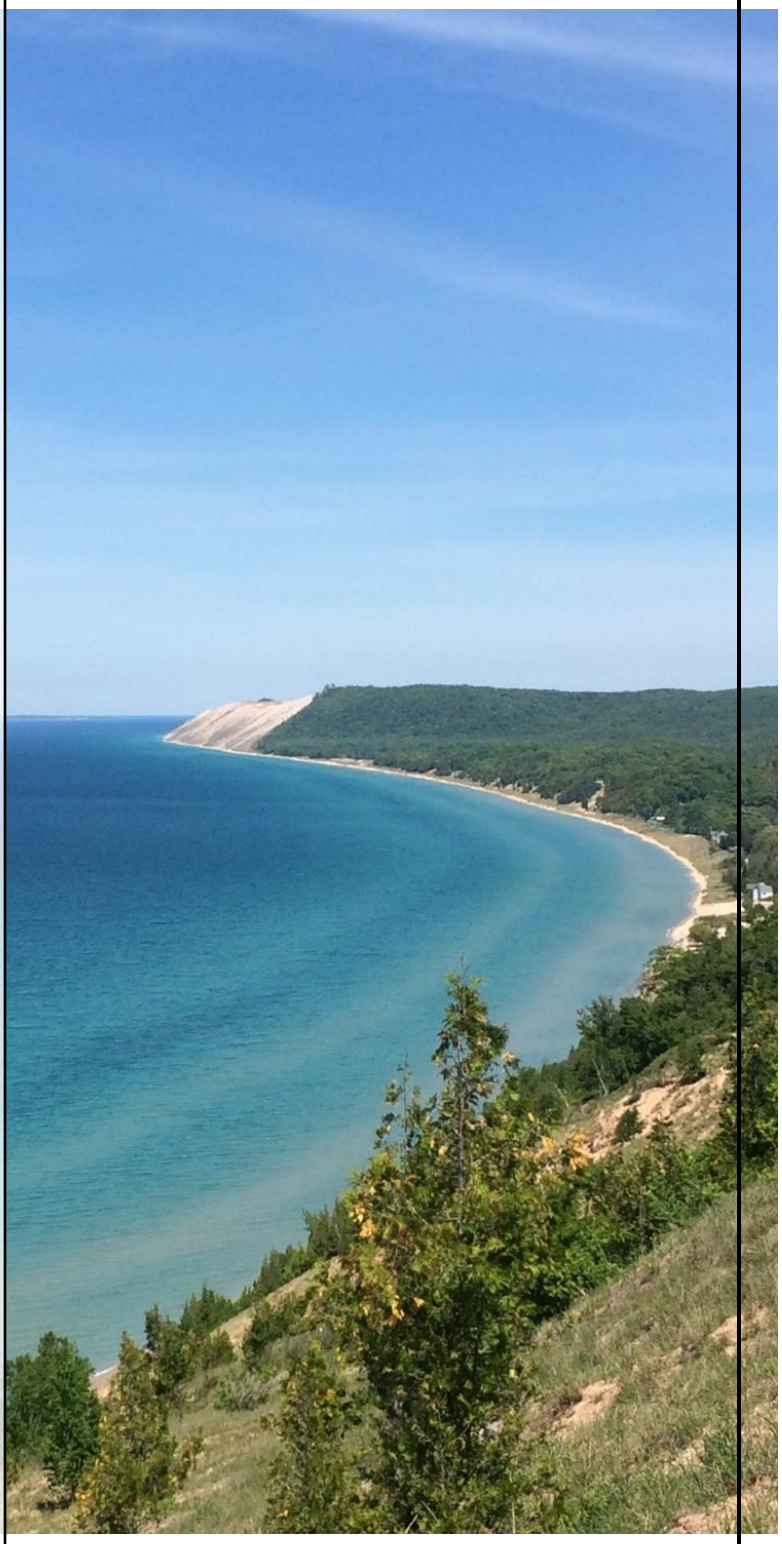
# Michigan Behavioral Health Crisis Services

## CMHSP 2020 Survey Results



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**Acknowledgement |** On behalf of BHDDA, we would like to extend a special thank you to all the CMHSP medical directors and staff for devoting time and effort with completing this survey. We recognize that in some cases it took several hours to collect and input the data. We are grateful for your efforts and because of your generosity, we were able to collect information from all of Michigan's forty-six community mental health service programs for this report.

# Table of Contents

# Introduction

Michigan's 46 community mental health service programs (CMHSPs) participated in an information gathering survey. The survey was supported and administered by the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA), in partnership with the Michigan Public Health Institute (MPHI). The purpose of the survey was to better understand the current publicly funded behavioral health crisis services offered through CMHSPs in terms of funding sources, hours of operation, staffing archetypes, and program implementation barriers and successes.

MDHHS has been working to address access issues to the continuum of psychiatric services through the Michigan Psychiatric Care Improvement Project (MPCIP). This initiative is the result of the recommendations generated through Michigan Inpatient Psychiatric Access Discussion (MIPAD); the Community, Access, Resources, Education, and Safety (CARES) Task Force; and related legislation.

MDHHS is taking a systemic approach to addressing these access issues through the expansion of community-based crisis services. The intention is to meet as many needs as possible through increased community-based, less restrictive crisis services, including residential options, thereby saving the psychiatric beds for people with more severe needs who cannot be served well in the community-based options. Broadly, this entails integration of crisis system improvements such as: MiCAL (a statewide crisis, warm line, and information and referral line), mobile crisis services expansion, a behavioral health treatment registry, a statewide medical clearance protocol, crisis stabilization units, psychiatric residential treatment facilities, and residential treatment facilities for adults. To help bolster and create these services, MDHHS plans to leverage a Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) 1115 Waiver and other authorities from the Centers for Medicare and Medicaid Services (CMS).

The survey gathered information on main program components around crisis response, specifically standard practices, innovative programs/services, and gaps in the crisis continuum. The information will be used to better understand the collective crisis infrastructure and capacity related to CMHSPs across Michigan's diverse social and geographic landscapes. An in-depth understanding of the current system will facilitate a capacity assessment and gap analysis, which is a prerequisite to the 1115 Waiver application. The information will also help MDHHS optimize its program policies and service expansion efforts.

# CMHSP Background

Michigan has a decentralized public behavioral health system with services coordinated through local community mental health service programs (CMHSPs). CMHSPs are publicly funded entities, created by county governments. There are 46 CMHSPs across the state; each program serves one to six counties (Appendix 2). Each CMHSP works within one of the ten Prepaid Inpatient Health Plans (PIHP) across Michigan. A PIHP provides oversight to the management and integration of Medicaid mental health and substance use disorder services. While the majority of people CMHSPs serve are Medicaid beneficiaries, they do serve people with other payment types.

Annually, CMHSPs deliver services to 300,000 children and adults[1] with the most severe and persistent mental health illnesses, substance abuse disorders, and developmental disabilities. CMHSPs coordinate local care and provide direct services such as assessments and referrals, case management, crisis intervention, and outpatient care.

A CMHSP will provide immediate care to a person experiencing an emergency. Other services require an individual to go through an assessment process that determines their eligibility for services based on severity of illness. If a person is not eligible to receive services through a CMHSP, they will be directed to community resources that may help.

[1] Community Mental Health Association of Michigan (CMHAM), https://cmham.org/wp-content/uploads/2018/12/CMHA-DidYouKnow-Infographic.pdf

# Methods

With guidance from MDHHS-BHDDA, MPHI developed the survey instrument. The initial survey draft was pilot tested with three CMHSPs between September and November 2019, and their feedback was incorporated into the final form of the survey. An individualized survey link was emailed to each CMHSP Director and clinical director in December 2019 and data collection ended in February 2020.

All CMHSPs self-reported their crisis services. Definitions of crisis services were included at the beginning of most sections; however, it should be noted that some services are not universally defined and thus respondents could have interpreted the question differently. Therefore, there may have been some variation in how some CMHSPs reported their services. This is a problem that extends beyond this report and requires action at state and national level to provide consistent language when defining services.[2] As a result, additional emphasis was placed on qualitative responses during the analytical process to ensure CMHSPs were reporting services according to the provided definitions.

Only services provided directly by a CMHSP or through a contract with a CMHSP are included in this survey. Therefore, while a service may exist in the state, only those that are provided or contracted by a CMHSP are included in this report.

The survey included four sections: (1) warm lines and hotlines; (2) crisis services for children and youth; (3) crisis services for adults; and (4) other crisis related information. For the most part, the survey was structured similar to how a person might encounter the crisis service process. A copy of the survey can be found in Appendix 1.

[2] Pinals, D. A., & Fuller, D. A. (October 2017). Beyond Beds: The Continuum of Care as a Public Health Approach. *National Association of State Mental Health Program Directors and the Treatment Advocacy Center*. https://www.treatmentadvocacycenter.org/storage/documents/beyond-beds.pdf

# Crisis Hotline and Warm Line Services

CMHSPs were asked to provide information related to their crisis and warm line services including hours of operation, funding sources, call volume, as well as staffing for these services. CMHSPs were not directly asked if they provide crisis hotline services as this is a mandated service, so it is assumed all CMHSPs provide crisis hotline services. Thirty-eight CMHSPs (83 percent) provide a warm line. The usage and definition of a warm line may vary among CMHSPs. Some respondents implied that they utilize their access department as their warm line, while others indicated that they use their triage/switchboard service as a warm line to direct the call to the correct department. It should be noted, CMHSPs may not operate crisis hotline and warm line services as distinctly different, especially if the service is contracted out.

A **crisis hotline** is a direct service delivered via telephone that provides a person experiencing distress with immediate support and/or facilitated referrals. The service provides a confidential venue for individuals to seek immediate support with the goal of decreasing hopelessness, promoting problem-solving and coping skills, and identifying individuals in need of facilitated referrals to medical, healthcare, and/or community support services (SAMHSA, 2012 and 2014).

A **warm line** is a direct service delivered via telephone that provides a person in distress with a confidential venue to discuss their current status and/or needs. Unlike hotlines, warm lines are for situations that are not considered emergencies but could escalate if left unaddressed (SAMHSA, 2012 and 2014). Warm lines typically provide active listening, problem solving, information, and referrals. A warm line may be a component of a crisis line. Individuals calling the warm line may or may not be open to services. Examples include: a parent struggling to put a child to bed, or an individual who is feeling extremely lonely or anxious and just wants to talk.

### Hours of Operation

CMHSPs were asked to provide the hours of operation for their warm line services. In total, 26 (68 percent) of the 38 CMHSPs who provide warm lines offer this service 24 hours a day (Table 1). Since CMHSPs are mandated to provide 24/7 hotline services, they were not asked to provide their hours of operation.

**Table 1: Hours of Operation for Warm Line Services (N = 38)**

| Hours of Operation | # | % |
|---|---|---|
| 24 hours | 26 | 68.4% |
| Business hours | 5 | 13.2% |
| Business hours + evening hours | 5 | 13.2% |
| Evening + night hours | 2 | 5.3% |

**The percent is rounded and therefore, may sum to more than100 percent.*

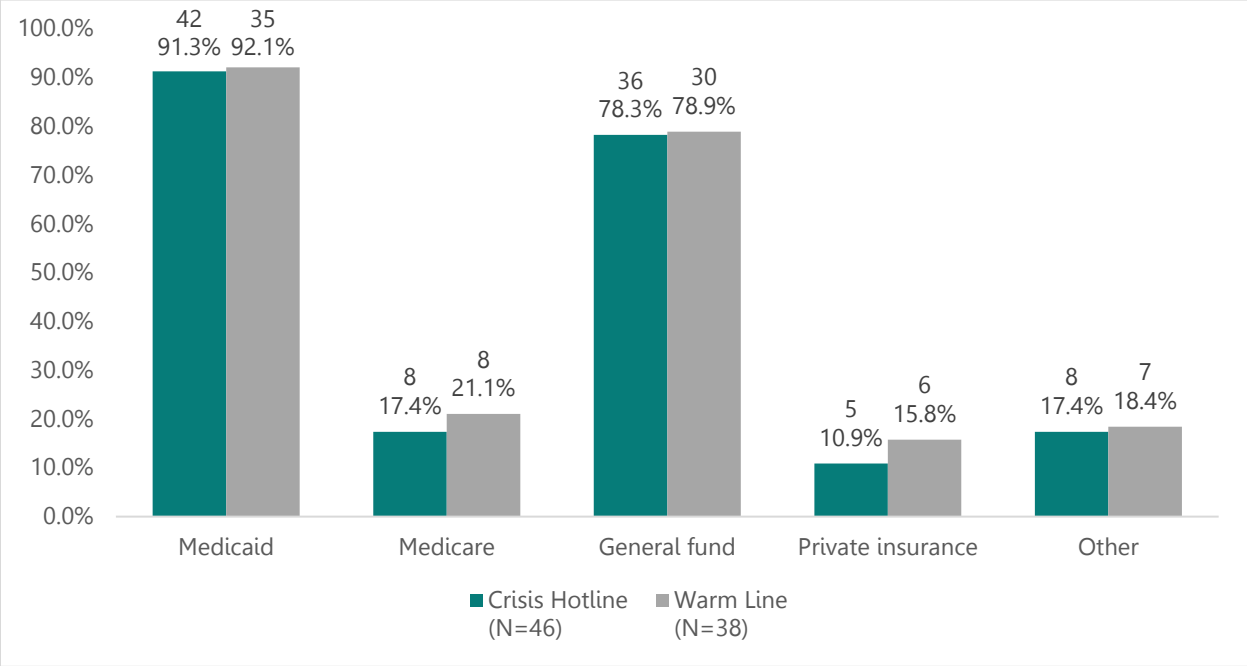
## Call Volume

A total of 31 CMHSPs reported combined call volume data, for both the crisis hotline and warm line, of 28,500 calls per month. These 31 CMHSPs cover 83.6 percent of Michigan's Medicaid population within their geographic boundaries. Please note, some CMHSPs estimated their data and some used actual data. Based on this information, the total call volume for the state is estimated at a little over 400,000 calls a year.

## Funding

CMHSPs were asked to report on the various funding sources for their crisis and warm line services. Medicaid is the primary funding source for both crisis hotlines (91 percent) and warm lines (92 percent) (Figure 1).

**Figure 1: Funding Source(s) for Crisis Hotline (N = 46) and Warm Line (N = 38) Services**




CMHSPs may have reported multiple "Other Funding" sources. Only specified sources are reported below:

| Other Funding Sources | Warm Line | Hotline |
|---|---|---|
| Certified Community Behavioral Health Clinics^ | 2 | 1 |
| Local (including matching, hospital contracts, and health millage) | 1 | 3 |
| Grants (not specified) | 1 | 1 |

*^Certified Community Behavioral Health Clinics are discussed further in the Innovative Initiatives section at the end of the report.*

## Staffing

CMHSPs were asked to report on how their crisis and warm line services are staffed. As shown in Table 2, seven CMHSPs use only internal staff for their crisis and warm lines. For the most part, CMHSPs use contractors either part or all of the time to staff their crisis hotline (85 percent) and warm line (82 percent) services.

**Table 2: Crisis Hotline & Warm Line Staffing Among CMHSPs**

| | Crisis Hotline (N = 46) | | Warm Line (N = 38) | |
|---|---|---|---|---|
| Service Staff | # | % | # | % |
| CMHSP internal staff | 7 | 15.2% | 7 | 18.4% |
| Contracting entity | 6 | 13.0% | 4 | 10.5% |
| Both internal staff and contracting entity | 33 | 71.7% | 27 | 71.1% |

CMHSPs used nine different contractors for crisis hotline services and eight contractors for warm line services. However, two contractors (Gryphon Place and ProtoCall Services) were specifically named by 26 CMHSPs for providing their crisis hotline services and by 21 CMHSPs for providing their warm line services.

**Table 3: Crisis Hotline & Warm Line Contractors**

| | Crisis Hotline* (N = 46) | | Warm Line* (N = 38) | |
|---|---|---|---|---|
| Contracting Entity Used | # | % | # | % |
| ProtoCall | 16 | 34.8% | 12 | 31.6% |
| Gryphon Place | 10 | 21.7% | 9 | 23.7% |
| Another CMHSP** | 4 | 8.7% | 4 | 10.5% |
| Listening Ear | 2 | 4.3% | 2 | 5.3% |
| Behavioral Health Response | 3 | 6.5% | 0 | 0.0% |
| America Back Office | 1 | 2.2% | 1 | 2.6% |
| Family and Children Services | 1 | 2.2% | 1 | 2.6% |
| Covenant Health Care | 1 | 2.2% | 0 | 0.0% |
| Common Ground | 1 | 2.2% | 1 | 2.6% |
| Wellplace | 0 | 00% | 1 | 2.6% |

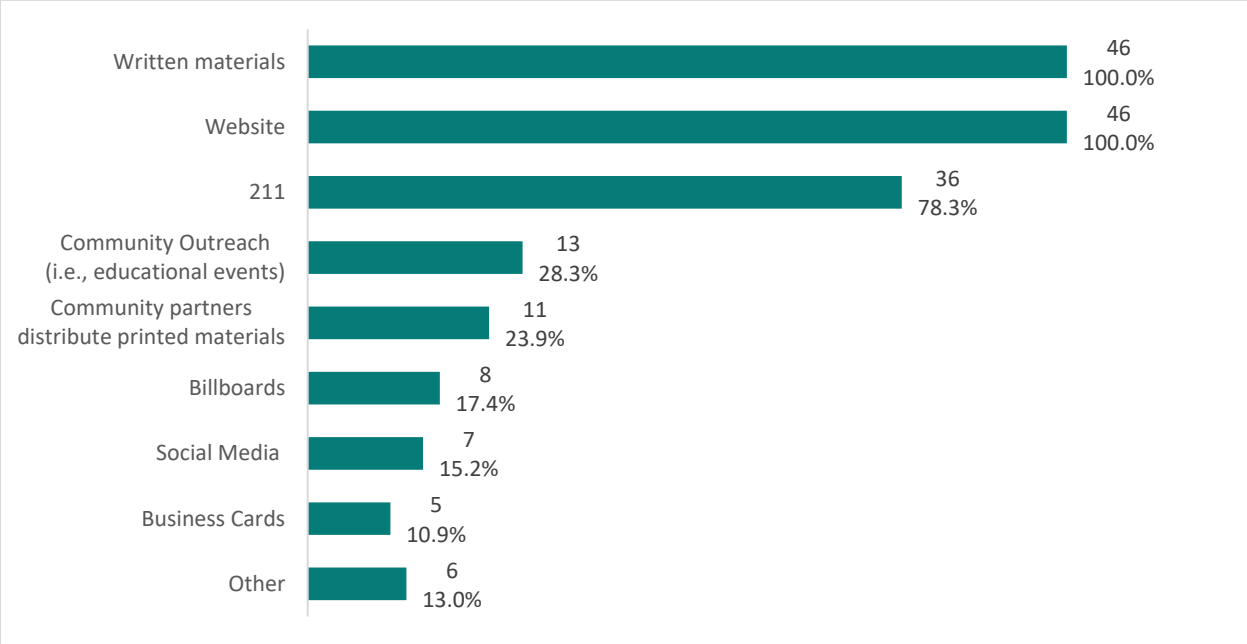
**May add up to more than 100 percent, as some CMHSPs use multiple contractors.*
***Four CMHSPs utilize another CMHSP for their warm line and/or crisis hotline services. For the CMHSPs that provide both crisis and warm line services and use contracted staff, all but one uses the same contractor for both services.*

It was noticeable that there are differences in how crisis hotline and warm line services are structured. For example, while some CMHSPs have a direct crisis hotline, others use their access hub and triage center (or switchboard) to provide these services.

### Crisis Line Awareness

CMHSPs were asked to select all of the different ways the community may know about their crisis phone number. The most common methods are shown in Figure 2.

**Figure 2: Method of Publicizing Crisis Line to Community by % of Reporting CMHSPs (N = 46)**




Outreach methods included in the "Other" category are press releases (n = 2), radio ads (n = 2), phonebook (n = 1), and TV ads (n = 1).

### Other Comments

CMHSPs were given an opportunity to share any additional information about their crisis hotline and/or warm line services.

- Eight CMHSPs reported that they have a combined warm line/crisis hotline that also serves as the access line during business hours.
- Two CMHSPs described that they provide crisis intervention through text and chat features, as well as phone.
- One CMHSP said they are exploring adding Certified Peers as part of the warm line staff.

**Barriers**

Three barriers were also reported that may limit the CMHSP's ability to provide appropriate follow up care. These barriers include:

- Inconsistent location information provided by crisis/warm line callers that, at times, has led to safety concerns around not being able to locate cellphone callers in crisis.
- When using contracted services, it is sometimes difficult to get accurate information from the person calling and may make follow-up care difficult.
- Cell phone calls sometimes disconnect before the staff member can get contact information and thus, the person in crisis cannot be called back.

# Mobile Crisis Services

This section presents information on CMHSPs' provision of mobile crisis services including funding sources, staffing, service locations, barriers, and successes. Mobile Crisis is frequently referred to as Intensive Crisis Stabilization Services as this is the name of the service per the Michigan Medicaid Provider Manual.

**Mobile crisis** is defined as entering the community to begin the process of assessment and definitive treatment outside of a hospital or healthcare facility. This may include providing acute mental health crisis stabilization and psychiatric assessment services to individuals within their homes and in other sites outside of a traditional clinical setting (SAMHSA, 2014; Allen et al., 2002; Scott, 2000).

While CMHSPs were asked if they provide mobile crisis services to adults, they were not asked if they provide this service to children since this has been a mandated service for children since October 2017. Of the 45 CMHSPs who responded to the question of whether they provide mobile crisis services to adults, 18 (40 percent) reported providing this service.

It is of important note, 14 CMHSPs provide mobile crisis services to either children (n = 10) and/or adults (n = 8) 24 hours a day, seven days a week, and will go anywhere in the community that a person may be in crisis.

### Hours of Operation

CMHSPs were asked to provide the actual hours that their mobile crisis services are operational. Times were then coded into four categories: 24 hours, business hours (between 8 am and 6 pm), business and evening hours (between 8 am and 11 pm), and evening and night hours only (between 5 pm and 8 am). For children, half (n = 23) CMHSPs have a mobile crisis team that operates during business hours plus some evening hours with another eight CMHSPs providing mobile crisis 24 hours per day (Table 4). Half (n = 9) of the 18 CMHSPs that provide mobile crisis services for adults operate on a 24 hours per day basis.

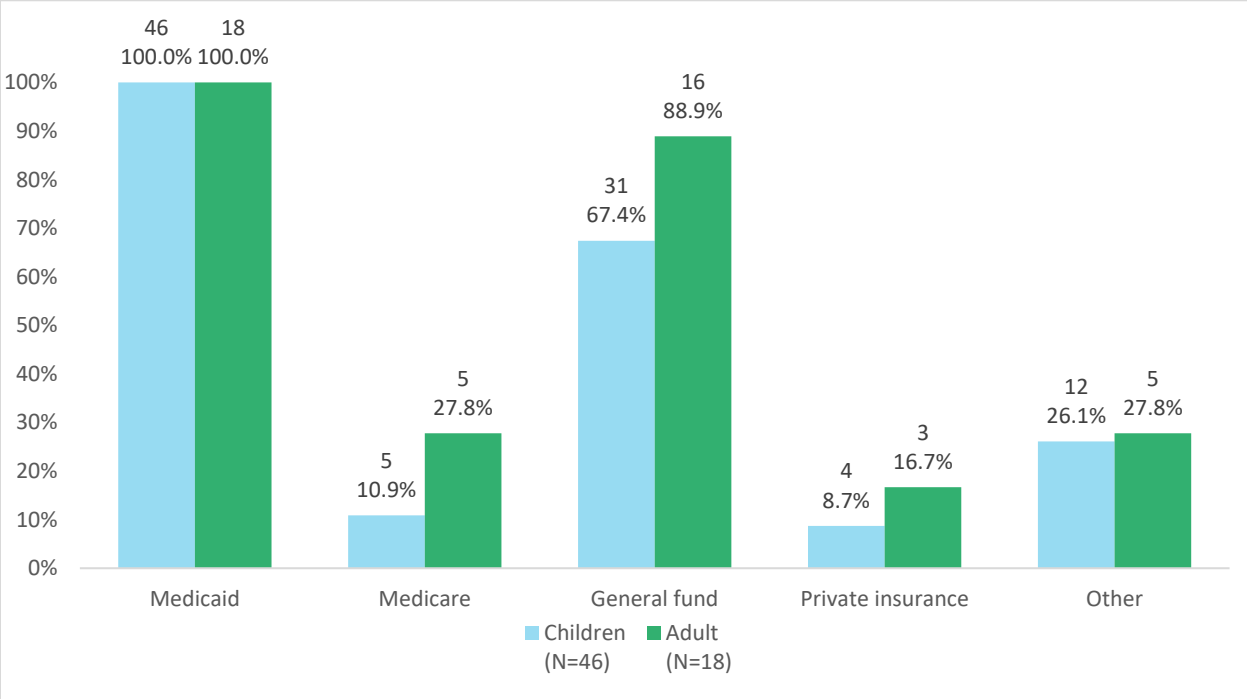
**Table 4: Hours of Operation for Mobile Crisis Services**

| | Children (N = 46) | | Adult (N = 18) | |
|---|---|---|---|---|
| Hours of Operation | # | % | # | % |
| 24 hours | 8 | 17.4% | 9 | 50.0% |
| Business hours | 9 | 19.6% | 6 | 33.3% |
| Business hours + evening hours | 23 | 50.0% | 3 | 16.7% |
| Evening + night hours only | 6 | 13.0% | 0 | 0.0% |

## Funding

CMHSPs were asked to indicate all of the various funding sources for their children and adult mobile crisis services. As Figure 3 shows, all CMHSPs who responded to this question (46 for children and 18 for adults) rely on Medicaid as a funding source. Additionally, General Fund is another key funding source reported by CMHSPs.

**Figure 3: Funding Source(s) for Children (N = 46) and Adult (N = 18) Mobile Crisis Team**



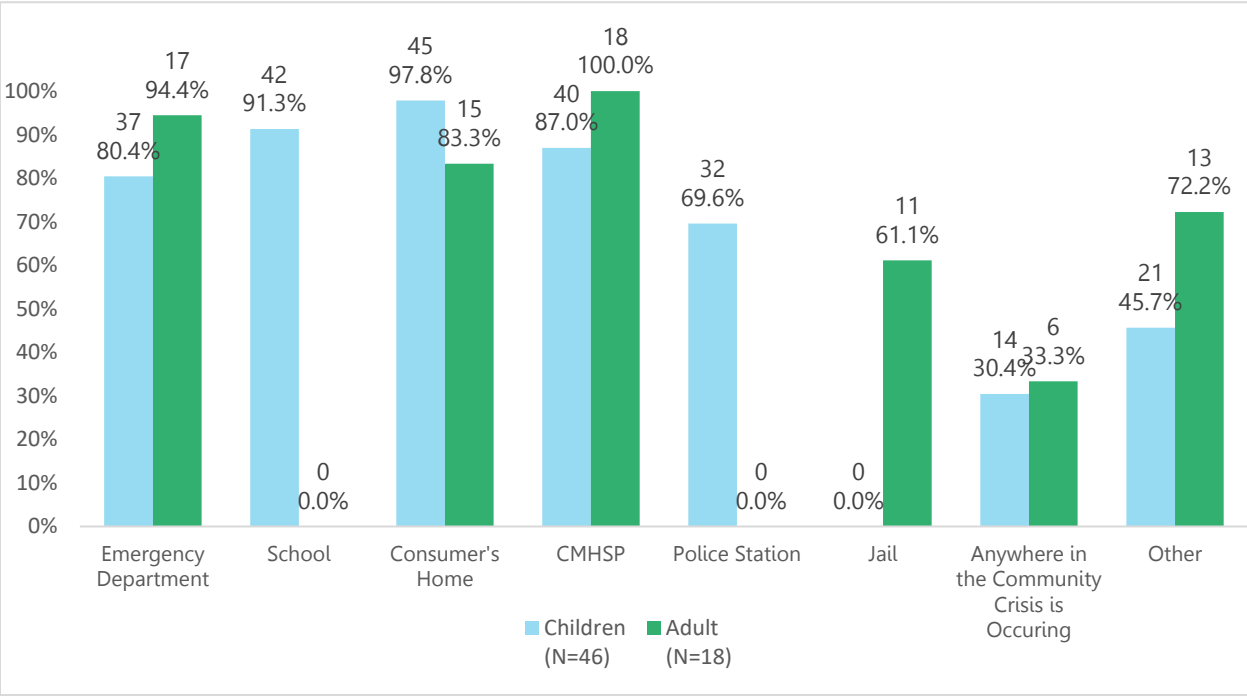

CMHSPs may have reported multiple other funding sources. Only specified sources are reported below:

| Other Funding Sources | Children Mobile Crisis | Adult Mobile Crisis |
|---|---|---|
| Certified Community Behavioral Health Clinic Grant | 3 | 4 |
| Local (including matching and health millage) | 2 | 1 |
| Grants (Michigan Health Endowment Fund and Block Grant) | 2 | -- |

## Locations

CMHSPs were asked if their mobile crisis team served their entire geographical region or only part. All but two (n = 44) CMHSPs provide children's mobile crisis to their entire region and 16 of the 18 CMHSPs provide adult mobile crisis teams service to their entire region. Figure 4 shows the various types of locations within the community where CMHSPs reported providing mobile crisis services to children and adults.

**Figure 4: Locations Where Mobile Crisis Team Provides Children (N = 46) and Adults (N = 18) Services**




Locations that were reported in the "Other" category for both children and adult mobile crisis services include: juvenile and adult courts, doctor offices, businesses, homeless shelters, domestic violence shelters, public libraries, schools, drop-in centers, and parking lots.

### Staffing

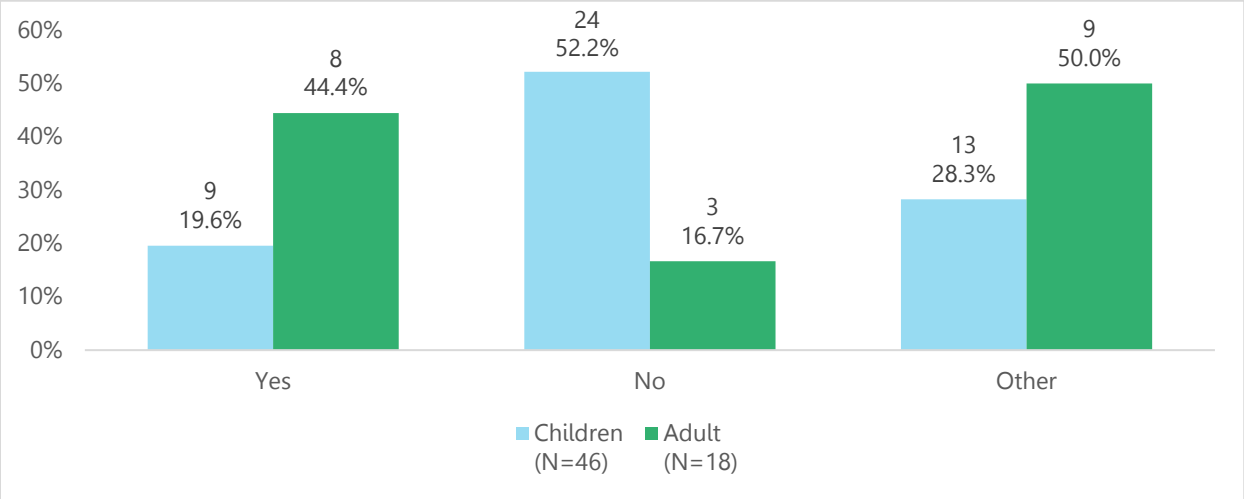
When asked who staffs their child and adult mobile crisis teams, the large majority of CMHSPs indicated that they use internal CMHSP staff either part or all of the time. For example, at least 80 percent of CMHSPs rely solely on internal staff for both their children's (37 of 46) and adult (15 of 18) mobile crisis teams (Table 5).

**Table 5: Mobile Crisis Service Staffing for Children (N = 46) and Adults (N = 18)**

| | Children (N = 46) | | Adult (N = 18) | |
|---|---|---|---|---|
| Service Staff | # | % | # | % |
| CMHSP internal staff | 37 | 80.4% | 15 | 83.3% |
| Contracting entity | 5 | 10.9% | 2 | 11.1% |
| Both internal staff and contracting entity | 4 | 8.7% | 1 | 5.6% |

Only nine (19.6 percent) CMHSPs with children's mobile crisis teams indicated they have full-time mobile crisis staff (Figure 5). For the 18 CMHSPs with an adult mobile crisis team, eight (44.4 percent) of those teams included full-time staff.

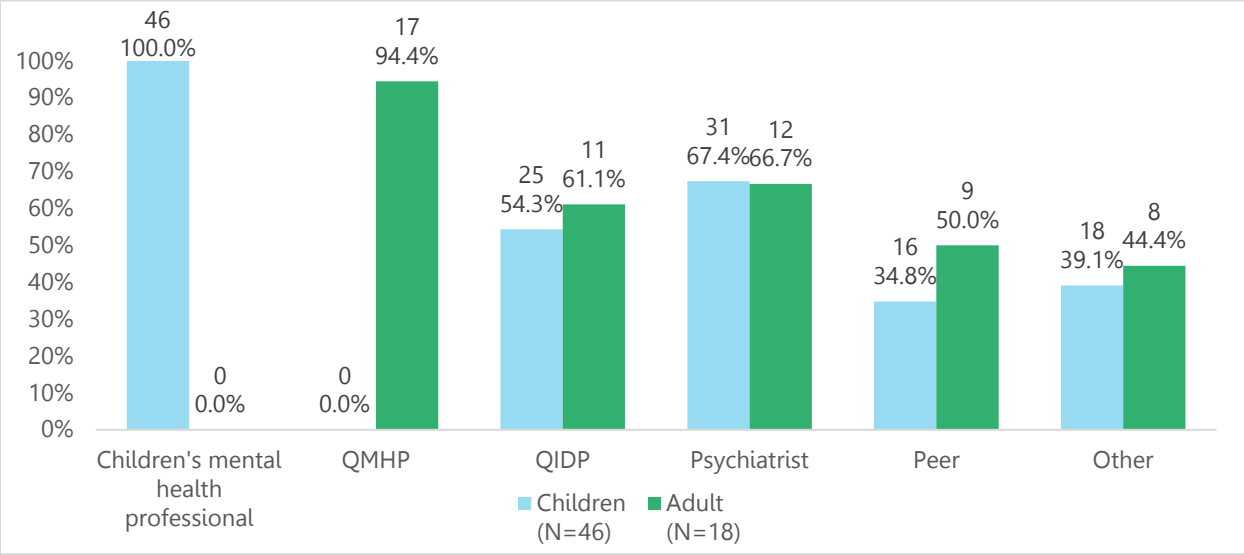
**Figure 5: Full Time Staff for Children (N = 46) and Adult (N = 18) Mobile Crisis Service**




CMHSPs who reported "Other" indicated that their mobile crisis team staff were a mix of full and part time or had other responsibilities beyond providing mobile crisis services.

CMHSPs were asked to list the different types of staff that are utilized for their mobile crisis team. All children's mobile crisis teams included children's mental health professionals, while most adult mobile crisis teams (94.4%) included qualified mental health professionals (QMHP). Over half of mobile crisis teams also included qualified intellectual disability professionals (QIDP) and psychiatrists (Figure 6).

**Figure 6: Staff Type within CMHSPs Children (N = 46) and Adult (N = 18) Mobile Crisis Services**



| Other Types of Staff | Children's Mobile Crisis | Adult Mobile Crisis |
|---|---|---|
| Parent support partner | 3 | 1 |
| Para-Professional | 2 | 1 |
| Social Worker | 2 | -- |
| Community Support Specialist | 1 | -- |
| Nurse | 1 | 3 |
| Student Intern | 1 | -- |
| Home-based Therapist | 1 | -- |
| Psychiatrist | 1 | 1 |
| Psychologist | -- | 1 |
| Recovery Coach | -- | 1 |

**Mobile Crisis Service Model**

CMHSPs were asked to indicate the model that they based their mobile crisis service on for children and for adults. There were eight CMHSPs that responded to this question for children and two for adults. Several listed more than one model as their basis for mobile crisis services. The models are as follows:

| Mobile Crisis Model | Children's Mobile Crisis | Adult Mobile Crisis |
|---|---|---|
| Milwaukee Model | 5 | -- |
| New Jersey Model | 4 | -- |
| Certified Community Behavioral Health Clinic model | 1 | 1 |
| Connecticut Model | 2 | -- |
| Children and Family Assessment Scale, PHQ-A kids, American Psychiatric Association (APA) Task Force model (Allen et al., 2002 and Scott, 2000) | 1 | -- |
| Assertive Community Treatment (ACT) Team | -- | 1 |

Almost all CMHSPs that mentioned an integration of mobile crisis and other crisis services indicated that communication and collaboration between teams was an important aspect of effectiveness and was a primary goal of all teams involved. Of note, integration was more commonly mentioned among moderate to small sized CMHSPs than larger agencies.

**Barriers**

All CMHSPs were provided an opportunity to list any barriers they may have encountered around providing mobile crisis services to children and adults, regardless if they indicated they provided the service. For both children and adult mobile crisis, 43 CMHSPs offered at least one barrier. Table 6 provides a listing of the various responses CMHSPs provided for children and adults.

Please note, this question was asked separately for children and adults and many of the CMHSPs listed the same barrier for both questions.

**Table 6: Barriers to Implementing and Sustaining Mobile Crisis Service Team**

| Barrier | # of CMHSPs indicating for Children | # of CMHSPs indicating for Adult |
|---|---|---|
| CMHSPs have difficulties in staffing the service like hiring qualified master's level staff, retaining staff, balancing staff workloads, and staffing after-hours. This barrier is heightened by the requirement for two staff members to be deployed. | 25 | 24 |
| The current reimbursement structure does not cover the cost of the service for many CMHSPs. | 15 | 16 |
| There is low demand and utilization of service, partially due to lack of awareness of people being served, and this impacts funding and staffing. | 11 | 5 |
| Some communities are resistant to the model, such as community members not wanting staff to enter their home, other community partners already providing similar service, and the preference to access care in emergency departments. | 11 | 2 |
| CMHSPs struggle to ensure staff safety, especially in remote locations with no cell phone service or when law enforcement is not available to accompany CMHSP staff. | 2 | 9 |
| CMHSPs described this model not working for rural communities. Large geographical service areas make accessing people in a timely manner difficult and options for contracting the service limited. | 7 | 4 |
| Hospital staff do not understand the mobile crisis services and the alternative crisis diversion options available to a person in crisis. | 2 | -- |
| It is hard to obtain contracts to serve non-Medicaid children. | 2 | -- |
| CMHSPs struggle to obtain parental authorization of the service, especially if child is located at school at time of crisis and parent does not agree to service. | 2 | -- |
| Medication adjustment is not included in the model. | 1 | -- |
| Coordinating care for children in foster care is difficult. | 1 | -- |

| | | |
|---|---|---|
| The ambulance is not able to transport to locations other than the ED and there is a lack of alternative transportation resources. | -- | 1 |
| A CMHSP with high demand for mobile crisis service has had to prioritize certain people in need at the front end of crisis because of the lack of resources to cover everyone in need. | -- | 1 |

**Factors Contributing to Success**

CMHSPs who provided mobile crisis were asked to provide factors that help make their mobile crisis services successful within the community. Overall, 42 CMHSPs provided at least one success factor for children mobile crisis services and 18 CMHSPs provided at least one success factor for adult mobile crisis services (Table 7).

**Table 7: Factors Contributing to Success of the Mobile Crisis Services Teams**

| Factors Contributing to Success | # of CMHSPs indicating for Children | # of CMHSPs indicating for Adult |
|---|---|---|
| CMHSPs rely on community partner support, such as referrals and long-term collaborations (e.g. Child and Family Services, law enforcement, shelters, local hospitals, and school systems). | 17 | 7 |
| Well-trained and dedicated staff provide the service, as well as supportive leadership. | 17 | 6 |
| CMHSPs use staff flexibly to cover this service, as well as perform other necessary roles in the CMHSP. | 10 | -- |
| CMSHPs educate community partners and use marketing campaigns to promote the service. | 7 | -- |
| Proactive crisis planning and the mobile crisis team is embedded into initial services, such as the triage department. | 2 | 2 |
| Additional funding sources which supported the development and maintenance of the service. | 2 | 2 |
| Communication between teams within the CMHSP leads to enhanced care coordination. | -- | 4 |
| Established clinical relationship with people receiving services helps to effectively resolve crisis situations. | 2 | -- |
| Visiting locations in the community allows care to come to the person in crisis. | -- | 1 |

| | | |
|---|---|---|
| Coordinating care with a primary care physician enhances access to supports. | -- | 1 |
| A steering committee oversees the direction of work. | 1 | -- |
| EHRs allow staff members to attain records and thus, people receive services efficiently. | 1 | -- |
| CMHSPs provide education to staff, so that they can provide better service to the community. | 1 | -- |
| CMHSPs review data on when a service is most utilized and establish hours of operation around this. | 1 | -- |
| The integration with the Parent Support Partner model into mobile crisis team has been beneficial. | 1 | -- |
| Integrating a Crisis Intervention Team (CIT) with mobile crisis has enhanced this service. | -- | 1 |

**Spotlight on Mobile Crisis Team's Indicators of Success**

Throughout the mobile crisis section of the survey, CMHSPs shared several indicators of success for both their children and adult mobile crisis services.

- Responding to where the crisis has occurred has significantly helped the child and family who are in crisis.
- There has been a reduction in psychiatric hospitalization.
- Evidence indicates there has been a reduction in incarceration.
- There has been a decrease in crisis residential placements.
- Mobile crisis teams have kept children out of emergency rooms.
- There has been an increased diversion rate of in-person admissions.
- CMHSPs shared they have heard and seen many individual's success stories.

# Psychiatric Emergency Center or Standalone Behavioral Health Crisis Center

CMHSPs were asked if they have a psychiatric emergency center (PEC) and whether or not they operate a standalone behavioral health crisis center for children and adults. For both types of centers, follow up information was asked about hours of operation, funding sources, and staffing. Although information about PECs and standalone behavioral health treatment centers were collected through separate lines of questions, their results are presented together within this section because of their close similarity in definition and service. It should also be noted that psychiatric emergency centers and standalone behavioral health crisis centers may be referred to by different names such as Crisis Receiving and Stabilization Units, Psychiatric Emergency Services (PESs), Comprehensive Psychiatric Emergency Programs (CPEPs), Clinical Decision Units (CDUs), and more recently, Emergency Psychiatry Assessment, Treatment, and Healing units, or EmPATH units[3]. Moreover, this report only presents information about PECs and standalone behavioral health crisis centers that are operated by CMHSPs directly or through a contract, they do not include centers that are operated by hospitals. These do exist in Michigan but are outside the scope of this report.

A **psychiatric emergency center (PEC)** is a facility with medical and mental health services that individuals in crisis can come to or be brought to for a period of up to 24 hours for evaluation and physical and mental healthcare services.

A **standalone behavioral health crisis center** is functionally a behavioral health emergency department which provides a 23-hour crisis observation or stabilization function but does not necessarily provide physical healthcare (Fitton and Reagan, 2018).

According to the survey results, no CMHSP currently offers a PEC for children or adults that meets the definition provided here and on the survey. One (2.2 percent) of Michigan's 46 CMHSPs has a standalone behavioral health crisis center for children. Three (6.7 percent) of the 45 responding CMHSPs operate a standalone behavioral health crisis center for adults.

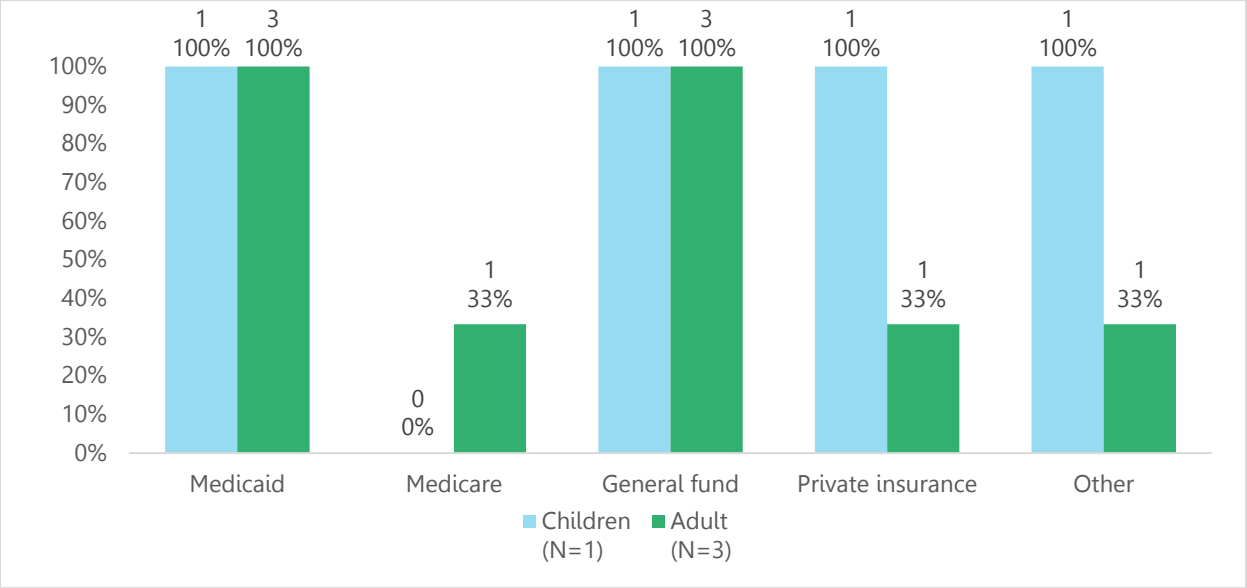
Three CMHSPs reported they were in the process of developing a standalone behavioral health crisis center for children and adults at the time this information was collected. Another CMHSP indicated they are developing a psychiatric emergency service for adults.

[3] Zeller, Scott. "Hospital-Level Psychiatric Emergency Department Models." Psychiatric Times, vol. 36, ser. 12, 31 Dec. 2019. https://www.psychiatrictimes.com/view/two-perspectives-emergency-medicine-and-psychiatry

## Funding

CMHSPs were asked to report on each of the funding sources they rely on for their standalone behavioral health crisis centers. As Figure 7 indicates, each of the children and adult standalone behavioral health crisis centers depend on Medicaid and General Fund to help support this service.

**Figure 7: Source(s) of Funding for Children (N = 1) and Adult (N = 3) Standalone Behavioral Health Crisis Center**




An example of funding sources in the "Other" category include Certified Community Behavioral Health Clinics Expansion Grant for both children and adult centers.

## Staffing

For the one CMHSP that provides a standalone behavioral crisis center for children and adults, internal staff are used for both services. The other two CMHSPs that only provide this service for adults rely on contractors to staff their centers.

# Co-located Behavioral Health Crisis Emergency Services

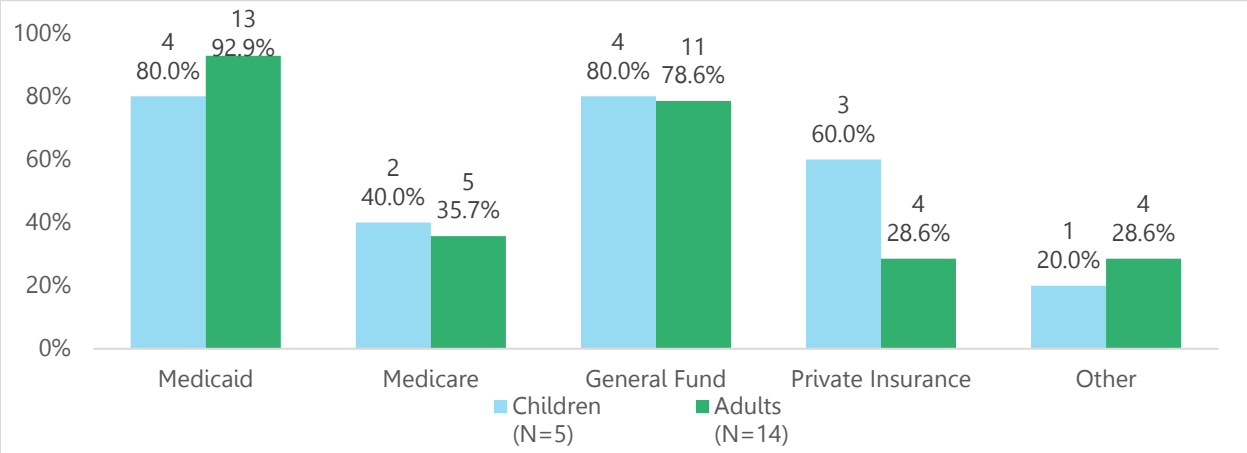
CMHSPs were asked if they provide staff for co-located behavioral health crisis emergency services for children and adults in a hospital emergency department. In order to be counted as having co-located staff, a CMHSP must have staff stationed within an emergency department for a specified period of time rather than responding to the emergency department when called. For example, several CMHSPs who indicated they have co-located staff at an emergency department commented that they send their mobile crisis team or preadmission screening staff to EDs upon request. In such cases, those CMHSPs were not counted as having co-located staff.

After a thorough review of the responses, it was determined that five (11 percent) of the 46 CMHSPs provide staff for co-located behavioral health crisis emergency services for children in a hospital emergency department. These five CMHSPs that offered children co-located service also had an adult co-located service. Nearly three times as many CMHSPs (14 of the 45 responding CMHSPs) provide similar staffing but targeted to adults. Two of these CMHSPs specifically noted that they provide this service but serve all age ranges including children and adults.

### Funding

CMHSPs offering children and adult co-located behavioral health crisis services reported the type of funding source used. As shown in Figure 8, Medicaid is the main financial source for children (n = 4) and adults (n = 13). Additionally, General Fund were also reported by four of the five CMHSPs providing co-located staff for children.

**Figure 8: Funding Source(s) for Children (N = 5) and Adult (N = 14) Co-Located Behavioral Health Crisis Services**

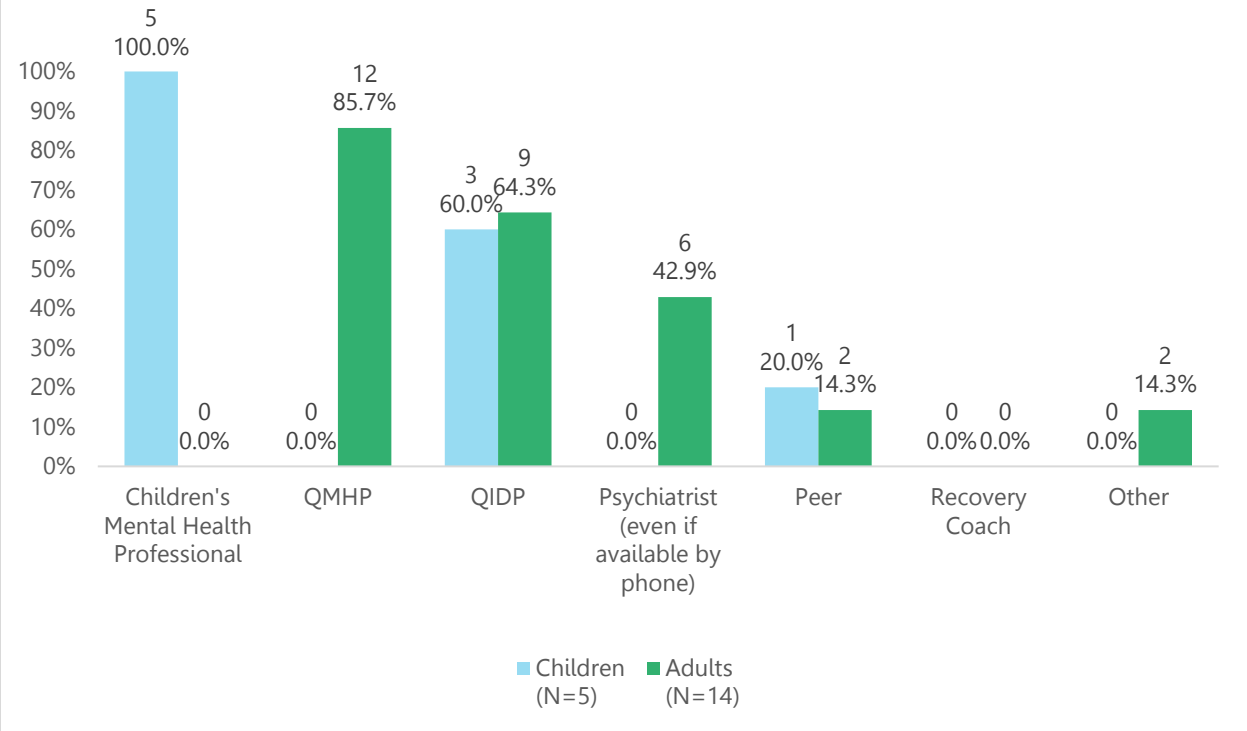


| Other Funding Sources | Children Co-located Service | Adult Co-Located Service |
|---|---|---|
| Hospital contracts and cost sharing w/ hospital | 1 | 2 |
| Other Grants | -- | 1 |
| VA Benefits | -- | 1 |

**Staffing**

CMHSPs were asked to report on each of the different types of staff that are utilized for the co-located behavioral health team in a hospital emergency department. As shown in Figure 9, the most common staffing type for children is Children's Mental Health Professional (n = 5) and then Qualified Intellectual Disabilities Professional (n = 3). As for adults, the most cited staff type was Qualified Mental Health Professional (n = 12) followed by Qualified Intellectual Disabilities Professional (n = 9).

**Figure 9: Staff Type for Children (N = 5) and Adult (N = 14) Co-Located Behavioral Health Crisis Services**




Other staffing types reported by CMHSPs include: Registered Nurse (n = 1), Certified Nurse Practitioner (n = 1), Physician's Assistant (n = 1), and master's level clinician (n = 1).

# Substance Use Disorder Treatment Services

Many crises involve substances and/or substance use disorders in addition to mental health issues. PIHPS are responsible for providing authorization, referrals, and placement for publicly funded substance use disorder services. Some PIHPs fulfill these responsibilities directly and some delegate these responsibilities, at least partially. CMHSPs must respond to mental health crises regardless of whether or not there are substances involved. To learn more about how CMHSPs handle such situations, a series of questions were asked that relate to the pre-screening, referral, and placement protocols used when substance use is part of the crisis response.

**SUD Trends in Pre-screens**

CMHSPs were asked if they could provide information about the frequency that substance use/abuse is a factor in pre-screens. Of the 15 CMHSPs that responded, 13 were able to provide a statistical estimate on their region's pre-screens. The 13 CMHSPs responded that 24 percent to 75 percent of the pre-screened population were under the influence of drugs/alcohol or had a SUD diagnosis. Specifically, five CMHSPs indicated at least 50 percent or more of pre-screened people were under the influence of drugs/alcohol or had a previous SUD diagnosis. Of note, although the question did not ask about the rate of a co-occurring diagnosis, six CMHSPs said they have a high percentage of people who have a co-occurring diagnosis. Two of the six shared data that 40 percent and 53 percent of pre-screens had a co-occurring diagnosis. Another CMHSP said their percent increased as treatment progressed.

**Emergent SUD Treatment Process**

CMHSPs were asked to identify how their staff refer to substance use disorder treatment services in an emergent situation. Several CMHSPs provided very detailed descriptions of their SUD processes while others simply indicated that they refer to the PIHP. Twenty-seven CMHSPs provided information regarding the authorizing entity for providing behavioral health treatment when SUD is involved.

- Twenty-two (81 percent) CMHSPs indicated they refer to the PIHP for authorization of services or placement.
- Five (19 percent) CMHSPs indicated that the PIHP delegates authorization of services to their agency.

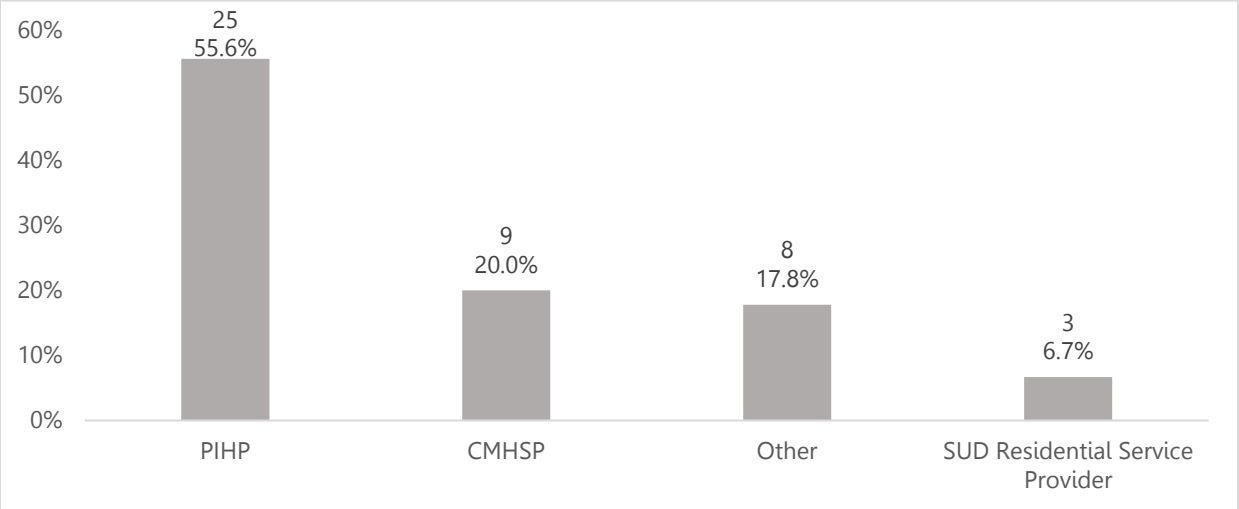
Other referral processes reported by 35 CMHSPs are summarized below. Please note, some CMHSPs listed multiple processes within their responses so they may be included in more than one category.

- Twenty-four directly refer people to SUD services (Outpatient, Detox, Sobering Facility, Short Term Housing, other community provider, etc.).
- Seventeen CMHSPs offer these immediate services (PAS, brief screen, assessment/ASAM).
- Eight assist people in a warm referral and assist them in connecting with community resources available to them in the area (i.e., local non-profits, local ED, etc.).
- Five use emergency department for medical concerns/acute withdrawal.
- Four CMHSPs specifically mentioned that services or the PIHP is available after business hours.
- Six CMHSPs specifically mentioned that they require PIHP authorization for services and the PIHP is NOT available after business hours.

It is to be noted that information was volunteered by the respondent and omission of a particular process, does not mean that it does not exist (i.e., even though the CMHSP did not state that they refer to PIHP for authorization, this could still be a part of their process).

In a multiple-choice question, CMHSPs were also asked who completed the screening for authorization of residential SUD services. As indicated in Figure 10, the majority of CMHSPs responded that the PIHP was the authorizing agent for SUD residential placements. CMHSPs (n = 6) described that the person in crisis/CMHSP staff utilized the emergency department until the authorizing agency was able to make a placement determination.

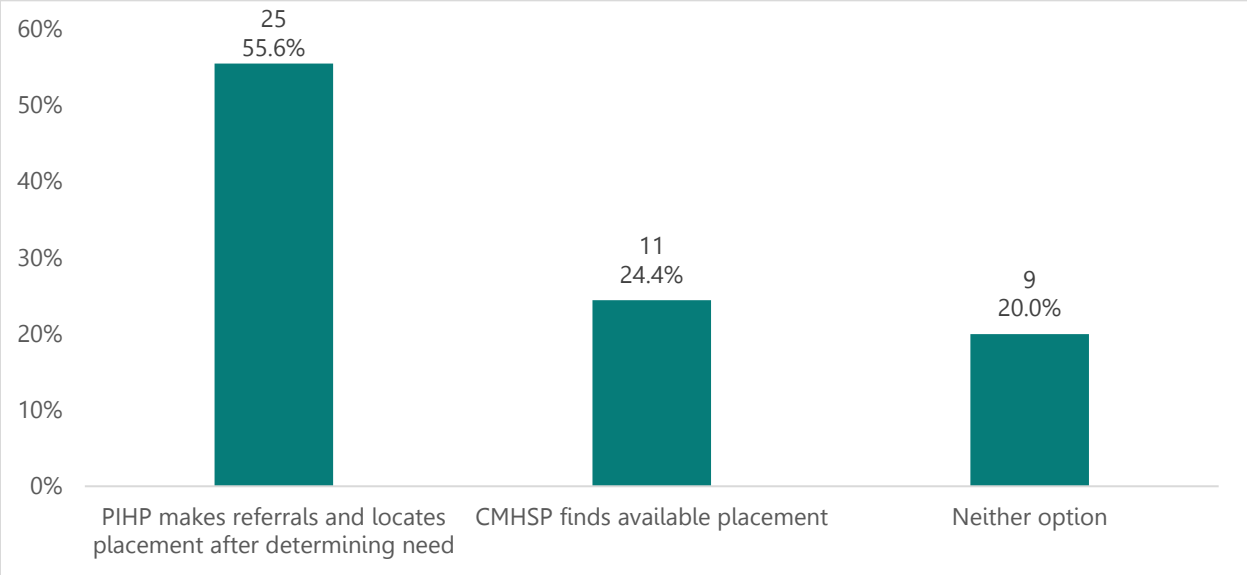
**Figure 10: Entity Completing Authorization Screening for SUD Residential (N = 45)**




All CMHSPs indicating the PIHP was the authorizing entity for SUD services, also stated that they utilized the PIHP in placing people in residential SUD services (Figure 11). For SUD residential placement, nine CMHSPs indicated "other". Many of these responses allowed for a combination

of placement methods, including that the CMHSP assisted in the placement for SUD residential services (n = 7) or that contracted entities make the referrals (n = 2).

**Figure 11: Method for Placing A Person in SUD Residential (N = 45)**



# Unplanned Crisis Respite Services

CMHSPs were asked if they provide unplanned crisis respite services for children and adults. In total, 19 (41 percent) of the 46 CMHSPs provide unplanned crisis respite for children. Ten (22 percent) of the 45 responding CMHSPs provide unplanned crisis respite for adults.

**Crisis respite centers and apartments** provide 24-hour observation and support by crisis workers or trained volunteers until a person is stabilized and connected with other supports. In some locations, peer support specialists provide encouragement, support, assistance and role models in a non-threatening atmosphere (National Alliance on Mental Illness).

CMHSPs that provide respite services were given an opportunity to describe their service in more detail. Additional information from several CMHSPs that provide unplanned respite to children include:

- Three CMHSPs indicated that they use crisis residential for providing respite.
- One CMHSP indicated they provide in-home crisis respite services for caregivers of children.
- One CMHSP indicated they contract with the circuit court to provide respite and crisis placements in foster families.
- One CMHSP indicated they use a contractor with a six-bed respite home and reserve two beds daily that can be used when families are in crisis.

Of the ten CMHSPs that provide unplanned crisis respite for adults, four CMHSPs specifically mentioned that they use unplanned crisis respite for populations with intellectual or developmental disabilities. The other six CMHSPs did not indicate a specific population that this service is intended for.

**Barriers**

Although not directly asked, several CMHSPs listed some limitations or barriers they have encountered with providing unplanned respite services as summarized below.

| | # of CMHSPs providing children respite | # of CMHSPs providing adult respite |
|---|---|---|
| Accessing care on short notice is difficult, even with a list of approved providers. | 2 | 1 |
| The licensing requirements for respite has made providing emergency crisis respite difficult. | 1 | -- |

# Crisis Residential Services

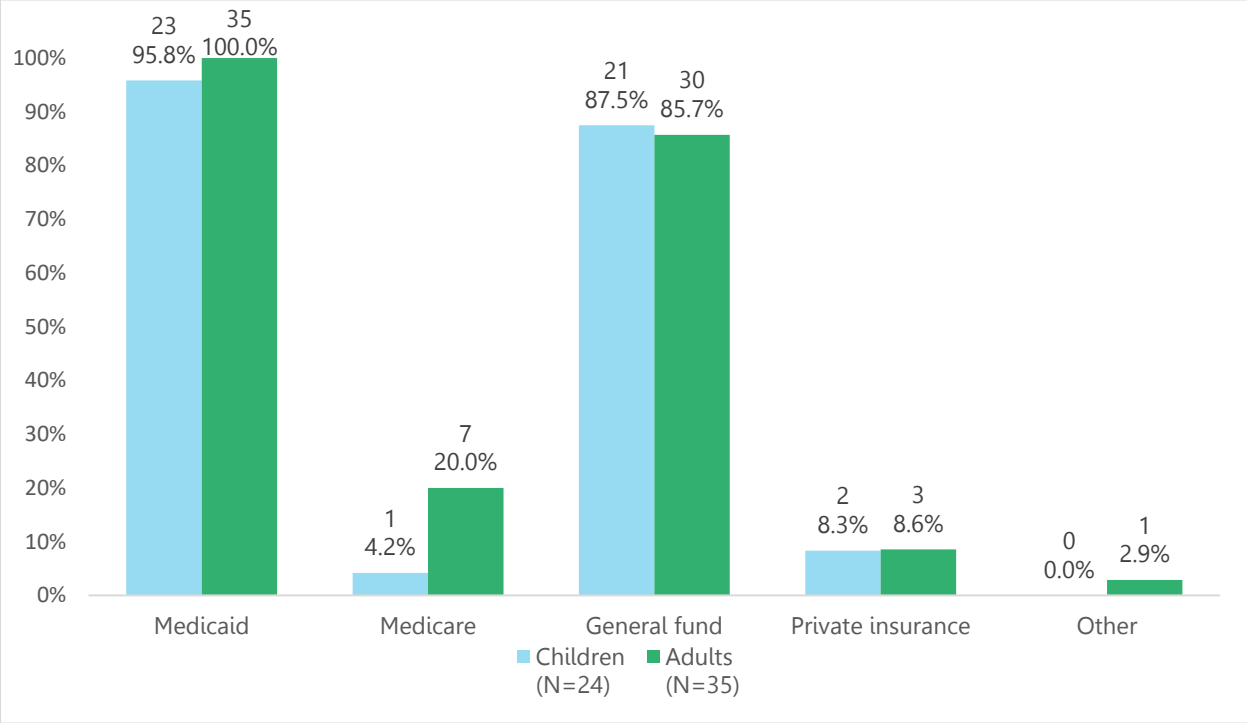
CMHSPs were asked whether they provide crisis residential services to children and adults. Just over half (24 out of 46) CMHSPs provide crisis residential services for children and youth while slightly more than three-fourths (35 out of 45 responding CMHSPs) provide crisis residential services for adults.

**Crisis residential services** are short-term, community-based services in a home-like setting with multi-day lengths of stay, often serving as a step-down from, or an alternative to, psychiatric hospitalization (Crisis Residential Association).

### Funding

CMHSPs were asked to list each of the funding sources for their crisis residential services for both children and adults. For children, 23 (96 percent) of the 24 CMHSPs rely on Medicaid and 21 (87 percent) also relying on General Fund (Figure 12). For adult residential crisis services, all 35 CMHSPs rely on Medicaid and 30 (86 percent) of these CMHSPs rely on General Fund.

**Figure 12: Funding Source(s) for Children (N = 24) and Adult (N = 35) Crisis Residential Services**




Funding sources in the "Other" category include VA Benefits (n = 1).

### Staffing

Of the 24 CMHSPs that provide crisis residential services for children, all are provided by a contracting entity (Table 8). Similarly, 34 out of 35 CMHSPs providing crisis residential services for adults rely solely or in-part on contractors for their staffing. One CMHSP uses only internal staff for their adult crisis residential services.

**Table 8: Crisis Residential Service Staffing for Children (N = 24) and Adults (N = 35)**

| | Children (N = 24) | | Adult (N = 35) | |
|---|---|---|---|---|
| Service Staff | # | % | # | % |
| CMHSP internal staff | 0 | 0% | 1 | 2.9% |
| Contracting entity | 24 | 100% | 32 | 91.4% |
| Both internal staff and contracting entity | 0 | 0% | 2 | 5.7% |

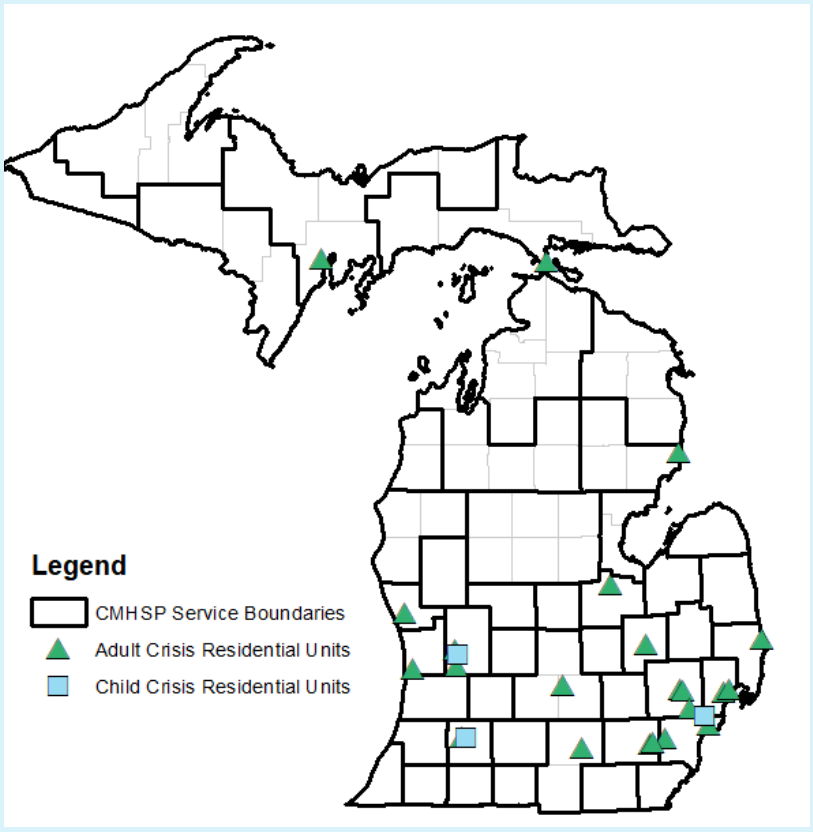
## Number of Crisis Residential Beds

In order to inform future conversations, the authors of this report decided that it was critical to add the number of beds at each of the crisis residential units to this report. Data was pulled from the Department of Licensing and Regulatory Affairs website as well as the individual crisis residential units' websites. It was determined that there are four children crisis residential contractor locations and 22 crisis residential locations for adults. The children crisis residential locations are licensed for six beds or less, except for one that is licensed for 7 to 12 beds; resulting in a maximum of 30 children crisis residential beds to which CMHSPs have access. Of the adult locations, 11 are licensed for one to six beds, six locations are licensed for seven to 12 beds, and an additional five locations are licensed for 13 to 20 beds. Therefore, there are no more than 278 beds statewide for adults assuming each location maintained the maximum number of beds.

## Locations of Crisis Residential Units

As Figure 13 represents, there is an uneven distribution of crisis residential units for both children and adults across the state. Please note, that two children crisis residential units are next door to each other, so only three blue squares are visible on the map. Furthermore, it should be clarified that the map only represents the crisis residential units that were reported by CMHSPs in the survey.

**Figure 13: Locations of Crisis Residential Units for Children (N = 24) and Adults (N = 35)**



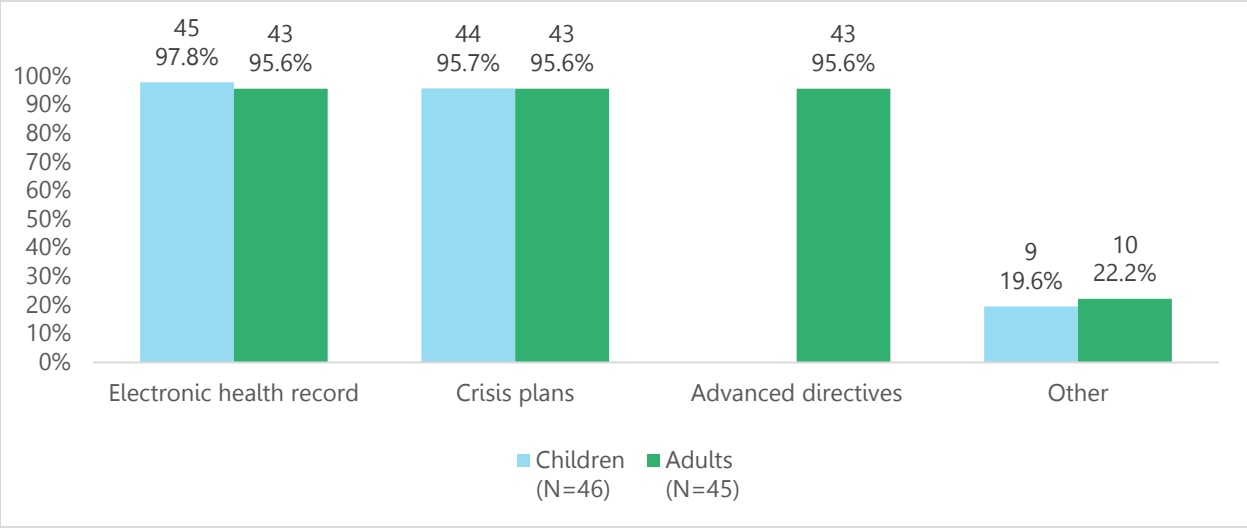
# Pre-Admission Screening (PAS)

### Records of People Receiving Services

CMHSPs were asked to provide information about the types of records they can access for children and adults while administering a pre-admission screen. As Figure 14 indicates, the majority of the 46 CMHSPs have access to crisis plans and electronic health records for a child. Among the 45 CMHSPs who responded for adults, similar findings were reported, but with the addition of advanced directives, as this was not an option for children.

**Pre-Admission Screening (PAS)** is also referred to as pre-screens, or pre-screening and is required through the Michigan Mental Health Code (Section 330.1409) to be administered by a mental health professional for persons in crisis by CMHSPs to determine medical necessity for an in-patient setting. If the person in crisis does not have medical necessity to be admitted, stabilization services can be provided, or crisis residential, or another crisis service along the spectrum of crisis services. The region's Prepaid Inpatient Health Plan (PIHP) should be notified of the person in crisis and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.

**Figure 14: Types of Records CMHSPs have Access to for Children (N = 46) and Adults (N = 45)**




Only specified sources are reported below for other types of person records:

| | Children | Adults |
|---|---|---|
| Appointments/Previous Services | 2 | 2 |
| Psychological/Psychiatric Evaluations | 2 | 2 |
| Medications | 1 | 1 |
| ER Records | -- | 1 |

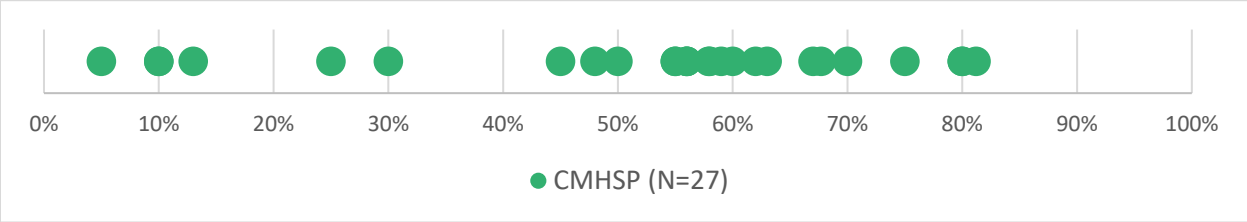
### EHR Platforms

CMHSPs were also asked which platform they used for their Electronic Health Record. The majority of CMHSPs used the company PCE at 82.6 percent (n = 38) and 13 percent (n = 6) using Streamline, while one CMHSP used "other", and one CMHSP was missing data.

### Person Open to Services

CMHSPs were asked to indicate the percent of the people who are pre-screened through their CMHSP over the course of a fiscal year who are not receiving services at the time of the pre-screen. Of the 27 CMHSPs who provided this information, more than half (n = 18) of CMHSPs reported that the majority of the persons they pre-screen are not open to services at the CMHSP.

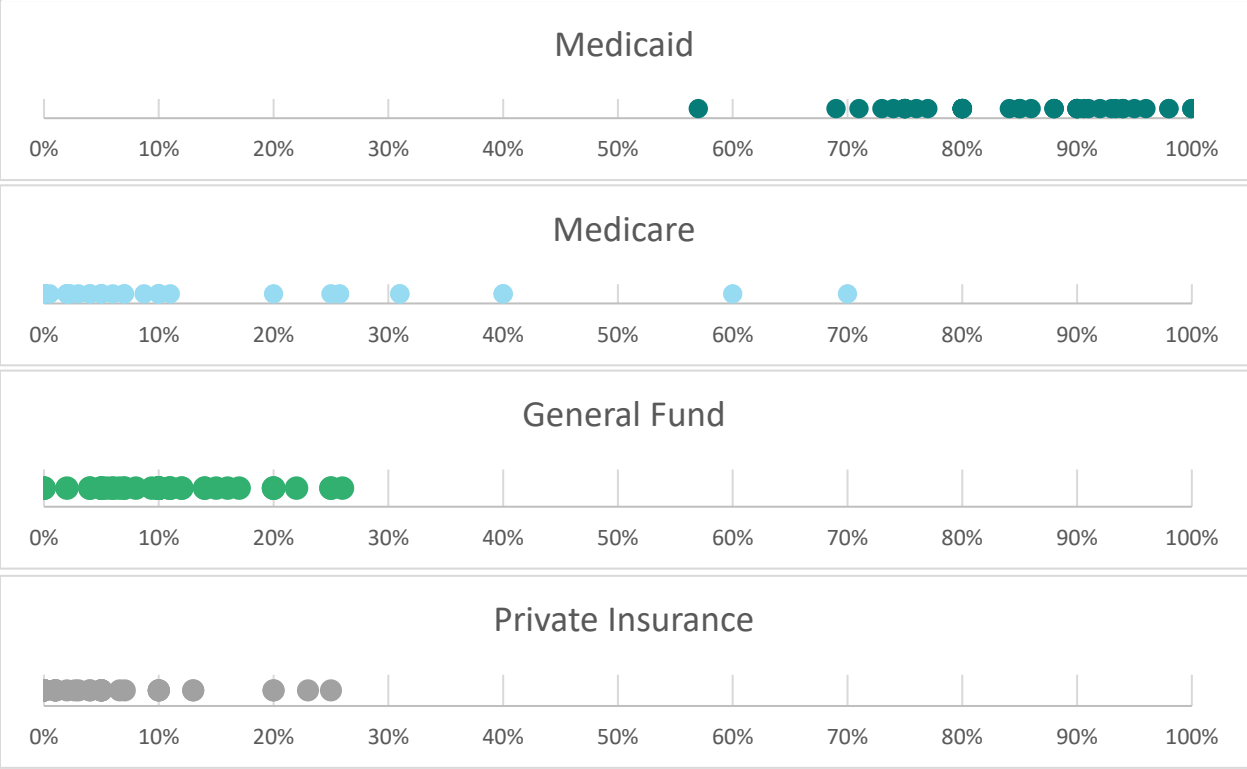
**Figure 15: Estimated Percent of People Not Open to CMHSP Services at the Time of Pre-screen (N = 27)**




### Funding

CMHSPs were asked to estimate the percentage of pre-screened individuals who are enrolled in Medicaid (primary or secondary), Medicare, private insurance and/or CMHSPs use General Fund dollars to cover the cost of pre-screens. All CMHSPs who responded indicated that at least 50 percent or more of their pre-screened population were insured through Medicaid, with the majority at or above 70 percent. Seven CMHSPs provided estimates that Medicare was used for more than 20 percent of their pre-screen population.

**Figure 16: Estimate of CMHSP Population Pre-Screened by Funding Source (N=45)**




**Staffing**

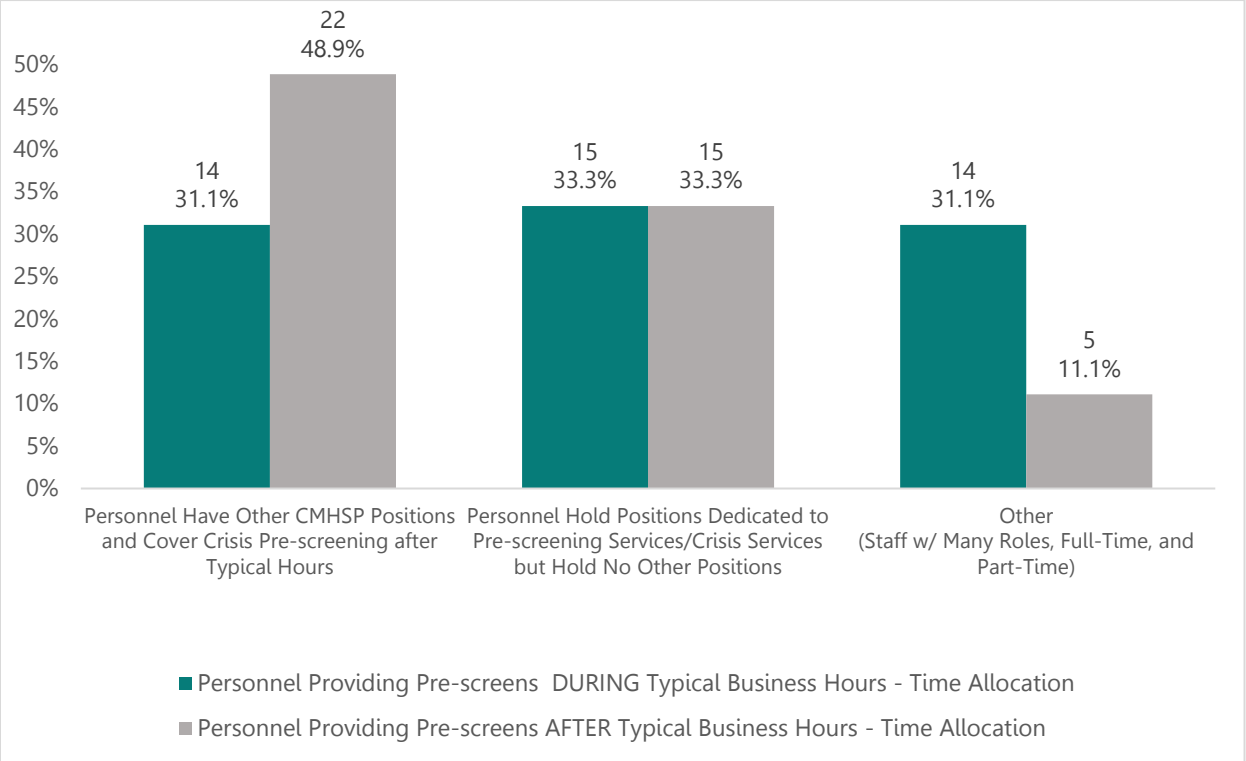
CMHSPs were asked about the types of staff who provide pre-screens for psychiatric hospitalization or out of home crisis services both during and after business hours. The majority (34 out of 45) of CMHSPs indicated that their internal staff are conducting pre-screens during and after business hours. Only two CMHSPs indicated that they only use contractors for pre-screening services during and after business hours.

**Table 9: Type of Staff Among CMHSPs Performing Pre-Screens (N = 45)**

| | Staff Providing Pre-screens DURING Typical Business Hours (N = 45) | | Staff Providing Pre-screens AFTER Typical Business Hours (N = 45) | |
|---|---|---|---|---|
| Service Staff | # | % | # | % |
| CMHSP internal staff | 38 | 84.4% | 35 | 77.8% |
| Contracting entity | 2 | 4.4% | 3 | 6.7% |
| Both internal staff and contracting entity | 5 | 11.1% | 7 | 15.6% |

CMHSPs were asked to describe the types of pre-screening staff in more detail. As Figure 17 shows, almost half the CMHSP staff providing after hours pre-screen have other positions at the CMHSP.

**Figure 17: Type of Internal Staff Among CMHSPs Performing Pre-Screens (N = 45)**



# Other Crisis Services

In addition to the crisis services described in the sections above, CMHSPs were asked if they provide any other crisis services for children and/or adults.

Ten CMHSPs listed other crisis services that they provide for children, including:

- Intensive Crisis Stabilization including 30 and up to 90-day crisis follow-up services such as: homebased therapy, family therapy, short-term case management, outpatient therapy, and/or warm transition to follow-up services (n = 4)
- Urgent psychiatric care services (n = 4)
- Home-based phone coaching, including adolescent dialectical behavior therapy (DBT) phone coaching and wraparound services (n = 2)
- A therapist can be sent to any school in the county through a grant-funded initiative (n = 1)
- Critical incident debriefs performed in the school or at the CMHSP for youth impacted by a critical incident (n = 1)

Thirteen CMHSPs listed other crisis services that they provide for adults, including:

- Intensive Crisis Stabilization services including case management, targeted case management, peer support services, and outpatient therapy (n = 9)
- Link and coordinate persons with ongoing resources (n = 4)
- Urgent psychiatric treatment and emergency doctors' appointments (n = 4)
- Behavioral, psychology, or risk assessments (n = 3)
- Link person with behavioral health homes for follow up care and intensive home or community living supports (n = 3)
- Safety planning and wellness calls (n = 3)
- Referral to evidence-based therapy (n = 2)
- Connection to benefits or assistance with Medicaid (n = 2)
- Psychiatric supervision and medication reviews (n = 2)
- After-hours crisis supports, such as an after-hours Engagement Center (n = 2)
- State approved Intensive Crisis Stabilization program (n = 1)
- Contract with providers for detox services and SUD intensive stabilization (n = 1)
- Offer transportation to services (n = 1)

# Barriers to Crisis Services

In addition to the barriers reported for specific crisis services listed throughout the sections above, CMHSPs were also provided an additional opportunity to share any other barriers they may have experienced with providing crisis services to children and adults. In general, all the barriers reported by the 15 responding CMHSPs could be categorized into one of four buckets (challenges with placement, staffing, transportation, and funding).

**Table 10: Other Barriers shared by CMHSPs**

| **Barrier** |
|---|
| Challenges with Placement (n = 11) |
| • There is a shortage of psychiatric beds and especially for certain consumer profiles.<br>• Lack of appropriate services for IDD or ASD diagnosed populations makes placing a the individual difficult.<br>• There is a shortage of programs for a person with a crisis and substance use disorders co-occurring need.<br>• CMHSPs have encounters with individuals who do not qualify for their services because other community supports have long waitlists.<br>• Finding alternative options for both children and adults including AFC placements, therapeutic foster care homes, transitional housing, state hospitalization placements and other options in the continuum of care is challenging.<br>• CMHSP struggles to serve individuals along state border and coordinate care for Michigan residents when they access care in border states' ED.<br>• The state hospital has been unresponsive or slow to placement requests.<br>• Community Inpatient Hospitals now require a nurse-to-nurse consult and lab results prior to accepting a person served for admission, which can lead to longer wait times in the ED. |
| Staffing Issues (n = 6) |
| • CMHSP staff often have multiple responsibilities in addition to crisis work, which leads to burn out and continuous staff shortages. |
| Transportation Issues (n = 2) |
| • Transportation to services is challenging especially when facilities are far away. |
| Funding (n = 2) |
| • One of the two CMHSPs specifically called out that finding funding for adult mobile crisis services is a challenge.<br>• Another CMHSP mentioned that they need crisis services for children, but due to a lack of additional funds, there is not enough staff to provide these services. |

# Innovative Initiatives

CMHSPs were invited to share any innovative initiatives their CMHSP may be doing or are planning to do in the near future. In addition, this section incorporates data from across the survey and expands upon previous sections. Please note, these initiatives only cover what was reported and perceived by the respondent as worthy of recognition. CMHSPs may not have mentioned an intervention even though they do provide it, therefore, the frequencies included here should be considered as minimums.

### a. Community Organization Partnerships

CMHSPs described long-term partnerships with a variety of community organizations that support crisis work and service collaboration. Some examples of these joint partnerships include:

- Work with a local affordable housing provider to help secure individuals safe and affordable housing options.
- Send a therapist into the district schools through a grant initiative.
- Provide crisis intervention services to students attending universities and colleges in the area.
- Supply iPads to the local emergency rooms, jails, and some law enforcement agency vehicles, so that partners can connect the individual in crisis with CMHSP staff, thereby receiving crisis services virtually without wait.

### b. Jail Diversion and Partnerships with Law Enforcement

Jails and law enforcement are specific community partners that several CMHSPs mentioned working with in providing crisis services. One CMHSP indicated they have staff stationed at the jail who provide crisis services for inmates that have mental health issues discovered in pre-booking or while incarcerated. Another CMHSP has clinical staff that work within the jail and at local police departments. These staff provide ride along services with the police to assist in follow up or in situations that require behavioral health support. A third CMHSP works with some of the local police departments to establish co-responder activities to follow up on individuals who have experienced crisis in their departments. The goal of the initiative is to engage people with services and or revise their treatment plan.

Three CMHSPs shared that they provide Crisis Intervention Team Training to police, sheriffs, and jail deputies. In addition, one CMHSP indicated their group meets regularly and offers other trainings on jail diversion options including hospitalization, crisis residential and intensive outpatient services to these partners. This CMHSP, in partnership with law enforcement and other community stakeholders, is in the process of starting a mental health court.

### c. Certified Community Behavioral Health Clinics

Throughout the survey, CMHSPs were asked about their funding for each crisis service. Four CMHSPs indicated they used Certified Community Behavioral Health Clinic Expansion Grant funding for at least one of their services. Certified Community Behavioral Health Clinic is a federally recognized certification established through the Excellence in Mental Health Act. In order for an entity to receive the CCBHC Expansion grant funding and this certification, they are required to provide nine types of services: (1) crisis mental health services; (2) screening, assessment and diagnosis, including risk assessment; (3) patient-centered treatment planning; (4) outpatient mental health and substance use services; (5) primary care screening and monitoring of key health indicators/health risk; (6) targeted case management; (7) psychiatric rehabilitation services; (8) peer support and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans. In addition, there are requirements on quality reporting, staffing, access to care, care coordination, and governance.

Since these Expansion Grant funds are only for a two-year period, those that had the funds expressed concern regarding the time limits of the funding. Additionally, CMHSPs mostly referenced CCBHC funding when describing the funding sources for crisis services and other programming in the survey.

### d. Cost Sharing Partnerships with Hospitals

Two CMHSPs indicated they have a contract or a cost-sharing partnership with local hospitals to perform pre-screens, regardless of insurance type. Another two CMHSPs have a contract with their local hospital to pay for staff at the co-located behavioral health crisis center.

### e. Mental Health Millage Board

Two CMHSPs indicated part of their funding was generated through a local millage and that their community had established a board to decide how to spend millage funding. The board decided to invest in the expansion of crisis stabilization services.

### f. Living Room Model of Crisis Services

Two CMHSPs indicated that they use the living room model which is a non-clinical service that offers individuals in crisis an alternative to visiting the emergency department to obtain services. It is designed as a relaxing space for people to resolve crises without needing a more intensive intervention. Peer support specialist and crisis clinicians staff this service and can provide referrals for emergency housing, if necessary. One of the CMHSPs that is using the living room model, indicated that they are looking to open another location within their region.

### g. Standalone Behavioral Health Crisis Centers

CMHSPs described standalone behavioral health clinics as another alternative to an emergency department for a person in crisis. As described in the standalone behavioral health crisis center section of this report, three CMHSPs provide one for adults and one CMHSP provides for children.

In addition, three CMHSPs plan to create or are in the development process for implementing a standalone behavioral health crisis center in order to divert individuals from emergency rooms.

### h. Urgent Psychiatric Care

As reported in the Psychiatric Emergency Center (PEC), no CMHSPs provide this service currently. However, one CMHSP shared they are in the process of exploring a PEC. In addition, three CMHSPs mentioned they offer urgent psychiatric care within their crisis stabilization for children and three for adults. Please note, there are other initiatives across the state that provide PEC services, however, this report solely focusses on those offered by CMHSPs.

### i. Crisis Stabilization Services

The intention of this service is three-fold: reduce the current crisis, prevent future crisis from happening, and assist in the navigation of community services. CMHSPs mentioned offering short-term crisis stabilization follow up care from 28 days, 30 days and 90 days for children including short term homebased and family therapy, case management, emergent psychiatric care, and individual outpatient therapy. For adults, the short-term crisis stabilization care is offered up to 28 or 30 days including short term case management/targeted case management, peer support services, intensive outpatient therapy, and warm transfers to other resources.

One CMHSP has a program in partnership with the local emergency department, that works to identify a person who frequently visits the ED with behavioral health needs. The purpose of the program is to engage the person in services and help keep them out of the ED. The CMHSP plans to propose the procedure to the PIHP and expand across the region.

Another CMHSP described how their intensive crisis stabilization service has been utilized and community partners expressed the value of this service.

### j. Recovery Coaches

Throughout the survey, recovery coaches were mentioned as a staff type used for different services. One CMHSP uses recovery coaches within their Sober Support Unit if a person must wait for treatment. Another CMHSP provides a warm hand off within emergency departments from crisis stabilization team to recovery coaches in SUD emergent situations. A CMHSP is piloting a recovery coach in a local ED in place of co-located staff for preadmission screening.

### k. Preventative and Business Hours Treatment to Reduce Crisis

CMHSPs shared strategies to employ preventative care and reduce crisis. Some examples are as follows, a CMHSP offers an Inpatient Recidivism Reduction Plan to address the need for improved proactive, preventative crisis services. The plan includes developing resources to address local barriers to accessing care in the chronic state before a crisis occurs. Another CMHSP shared how the internal staff have done a good job at providing care and treatment during the day in the way

of therapy, case management, going to the family home, family education, crisis planning, etc. so that after-hours crises are minimized.

### l. Reaching Across Large Geographical Regions

Multiple CMHSPs cited large geographical regions as a challenge to delivering crisis services. A CMHSP shared some of their strategies to cover a large geographical region. These include partnering with all local hospitals to co-locate emergency services workers during weekdays and nights. On weekends, the on-call clinician performs a tele-pre-screen from any local clinic or hospital, which allows the CMHSP staff to respond faster and reduces mileage. Moreover, one CMHSP has opened satellite offices to offer crisis and SUD services to individuals within their area with this need.

### m. Staff Retention and Tele-Assessments

A common barrier across CMHSPs is retaining staff for crisis services. Three CMHSPs described their use of tele-assessments. The purpose of this initiative is to improve response time and reduce staff burden. Specifically, one CMHSP shared that tele-assessments are part of a staff retention mechanism because on-call is frequently cited as the reason staff leave a CMHSP.

### n. Creative Uses of Children's Mobile Crisis

One CMHSP mentioned that they utilize children's mobile crisis staff for post inpatient and crisis residential discharges. The CMHSP wrote that this method decreased 30-day recidivism. The CMHSP is also utilizing it during the day to respond to requests from the school, which has improved relationships with the school and provided children with integrated and comprehensive care.

# Using Data to Address Community Needs

CMHSPs were asked to share any local and regional data analyses or local planning initiative information focused on crisis. Below is a listing of the different types and ways data are used to help CMHSPs provide behavioral health services within their community.

- Adult and children service dashboards that include: total count of persons receiving services, average requests per day, the percent of requests that are face-to-face, the count of screening request by type, count of request by location, count of request by living arrangement, and count of request by level of care being referred. In addition, this CMHSP collects data on the number and percent of diversions, as well as the number of crisis residential admissions.

- Tracking the dates and times of requests for intensive crisis stabilization services.

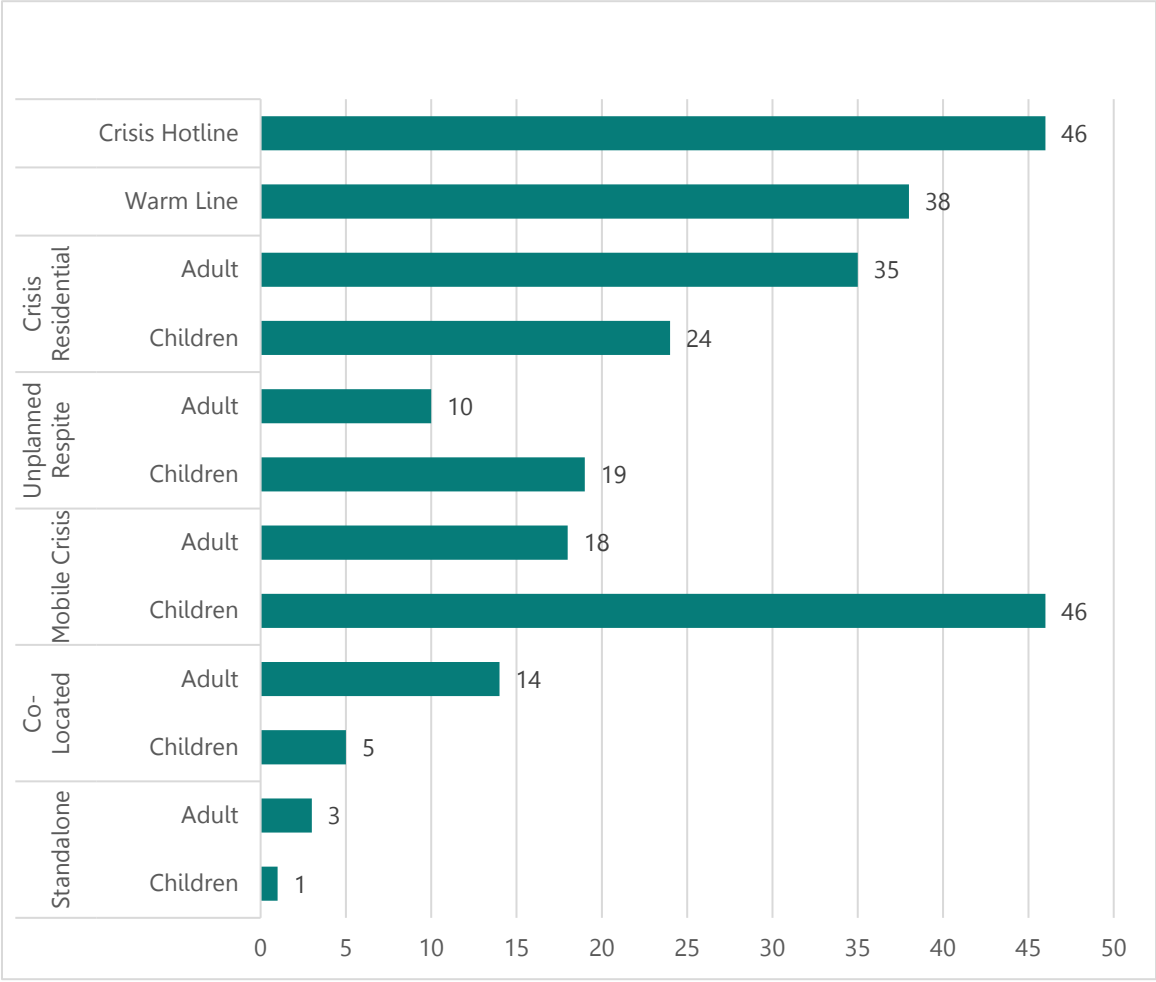
- Recording data on the following: Medicaid billing codes of crisis interventions, inpatient authorizations, and crisis residential authorizations by county, time of day, and month. This CMHSP also tracks funding source for emergency screenings by month.

- Survey community partners to ascertain what areas of service need improvement and then work within financial restrictions to address those services.

# Summary of Services and Funding Across CMHSPs

This section presents a summary of the behavioral health crisis services provided by Michigan's CMHSPs along with the types of funding and staffing these CMHSPs use within their Programs. Figure 18 shows the number of CMHSPs providing each of the crisis services included in this report.

**Figure 18: Total CMHSPs Providing Each Service**



**Funding Source**

CMHSPs rely on a variety of funding sources to support their crisis services. However, the appropriation of these funds across services is complex, intertwined, and vary based on locality and availability of finding types. For example, certain funding sources may be mandated towards specific services while other funding sources can be used at the discretion of the CMHSP. To provide some insight on the types of funding sources used by CMHSPs for providing different services, Table 11 summarizes each behavioral health crisis service and the number of CMHSPs that use the various types of funding to help support that service.

**Table 11: Total CMHSPs Funding Source Breakdown**

| Service | | Medicaid | | Medicare | | General Fund | | Private Insurance | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | # | % | # | % | # | % | # | % | # | % |
| CMHSPs use for at least one service (n = 46) | | 46 | 100% | 16 | 34.8% | 42 | 91.3% | 13 | 28.3% | 15 | 32.6% |
| CMHSPs use for all crisis services (n = 46) | | 41 | 91.1% | 1 | 2.2% | 4 | 8.7% | 1 | 2.2% | 0 | 0.0% |
| Crisis Hotline (n = 46) | | 42 | 91.3% | 8 | 17.4% | 36 | 78.3% | 5 | 10.9% | 8 | 17.4% |
| Warm Line (n = 38) | | 35 | 92.1% | 8 | 21.2% | 30 | 78.9% | 6 | 15.8% | 7 | 18.4% |
| Mobile Crisis | Youth (n = 46) | 46 | 100% | 5 | 10.9% | 31 | 67.4% | 4 | 8.7% | 12 | 26.1% |
| | Adult (n = 18) | 18 | 100% | 5 | 27.8% | 16 | 88.9% | 3 | 16.7% | 5 | 27.8% |
| Standalone | Youth (n = 1) | 1 | 100% | 0 | 0.0% | 1 | 100% | 1 | 100% | 1 | 100% |
| | Adult (n = 3) | 3 | 100% | 1 | 33.3% | 3 | 100% | 1 | 33.3% | 1 | 33.3% |
| Co-located | Youth (n = 5) | 4 | 80.0% | 2 | 40.0% | 4 | 80.0% | 3 | 60.0% | 1 | 20.0% |
| | Adult (n = 14) | 13 | 92.9% | 5 | 35.7% | 11 | 78.6% | 4 | 28.6% | 4 | 28.6% |
| Crisis Residential | Youth (n = 24) | 23 | 95.8% | 1 | 4.2% | 21 | 87.5% | 2 | 8.3% | 0 | 0.0% |
| | Adult (n = 35) | 35 | 100% | 7 | 20.0% | 30 | 85.7% | 3 | 8.6% | 1 | 2.9% |

All CMHSPs use Medicaid for at least one service and 41 CMHSPs use this funding source for all the crisis services that they indicated they provide on the survey. The General Fund is used by 91 percent of CMHSPs for at least one crisis service and only four (8.7 percent) use it for every service they provide. Private insurances are less utilized funding source by CMHSPs.

**Other Funding Types**

Table 12 is a breakdown of the "other" category in Funding Sources. Within the "other" category for funding, the most common funding source is a variety of different local funds, which include local hospital cost sharing partnerships, county contracts, and other county funds. Grants and CCBHC Expansion grants were each identified 13 times as funding sources for specific services.

**Table 12: Total CMHSPs "Other" Funding Source Breakdown**

| Service | | Local Funding Sources* | Millage | Grants | CCBHC | VA Benefits |
|---|---|---|---|---|---|---|
| | | # | # | # | # | # |
| Crisis Hotline | | 4 | 1 | 1 | 1 | 0 |
| Warm Line | | 2 | 0 | 1 | 2 | 0 |
| Mobile Crisis | Youth | 4 | 2 | 5 | 3 | 0 |
| | Adult | 1 | 1 | 0 | 3 | 0 |
| Standalone/PEC | Youth | 0 | 0 | 1 | 1 | 0 |
| | Adult | 1 | 0 | 1 | 1 | 0 |
| Co-located | Youth | 2 | 0 | 2 | 2 | 0 |
| | Adult | 2 | 0 | 2 | 0 | 1 |
| Crisis Residential | Youth | 0 | 0 | 0 | 0 | 0 |
| | Adult | 0 | 0 | 0 | 0 | 1 |
| Total Services Utilizing Other Funding | | 16 | 4 | 13 | 13 | 2 |

**Local Funding Sources include hospital contracts, county contracts, local county funds, and liquor tax.*

# Limitations

The intent of the survey and subsequently, this report was to provide the reader with a general understanding of the type and scope of publicly funded crisis services offered throughout the state of Michigan. With that said, there are a few limitations to the data and interpretations of this report.

- Not all behavioral health services have consistent terminology or universal definitions, which may have caused some slight differences in how respondents interpreted the types of services mentioned in this report. This issue persists beyond this report and needs to be addressed at the state and/or national level.

- Much of the information in this report was directly or indirectly based on open text responses written in by respondents. In some cases, some of the answers were fairly short and/or vague, which limited our ability to analyze that information.

- Although not necessarily a limitation, readers should be aware that this report does not cover all psychiatric crisis services in Michigan. Rather, it focuses on psychiatric crisis services provided by CMHSPs and/or their contractors.

# Conclusion

The information presented in this report aims to provide a general overview of crisis services provided by CMHSPs throughout the state of Michigan at the time the survey was administered. It is also intended to identify potential gaps in service delivery, barriers to community-based care, and creative solutions used by CMHSPs. Moreover, the report highlights key elements to address in any crisis system of care work and seeks to stimulate discussion.

Throughout the various crisis service sections of this report, several key themes emerged which should be part of any psychiatric care improvement efforts that take place in Michigan. These themes include:

- Lack of consistent definitions for crisis services: Throughout a comprehensive and thorough review of the survey data, it was clear that not all CMHSPs interpreted the various crisis services the same way. For example, a number of CMHSPs indicated they provided certain services such as mobile crisis, PECs, co-located staff within an emergency department when, upon further review of open-text descriptions, it was found that the services they were providing did not meet the definition for that service. In another example, Intensive Crisis Stabilization Services (ICSS) can be used as a term for Mobile Crisis or as a reference to Crisis Stabilization teams in some CMHSPs. One of the main reasons for this inconsistency may be the lack of universal service definitions that has resulted in individuals interpreting services differently. These inconsistent interpretations have been an ongoing concern throughout the behavioral health community for many decades.[4,5]
- Staffing: Staffing was cited by CMHSPs as both a barrier and a factor contributing to success. Many CMHSPs expressed their concerns and challenges with recruiting and retaining qualified staff to support crisis services. Staff may find crisis services burdensome because they are tasked with crisis work on top of their assigned duties. Burnout and stress were cited as common reasons why staff left CMHSPs. Within mobile crisis, well-trained and dedicated staff was cited as the second most common factor of success. Staff can also contribute to the success of crisis services by providing care and treatment during the day in the way of therapy, case management, going to the family home, family education, crisis planning, etc. so that after-hours crises are minimized. Many CMHSPs described ways that

[4] Pinals, D. A., & Fuller, D. A. (October 2017). Beyond Beds: The Continuum of Care as a Public Health Approach. *National Association of State Mental Health Program Directors and the Treatment Advocacy Center*. https://www.treatmentadvocacycenter.org/storage/documents/beyond-beds.pdf

[5] Auger, T. J. (1974). Mental health terminology: A modern tower of Babel? *Journal of Community Psychology, 2(2), 113–116.* https://doi.org/10.1002/1520-6629(197404)2:2<113::AID-JCOP2290020205>3.0.CO;2-H

they have tried to recruit and retain crisis service staff such as contracting nurses to cover after hours care, using telemedicine when appropriate, providing stipend to on-call staff, and offering training to improve staff's skills.

- Substance usage related to Preadmission Screenings: An ongoing issue many CMHSPs face is the percentage of individuals with co-occurring diagnosis and/ or substance use at the time of the pre-screen. This often makes it more difficult to place the individual into the appropriate care setting. In addition, CMHSPs cited a shortage of services for a person with co-occurring needs, further exacerbating the challenge of placing the person.
- Funding: A lack of funding was mentioned by many of the CMHSPs and this limits their crisis service delivery. CMHSPs mentioned that the lack of available funds prevents them from providing additional services. In addition, CMHSPs specifically indicated that children's mobile crisis fee for services revenue does not cover costs for rural CMHSPs with low utilization of the service. Pursuing alternative or creative funding sources such as CCBHC expansion grants and local millage, for example, were some of the ways CMHSPs can sustain their crisis services.
- Rural Challenges: CMHSPs that serve large rural geographic regions have unique challenges directly related to service delivery due to the long distances and time it takes to travel to certain locations. Another challenge is cell phone reception, which impacts the ability for a crisis line staff to connect a person with care if calls are dropped. Moreover, the lack of consistent cell service can impact staff safety when traveling in the community for mobile crisis services. Rural CMHSPs also shared that recruiting staff was a challenge. In an effort to overcome these challenges, rural CMHSPs' service delivery may operate somewhat differently than CMHSPs who serve urban areas. Some rural CMHSPs have addressed these challenges through Telehealth and videoconferencing, like in their pre-admission screens in Emergency Department and jails; providing crisis services via Zoom to some after hour screening sites; or on weekends the on-call clinicians use Zoom to screen individuals while located at a local clinic or co-located hospital office that is closer to the clinician's home.
- Alternatives to Emergency Departments: To avoid unnecessary interactions with the emergency department, several CMHSPs have developed alternative options such as the living room model and standalone behavioral health crisis centers, where a person can go to receive more appropriate care. Many CMHSPs mentioned that they are in the process of developing these alternative settings.
- Community Partnerships: Across the CMHSPs, one of the more common factors related to overall program success was the number and type of community partners who are part of the crisis care system. CMHSPs have formed partnerships with law enforcement, schools, and community hospitals that have resulted in unique service delivery models and more direct access to care. For example, a CMHSP has a staff therapist that can be sent to any school in the district to provide services.

# Appendix 1: CMHSP Survey 2019

Thank you for agreeing to participate in this survey. As was stated in Dr. Mello's letter, this is not a compliance survey. It is an information gathering survey. We will not share individual identifiable CMHSP data unless we ask your permission first.

This survey is our attempt to increase our understanding of the current crisis services offered by CMHSPs for all populations and all funding sources, not solely Medicaid. We are interested in innovative crisis practices, barriers to effective crisis services, as well as standard practices. We ask you to fill this survey out as completely as possible, including sharing information on crisis service that we don't ask about elsewhere in the survey.

If you have any questions or comments about the content of the survey, how the information will be used, or the Michigan Psychiatric Care Improvement Project, I encourage you to reach out to me:

Krista Hausermann, LMSW, CAADC
Strategic Initiative Specialist
Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services
Office Phone: (517) 335-4952

Thank you in advance for your partnership!

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The survey is divided into four main sections: Warm lines and Hotlines; Crisis Services for Children and Youth; Crisis Services for Adults; and Other.

You can start the survey and finish it later, as long as you access the survey from the same IP address (same computer and same network). Otherwise, if you try to access the survey link from a different IP address than you began the survey with, it will take you to the start of the survey and not record any of your answers. We recommend that you complete the survey from start to finish in one sitting to avoid these issues.

If you have questions about the technical aspects of the survey, please feel free to contact us at MPCIP-support@mphi.org.

We thank you in advance for your cooperation.

---

Q3 What CMHSP do you represent? (select from drop down list)

Q4 Does your CMHSP provide warm line services?

A Warm Line: A direct service delivered via telephone that provides a person in distress with a confidential venue to discuss their current status and/or needs. Unlike hotlines, warm lines are for situations that are not considered emergencies but could potentially escalate if left unaddressed. (definition adapted from SAMHSA, 2012 and 2014). Warm lines typically provide active listening, problem-solving and information and referral. Warm line services may be a component of a crisis line. People calling the warm line may or may not be open to services or requesting services. Examples are: a parent struggling to put a child to bed or someone who is feeling extremely lonely or anxious and just wants to talk.

- ○ Yes
- ○ No

Q5 What are the funding sources for the warm line at your CMHSP? (select all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ General Fund
- ☐ Private Insurance
- ☐ Other, please explain: _____

Q6 What are the hours of operation for your warm line?

- ○ Open Time: _____
- ○ Close Time: _____

---

Q7 Who staffs your warm line?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

---

Q8 Please indicate which hours your internal staff and the contracting entity operate the warm line, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity end time: _____

---

Crisis hotlines: are defined as "a direct service delivered via telephone that provides a person who is experiencing distress with immediate support and/or facilitated referrals. This service provides a person with a confidential venue to seek immediate support with the goal of decreasing hopelessness; promoting problem-solving and coping skills; and identifying persons who are in need of facilitated referrals to medical, healthcare, and/or community support services" (SAMHSA, 2012; SAMHSA, 2014).

Q10 What are the funding sources for the crisis hotline at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q11 Who staffs your crisis hotline?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q12 Please indicate which hours your internal staff and the contracting entity operate the crisis hotline, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity end time: _____

Q13 How does the community know about your crisis line phone number? (Select all that apply)

- ☐ Website
- ☐ 211
- ☐ Written materials distributed to new consumers
- ☐ Other, please explain: _____

Q14 What is the crisis line's approximate call volume? (This includes both the warm line and crisis hotline).

- ○ Please indicate your approximate call volume if known (e.g. calls per day, week, month, year) _____
- ○ Not sure (please provide email of a staff member who would be able to provide approximate call volume) _____
- ○ Data is not tracked

Q15 Is there any other information about your warm lines or hotlines that you would like to share?

_____

_____

Q16 Next, we want to learn more about a variety of crisis services provided to children and adults.

Crisis Services Available for Children and Youth

The next set of questions, numbers 18 through 51, are all focused on Children and Youth.

Please use the following definitions when responding to questions about the crisis services your CMHSP provides for your pediatric population:

Mobile Crisis: going out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. This may include providing acute mental health crisis stabilization and psychiatric assessment services to individuals within their homes and in other sites outside of a traditional clinical setting (Substance Abuse and Mental Health Services Association, 2014; Allen et al., 2002; Scott, 2000).

Standalone Behavioral Health Crisis Center: is functionally a behavioral health ED (physical health care is not necessarily provided) which provides a 23-hour crisis observation or stabilization function (Fitton & Reagan, 2018). Common Ground in Oakland is an example.

Psychiatric Emergency Center (PEC): A facility with medical and mental health services where individuals in crisis can come or be brought for a period of up to 24 hours for evaluation and physical and mental health care services.

Crisis Respite: Voluntary, short-term, overnight programs that provide unplanned community-based, non-clinical crisis support. They operate 24 hours per day in a homelike environment (Definition adapted from Peer Respites Action and Evaluation).

Q18 These questions are around the Mobile Crisis Team for children and youth. Please feel free to attach the Mobile Crisis Team (Intensive Crisis Stabilization Services) Certification if the information is up to date.

Q19 What are the funding sources for mobile crisis at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q20 What are the hours of operation for your mobile crisis team for children and youth?

- ○ Open Time: _____
- ○ Close Time: _____

Q21 Does your children/youth mobile crisis team serve all geographical areas within your CMHSP region?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q22 In what locations are mobile crisis services provided? (Select all that apply)

- [ ] Emergency Department
- [ ] School
- [ ] Consumer's home
- [ ] CMHSP
- [ ] Police Station
- [ ] Other, please explain: _____

Q23 Is the location of services dependent on: (Select all that apply)

- [ ] The time of day when crisis occurs
- [ ] Consumer currently open to services
- [ ] Other factors, please specify: _____
- [ ] None of the above

Q24 Who provides mobile crisis services for children and youth?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q25 Do the children and youth mobile crisis team staff work full-time on the mobile crisis team?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q26 What types of staff are utilized for the mobile crisis team? (Select all that apply)

- ☐ Children's Mental Health Professional
- ☐ QIDP
- ☐ Psychiatrist (even if available by phone)
- ☐ Peer
- ☐ Other, please specify: _____

Q27 Did you design your mobile crisis team around an existing model (i.e. evidence-based model or published promising practices)?

- ○ Yes, please specify which one(s): _____
- ○ No
- ○ Unsure

Q28 How does mobile crisis integrate with your CMHSP's other 24/7 crisis response, pre-screening services?

_____

_____

Q29 What are the barriers to implementing mobile crisis services for children and youth?

_____

_____

Q30 What factors have contributed to the success of the mobile crisis services for children and youth?

_____

_____

Q31 Does your CMHSP operate a standalone behavioral health crisis center for children and youth?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q32 What are the funding sources for a standalone behavioral health crisis center for children and youth at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q33 What are the hours of operation for your standalone behavioral health crisis center for children and youth?

- ○ Open Time: _____
- ○ Close Time: _____

Q34 Who staffs your standalone behavioral health crisis center for children and youth?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q35 Please indicate which hours your internal staff and the contracting entity operate the standalone behavioral health crisis center for children and youth, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity end time: _____

Q36 How many standalone behavioral health crisis center locations for children and youth do you have?

_____

_____

Q37 Do you have a Psychiatric Emergency Center (PEC) for children and youth, defined as a facility with medical and mental health services where individuals in crisis can come or be brought for a period of up to 24 hours for evaluation and treatment services?

- ○ Yes, please describe: _____
- ○ No
- ○ Other, please explain: _____

Q38 What are the funding sources for Psychiatric Emergency Centers (PEC) for children and youth at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q39 What are the hours of operation for your Psychiatric Emergency Centers (PEC) for children and youth?

- ○ Open Time: _____
- ○ Close Time: _____

Q40 Who staffs your Psychiatric Emergency Centers (PEC) for children and youth?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q41 Please indicate which hours your internal staff and the contracting entity operate the PEC for children and youth, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity end time: _____

Q42 Do you provide staff for co-located behavioral health crisis emergency services for children and youth, in a hospital emergency department?

- ○ Yes, please provide a description _____
- ○ No
- ○ Other, please explain: _____

Q43 What are the funding sources for these co-located services at your CMHSP? (select all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ General Fund
- ☐ Private Insurance
- ☐ Other, please explain: _____

Q44 What types of staff are utilized for the co-located behavioral health team in a hospital emergency department? (Select all that apply)

- [ ] Children's Mental Health Professional
- [ ] QIDP
- [ ] Psychiatrist (even if available by phone)
- [ ] Peer
- [ ] Recovery Coaches
- [ ] Other, please specify: _____

Q45 Do you provide Crisis Residential services for children and youth as defined by the Medicaid Provider Manual?

- ○ Yes, please describe _____
- ○ No
- ○ Other, please explain: _____

Q46 What are the funding sources for crisis residential services for children and youth at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q47 Who staffs your Crisis Residential Services?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q48 Do you offer unplanned crisis respite services for children and youth?

- ○ Yes, please describe: _____
- ○ No

Q49 When pre-screening children and youth who are currently receiving CMHSP services, does staff have access to any of the following consumer records: (Select all that apply)

- ☐ Electronic Health Record
- ☐ Crisis Plans
- ☐ Other, please specify: _____

Q50 Do you offer any other crisis services for children and youth?

- ○ Yes, please describe: _____
- ○ No

Q51 Is there any other information about crisis services for children and youth that you would like to share?

_____

_____

Crisis Services Available for Adults

Questions 53 through 89 focus on the adult population.

Please use the following definitions when responding to questions about the crisis services you offer for your adult population:

Mobile Crisis: going out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. This may include providing acute mental health crisis stabilization and psychiatric assessment services to individuals within their homes and in other sites outside of a traditional clinical setting (Substance Abuse and Mental Health Services Association, 2014; Allen et al., 2002; Scott, 2000).

Standalone Behavioral Health Crisis Center: is functionally a behavioral health ED (physical health care is not necessarily provided) which provides a 23-hour crisis observation or stabilization function (Fitton & Reagan, 2018). Common Ground in Oakland is an example.

Psychiatric Emergency Center (PEC): A facility with medical and mental health services where individuals in crisis can come or be brought for a period of up to 24 hours for evaluation and physical and mental health care services.

Q53 Does your CMHSP operate a mobile crisis team as defined, for adults?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q54 What are the funding sources for adult mobile crisis at your CMHSP? (select all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ General Fund
- ☐ Private Insurance
- ☐ Other, please explain: _____

Q55 What are the hours of operation for your adult mobile crisis team?

- ○ Open Time: _____
- ○ Close Time: _____

Q56 Does your adult mobile crisis team serve all geographical areas within your CMHSP region?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q57 In what locations are adult mobile crisis services provided? (Select all that apply)

- ☐ Emergency Department
- ☐ Consumer's home
- ☐ CMHSP
- ☐ Jail
- ☐ Other, please specify: _____

Q58 Is the location of services dependent on: (Select all that apply)

- ☐ The time of the day when crisis occurs
- ☐ Consumer who is currently receiving CMHSP services
- ☐ Other factors, please specify: _____
- ☐ None of the above

Q59 Who provides mobile crisis services for adults?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q60 Do adult mobile crisis team staff work full time on the adult mobile crisis team?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q61 What types of staff are utilized for the adult mobile crisis team? (Select all that apply)

- ☐ QMHP
- ☐ QIDP
- ☐ Psychiatrist (even if available by phone)
- ☐ Peer
- ☐ Other, please specify: _____

Q62 Did you design your adult mobile crisis team around an existing model (i.e. evidence-based model or published promising practices)?

- ○ Yes, please specify which ones: _____
- ○ No
- ○ Unsure

Q63 How does mobile crisis integrate with your CMHSP's other 24/7 crisis response, pre-screening services?

_____

_____

Q64 What are the barriers to implementing mobile crisis services for adults?

_____

_____

Q65 What factors have contributed to the success of mobile crisis services for adults?

_____

_____

Q66 Does your CMHSP operate a standalone behavioral health crisis center for adults?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q67 What are the funding sources for standalone behavioral health crisis centers for adults at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q68 What are the hours of operation for your standalone behavioral health crisis center for adults?

- ○ Open Time: _____
- ○ Close Time: _____

Q69 Who staffs your standalone behavioral health crisis center for adults?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q70 Please indicate which hours your internal staff and the contracting entity operate the standalone behavioral health crisis center for adults, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity end time: _____

Q71 How many standalone behavioral health crisis center locations for adults do you have?

_____

_____

Q72 Do you have a Psychiatric Emergency Center (PEC) for adults, defined as a facility with medical and mental health services where individuals in crisis can come or be brought for a period of up to 24 hours for evaluation and treatment services?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q73 What are the funding sources for Psychiatric Emergency Center for adults at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q74 What are the hours of operation for your Psychiatric Emergency Center (PEC) for adults?

- ○ Open Time: _____
- ○ Close Time: _____

Q75 Who staffs your PEC for adults?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q76 Please indicate which hours your internal staff and the contracting entity operate the PEC for adults, respectively:

- ○ CMHSP internal staff start time: _____
- ○ CMHSP internal staff end time: _____
- ○ Contracting entity start time: _____
- ○ Contracting entity start time: _____

Q77 Do you provide staff for co-located behavioral health crisis emergency services for adults in a hospital emergency department?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q78 What are the funding sources for your co-located behavioral health crisis emergency services for adults in a hospital emergency department? (select all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ General Fund
- ☐ Private Insurance
- ☐ Other, please explain: _____

Q79 What types of staff are utilized for the co-located behavioral health team in a hospital emergency department? (Select all that apply)

- [ ] QMHP
- [ ] QIDP
- [ ] Psychiatrist (even if available by phone)
- [ ] Peer
- [ ] Recovery Coach
- [ ] Other, please specify: _____

Q80 Do you provide Crisis Residential Services for adults as defined by the Medicaid Provider Manual?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q81 What are the funding sources for Crisis Residential Services at your CMHSP? (select all that apply)

- [ ] Medicaid
- [ ] Medicare
- [ ] General Fund
- [ ] Private Insurance
- [ ] Other, please explain: _____

Q82 Who staffs your Crisis Residential Services?

- ○ CMHSP internal staff
- ○ Contracting entity (please indicate the name of the contracting entity used) _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q83 Do you offer unplanned crisis respite services for adults?

- ○ Yes, please describe: _____
- ○ No

Q84 Do you provide crisis stabilization services to adults?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q85 Do you bill Medicaid for crisis stabilization services provided to adults?

- ○ Yes
- ○ No
- ○ Unsure

Q86 What crisis stabilization services do you provide to adults?

_____

_____

Q87 When screening adults who are currently receiving CMHSP services, does staff have access to any of the following consumer records: (Select all that apply)

- ☐ Electronic Health Record
- ☐ Crisis plans
- ☐ Advanced Directives
- ☐ Other, please specify: _____

Q88 Do you offer any other crisis services for adults?

- ○ Yes, please describe: _____
- ○ No

---

Q89 Is there any other information about crisis services for adults that you would like to share?

_____

_____

---

Staffing Psychiatric Hospital Pre-screening Services

Please answer the following questions based on your CMHSP policies and procedures.

---

Q91 If a consumer goes directly to a psychiatric hospital to be evaluated for admission, does your CMHSP (check all that apply):

- ☐ Conduct an in-person screening prior to authorization for hospitalization
- ☐ Conduct a phone consultation with psychiatric hospital staff prior to authorization
- ☐ Provide retrospective review and authorization (screening is done by psychiatric hospital staff without your CMHSP involvement)
- ☐ Other, please specify: _____

---

Q92 If a consumer goes to an Emergency Department to be evaluated for psychiatric hospital admission, does your CMHSP (check all that apply):

- ☐ Conduct an in-person screening prior to authorization for hospitalization
- ☐ Conduct a phone consultation with psychiatric hospital staff prior to authorization
- ☐ Provide retrospective review and authorization (screening is done by psychiatric hospital staff without your CMHSP involvement)
- ☐ Other, please specify: _____

Q93 During typical business hours for your CMHSP, who provides pre-screens for psychiatric hospitalization or out of home crisis services?

- ○ CMHSP internal staff
- ○ Contracting entity personnel, please specify what entity: _____
- ○ Both CMHSP staff and a contracting entity (please indicate the name of the contracting entity used) _____

Q94 Which of the following best describes the CMHSP personnel who provide pre-screens for psychiatric hospitalization or out of home crisis services during typical business hours?

- ○ These personnel hold positions dedicated to pre-screening services and crisis services, but hold no other positions with the agency
- ○ These personnel have other CMHSP positions during the day, and periodically cover crisis pre-screening during typical business hours
- ○ Other, please describe: _____

Q95 After typical business hours, who provides pre-screens for psychiatric hospitalization or out of home crisis services?

- ○ CMHSP internal staff
- ○ Contracting entity personnel, please specify what entity: _____
- ○ Both CMHSP staff and a contracting entity, please indicate the name of the contracting entity used: _____

Q96 Which of the following best describes the CMHSP personnel who provide pre-screens for psychiatric hospitalization or out of home crisis services after typical business hours?

- ○ These personnel hold positions dedicated to pre-screening services and crisis services, but hold no other positions within the agency
- ○ These personnel have other CMHSP positions during the day, and periodically cover crisis pre-screening after typical hours
- ○ Other, please specify: _____

Q97 Who provides ACT services for your CMHSP?

- ○ The CMHSP directly provides these services
- ○ Contracted entity(ies) provide these services, please specify what entity(ies): _____
- ○ Both CMHSP and contracted entities, please specify what entity(ies): _____

Q98 Is your CMHSP connected to the National Suicide Hotline, which means you receive calls for your region?

- ○ Yes
- ○ No
- ○ Other, please explain: _____

Q99 How does your staff refer to Substance Use Disorder Treatment Services in an emergent situation?

_____

_____

Q100 Who conducts screening for authorizing SUD residential services?

- ○ CMHSP
- ○ PIHP
- ○ SUD Residential Service Provider
- ○ Other, please specify: _____

Q101 Which of the following best describes how consumers are placed in residential SUD services?

- ○ PIHP makes referrals and locates placement after determining need
- ○ CMHSP finds available placement
- ○ Neither option, please explain: _____

Q102 Please share with us any local/regional data analyses and/or current or recent past local planning initiatives around crisis, which may be helpful in understanding the current crisis system. (There is a feature at the end of this section where you can attach any documents you would like to share.)

_____

_____

Q103 Do you have any data you can share around the incidence of substance use/abuse as a factor in pre-screens?

_____

_____

Q104 Over the course of a fiscal year, what percent of the people who are pre-screened through your CMHSP are not open consumers at the time of the pre-screen? (An open consumer is someone currently receiving CMHSP services.)

- ○ Percentage _____
- ○ Data not available

Q105 Of the people who are pre-screened through your CMHSP, what percent have Medicaid as primary or secondary, Medicare, General Fund or private insurance? (It is okay if percents add up to more than 100%)

- ○ Medicaid as primary or secondary _____
- ○ Medicare _____
- ○ General Fund _____
- ○ Private Insurance _____

Q106 What electronic health record (EHR) do you use?

- ○ PCE
- ○ Streamline
- ○ Other, please enter: _____

Q107 We encourage you to share other information about crisis services at your CMHSP, such as additional crisis services not mentioned, barriers, innovative ideas you have implemented or are exploring, etc.

_____

_____

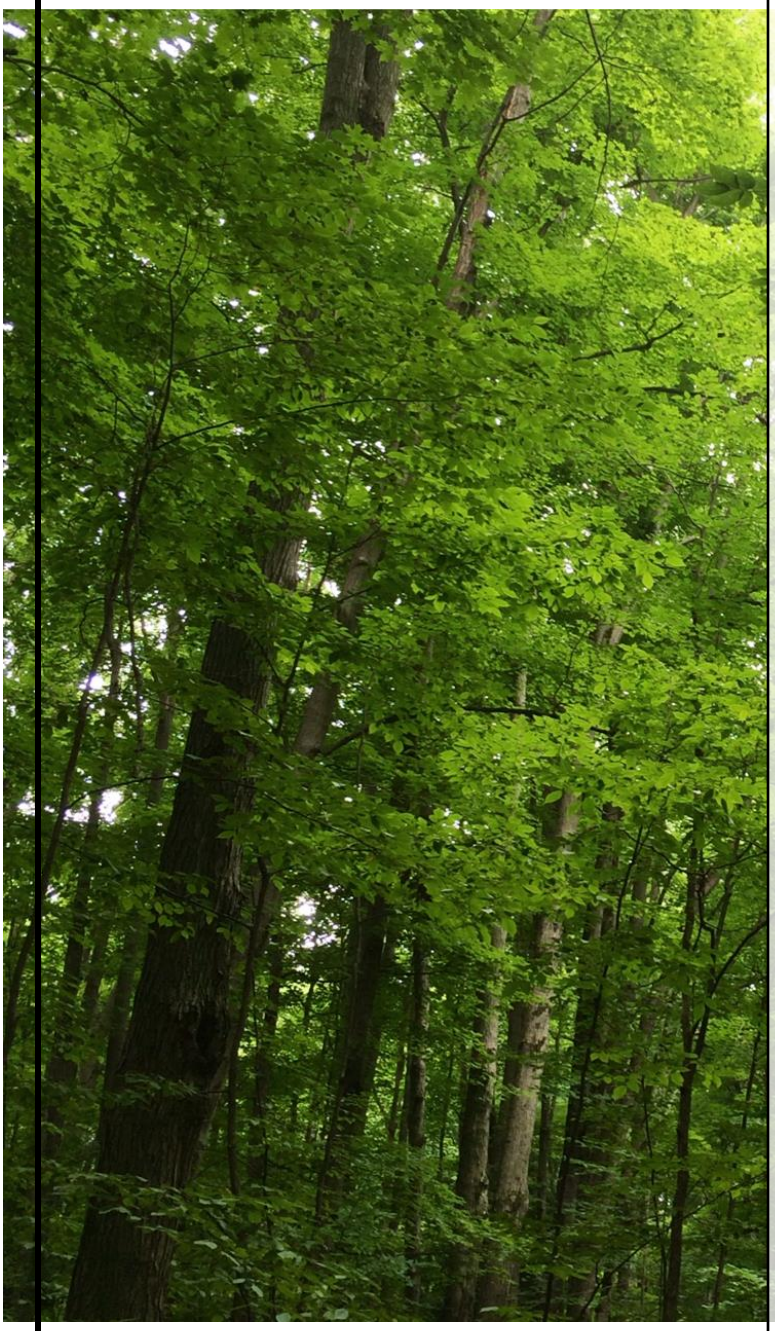
Q108 Please feel free to attach any documents regarding crisis services you think would be helpful, like service descriptions.

Q109 We may reach out to you with questions about your survey. Please provide us with your contact information (name, phone number, email address).

- ○ Name _____
- ○ Phone _____
- ○ Email _____

# Appendix 2: Table of the CMHSPs and Counties

| CMHSP | Counties Covered | CMHSP | Counties Covered |
|---|---|---|---|
| Allegan County CMH Services | Allegan | Macomb County CMH Services | Macomb |
| AuSable Valley CMH Authority | Iosco, Oscoda, Ogemaw | Monroe CMH Authority | Monroe |
| Barry County CMH Authority | Barry | Montcalm Care Network | Montcalm |
| Bay-Arenac Behavioral Health Authority | Arenac, Bay | network180 | Kent |
| Berrien Mental Health Authority d/b/a Riverwood Center | Berrien | Newaygo County Mental Health Center | Newaygo |
| Centra Wellness Network | Manistee, Benzie | North Country CMH Authority | Emmet, Kalkaska, Antrim, Charlevoix, Cheboygan, Otsego |
| CMH Authority of Clinton-Eaton-Ingham Counties | Eaton, Ingham, Clinton | Northeast Michigan CMH Authority | Montmorency, Presque Isle, Alcona, Alpena |
| CMH for Central Michigan | Gladwin, Isabella, Mecosta, Midland, Clare, Osceola | Northern Lakes CMH Authority | Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford |
| CMH of Ottawa County | Ottawa | Northpointe Behavioral Healthcare Systems | Dickinson, Iron, Menominee |
| Community Mental Health & Substance Abuse Services of St. Joseph County | St. Joseph | Oakland Community Health Network | Oakland |
| Copper Country CMH Services | Houghton, Keweenaw, Baraga, Ontonagon | Pathways Community Mental Health | Delta, Luce, Marquette, Alger |
| Detroit Wayne Integrated Health Network | Wayne | Pines Behavioral Health Services | Branch |
| Genesee Health System | Genesee | Saginaw County CMH Authority | Saginaw |
| Gogebic CMH Authority | Gogebic | Sanilac County CMH | Sanilac |
| Gratiot Integrated Health Network | Gratiot | Shiawassee Health & Wellness | Shiawassee |
| HealthWest | Muskegon | St. Clair County CMH Services | St. Clair |
| Hiawatha Behavioral Health | Mackinac, Chippewa, Schoolcraft | Summit Pointe | Calhoun |
| Huron Behavioral Health | Huron | The Right Door for Hope, Recovery and Wellness | Ionia |
| Integrated Services of Kalamazoo | Kalamazoo | Tuscola Behavioral Health Systems | Tuscola |
| Lapeer County CMH Services | Lapeer | VanBuren Community Mental Health Authority | Van Buren |
| Lenawee CMH Authority | Lenawee | Washtenaw County CMH | Washtenaw |
| LifeWays CMH | Hillsdale, Jackson | West Michigan CMH System | Lake, Mason, Oceana |
| Livingston County CMH Authority | Livingston | Woodlands Behavioral Healthcare Network | Cass |



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