Mental Health Association in Michigan

THE ADVOCATE

SUMMER 2023 ISSUE

Letter From the President & CEO

Dear Friend and Supporter of the Mental Health Association in Michigan:

Welcome to the Summer edition of the Association's print newsletter, The Advocate. We hope this edition of the Advocate finds you and your loved ones enjoying the warmth of the season and time to relax. Relaxation? Yes. Even if you can only relax for ten minutes, it is beneficial. Our minds, like computers, need to be idled, if only for a while so we can reset. Rest is a vital component of good mental health.

"Rest is not idleness, and to lie sometimes on the grass under trees on a summer's day, listening to the murmur of the water, or watching the clouds float across the sky, is by no means a waste of time."
- John Lubbock (English banker, naturalist, and archaeologist)

In this edition of the Advocate, we will fill you in on the activities of the Association and talk a bit about the history of the Mental Health Association in Michigan. Our organization, which changed its name to the Mental Health Association in Michigan, was founded in 1936, and was originally known as the Michigan Society for Mental Hygiene. The first organizational meeting of the Society was held on January 7, 1936, at the Statler Hotel in Detroit, Michigan.

In 2023, our verbiage has evolved in how we describe mental illness and the challenges people with mental health conditions experience. We no longer refer to mental health conditions as "nervous disorders" or "mental defects." Inpatient psychiatric hospitals are no

MHAM's Statement on Racism & Equality

The Mental Health Association in Michigan considers racism to be detrimental to the individual, collective mental health, and well-being of persons of color. MHAM understands that racism undermines mental health. MHAM is committed to anti-racism in all that we do. The time is now for those systems that are inhabited by racism and discrimination to be reformed and MHAM is committed to working toward that end.

longer called asylums or hospitals for the feeble-minded. We worry less about overcrowding of state psychiatric hospitals because we have so few remaining. Treatments have advanced greatly over the past thirty years and this has decreased the need for multiple state psychiatric hospitals.

In today's world, we worry about the lack of access to inpatient psychiatric treatment for those who are experiencing uncontrolled symptoms of mental illness. We pay attention to the quality of care in state and community psychiatric hospitals, but nowadays, we are just as focused on quality care in outpatient treatment settings. We continue to advocate at the state and local level for mental health policy that supports a reduction in the prevalence rates of mental health and substance use disorders.

We clamor for equity in the treatment of both mental health and substance use disorders. We are dogmatic in our belief individuals struggling with mental health conditions and substance use disorders should be offered and provided with the most advanced treatments available. We fervently believe mental health should be treated in the same way as physical health.

Although policy work does seem to be "invisible," the impact of our work can be seen when state laws are adopted or amended that further MHAM's goal to ensure quality mental health and substance use disorder supports and services are readily available to all Michigan citizens. For example, in 2022, Senate Bill 412 was signed into law by Governor Whitmer. Senate Bill 412, which was sponsored by former Senator Curtis Hertel, Jr., codified protections against step therapy and prior authorizations for individuals with Medicaid in need of psychiatric medications. What does this mean? It means a person with Medicaid who needs a medication, such as an anti-psychotic, will not have to be placed on an older drug that may have more side effects and a lower rate of efficacy before newer drugs can be utilized. Policy changes are not felt until the policy or changes in law are implemented at the grassroots level. When laws are being changed or Federal court judges are creating opinions about policy, then there is a sense of things happening "above our heads." At the governmental level, there are things happening "above our heads." The policy eventually finds its way down to earth and when the policy change impacts someone or something that is important to us, we experience the change directly. It is no longer an amorphous "decision somewhere," but it becomes a concrete reality. The changes in the Auto No-Fault laws a few years ago are an example of this idea.

When MHAM began in 1936, psychiatric treatment was in its infancy. There were few treatments available for those who were afflicted by a serious mental health problem, and many were warehoused for years in large institutions that often forgot about them. In the 1800's, reformer Dorothea Dix campaigned valiantly in many states for changes in the way that individuals with mental illness were treated. State hospitals across the United States were built in accordance with a model created by Thomas Story Kirkbride and Dorothea Dix was influential in helping to bring his model into reality. In Michigan, these state hospitals were influenced by the Kirkbride Plan: Traverse City; Clinton Valley Center and Kalamazoo Psychiatric Hospital.

In 2023, we have replaced the state hospital with the prison and the jail and homelessness. In the 1700's – 1800's, families cared for their mentally ill family members and loved ones, who were often hidden from public view. Those who did not have families often wandered the countryside. Today, many families continue to care for their loved ones who suffer with significant mental health and substance use disorders. Despite having a public mental health system that is intended to support individuals with these conditions, we often hear about the problems people experience as they seek to access mental health services.

Since MHAM began its work in 1936, we have come a long way. At the same time, there is still so much that needs to be done.

This edition of the Advocate will talk about 21st century mental health public policy. The focus for MHAM has shifted toward ensuring there is a comprehensive continuum of care available to individuals with mental health and substance use disorders. Michigan has a gap in its service array for psychiatric treatment which often means children, youth and adults who need specialized residential psychiatric treatment, are either unable to access this type of care or, if their insurance covers this service, they are forced to go out of state. This is one of many mental health public policy issues that need to be addressed in our state. Read on!
We hope you find this edition of the Mental Health Association in Michigan's Summer Edition of the Advocate educational and enlightening!

Enjoy your summer and stay tuned!

With Gratitude,

Marianne Huff, LMSW
President & CEO
MHAM

THANK YOU!

Thank you to the following organizations for their generous contributions, which will greatly support our mission and help make a positive impact in the lives of those we serve:

Ethel and James Flinn Foundation
Gerstacker Foundation
Helen Kay Charitable Trust
World Heritage Foundation

DTE Foundation | Inseparable
United Way for Southeastern Michigan
Dr. Oliver Cameron | Arlene Gorelick

MHA Mental Health Association in Michigan

Addressing mental health symptoms early is critically important for overall health.

The delays in treatment for mental health conditions are longer than many other health conditions. Getting screened increases the chances of getting treatment. MHAM has free, anonymous, and scientically validated mental health screens at www.mha-mi.com/Mental-Health-Screenings

Mental Health Parity

Mental health and substance use disorder (MH/SUD) parity is the ability to access care that is equitable to care provided for medical-surgical reasons. Parity is present when an insurance company provides coverage for MH/SUD benefits in a manner that is comparable to coverage provided for medical-surgical benefits. Parity ensures treatment for MH/SUDs is not being inequitably restricted and reduces barriers to accessing care. Improving access to care is a critical issue, as a 2021 national survey found, inadequate coverage of mental health services and the inability to afford care were top reasons for not receiving treatment. In 2019, only 13% of Michigan residents with a SUD received treatment and 34% of Michigan residents with any mental illness did not receive treatment.

Coverage can be restricted through limitations, including financial, quantitative, and non-quantitative. Financial limitations are cost sharing requirements, including copays, coinsurance, deductibles, and out-of pocket maximums. Quantitative treatment limitations are numerical restrictions on the frequency, duration, or quantity of treatment and include day and visit limits. Non-quantitative treatment limitations (NQTLs) are non-numerical restrictions and include any process, strategy, evidentiary standard, or other criteria used to limit the scope or duration of benefits provided. NQTLs commonly appear as prior authorizations, medical necessity reviews, and fail first policies.

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was created to prevent private health plans from placing restrictive limitations on MH/SUD benefits if comparable limitations do not exist for medical-surgical benefits. States are responsible for enacting regulatory laws to ensure insurance company compliance. Unfortunately, Michigan has been unable to enact any legislation supportive of parity, as all four proposed bill packages have failed to advance past their respective committees. As a result, Michigan has minimal insight into whether the protections of the MHPAEA are being applied, as well as if Michiganders are being wrongfully restricted from needed treatment. Data from the 2022 Report to Congress shows inequity is likely, as 0 of the 216 NQTLs evaluated complied with the MHPAEA.

16 other states have enacted parity legislation that requires specific reports to be submitted by their insurance companies that would determine their parity compliance on a continuing basis. As a result, these states have gained clarity into their respective insurance companies' practices, and several have made their enforcement actions publicly available. Of note, parity compliance reports in New York resulted in 300 consumers being reimbursed a collective $2 million; a sum representing out-of-pocket costs of previously denied claims.

Enhancing access to mental and substance use disorder healthcare starts with ensuring equity of services. Michigan must prioritize enactment of parity legislation that will be effective in clearly identifying disparity and grant the insurance department the authority to correct it. Until this occurs, Michiganders could continue being denied coverage to needed MH/SUD treatment of which they have a right to receive.

Charitable Requests

A request to the Mental Health Association in Michigan through your will is a powerful expression of your commitment to improving the care and treatment of mental illness, promoting positive mental health, and preventing the onset of mental disorders. A bequest can be unrestricted or restricted, and the full amount of your gift is tax deductible. If you would like more information about making a gift through your will, please contact MHAM President & CEO, Marianne Huff at mhuff@mha-mi.com or call 517.898.3907.

MHAM Highlights

The past year has been busy for the MHAM staff. Kristen Taylor, MHAM's Education and Community Outreach Director, has been working diligently to provide our members and community with opportunities to learn more about mental health.

Some of the great webinars and educational opportunities that have been provided (and our available on our YouTube Channel):

1. We hosted a total of 16 events in 2022, including a webinar on assisted outpatient treatment (AOT).
2. To date in 2023, MHAM has hosted 20 events, including webinars on mental health parity and integrated care.
3. MHAM hosts member only events, including two annual webinar public policy updates.
4. We held our first in-person Town Hall Series, starting at Hope Network in Grand Rapids, February 2023. Since then, we have held them in East Lansing (May), Traverse City (August).
5. Future town halls are scheduled for Downtown Detroit, Southfield, and Clinton Township.
6. Webinars on BIPOC and LGBTQ+ issues in mental health.
7. Our events are now approved for MCBAP contact hours.

Mental Health Parity & House Bill 4707

MHAM has written frequently about the many barriers that exist for Michiganders seeking treatment for mental health and substance use disorders. Frequently we talk about the lack of available outpatient mental health services that include various psychotherapeutic approaches and medication when appropriate. We then look to the other end of the mental health treatment continuum of care and assess the lack of inpatient or acute care treatment options for people who are experiencing a mental health emergency. In our efforts to solve the problems at the beginning (outpatient) and the end (inpatient), we can forget to consider the middle. In other words, what exists for individuals with a mental health or substance use disorder who need an intermediate level of care? Intermediate means the person does not require inpatient treatment, but whose needs cannot be met in the outpatient setting. Sometimes, this type of treatment is provided in a residential setting.

In Michigan, for people with private insurance who might need an intermediate level of care for a mental health condition, they will be hard pressed to find residential treatment programs. For example, if an individual is struggling with an eating disorder or personality disorder, they would have to go out of state to find treatment. Individuals who have private insurance may not be able to access specialized residential psychiatric care that may be necessary to treat certain conditions. The reason for this is simple: Michigan does not have a way to license the programs.

To complicate the situation, the Insurance Code currently provides for specific treatments for substance use disorders. In other words, Michigan Law provides a vehicle for the licensure of residential treatment for drugs and alcohol, but does not provide a way to license residential treatment for psychiatric conditions. House Bill 4707 addresses this by amending section 3425 of the Insurance Code.

According to a House Fiscal Agency analysis of HB 4707 dated July 25, 2023:

Currently, section 3425 of the act requires insurers that deliver, issue for delivery, or renew a health insurance policy in the state to provide coverage for both intermediate and outpatient care for substance use disorder. Those terms are defined to mean the use of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs: chemotherapy, counseling, detoxification services, or other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan. Intermediate care is provided in a residential therapy setting, and outpatient care is provided on both a scheduled and a nonscheduled basis.

The bill would amend section 3425 to instead require coverage for medically necessary treatment of a mental health or substance abuse disorder.

The value of HB 4707 is it expands the continuum of care by ensuring individuals who need specialized treatment for a condition that cannot be addressed adequately in the outpatient setting are able to receive it.

A Bit of History Worth Knowing

The first board members included Dr. Grover C. Pemberthy, who served as the President of the Michigan State Medical Society in 1935, as President. Bishop Lewis Bliss Whittemore, who was a third bishop of the Episcopal Diocese of West Michigan, served as Vice President. George E. Parker of the National Bank of Detroit was Treasurer and George M. Read, who served as a clerk in the United States Federal Court, was Executive Secretary.

When the Michigan Society for Mental Hygiene was founded in the 1930's, the state of Michigan was faced with a lack of funding for state psychiatric hospitals due, in part, to the challenging economics created by the Depression. Plans to develop more state hospitals in 1931 were curtailed as a result.

In 1937, there was the establishment of the State Hospital Commission by the legislature. Over-crowding and poor conditions inside the former asylums were garnering more public attention. Despite the good intentions of reformer Dorothea Dix, who was a national mental health advocate in the 1840's who advocated extensively for improved conditions in many state asylums, many of Michigan's state hospitals were not hospitable environments for those who were living in them.

The Commission, which consisted of seven members appointed by the Governor and approved by the Senate, was responsible for the state psychiatric system. The desire to build more hospitals was curtailed by the lack of funding until 1937 when the Commission was established.

The Director of the State Hospital Commission, Dr. Joseph Barrett, presented a paper to the board of the Michigan Society for Mental Hygiene at one of its meetings in 1938. The paper was entitled, "A State-wide Coordinated Mental Hygiene Program." At that time, the Society was focused on ensuring conditions at state hospitals were improving, rehabilitative and humane. There were also directors of the state psychiatric hospitals who were members of the Society.

The Society's stated purpose was, "To encourage and promote throughout Michigan a program for the conservation of mental health, the reduction and prevention of nervous and mental disorders and mental defect and the scientific and humane care and treatment of those suffering from any of these disorders." Almost ninety years later, the Mental Health Association in Michigan continues to work toward the fulfillment of the Society's goals.

MHAM'S former logo

Managing Mental Health in Nursing

By Mackenzie Childs RN, BSN

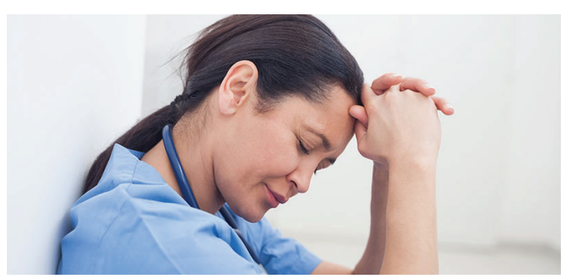
For most people, balancing work and mental health can be a struggle. I know firsthand how difficult it is to take care of others while also taking care of myself. With May being mental health awareness month, I want to shed some light on my experience with taking care of my mental health while working as a nurse. One of the leading contributors to nurses leaving bedside nursing is mental health related burn out. When using the phrase, "mental health," I am referring to the emotional and physiological wellbeing of somebody. It is extremely important for employers and workers to understand how to recognize burn out from lack of mental health support, I find this especially true in healthcare.

Working as a nurse, the last few years has come with lots of ups and downs. Nurses work twelve hour shifts and face life or death situations on a regular basis. One of the biggest challenges I have faced as a nurse is breaking through the stigma surrounding mental health. People often feel they will be looked down upon if they admit to struggling mentally. Historically mental health has not been talked about enough in healthcare, but recently there has been an increased emphasis on the subject and ways to help healthcare workers navigate their mental health.

Nursing and other healthcare workers are placed in hard situations, emotionally, while still having to think critically and clearly. To do this, I have had to learn many coping skills and ways to boost my mental health. Thankfully, I have always worked for an organization that prioritizes and cares about the mental health of nurses and other employees. One of the ways they support us is by offering free counseling services. Each employee is given the opportunity to speak with a counselor anytime they need. Leadership also checks in on us weekly and allows for a safe space to vent feelings or concerns. We are encouraged to be honest about our emotions and to ask for help in the workplace. I think knowing it is a safe place to talk about my feelings has helped immensely while I began my nursing career. I have always felt my mental health was prioritized in my workplace, but I know the same cannot be said for everyone. Because of this, I believe it is very important for everyone to learn how to improve their mental health outside of work as well.

Although I have always felt supported at work, a large portion of balancing my mental health was done outside of work. I feel my best mentally when I am getting enough sleep, eating healthy foods, spending time outside, and making time for friends and family. When talking with other nurses, they share with me ways they manage their mental health including spending time with family, taking a day off, learning a new hobby, listening to music, working out, having a self-care night, and spending time alone to de-compress.

While researching how I can improve my mental health, I found a few helpful tips from the Center for Disease Control and Prevention (CDC). These included taking time to reflect on positive experiences, doing yoga or meditation, exercising regularly, and staying connected in the community. (Coping with stress 2023). There is no right or wrong ways to de-stress. The most important part is setting aside time to make sure it happens. I hope to see more resources become available for people in high stress jobs and a continued push for everyone to prioritize their own mental wellbeing.

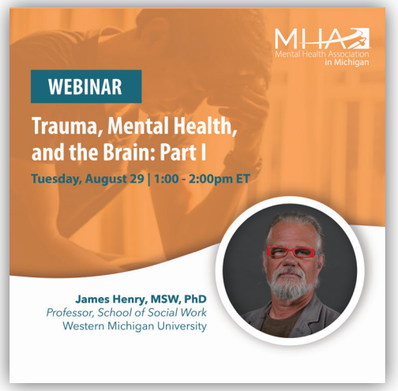


Educational Webinars

MHAM is working to provide public education about matters related to behavioral health care. Visit our website www.MHA-MI.com/events for more information.

Interaction of Trauma with Mental Health Webinar Series

James Henry, MSW, PhD, from Western Michigan University's School of Social Work will be presenting a four-part series on trauma. The first two will focus on trauma, mental health and brain, while session three will be on trauma screening and assessment for children and adults. The final webinar will speak to the power of resiliency to heal trauma, build mental health and restore functioning. We hope you will join us!



Mental Health Statistics for 2022

According to Mental Health America's, "State of Mental Health In America Report 2023," Michigan ranks 35th in the country for the incidence of mental health conditions among our children and youth (meaning there are only 15 states doing more poorly than Michigan) and access to mental health services for them. You can access the 2023 report by going to mhanational.org and do a search for 2023 State of Mental Health in America Report.

On a quarterly basis, we receive data from our parent organization, Mental Health America. The data is obtained through anonymous mental health screenings available through the Mental Health America and MHAM website. The information we receive from the screening tools is identified and provides us with valuable information about who is suffering the most with mental health conditions. For example, in 2022, 33,554 Michigan citizens took the mental health screenings. Here are some of the results:

- 29.89 % took the depression screening. The majority of respondents scored between the moderately, moderately severe to severe range of symptoms.
- 17.49% took the bipolar screening.
- 17.02 % took the anxiety screening.
- 9.34 % took the ADHD screening.
- 78.58% of all respondents scored in the moderate, severely moderate to severe range of symptoms for all screenings.
- 29.81% were between 18-24.
- 17.44% were between 24-35.
- 34.24 % were between 11-17.

According to the anonymous mental health screening data MHAM obtained last year, almost 65% of those who took the screenings were between the ages of 11 and 24 years of age.

Decriminalization of Mental Illness: Fixing a Broken System

By Honorable Milton L. Mack, Jr., State Court Administrator Emeritus, State of Michigan

Waiting four months for a state psychiatric hospital bed to become available, Jamycheal Mitchell died of a heart attack after starving himself in a Virginia jail cell. He had been arrested for stealing $5.05 worth of snacks from a 7-Eleven. He had a mental illness and had thought he was in a relative's store. He was arrested, jailed, found incompetent to stand trial, and ordered into a state hospital to restore competency. No bed was available, so he waited in jail until he died. He was 24.

As tragic as Jamycheal Mitchell's story is, it is not uncommon for those suffering from serious mental illnesses to languish in jails or hospital emergency rooms. Jails and prisons have replaced mental health facilities as the primary institutions for housing persons suffering from mental illness. Our criminal justice system has become a revolving door for persons with mental illness, with the same persons cycling through the system again and again at great cost.

With timely and appropriate services and support, most mental illnesses are treatable, and recovery is possible, reducing the likelihood of behavior that can lead to incarceration. However, outdated and untimely responses to mental illness now block treatment and services that can prevent crime and lead to recovery. 3 Rigid legal standards for involuntary treatment and the lack of an adequately funded community-based mental health system have led to a public safety crisis. Instead, the criminal justice system is systematically being used to criminalize mental illness and re-institutionalize persons with mental illnesses into jails and prisons.

For people suffering from serious mental illness, many state court systems are currently unable to order needed treatment as an alternative to incarceration. Judges and court personnel are in a unique position to describe to policymakers what they see in their courtrooms every day – a broken system, leading to compromised public safety, excessive incarceration, and damaged lives. Policy makers need to provide our courts with better tools to meet this challenge. New legal standards that promote early intervention, combined with easily accessible assisted outpatient community-based treatment, will create the best opportunity to begin to reduce the use of jails and prisons as the de facto mental health system.

The Conference of State Court Administrators (COSCA) advocates (1) An "Intercept 0" capacity based standard for court-ordered treatment as used in court-ordered treatment of other illnesses to replace the dangerousness standard now applied, (2) Assisted Outpatient Treatment (AOT) under a capacity based standard, and (3) robust implementation of Intercepts 1 through 5 of the Sequential Intercept Model. COSCA supports court leadership to convene parties interested in mental health issues to address more effective court involvement with these issues in the three ways advocated in COSCA policy paper: Decriminalization of Mental Illness: Fixing a Broken System.

The cost for psychiatric services spent in correctional environments, combined with the increased rate of recidivism for those with mental illness who are not appropriately supported means that these societal fiscal and human expenditures must be made again and again with no measurable benefit.

These recommendations, if implemented, will enable the courts to do a better job of effectively managing mental health cases. Courts can help forge a path toward policies and practices that treat those with mental illness more effectively and justly.

To learn more about COSCA and the Sequential Intercept Model for court-ordered treatment, please read COSCA's policy paper: Decriminalization of Mental Illness: Fixing a Broken System

State Courts' Response to Mental Illness

On March 30, 2020, the Conference of Chief Justices (CCJ) and Conference of State Court Administrators (COSCA) established the National Judicial Task Force to Examine State Courts' Responses to Mental Illness (Task Force). We have been honored to serve as the Task Force Co-Chairs. With the support of the National Center for State Courts and funding from the State Justice Institute, the Task Force engaged in research, developed tools and resources, delivered training, education and technical assistance, and developed best practice and policy recommendations for courts and communities.

The prevalence of mental illness in the United States has an enormous impact on states and communities and a disproportionate impact on our state and local courts. According to the National Institute of Mental Health, nearly one in five U.S. adults live with a mental illness – over 50 million in 2020 – and over 13 million adults live with serious mental illness. For too many individuals with serious mental illness, substance use disorder, or both, the justice system is the de facto entry point for obtaining treatment and services. There are many causes, not the least of which is the criminalization of mental illness and the lack of alternative approaches and resources to support the diversion of individuals from the courts and into treatment.

People with mental illnesses in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized. Every year, approximately 2 million arrests are made of people with serious mental illnesses. As a result, more than 70 percent of people in American jails and prisons have at least one diagnosed mental illness or substance use disorder, or both. Up to a third of those incarcerated have serious mental illnesses, a much higher rate than is found at large. On any given day, approximately 380,000 people with mental illnesses are in jail or prison across the U.S., and another 574,000 are under some form of correctional supervision.

And this is not just a criminal justice issue. The needs of adults, children, and families impacted by serious mental illness touch every aspect of the court system, including civil, probate, domestic relations, guardianship, juvenile, and child welfare cases. While the statistics can be overwhelming and the challenges immense, a national focus on the problems has created great momentum for change. A Resolution recently adopted unanimously by CCJ and COSCA states that while "many courts have implemented successful programs, improved court practices and procedures, and initiated significant reform, there is still a need and responsibility for all state and local courts to lead and promote systemic change in the ways that courts and communities respond to individuals with serious mental illness…."

In July 2022, after almost three years of effort, the Task Force adopted its Findings and Recommendations to be used by state and local court leaders in their efforts to examine and address the changes that are needed. These recommendations have now been endorsed by CCJ and COSCA. This report reviews the highlights of the work of the Task Force, provides examples of successful programs from across the nation, and shares the recommendations for change that call for action by all state and local court leaders, behavioral health and other community partners, and other state and federal agencies as we work together and more effectively to meet the needs of justice-involved individuals with serious mental illness.

This letter was written by the National Judicial Task Force to Examine State Courts' Response to Mental Illness Co-Chairs Chief Justice Paul L. Reiber of the Supreme Court of Vermont, and Chief Administrative Judge Lawrence K. Marks of the New York State Unified Court System.

Statewide Implementation of Assisted Outpatient Treatment Needs A Boost

By Patricia Streeter, PhD, Michigan Attorney and MHAM Partners in Crisis Coordinator

When the Assisted Outpatient Treatment (AOT) law took effect in Michigan in 2005, it created a new mental health treatment option and new standard for treatment. AOT is designed for people living with severe mental illness who are not receiving or complying with their recommended mental health treatment. Until this law, the only option was a form of custody: hospitalization or incarceration. A series of bills in 2016-2018 allowed earlier intervention, so that a crisis is no longer required to act.

Michigan has some of the best laws in the nation for assisted outpatient treatment. Implementation of those laws, however, has faltered. Courts have been effective as a convening body, but the full community is needed to make it work, including the CMHs, hospitals, ERs, law enforcement, jails, and any other stakeholders impacted by the lack of mental health coordination. Unless all stakeholders are brought together to regularly monitor progress and continue to make improvements, the process does not function and the cycle of catch and release or incarceration is perpetuated. This is costly and produces risk of tragedy.

When AOT works, it has value, as reported by the State of New York, another state with AOT. It's AOT recipient outcomes, 1999 to present, show a 66% reduction in psychiatric hospitalizations, 73% reduction in incarceration, and 64% reduction in homelessness.

AOT RECIPIENT OUTCOMES:

Event	Prior to AOT	Most Recent Follow-up	% Reduction
Psychicatric hospitalization	95%	32%	66%
Incarceration	29%	8%	73%
Homelessness	29%	11%	64%

Several Michigan counties are effectively using AOT, among them Huron, St. Clair, Wayne, and Genesee. Expanding this new system of care statewide remains slow, primarily due to lack of knowledge of the law.

We are now 18 years after enactment, and most of the public, attorneys, and even some judges, remain clueless of this treatment option. Significantly, they are unaware of the new standard: ordering AOT does not require the person to be an imminent threat to self or others.

The new standard does not require a crisis, but rather, impaired judgment due to mental illness that creates a significant risk of harm. The court decides if treatment is necessary. The clinicians determine the appropriate use of hospitalization and outpatient treatment.

Two elements of New York's law missing in Michigan are the requirement that each county establish a local AOT program to implement the statute and requiring the state-level mental health department to monitor and oversee the implementation of AOT statewide. New York also provides a robust data collection and reporting scheme available to the public.

The State of Michigan does not provide publicly available AOT data and does not have a centralized location for the public to navigate the AOT process. This information is, however, provided by the Center for Behavioral Health at Wayne State University, which provides an AOT toolkit to bridge the gap of mental health treatment law and implementation. This Toolkit is designed to provide Michigan courts, mental health providers, hospitals, individuals struggling with mental illness, families and advocates, and law enforcement the resources they need to effectively utilize AOT.

There is more work to be done in Michigan. We need to implement the legislation we have, educate all stakeholders across the AOT continuum, and assure coordination responsibilities at the state level, with data collection, reporting and analysis.

Resources provided upon request.

MHAM Survey

Mental Health Association in Michigan

Mental Health Association in Michigan (MHAM) values your membership and feedback. Your responses will strongly influence how MHAM approaches its community education and mental health public policy work and enables us to respond to feedback about mental health-related issues important to you. Please use the return envelope to submit your survey. **Return this survey by Friday, October 27, 2023 to be entered into a $50 Amazon gift card drawing.** Thank you for your participation!

1. Why are you interested in mental health issue) (check all that apply)

- General interest in mental health
- You have lived experience with mental health issues
- You have a loved one with mental health issues
- You are in the mental health profession
- You are a legislator/policy maker

2. Why do you support MHAM? (check all that apply)

- Improve mental health services for Michigan citizens
- Help citizens, families, employers better recognize mental health conditions
- Help employers support employees with mental health conditions
- Increase public awareness of mental health conditions and the need to address them
- Work with state government on laws that improve the mental health care system
- Provide a voice for mental health care recipients in government
- Help mental health care recipients advocate for system improvements
- Track developments regarding changes or improvements to the system

3. How long have you been an MHAM supporter?

_____

4. Do you currently receive email communications from MHAM?

- Yes
- No

5. Do you follow MHAM's social media? (Twitter, Facebook, LinkedIn, Instagram, YouTube) If yes, in the open field, please indicate which ones.

- Yes
- No

6. Do you support other Michigan nonprofit mental health organizations?

- Yes
- No

7. What other mental health-related concerns or issues would you like to see MHAM address through advocacy or public education?

_____

_____

8. What type of content would you like to see in email communications, topics for monthly education webinars or other in-person events?

_____

_____

9. For member demographic purposes, the following question is optional. What age bracket do you belong?

- 18-24
- 25-32
- 33-45
- 46-55
- 55+

Membership Form

Advocacy | Support | Education

Mental Health Association in Michigan

Application Date: _____

MEMBERSHIP LEVEL

- ☐ **Individual Member | $50**
- ☐ **Organizational Member | $300**
- ☐ **Discounted Individual Member | $25**
  (Students, retirees, military, persons with lived experience or financial hardship)

INDIVIDUAL MEMBER CONTACT INFORMATION:

First Name: **Last Name:** **Credentials:**

Title: **Org/Comp:**

Address: **City:**

Zip: **Phone:** **E-Mail:**

OGANIZATIONAL MEMBER CONTACT INFORMATION:

Organization Name:

(Main Contact) First Name: **Last Name:** **Credentials:**

Title: **Website:**

Address: **City:**

Zip: **Phone:** **E-Mail:**

(2nd Contact) First Name: **Last Name:** **Credentials:**

Title: **Phone:** **E-Mail:**

(3rd Contact) First Name: **Last Name:** **Credentials:**

Title: **Phone:** **E-Mail:**

Other Notes:

Return this page to office@mha-mi.com or P.O. Box 11118, Lansing, MI 48901 or go to www.mha-mi.com/Membership

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The Mental Health Association in Michigan
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In case you are not familiar with The Mental Health Association in Michigan (MHAM) or you have not heard about our history, we wanted to make certain we let you know who we are and why we exist. We exist because of individuals with mental health conditions. We know **Mental Health Matters Every Day.**

MHAM is an organization representing a broad base of people working together to advocate with and on behalf of individuals with mental illness and substance use disorders. MHAM incorporated as a non-profit entity under Michigan statutes in 1936 and holds 501(c)3 tax-exempt non-profit status with the Internal Revenue Service. MHAM maintains a non-partisan posture in its social action and public efforts. MHAM is the state affiliate for the national organization, Mental Health America (MHA), formerly known as the National Mental Health Association.

MHAM is the state's oldest non-profit organization and non-governmental agency concerned with the broad spectrum of mental illness across all age groups. The Association's mission is to promote quality mental health and substance use disorder supports and services and the availability of mental health treatment through advocacy and education.

MHAM works by:

- Gathering and interpreting information about mental health problems and conditions to the public and individuals who shape public policy in Michigan.
- Evaluating a variety of public and private mental health services; making recommendations for improvements in these programs; and stimulating demonstration projects to link individuals to needed services.
- Making available to the public, as well as providers and recipients of mental health services, educational literature covering all aspects of mental health and mental illness.