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Community Health &  
Research Center

Testimony before the Michigan House of Representatives Human Services Committee

Presented by:

- Mona Makki, Director, Community Health and Research Center at ACCESS
- Jessica Kowalski, Deputy Director of Medical Services at ACCESS

### **[Opening]**

Good afternoon, Chair Roth, Vice Chairs Kelly and Edwards, and distinguished members of the committee. Thank you for your time today and for your commitment to learning more about the process of obtaining substance use disorder services within the community mental health system in Michigan. We deeply appreciate your interest in this important issue that affects so many Michiganders.

My name is Mona Makki, and I serve as the Director of the Community Health and Research Center at the Arab Community Center for Economic and Social Services (ACCESS). We are proud to be contracted by the State of Michigan and the Detroit Wayne Integrated Health Network (DWIHN) to provide both mental health and substance use disorder services. Joining me today is my colleague, Jessica Kowalski, who serves as the Deputy Director of Medical Services at ACCESS. Together, we bring experienced perspectives to help illustrate the reality of navigating the current system of care.

Investing in substance use disorder services is not only the right thing to do morally, but also the smart thing to do economically. Strong treatment systems lead to fewer arrests and less strain on the criminal justice system, reduced homelessness and emergency service utilization, and healthier, more productive communities overall. While Michigan has recently seen a decline in opioid overdose deaths, substance use disorder remains a serious public health concern that requires sustained attention and resources. We must continue to invest in treatment now to prevent further escalation and avoid greater costs down the road. That being said, efficiencies within the system could be significantly improved and that is what I'm here to speak with you about today.

### **[Explaining the Current Process]**



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Today, I would like to walk you through the process an individual who is accessing community mental health services must go through in our state.

Currently, the journey begins with a phone call to the PIHP (Prepaid Inpatient Health Plan) in our case, DWIHN (Detroit Wayne Integrated Health Network). This intake call lasts at least an hour and a half (excluding any hold times or language barriers), during which an individual is asked a lengthy set of questions. At the conclusion of that call, the PIHP determines which agency will receive the case and schedules the first appointment—sometimes up to two weeks later.

At that first agency appointment, the focus is primarily on paperwork. The client must sign consent forms to allow DWIHN to release their chart. This process alone takes close to an hour. Once submitted, DWIHN then has up to 24 to 48 hours to release the file back to the agency.

Only at the second appointment can the ASAM (American Society for Addiction Medicine) assessment be completed—a detailed evaluation to determine the appropriate level of care. This assessment itself can take up to two hours. Then, at the third or even fourth appointment, the therapist is finally able to complete an individualized treatment plan and begin making necessary referrals—whether for peer support, psychiatric care, transportation, employment, or other vital support services.

In short, a client who courageously reaches out for help with substance use disorder must go through as many as five separate appointments before they can meaningfully begin treatment. From staff reports, four out of five clients do not make it through this process to get to treatment portion of their care.

### **[Upcoming Improvements]**

Fortunately, there is progress on the horizon. Effective October 1st, thanks to MDHHS assuming responsibility for the CCBHC (Certified Community Behavioral Health Clinic) program from the PIHPs, this process will be slightly simplified. We will now be able to conduct the CCBHC intake process directly for anyone seeking outpatient SUD services. This change streamlines care, removes the middle layer of authorizations, and ultimately gets people into treatment faster. However, there are still substantial paperwork requirements for the CCBHC model that SUD clients will have to complete, including but not limited to six consent forms, orientation checklist, a level of care assessment, an Integrated Biopsychosocial (IPBS), the ASAM assessment, Pre-plan, and Treatment plan (Individual Plan of Service).



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[DEMO OF VISUAL]

### **[Remaining Challenges]**

Because of these cumbersome processes, many individuals seeking substance use disorder care are forced to look outside of the community mental health system. In my role as Deputy Director of Medical Services at ACCESS, we often see patients turn to our primary care clinic instead. There, we can initiate medication-assisted treatment as a walk-in service the very same day they are ready to begin. This approach helps ensure that we do not lose individuals in need due to delays or unnecessary barriers but instead engage them in treatment at the critical moment when they are most motivated to start their recovery journey

However, even with improved access under the CCBHC model, several fundamental challenges will remain:

**Workforce Shortages** – The State’s current requirements for SUD professionals are extremely rigorous, requiring 2,000 hours of post-graduate counseling experience, 186 hours of additional education, and 100 hours of direct supervision by a fully licensed professional. While well-intentioned, these requirements severely limit the number of qualified providers. Compounding this, Michigan does not accept transfers of addiction credentials from other states, creating unnecessary barriers to expanding the workforce.

**Paperwork Burden** – The volume of paperwork remains overwhelming: consent forms, assessments, treatment plans, and extensive reporting requirements. This burden discourages both clients from staying engaged and providers from wanting to work in this field.

**Data Misrepresentation** – Because the process for entering SUD treatment is so lengthy and cumbersome, fewer individuals pursue it. As a result, state-level data suggests fewer people are seeking substance use treatment as a primary concern compared to mental health. This is misleading—not because substance use disorder is less prevalent but because the barriers to care are simply higher.

### **[Recommendations for Change]**

The best approach to successful care is meeting people exactly where they are, in the moment they are ready. When someone reaches out for help with substance use disorder, **we cannot afford to put them through weeks of delays and layers of bureaucracy.**



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We must also address the stigma that continues to surround substance use disorder. Stigma, coupled with workforce shortages, leaves too many people without access to life-saving services. To move forward, we recommend:

- **Expand the workforce pipeline** by reducing excessive state requirements for credentialing while still ensuring quality standards.
- **Allow licensure reciprocity** so addiction specialists and behavioral health professionals from other states can practice in Michigan.
- **Provide financial incentives** (such as loan repayment, scholarships, retention bonuses, and paid trainings) to encourage professionals to specialize in substance use disorder care.
- **Increase access through walk-in services** so individuals can receive assessments, treatment initiation, and referrals on the same day they present for help.
- **Develop and expand more low-barrier treatment options** such as same-day access to medication-assisted treatment (MAT), telehealth services, and simplified intake requirements.
- **Strengthen prevention strategies** that address risk factors early, particularly among youth and high-risk populations.
- **Expand risk-reduction models** that meet individuals where they are, reducing immediate harm while building trust and engagement.
- **Invest in wraparound models of care** that integrate mental health, physical health, housing, peer recovery, and social supports to sustain recovery long-term.

### [Closing]

Quotes from clients regarding accessing care: *“It felt like the system was designed for me to quit”* & *“It would be easier to overdose and die than seek treatment for my issue”* & *“You have to spend five to six hours on the phone just to get to the right person”*

The individuals we serve are our neighbors, our friends, and our loved ones. Substance use disorder does not discriminate; it impacts every community, every family, and every background.



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When someone bravely raises their hand for help, our system must be ready to respond quickly, compassionately, and effectively.

[New ACCESS to Recovery Center- a state of the art 51,000 square foot facility with wraparound withdrawal management, crisis stabilization services, and short term residential services]

As members of the Appropriations Committee, you understand better than anyone that where we invest our dollars reflects our priorities and shapes our future. An efficient, accessible substance use disorder system is an investment that pays off across multiple sectors: reducing criminal justice costs, alleviating the burden on emergency rooms and homeless shelters, and strengthening Michigan's workforce and families. Every dollar spent wisely on treatment today saves many more in downstream costs tomorrow, and most importantly, saves lives.

Thank you again for your time, for your leadership, and for your continued dedication to strengthening Michigan's behavioral health system. We look forward to answering any questions you may have.