Crisis Stabilization Units in Michigan

Concept Paper

Background and Purpose

The Michigan State legislature passed Public Act (PA) 402 of 2020, which adds Chapter 9A (Crisis Stabilization Units) to the Mental Health Code. The new chapter requires the Michigan Department of Health and Human Services (MDHHS) to establish minimum standards and requirements and provide for certification of crisis stabilization units (CSUs). CSUs are meant to provide a short-term alternative to emergency department and psychiatric inpatient admission for people who can be stabilized through treatment and recovery coaching within 72 hours.

To develop certification criteria, MDHHS hired Public Sector Consultants (PSC) to convene and facilitate an advisory group of stakeholders for a series of statewide discussions and listening sessions on topics including rural areas, persons served, and children. The advisory group prepared for discussions in advance by reviewing selected readings from the National Council on Behavioral Health's *Roadmap to the Ideal Crisis System* and the Substance Abuse and Mental Health Services Authority's *National Guidelines for Behavioral Health Crisis Care*. PSC and the department have also consulted with other states and reviewed national guidance to identify best practices for the implementation of CSUs. The following outline of Michigan's CSU model is based on guidance that has been offered by stakeholders in the advisory group and listening sessions, PA 402, and best practice guidelines. It is important to note that, as certification standards are developed, flexibility for implementation in rural vs. urban areas will need to be considered.

A Vision for CSUs in Michigan

Vision

Advisory group members were asked to imagine a future in which Michigan has established a world-class crisis response system that includes the certification of high-quality CSUs. Their vision included six main themes:

Improved access to care: There is no wrong door to access a CSU and insurance is not a barrier. All Michiganders know about CSUs, have easy access to a CSU when needed, and the capacity of CSUs meet the needs of the community.

Appropriate levels of care: Patients have the least restrictive care and are triaged to the appropriate level of care to stabilize them quickly. There is a decrease in inappropriate psychiatric hospitalizations and emergency department use.

Coordinated care: Stakeholders, including law enforcement, 911, 988, and emergency medical services (EMS), mobile crisis responders (of any type including multidisciplinary response teams [MDRT], Mobile Crisis Stabilization Services (MCSS), youth mobile crisis, juvenile urgent response teams (JURT), etc.) coordinate care for individuals in crisis. Individuals receive coordinated contact around their health from the initial CSU visit to community support follow-ups. Coordination occurs across systems and agencies including child welfare, aging and older adult services, and behavioral health systems and supports.

Positive individualized experience: CSUs provide high quality of care for those in crisis. People feel safe, respected, and supported in comfortable spaces that maximize privacy. Intake and release are seamless for the individual and the individual can expect that there will be linkage to further services beyond the period of crisis.

Family Driven/Youth Guided Care: Family and fictive kin are an important, if not the most crucial, part of a youth's support network. Because of the important role of family/fictive kin, treatment of youth optimally occurs as a part of a family unit. CSUs provide family-driven/youth-guided care which involves and supports the family as well as the youth.

Natural Supports: CSUs recognize the importance of family and friends in a person's recovery and seek to maximize positive impact through the involvement and support of a person's informal support network.

CSU Model Concept

The elements of a CSU model for Michigan below are based on and incorporate input received from stakeholders, best practices recommended by SAMHSA, and PA 402 of 2020.

Eligible Provider Entities

Per PA 402 of 2020, the following entities are eligible to establish and operate a crisis stabilization unit.

- CMHSP preadmission screening units
- Psychiatric hospitals
- General hospitals (must have 24-hour access to a preadmission screening unit for crisis services and establish a formal agreement with a CMHSP or regional entity for services provided to individuals using public behavioral health funds)

Populations Served

CSUs must provide crisis stabilization services to:

- All people in crisis, regardless of health care coverage
- Children and adults experiencing a crisis related to mental health, substance use, or both

Meeting the needs of diverse populations

Children and adults should be treated in physically separate facilities but in a parallel fashion. CSUs should ensure that all care and treatment is offered in a culturally competent manner. CSUs should be prepared to serve diverse populations, including tribal communities and other at-risk groups. CSUs must also have interpreters available on an as-needed basis to serve all populations. CSUs must be prepared to meet the needs of adults with serious mental illness (SMI), children with serious emotional disturbance (SED) and their families, people with intellectual and developmental disabilities (IDD), individuals with substance use disorders (SUD) in crisis, as well as people with co-occurring mental health and substance use issues.

Basic Requirements

CSUs must:

- Initiate assessment and treatment interventions upon arrival
- Conduct an initial psychosocial assessment and psychiatric evaluation within 24 hours
- Provide up to 72 hours of care
- Ensure timely access to appropriate medical services for physical health needs and provide ambulatory care level support for physical health
- Treat crises related to both mental health and substance use
- Provide treatment in the least restrictive manner possible, including providing care for individuals seeking voluntary treatment, and may treat individuals who need involuntary treatment for up to 72 hours (consistent with Sec. 409), after which the individual must be provided with the clinically appropriate level of care, resulting in one of the following:
    - The individual is no longer a person requiring treatment.
    - A referral to outpatient services for aftercare treatment.
    - A referral to a partial hospitalization program.
    - A referral to a residential treatment center, including crisis residential services.
    - A referral to an inpatient bed.
    - An order for involuntary treatment.

Geographic and Population Considerations

Different CSU models may be needed for different geographic locations and patient populations. While basic requirements will be the same for all CSUs, the way in which requirements are met will be based on the needs of the community. It is also critical that the needs of adults with SMI, children with SED, and adults or children with I/DD guide how CSUs are implemented within a community.

Staffing Requirements

CSUs must:

- Provide access to 24/7/365 multidisciplinary staff including psychiatrists, psychiatric nurse practitioners, nurses, licensed and/or credentialed clinicians, and peers
- Ensure staffing levels and types of staff are adequate to provide required services and meet the needs of the population
- Meet staff-to-client ratios established by MDHHS

Importance of Peers

Peers should be present at each step of the patient process from intake and treatment to release and transportation. Peer support helps patients navigate a crisis and can help reduce staffing shortages.

Flexibility in Staffing

CSUs will be established with certain flexibilities in filling staff roles. CSU policies should not dictate CSU staff be directly employed by the CSU and should allow for or promote the use of telehealth services.

Physical Space Requirements

CSUs must:

- Provide a trauma-sensitive, comfortable, home-like environment
- Plan for special populations (e.g., I/DD, gender sensitive approaches)
- Provide separate waiting areas and treatment spaces for children and their families and adults
- Have spaces that ensure privacy
- Ensure physical spaces for sleeping and treatment are welcoming, conducive to recovery, and family- and individual-friendly
- Provide for individual physical needs (e.g., food, shower facilities)

Operational Standards

General

CSUs must:

- Accept all referrals including self-referrals and do not require medical clearance prior to accepting them and initiating crisis response
- Assess and support medical stability throughout stay; deliver care for most minor physical health challenges; transfer to medical facility if required
- Carry out limited medical emergency receiving and evaluating functions (i.e., identify the need for medical attention in a hospital)
- Establish protocols for transfers between ED/CSU based on medical stability utilizing MI-SMART medical clearance protocols
- Establish protocols for pharmacy and medication administration, as well as safety and emergency protocols
- Establish discharge planning protocols, including referrals and warm hand-offs to clinically appropriate levels of care (see above)
- Establish protocols for both voluntary and involuntary admission consistent with Sec 409 of the Mental Health Code.

Law Enforcement, Mobile Crisis, EMS, and other First Responders

CSUs must:

- Offer walk-in and first responder drop off options
- Follow a "No-rejection" policy for all drop-offs and walk-ins
- Offer a dedicated first responder drop off area

Complaint Resolution

CSUs must:

- Afford individuals served all recipient rights under MHC Chapter 7.
- Establish complaint process separate and distinct from providers and not delegated by MDDHS to CMHSP or contractor.

System Collaboration Requirements

CSUs must:

- Ensure linkage and partnership with MiCAL
- Ensure a pre-admission screening unit is available on a 24-hour basis to provide crisis services on a voluntary basis.
- Hospitals must establish a formal agreement with a CMHSP or regional entity for services provided to individuals using public behavioral health funds
- Operate within a real-time regional bed registry (e.g., OpenBeds/MiCARE)
- Establish and maintain crisis response partnerships with law enforcement, dispatch, EMS, and other mobile crisis response systems in the region
- Develop shared agency-to-agency protocols for coordination and care management that are supported by real-time electronic processes
- Participate in coordinated staff trainings such as the Behavioral Health Emergency Partnership (BHEP) training to maximize crisis continuum coordination

Data/Reporting Requirements

- CSUs must provide timely reports to MDHHS, as required. These could include:
    - Data on number served
    - Data on demographics capturing prevalence of populations served and examined related to diversity and equity
    - Data on insurance types billed
    - Disposition of all individuals served
    - Percentage of law enforcement, mobile crisis, and first responder referrals and percentage not referred to emergency department for medical care and not arrested (i.e., hospital and jail diversion)
    - Law enforcement and first responder drop-off time
    - Average length of stay per person served
    - Percentage completing outpatient follow up
    - Readmission rate within 30 days to CSU, crisis residential facility, or inpatient psychiatric hospital.
    - Total cost per crisis episode

Certification and Accreditation

CSU's must:

- Obtain JCAHO, CARF, or similar organization accreditation by soonest of 1/12/2023 or 3 years following MDHHS certification