



Michigan Mental Health Commission

established by Governor Jennifer Granholm's Executive Order 2003-24

PROPOSED CROSS-CUTTING ISSUES AND OPTIONS

Cross-cutting Issue 1: Who Should Be Served?

The question of who should be served by Michigan's public mental health system cuts across all of the key issues developed by the commission's work groups. The focus of public mental health policy in Michigan and across the country has been on those individuals with the most severe and persistent mental illnesses. Michigan's Constitution and Mental Health Code both mandate service for persons with mental disorders, with the Code placing priority (defined as a "majority of resources") on persons who are in emergent or urgent situations (defined in law) or experiencing the most severe forms of disorder (undefined).

This system focus has been intensified by the evolution of Michigan's choices for funding the public mental health system. Prior to 1999, legislative funding to CMHSPs for treatment and support service was made through one line item that did not depend on a consumer's reimbursement status. Since that time, basic CMH care dollars have been split into Medicaid (80%) and non-Medicaid (20%) lines, with a prohibition against using any of the former (even dollars which are from Michigan's general fund as a Medicaid match) to benefit a non-Medicaid recipient. The cataclysmic decrease in ability to respond to persons not enrolled in Medicaid (or fluctuating in and out each month by having to "spend down" income) has helped leave CMHSPs with fewer resources for screening, early intervention, or treatment of persons whose conditions are of moderate or mild severity.

Clearly the public mental health system must retain an ability to respond to crises and must have multiple options available, which may vary in mix and intensity over time, for persons experiencing severe manners of mental illness or emotional disorder, which should have uniform operational definitions across the state. {NOTE: Following this issue brief are draft Service Selection Guideline Principles to aid consumers, families, providers, and managers in the matching of treatment/support options—primarily for priority cases under the law—to a recipient's needs, desires and circumstances. The Principles were developed in 1999-2000 by the same individuals and organizations cited in the paper for Cross-cutting Issue 2.}

The system's current limitations in areas like prevention and early intervention (both stressed in the governor's executive order for the commission) do not reflect the significant advances made over the last two decades in brain research and the development of effective treatments. Recovery from serious mental illness is now more possible, and the value of early diagnosis and treatment has been clearly documented. The current focus on providing treatment primarily to the most severely ill does not help children and adults at the early stage of their illnesses when treatment would be most effective and the possibility for full recovery is the greatest. The unintended consequence of a system that requires a person with mental illness to "fail first" before accessing treatment is a system that manages symptoms and accepts disability instead of promoting recovery.

Thus, it is suggested the commission advance funding, organizational and operational strategies that: (1) bring new income into the public mental health system for early detection and response; (2) aid the system in connecting those who require such services with other community resources also capable of providing them; (3) support the enactment of parity legislation for those with private health insurance; and (4) promote maximum flexibility for responding to the needs of persons and families working toward recovery from mental illness or emotional disorders

Principles for Mental Illness Service Selection Guidelines in the Publicly Funded Mental Health System

1. Service development must incorporate person- and family-centered planning.
2. Recipients must receive the most clinically appropriate treatment and support they require.
3. Medical necessity criteria utilized should be broad enough to support the provision of clinically appropriate services.
4. Criteria for responding to acute psychiatric crises must be well defined.
5. Procedures for responding to persons with developmental disability who are in acute psychiatric crisis must be included.
6. Procedures for responding to persons with substance abuse disorder who are in acute psychiatric crisis must be included.
7. Criteria for enhanced service eligibility for persons with severe, persistent conditions and psychiatric disorders must be included.
8. Certain diagnoses should automatically qualify an individual for enhanced eligibility.¹
9. Respective criteria for high acuity and enhanced service eligibility should be identical for both Medicaid and non-Medicaid recipients.
10. Criteria for high acuity and enhanced service eligibility should cover both adults and children.
11. Criteria for service to individuals who have neither acute psychiatric crisis nor severe and persistent mental disorder must be included.

¹ At minimum, these might be: schizophrenia; schizoaffective disorder; bipolar disorder; major depression; delusional disorder; and psychotic disorder not attributable to general medical condition or substance abuse. There must also be respective statewide criteria for non-diagnostic circumstances requiring enhanced eligibility of adults and minors. For the latter, this takes on extra importance because of the difference in diagnoses seen between children and adults. (The leading diagnoses among minors served through the public mental health system in FY-02 were: Attention Deficit and Disruptive Behavior; Adjustment Disorders.)

12. Criteria for the continuation of a service must be in place and need not be at the same level as those at the initiation of the service.
13. Planning for transition from a given service must include the recipient and the family of a minor recipient as soon as possible.
14. Discharge from a given service may not occur if a clinically appropriate alternative service is unavailable and the recipient or family of a minor recipient chooses to remain with the existing service.
15. Substance abuse should not disqualify an individual from receipt of service for treatment/support of a diagnosed mental illness or emotional disorder.
16. Guidelines must address collaborative and boundary issues between mental health and other human service systems.
17. Guidelines must be uniform throughout the state and readily understandable by consumers and their advocates (across various cultural groups), with sufficient detail so that these individuals can determine whether or not they meet criteria for any given service.