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MAASE White Paper

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The Future of Mental Health Services in Michigan

Background and Purpose

In February of 2013 Governor Richard Snyder issued an executive order establishing the Mental Health and Wellness Commission. This bipartisan Commission was charged with developing key recommendations to strengthen our mental health system in Michigan. Five work groups were established under bipartisan leadership, and MAASE was invited to participate in the work group chaired by Senator Rebekah Warren regarding Education, Employment, and Veteran Items.

MAASE convened its own internal work group in October of 2013 for the purpose of developing input to Senator Warren's work group. This paper is the result of that work.

Findings

After study of the law and research, including sharing of experiences, we find the Michigan Mental Health system to be a loose collection of services scattered across the state rather than the seamless, transparent, statewide system, which we desire for children, youth and adults. Publically available/funded mental health services are county-based and locally controlled, with decision-making and program planning by and large delegated to the county level. Additionally, there appear to be no clear, measurable standards established at the state level for program access, program quality or service availability. Therefore, we conclude that the menu of services available in each Michigan Mental Health authority is a function of a combination of geography, local resources both human and fiscal, and locally determined appropriateness of services and supports. Access to programs and points of entry also appear to be a function of local decision-making. While intended to meet the diverse needs of consumers across the state, this approach has contributed to a disconnected "system" that can be challenging to navigate and comprised of disparate or inconsistent service offerings.

Currently Michigan Mental Health has no governance accountability for interfacing with the other state systems that support the same clientele, such as Education, Health and Human Services, or Juvenile Justice. There is no mandate for coordinated planning for services at the county level, nor is there mandated coordination for planning of individual services at the client level. In fact, there are numerous barriers to such collaboration, including lack of human and fiscal resources to carry out needed coordination and collaboration, lack of a clear mandate to coordinate in the interest of the health and wellness of the individual being served and various privacy/consent protections. The net result is both gaps and overlaps in service driven by the locally determined decisions around availability of, and access to, needed supports. The challenges to better coordination and collaboration are numerous yet; there are places in our state where the shared vision of truly habilitative support systems is being realized. Inroads are being made in coordinated planning, sharing of resources, and providing appropriate services closer to the client. These pockets of excellence serve as models and inspiration that could be mined for effective and efficient practice and policy.

Concepts for Consideration

It is critical for Michigan Mental health to:

1. Function as a unified system with established standards and accountability for outcomes, especially with regard to services to children and their families.
2. Develop consistent criteria that facilitate access to mental health services, regardless of insurance coverage or lack thereof.

3. Establish procedures to locate, identify and serve all children, youth and adults who require mental health services.
4. Implement a consistent, two-pronged approach in providing services:
    a. Preventative, which is providing supports/services that will help prevent mental health challenges.
    b. Responsive, that is supporting mental health problems that exist despite preventative services.
5. Share accountability for coordinated delivery of mental health services across state agencies as a foundation for coordinated systems at the local level.

Actions Needed to Realize Concepts

1. **Establish a statewide system of mental health services that is accessible, coordinated, and both preventative and responsive.**
    a. Revise the mental health code to identify a mandatory full continuum of research/evidence-based mental health services, based on varying severity of issues, with equal access across the state.
    b. Revise the mental health code to establish a state-level baseline of standards/policies that guide the services to be developed and delivered by all local CMH authorities.
    c. Promulgate rules to support consistency in policy, practice and procedure across CMH authorities.
    d. Establish specific service guidelines based on common intake criteria that will be implemented statewide.
    e. Revise the mental health code so that the funding system is equitable statewide (i.e., not variable by county) and also adequate to meet constitutional obligations.
    f. Remove language in the mental health code that allows services to be provided "if available."
    g. Require that each CMH authority work in collaboration with public education and the medical community to proactively locate, identify, and serve children and families in need of mental health services (i.e., an affirmative "child find" obligation similar to that of education under the Individuals with Disabilities Education Act).

2. **Mandate coordinated planning and service delivery at the county level including, but not limited to, Mental Health, Education, Health and Human Services, and Juvenile Justice.**
    a. Require receipt of full funding to be contingent upon state approval of a countywide cooperative agreement that identifies a plan for meaningful collaboration, including funding agreements. Alignment of CMH authority boundaries with Intermediate school district boundaries might be one step toward facilitating ongoing planning/collaboration and supporting better alignment of services.
    b. Require that countywide cooperative agreements provide for seamless coordination of pre-admission treatment, referral, and discharge planning that includes the parent and public education, mental health, client, and court representatives.
    c. Require policies and procedures that promote objectivity and limit delays in service when clients move across county lines.
    d. Require school district and school building improvement plans to include mental health components (including accountability and evaluation of these components).
    e. Revise the mental health code to require sharing of school-based mental health confidential information with parent consent (i.e., eliminate the subjective latitude of mental health officials to withhold certain information despite informed consent).

3. **Systemically address the fundamental misunderstanding of the role, mission and expertise across systems, so that health systems may appreciate the educational mandate of schools and schools may appreciate the habilitative mandate of health systems.**
    a. Require that both state- and local-level mental health and education administrators and policy makers participate in an ongoing forum for common understandings and collaborative outcomes.
    b. Work for consistency in use of language, particularly with regard to the school age population.

c. Require that all general and special educators take coursework at the pre-service level to understand the basis of and support for mental health-related interventions for children and youth.

4. **Improve access to mental health services by optimizing administrative operations, eliminating any unnecessary layers of bureaucracy, and increasing transparency.**
   a. Revise rules regarding insurance payments to allow equal access to services (i.e., Medicaid or private insurance should create no barrier.)
   b. Revise timelines for decision-making/action in the mental health code to address children's and youth's needs, particularly those with acute issues, in a timely way.
   c. Revise R330.1208 part 3 to require a group of individuals to determine the "severity" of the mental illness.
   d. Provide clearer definitions of severity and who makes the ultimate decision about eligibility/placement.
   e. Revise the mental health code to require school-based service (prevention and after care) for all school-aged students.
   f. Require CMH personnel offices to be located in schools when the caseload reaches 10% of the student population.
   g. Require that adequate services be delivered as close to the client as possible. In impoverished urban areas where transportation may be a barrier, this may mean delivering services in existing neighborhood/school facilities. In less populated rural areas it may mean that services are always available within a 90-minute drive.
   h. Establish an independent panel to examine and identify other systemic barriers to consistent access to services, collaboration across agencies (schools, community, private sector.)
   i. Develop an accountability system that monitors implementation and impact of resulting changes.

5. **Provide adequate funding and support for preventative, research-based mental health services in the community and in schools.**
   a. Revise the mental health code to include prevention/proactive language that will allow a person to be supported before the need becomes a crisis and leads to potential physical harm to self or others.
   b. Require annual universal screening of all children attending public school programs.
   c. Require preventative care plans within the school.
   d. Require education regarding health living for families/children who meet "at risk" criteria.

MAASE strongly believes that implementation of the above recommendations will assure that those with mental health issues can become contributors in building a Michigan future that includes a positive quality of life, safety, and independence for all. MAASE stands ready to participate in and support future work toward this critical goal.

For the Executive Board,

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