve or what outcomes these services achieve.

**Lack of Coordination**

The report decries the lack of coordination at the leadership level among different federal agencies. It notes that a Federal Executive Steering Committee for Mental Health, established in 2003 to coordinate services across federal agencies, has not met since 2009. The report further states that the Substance Abuse and Mental Health Services Administration (SAMHSA) is charged with promoting coordination across the federal government on mental illness and concludes that such coordination is not effectively occurring. The report does not note that SAMHSA coordinates the Behavioral Health Coordinating Committee (BHCC) within the U.S. Department of Health and Human Services (HHS) and the BHCC has recently formed a subcommittee for serious mental illness to better coordinate efforts on serious mental illness within HHS.

The lack of coordination also applies to individual agencies responsible for administering multiple programs. For example, the National Institutes of Health (NIH) has multiple institutes, including the National Institute of Mental Health (NIMH) that conduct research relevant to serious mental illness. According to the report, the NIH categorizes all of its mental health programs under the category “Scientific Research” yet is unable to state how much funding in total goes into research on serious mental illness. Recognizing this as a problem, NIMH is currently developing a method to categorize all research grants related to serious mental illness across all institutes.

**Inadequate Evaluations**

The GAO’s report also reveals that a majority of federal programs targeted for people with serious mental illness have not been evaluated for effectiveness. Only 9 of the 30 programs have completed program evaluations, 7 of them by SAMHSA. Particularly noteworthy is that none of the 8 programs administered by the U.S. Department of Veterans Affairs (VA) have completed program evaluations. This is troubling because without such an evaluation, it is difficult to assess whether the services provided by these programs are effective.

Lack of coordination and lack of accountability in the provision of services to people with serious mental illness are longstanding problems. In 2009, NAMI issued a report assessing the performance of state mental health agencies in providing services to serious mental illness. In that report, we emphasized that many states were unable to provide even basic information about their mental health services. These states did not collect data on specific services provided, who the services were provided to, or what outcomes were achieved through services provided.

In recent years, SAMHSA has worked to improve data reporting by states through its Uniform Reporting System (URS). However, reporting by states is still voluntary, even though all states receive federal funds through the Mental Health Services Block Grant. And, the criteria used by states to report data are not uniform, making it very difficult to compare performance across states or to assess whether public dollars are being spent wisely and appropriately.

**Exclusion of Programs administered by CMS**

One limitation of the GAO’s report is that it did not examine programs administered by the Centers for Medicare and Medicaid Services (CMS), the agency that administers the Medicare, Medicaid and Children’s Health Insurance Program (CHIP) programs. As noted in the GAO’s report, Medicaid is the most significant source of funding for mental health services. Medicare is also an important source of funding as is CHIP for children and adolescents with serious mental health conditions.

Medicaid in particular is more than simply a source of payment for services. The structure of the Medicaid program as well as the use of Medicaid options and waivers has much to do with shaping mental health services, particularly in the community. Despite this, it is very difficult to find specific information about what mental health services are paid for.
through Medicaid and what results are achieved through these services because CMS does not collect this data. NAMI urges additional examination of the Medicaid program with respect to coordination and evaluation to benefit people with serious mental illnesses and their families.

NAMI’s Recommendations

At a time in which payment for health care and mental health care services are increasingly being linked to performance, services to people with serious mental illness are at risk of lagging even further behind than they are today. This is in no small part due to poor coordination and data collection on services and outcomes. Severe gaps in availability of quality mental health services and supports have devastating consequences for individuals with serious mental illness, their families, and American society. The evidence of this public health crisis can be seen in the growing ranks of youth and adults with mental illness who are dropping out of school, experiencing homelessness, incarcerated in jails and prisons, or spending hours or days in emergency rooms seeking help that is too often not available. We know that we can do better.

NAMI recommends the following steps for improving federal coordination and accountability on services for people with serious mental illness.

1. Create a high level position within the federal government responsible for coordinating federal programs serving people with serious mental illness, developing evaluation criteria and outcome measures, and holding relevant federal agencies responsible for achieving relevant outcomes. More effective coordination between programs responsible for research, services, and financing mental health services is particularly important. Coordination must be directed at achieving outcomes.

2. Identify as a priority for federal funding people with serious mental illness whose lives have been significantly impacted by their illness and the families of such individuals. Federal policies should prioritize both services to prevent adverse outcomes associated with serious mental illness such as homelessness and criminal justice involvement and services designed to facilitate the early identification of psychosis, recovery, education and employment.

3. Conduct a thorough review of the Medicaid and Medicare programs to determine what resources are spent on serious mental illness and whether these programs are measuring and achieving positive outcomes for those being served.

See the new websites for NAMI and NAMI Texas

www.NAMI.org
www.namitexas.org

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USA Today Blazes a Trail for Mental Health Care Reform

---By Bob Carolla, NAMI, | Feb. 05, 2015

Thank you USA Today.

It’s rare that a national publication devotes a series about mental illness over the course of a year. But that’s exactly what USA Today did. In 11 installments, the newspaper published the series The Cost of Not Caring: The Financial and Human Toll for Neglecting the Mentally Ill.

The paper’s in-depth commitment to the topic has made an important contribution to national dialogue about mental illness—an issue that too often is neglected or subject to stigma. From how mental illness is subject to discrimination, to comedians using stand-up as education and therapy, to medical breakthroughs, the breadth and scope of content is vast. NAMI considers the series one of the most significant developments for mental health in 2014.

As the nation’s largest newspaper, with a circulation of 3.3 million people, it raised awareness like few media outlets have ever done.

“Many people that do not have personal experience with mental illness and our mental health system have said they had no idea regarding the lack of help, the stigma and the many that end up incarcerated,” wrote one NAMI California member.

“It was packed full of important newsworthy information to increase the general public’s awareness of the plight of the mentally ill,” said a NAMI Florida member.

NAMI worked closely with USA Today on the series, providing research assistance and helping to find individuals and families affected by specific issues so that personal stories could educate readers. NAMI state and local leaders circulated the stories by email or social media to their members—as well as to legislators, law enforcement and others in their communities.

On NAMI’s Facebook page the stories were shared an average of 1,600 times and had 2,200 likes. The buzz was considerable, help to energize conversations and advocacy at all levels.

The series was journalism at its best—and a public service.

Links to each story can still be circulated individually or as a complete series (See below). Send them to friends, advocates, policymakers and others. Encourage them to read the truth about the mental health care system.

If news media in your community have not published or
broadcast a series about mental health issues consider sharing the USA Today series with their editors or reporters as a model for the kind of public service they too can perform.

- **Cost of not caring: Nowhere to go May 12, 2014**
- **Cost of not caring: Stigma set in stone June 26, 2014**
- **Mental illness cases swamp criminal justice system July 21, 2014**
- **Mental Disorders Keep Thousands of Homeless on the Streets August 8, 2014**
- **40,000 suicides annually, yet America simply shrugs Oct. 10, 2014**
- **The Fortunate Mother: Caring for a son with schizophrenia Nov. 16, 2014**
- **Substance abuse treatment often impossible to find Dec. 19, 2014**
- **Solutions to woes of mentally ill exist but aren’t used Dec. 22, 2014**
- **Early intervention could change nature of schizophrenia Dec. 31, 2014**

**After years of spending cuts to mental health programs, lawmakers have begun to boost funding for the most effective approaches**


Horrible violence committed by people who are mentally ill has reignited state policy debates over gun control. But it also, much less visibly, has been the catalyst behind concerted action on another front: mental health care.

Over the past two legislative sessions, at least 36 state legislatures have increased general fund appropriations for inpatient and outpatient mental health care for children, adolescents and adults. And nearly every state has enacted new laws in areas ranging from jail diversion strategies to school-based behavioral health services to programs aimed at reducing the stigma of mental illness. Thirty state policy initiatives enacted in 2013 received the gold star "best practices" designation by the National Alliance on Mental Illness.

From the mass killings at Sandy Hook Elementary School to the most recent shootings at Florida State, the gunmen had severe mental disorders that went unnoticed, untreated or unreported.

The Sandy Hook tragedy in December 2012, in particular, "opened up the eyes of governors and state legislators around the country that mental health has been cut enough," says Andrew Sperling, director of legislative advocacy with the National Alliance on Mental Illness. "We’ve seen largely bipartisan agreement that there are gaps in the public mental health system, and recognition that cutting mental health care has severe downstream consequences."

Former Colorado Representative Cheri Gerou (R), who served on the Joint Budget Committee, agrees. "I think it’s clear that we haven’t done enough, and we’re coming to understand the value of better approaches to prevention, intervention and treatment," she says. She supported a 13.5 percent increase in the general fund appropriation for mental health services, to "make Colorado a healthier state," she says.

**Up From Years of Cuts**

Sperling and others are quick to point out that recent funding increases are dwarfed by the $4.35 billion reduction in mental health care budgets that states made collectively between 2008 and 2012.

The Texas Legislature, for example, boosted mental health spending in the 2013-15 budget by more than $250 million, or about 15 percent—the largest such increase in the state’s history. But "even with the new money," says Texas Representative Garnet Coleman (D), a champion of mental healthcare reform, "our per capita funding for mental health is below what it was in 1999, and we’ve slipped from 43rd to 48th in the nation."

Coleman says that mental health spending in Texas "really began to get whacked every year, starting in 2003. We were cutting programs and services even when we didn't need to."

Coleman laments the fact that Texas is among the states that declined to opt into Medicaid expansion—which would have increased mental health care funding. "opened up the eyes of governors and state legislators around the country that mental health has been cut enough," she says. Andrew Sperling, director of legislative advocacy with the National Alliance on Mental Illness. "We’ve seen largely bipartisan agreement that there are gaps in the public mental health system, and recognition that cutting mental health care has severe downstream consequences."

**Connecting the Dots**

Although shootings spurred some legislative action on gun reform and mental health, there’s little independent research on the relationship between gun violence and mental health. Certain psychiatric illnesses have been linked to an increased risk for violence, but a compelling body of research suggests that the vast majority of people with mental disorders do not commit violent acts. People with mental illness, in fact, are actually more likely to be the victims of violent crime than the perpetrators.

Coleman, for one, decries the extent to which mental illness and gun violence have been linked—a connection that runs the risk of further stigmatizing and deterring people from seeking help for fear they will be viewed as deranged and violent, he says.
A recent report by Columbia University’s 2x2 Project, which focuses on public health issues, noted a 2013 Gallup poll showing a majority of Americans now believe the biggest cause of gun violence is not easy access to guns, but the failure of the mental health system to identify individuals who pose danger to others.

"The connection between mental illness and guns has crowded out the issue of gun control," authors of the report wrote. "Although there are many reasons to invest more resources in our mental health system, there is little evidence that focusing on mental health screening—especially at the expense of gun control—will prevent shootings."

Coleman agrees. "This is politics, pure and simple—not policy," he says. "When increased spending on mental health doesn't lead to a reduction in gun violence, I think we're going to see a lot of pressure to retrench."

**Comprehensive Packages**

Senator Charles Schwertner (R), who chairs the Texas Senate's Committee on Health and Human Services, says that although the growing alarm over incidents like Sandy Hook played a role in legislators' decision to increase mental health spending, "the things we’re funding are not tailored just to preventing gun violence." Targets for funding include peer-support groups for veterans, crisis intervention, reducing waiting lists, creating alternatives to incarceration, expanding community mental health centers, and developing supportive housing and employment. "It’s a really transformative package," he says.

In the wake of the Sandy Hook shootings, Connecticut legislators in the spring of 2013 also approved a comprehensive package of bills weaving together mental health, school safety and gun control. The new laws target assault weapons but also include a wide range of mental health care initiatives focused on early identification and intervention and on mental health literacy.

The package also created a new statewide Children's Mental Health Task Force and broader public information campaigns, mandatory training for teachers and other school employees in how to spot and report signs of mental disorders in children, and a major study of incarcerated youth with mental health problems.

The four other states that tightened gun laws—Colorado, Delaware, Maryland and New York—also made background checks mandatory and placed stricter limits on assault weapons and high capacity magazines. In addition, Arkansas, New York and Tennessee passed "duty to warn" laws, requiring mental health professionals to notify law enforcement officials about patients they believe might be a danger to society.

**New Policies and Practices**

In its recent report on mental health legislation enacted in 2013, the National Alliance on Mental Illness grouped state initiatives into a number of categories and identified notable efforts in each category:

**Mental Health System Improvement.** Colorado lawmakers allocated $18.5 million to create a single, statewide mental health crisis hotline, establish five around-the-clock crisis centers, increase the number of psychiatric beds, and develop housing alternatives for people with mental illnesses. Oregon legislators appropriated $67 million to expand psychiatric residential treatment programs and promote children’s mental health. The California Legislature earmarked $143 million to add hundreds of new crisis and triage positions to the mental health workforce. And in Utah, lawmakers passed a new law aimed at integrating programs that address mental health, physical health and substance abuse.

**School-based Programs and Services.** Texas now requires training for K12 teachers and staff to recognize and respond to signs of mental health disorders in students. Utah requires school districts to offer annual seminars to parents on mental health, including depression and suicide prevention. Maryland, Minnesota and Rhode Island passed initiatives aimed at strengthening the link between schools and behavioral health programs.

**Suicide Prevention.** Kentucky established mandatory training requirements in suicide assessment and treatment for social workers, family therapists, professional counselors, psychologists and occupational therapists. Alaska, Oklahoma, Utah and Washington also approved new funding for suicide prevention.

**Criminal Justice.** Following the lead of a dozen or so other states, Arizona laid the groundwork for creating special courts for defendants with mental illnesses. Missouri created a veterans' treatment court to handle cases involving substance abuse or mental illness among current or former military personnel. South Dakota will allow judges to consider treatment options when imposing a sentence if a defendant who is a veteran or military service member pleads guilty or no contest. Montana revised its probation and parole system to work more effectively with prisoners who have a serious mental illness. Minnesota established a working group to examine juvenile justice and mental health. Texas will require local mental health authorities to create jail/diversion strategies that shift people with serious mental illness out of the criminal justice system and into treatment.

**Community Mental Health.** Pennsylvania has earmarked funding for community-based programs that integrate preventive care, disease management, behavioral health and pharmacy services. Texas and Minnesota approved initiatives aimed at broadening choices and increasing access to housing and employment opportunities for people who are mentally ill. Michigan allocated funds for comprehensive, home-based mental health services and a pilot program for high-intensity care management.

**Telemedicine.** Idaho, Indiana and Utah approved legislation allowing the delivery of mental health services via two-way video and other communication technology. The goal is to increase access to specialized mental health care in rural areas, address workforce shortages and integrate physical and mental health care.

While lauding these and other efforts on the part of states, the National Alliance on Mental Illness report emphasized
that it will take strong and sustained efforts in coming years to rebuild public mental health systems "to provide children, youth and adults with the mental health care they need to stabilize, recover and live healthy lives," the report concluded.

**Mental Health First Aid: A New Grassroots Strategy**

Few people know how to help someone who is developing a mental illness and even fewer know where to turn when such illnesses result in a crisis. That's the idea behind Mental Health First Aid, which aims to equip adults and young people with skills to recognize, manage and prevent mental illness.

Designed along the lines of traditional first aid and CPR courses, the first aid curriculum comes with custom features to adapt to all kinds of audiences—from teachers, ministers and child welfare workers to law enforcement officials and emergency first responders.

A growing network of certified instructors—currently 4,800 in all 50 states—provides the small group, eight-hour training that includes lessons, roleplaying and other exercises, and a range of informational material. The training costs $50 to $75, but is available free of charge in many cases.

Since 2008, more than 70,000 Americans have undergone training, says Betsy Schwartz, vice president of public education and strategic initiatives at the National Council for Behavioral Health. That number is expected to increase significantly over the next few years because of growing support from state policymakers, she says. As of mid-2014, 12 states had appropriated funds to grow the network of certified instructors and/or pick up the tab for teachers, school counselors, police officers and certain other groups to receive the training.

That's important, says George DelGrosso, CEO of the Colorado Behavioral Healthcare Council, because until now, the program in his state had been piecemeal, relying largely on donations and on the efforts of cash-strapped community mental health centers. "Now we have the funds to do it right," he says.

DelGrosso says when he met with members of the legislature's Joint Budget Committee last spring, he sensed "a strong commitment to doing a better job of identifying and helping people suffering from depression, substance abuse and other problems at an earlier stage. The focus was on what we can do to empower people, and help families and communities heal."

One of the things that former Representative Cheri Gerou (R) says appealed to her was the ripple effect of a program like Mental Health First Aid. "Once you can help someone cope better and live a better life, it makes life better for everyone around them," Gerou says.

The committee approved $1 million in support for the first aid training throughout Colorado over the next two years. Other states that have put money on the table are Arizona, Connecticut, Illinois, Indiana, Maryland, Michigan, Minnesota, Nebraska, New York, Texas and Washington.

Mental Health First Aid was developed by a husband/wife team of mental health professionals in Australia in the mid-2000s, and to date has been replicated in the U.K., Canada, Finland, China, Singapore and 20 other countries.

A growing body of research suggests that the training is effective in several areas: increasing assistance to those in need, including establishing connections to professional help; reducing misinformation and stigmatizing attitudes; and decreasing the social isolation of those living with mental illness.

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**Where Are the Mental-Health Providers?**

*As more patients seek help, advocates scramble to expand providers’ ranks*


Millions of Americans with mental illness are hearing a loud and clear message: Get help. There’s still one question: Who is going to treat them?

The shortage of mental-health providers in the U.S. has long been considered a significant problem. But it is becoming more acute as people are encouraged to seek treatment, or find they are able to afford it for the first time as a result of new federal requirements that guarantee mental-health coverage in insurance plans.

That’s prompting a sea change in attitudes among mental-health advocates, who are starting to look at solutions that are broader than just training more psychiatrists.

**Losing Ground**

Some 96.5 million Americans were living in areas with shortages of mental-health providers as of September 2014, according to an assessment by the Health Resources and Services Administration, a unit of the Department of Health and Human Services. That number is up from around 91 million in 2012.

Explanations for the shortage of psychiatrists include the long pipeline for training them, as well as low pay and high turnover for some positions. The attempted solutions have often mirrored proposals for addressing the national shortage of primary-care physicians—and have had few successes in making a dent in the problem.

There has been no increase in federally funded residency slots to train physicians, despite provider groups pushing hard for this for more than 15 years. Federal payments to incentivize people to work in areas that find it particularly hard to attract physicians, meanwhile, have succeeded in alleviating some of the most acute shortages, but have done little to address the broad shortage that persists nationwide.

The result is a growing acceptance that psychiatrists aren’t
the only acceptable mental-health providers, even from groups that have long resisted this.

“If you’re starting to feel unwell, you don’t go straightaway to an oncologist or a surgeon,” says Debbie Plotnick, senior director of state policy for Mental Health America, an advocacy group. “We need to educate the public there are more than just psychiatrists.”

Team Effort

Even the American Psychiatric Association has warmed to its physician members’ working more closely with nurse practitioners and physician assistants, after a long history of protectiveness over its members’ powers. The organization last year released a commissioned report seen as a major shift by many, including Ms. Plotnick. The report called for team-based care for people with mental illness and substance-abuse disorders.

“The roles are defined. Everyone is treating to outcome and remission,” says Sam Muszynski, the psychiatric association’s director of health-care systems and financing. “There are just treatment protocols that need to be followed.” He notes that under the team model, the physicians remain in charge, supervising other medically trained providers.

California community-health centers are also gaining acclaim for their efforts to merge primary-care and behavioral-health services under one roof, which often ensures that many aspects of mental health can be addressed by providers other than psychiatrists.

Help From Technology

Health-care officials also hope that technology can provide assistance in relieving the shortage.

Robert Bosch Healthcare Systems Inc. says it has developed a device that providers can use to monitor patients with bipolar disorder and major depression, to make sure they are managing their illness through medication and behavioral therapy.

The device, based on technology used for people with heart disease and diabetes, uses branching logic to ask patients a series of questions about their symptoms in a five-minute daily session. It then offers guidance on what they should be doing in response. The answers are reviewed by a care manager, usually hired by an insurer, who flags any need for further intervention.

A Journal of Mental Health study published last year of 38 users of such a device found an 82% decrease in hospital admissions and 75% decrease in emergency-room visits, with participants reporting improvements in quality of life as well.

Ms. Radnofsky is a Wall Street Journal reporter in Washington. She can be reached at louise.radnofsky@wsj.com.

Recap: The State of the Union in Mental Health and Addiction

---February 10, 2015 | The Kennedy Forum

Last Tuesday, Patrick J. Kennedy and former Surgeon General David Satcher announced a groundbreaking new alliance and released new public opinion data that outlines how Americans feel about mental health and addiction today. Kennedy and Dr. Satcher are teaming up to create the Kennedy Center for Mental Health Policy and Research, which will be housed at the Satcher Health Leadership Institute at the Morehouse School of Medicine in Atlanta.

The Center will focus attention on a few key areas, including:

- Quality, with a focus on provider accountability, outcomes, and the need to set clear and achievable standards that all providers can adopt and use.
- Innovation, with a focus on cutting-edge technology, ongoing research, and leveraging the promise of big data.
- Equity, with a redoubling of efforts to end disparities, fully implement parity, and support justice system reforms.
- Integration, with an emphasis on caring for the whole person, and ensuring that all Americans can get a “checkup from the neck up.”

The announcement of the Center comes as 71% of Americans are calling for “significant” or “radical” changes in the way mental health and addiction are treated. In addition, a majority of survey respondents highlighted two key areas of focus for reform: “Improving quality of care for people with mental health conditions” and “making sure people with mental health conditions have access to the care they need regardless of where they live, their ethnicity, or their background.”

During a discussion moderated by Ceci Connolly, Kennedy and Dr. Satcher challenged businesses, insurers, government officials, and the mental health and addictions community to demand the changes highlighted in the survey, one of which is ensuring that mental health and physical health are treated equally.

“Historically, we have separated the treatment of our mental health and our overall health — to our detriment,” remarked Kennedy during the event. “We stand on the doorstep to make progress in advancing the work started by JFK over 50 years ago.”

For more highlights from the event, and to join the discussion, follow #mentalhealthsotu on Twitter and like The Kennedy Forum on Facebook.
Congressional Briefing Details Obstacles Created by the HIPAA Privacy Rule

(Feb. 12, 2015) The hurdles raised by the HIPAA Privacy Rule were detailed today by experts and family members at a Congressional briefing on the HIPAA privacy rule.

The two-decade-old privacy law under the Health Insurance Portability and Accountability Act (HIPAA) was created in part to protect patients' information, but it also can reduce the quality of care that individuals with untreated severe mental illness receive.

"Interpreting the privacy rule to keep family members and caregivers in the dark about loved ones in psychiatric crisis is a common misuse of HIPAA," said Doris A. Fuller, executive director of the Treatment Advocacy Center. "We need to make it easier for families to be involved when individuals are too ill to provide critical health information or to make informed decisions about their treatment needs.

"The way that HIPAA has been interpreted has prevented communication with the very people who have a deep and often lifelong relationship with the patient and who will be responsible for managing or providing care in the community," said Dr. Morse, MD, MPA.

"We must strive to make HIPAA clearer to providers, patients, and loved ones," said Congresswoman Eddie Bernice Johnson. "Second, we must work to remove the barriers that parents and caregivers of individuals with serious mental illness (SMI) face when seeking treatment for their loved ones."

Panelists cited the Helping Families in Mental Health Crisis Act as one solution. The bill would make it absolutely clear that medical professionals are permitted to listen to information that family or friends have about an individual’s medical condition or prior treatment history. Too many providers cite HIPAA liability as to why they refuse to talk with family members or receive any medical information.

"Murphy's bill would clarify HIPAA and help hurting people like my son and my family," said Kathy Harkey, mother of a son who died after struggling with severe mental illness. "No one should have to suffer as we have. No one should have to die from a treatable mental illness."

The briefing was hosted by the Treatment Advocacy Center at the invitation of Representatives Eddie Bernice Johnson (D-Texas) and Tim Murphy (R-PA).

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.

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[ ] NEW [ ] RENEWAL

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Make Checks payable to NAMI Concho Valley

Mail to: Jackie Shannon, Membership Coordinator

NAMI Concho Valley

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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

We are grateful to MHMR for distribution of the newsletter.

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NAMI Concho Valley Newsletter

March 2015

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 Counseling & Guidance Center…………..944-2561