

## Hearing with Michigan Mental Health Commission

### Testimony

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In light of recent events at the Navy Yard in Washington, it seems especially poignant to be talking about mental health and ways we can address need in Michigan today.

As I was driving home last night, listening to the radio, I heard stories about Aaron Alexis, the gunman who shot 12 people in a Washington Navy Yard. How there was a host of warning signs that the Navy should have picked up on. How this gunman had a history of mental health concerns. This was presented as very dangerous, something that, had it been recognized sooner, could have prevented a terrible tragedy.

Immediately following the story of the Navy gunman was a piece about Seattle, WA and how "unstable people" have made downtown "jittery." There was talk of a schizophrenic man stabbing someone, people's personalities changing with the time of day, drug use. In all these news stories, mental illness is presented as synonymous with violence and danger to "normal" people.

Harvard Health Publications published a study which found no significant difference between those with mental illness committing acts of violence compared with people from the same neighborhood; the only increase was when substance abuse was included. The New York Times, in a December 2012 article reported less than 4% of violent acts were committed by those with mental health concerns. Research consistently finds no significant connection between mental health and violence but popular news and entertainment media continue to connect the two without regard, when in fact those with mental illness are far more likely to be victims of violence than perpetrators.

I currently serve as the Director of the Inner City Clubhouse, under auspice agency Detroit Central City CMH. The Clubhouse model is recovery focused, which is somewhat revolutionary in the world of mental health. It was (and still is) assumed that those suffering from a severe and persistent mental illness would never get better or be able to function in society. Clubhouse is built to engage members and have members work alongside staff in organizational functions, to be treated like people with problems, a label I think each person in this room could sometimes claim. Our model is built to minimize shame and stigma in our members; if those with issues can be successful and independent, even with supports, society benefits.

As a mental health professional working here in Detroit, I see the difficulties my members face on a daily basis. What goes unnoticed are those people who can't or won't seek help due to stigma. Stigma is defined as signs of social unacceptability; shame and disgrace are attached to the dictionary definition. My members speak often of the shame they felt telling others their diagnosis, the shame of being

honest about what was happening in their head, the disgrace of walking into a community mental health building and knowing others were seeing them enter.

Shame researcher Berné Brown identified shame as being harmful to peoples' ability to change; feeling shame actually *prevents* those who need help from doing what is needed. Shaming people is not working, nor has it ever worked to change people– it works only to brush our most vulnerable citizens under the rug, then make them ashamed at being hidden.

Stigma and access go hand in hand; without open knowledge of available supports, those who do need help are not able to find it. Education, housing and transportation are the trifecta of access issues. If you can't read, how do you find a website with information about service? How do you look in the phonebook if your neighborhood doesn't have any? Without stable housing each month, could you take 90 days to check into substance abuse treatment? When you have one loaf of bread in your cupboard, how can you justify \$3 to pay for bus fare to your psychiatrist's office, where you may not be seen for hours? This information is readily available to those of us who are able to read or use the computer, but before blaming untreated mental illness for our woes, we need to look at funding and how those who need help are able to seek it.

Clubhouse works to decrease issues with access by providing transportation, educational programs and housing supports, but we are a small part of the mental health community. Case managers in community mental health are begged for bus fare from their consumers; not money, not food – bus fare to attend the treatment they so desperately need.

On the state level, I believe there are several points at which these issues may be addressed. First and foremost is awareness of how deeply mental health intersects with areas of concern. Abraham Maslow, an American psychologist, created a hierarchy of needs (attached) to understand how people view their problems and work to change. On the bottom of the pyramid rest our basic needs: food, shelter, water. Above this, safety, both physical and emotional safety. It is only after our basic needs are met and we feel safe that we can work on our needs for belonging, self-esteem and achievement. Traditionally our system asked people to address their mental health without acknowledging how being in an unsafe neighborhood, living in an abandoned house, or not having money for food, have an impact. I challenge anyone in this room to be in a similar situation and not be depressed.

Secondly and most importantly, our government needs to promote awareness of facts. Actually listening to people who are dealing or have dealt with mental health issues is the best and easiest way to begin; making rules or writing laws which fit with lived experience and the needs of Michigan's citizens will only happen when legislators understand and respect the autonomy of these citizens – as full adults able to make their own decisions and live their own lives. Funding for promotional campaigns is a small piece, but increasing funding for evidence based programs and supporting those working with these consumers is what really matters. It is impossible to increase access to services when case managers are handling caseloads in the hundreds, working unpaid overtime and making \$15 an hour. It is impossible to provide effective treatment when consumers have been seen by three different therapists within a year and start from zero each time. Consumers who have severe and persistent

mental illness are treated like castoffs, seeing only the youngest and newest therapists because those are the only clinicians willing to stay in the Cass Corridor for \$27,000 a year.

The last argument I will make is a financial argument. Michigan needs to prioritize mental health services not only because it's the right thing to do, but because it makes fiscal sense. Those with mental illness are often hospitalized when not compliant with treatment (either medication or psychotherapy). Increasing the quality of treatment would increase compliance and reduce money spent in psychiatric hospitalizations. If a consumer is working on her depression, she is less likely to attempt suicide and need hospitalization. If a consumer is taking his medication, he won't be needing substance abuse treatment because he won't be drinking to quiet the voices in his head.

It also makes sense for the state to prioritize funding for supportive services, including housing, employment and education. If a person who is stable and working on issues is able to hold a job, this person would not need support from social security disability. If one is working, one can pay rent, reducing the strain on shelters and low income housing. Working can improve self-esteem and decrease relapse; people need purpose in their daily life, to feel like something was accomplished. The same applies to obtaining a GED or enrolling in college courses – these are valuable experiences which would be out of reach without support from these programs.

An isolationist approach has not been effective. Stigmatizing and shaming those with mental health concerns has not been effective. It is time to have a recovery oriented mindset and a holistic approach. We need to listen to the people who are affected by state decisions, and never forget – people with mental illness are, at the core, people.

## References

- Appleby, L., Mortensen, P.B., Dunn, G. & Huroeh, U. (2001). Death by homicide, suicide and other unnatural causes in people with mental illness: a population-based study. *The Lancet*, 358, 2110-2112.
- Friedman, Richard A. (2012). "In Gun Debate, a Misguided Focus on Mental Illness." *New York Times*, New York, NY. Online at <http://www.nytimes.com/2012/12/18/health/a-misguided-focus-on-mental-illness-in-gun-control-debate.html? r=0>.
- Harvard Mental Health Letter. (2011). "Mental Illness and Violence." Online at [http://www.health.harvard.edu/newsletters/Harvard\\_Mental\\_Health\\_Letter/2011/January/mental-illness-and-violence](http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2011/January/mental-illness-and-violence).
- Mental Health Reporting. (2007). "Mental Health Fact Sheet." Online at [http://depts.washington.edu/mhreport/facts\\_violence.php](http://depts.washington.edu/mhreport/facts_violence.php).
- McLeod, Sam. (2013). "Maslow's Hierarchy of Needs." Online at <http://www.simplypsychology.org/maslow.html>