Crisis Stabilization Units in Michigan

Background and Purpose

Michigan Public Act (PA) 402 of 2020 added Chapter 9A (Crisis Stabilization Units) to the Mental Health Code, which 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 crisis receiving and stabilization facilities and provide an alternative to emergency departments for individuals who can be stabilized typically within several hours but in no longer than 72 hours. CSU services are intended to return individuals to their baseline (pre-crisis) level of functioning and do not replace post crisis stabilization treatment.

To develop a model for CSUs in Michigan, MDHHS engaged 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 and their families. The advisory group reviewed and discussed 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 also consulted with other states and reviewed national guidance to identify best practices for the implementation of CSUs. The advisory group focused primarily on CSU services for adults. The model concept described below is based on their guidance as well as that of experts in children's behavioral health services.

While this document provides a high-level overview of the key concepts and stakeholder priorities for CSUs in Michigan, a set of certification rules currently under development will provide much greater detail regarding the requirements for CSU implementation and service delivery.

Key Terminology

Crisis Residential Services[1] means services intended to provide a short-term alternative to inpatient psychiatric services for individuals experiencing an acute psychiatric crisis when clinically indicated. These services may only be used to avert an inpatient psychiatric admission, or to shorten the length of inpatient stay. Services may be provided for a period of up to 14 days per crisis residential episode, though this may be extended based clinical need as determined by an interdisciplinary team.

Crisis Services[5] are services for anyone, anywhere, and at any time. Crisis services include crisis lines accepting all calls and dispatching support based on the assessed need of the caller, mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and crisis receiving and stabilization facilities (CSUs and Urgent Cares) that serve everyone that comes through their doors from all referral sources.

Crisis Stabilization Unit[2] means a prescreening unit established under section 409 or a facility certified under chapter 9A that provides unscheduled clinical services designed to prevent or ameliorate a behavioral health crisis or reduce acute symptoms on an immediate, intensive, and time-limited basis in

response to a crisis situation. Crisis services may be provided for a period of up to 72 hours, after which the individual must be provided with the clinically appropriate level of care.

Psychiatric residential treatment facility or **PRTF**[2] means a facility other than a hospital that provides psychiatric services, as described in 42 CFR 441.151 to 441.182, in an inpatient setting to individuals under age 21. PRFTs are expected to provide care that results in successful integration of patients back into the community within 60-120 days after admission, including reintegration with family whenever possible and appropriate.

Respite Care[6] means services provided on an intermittent or short-term basis because of the absence or need for relief of the caregiver. Respite is intended to support the primary caregiver. This service can be provided in the individual's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. This service is accessible to adults with intellectual and developmental disabilities and children.

Treatment means care, diagnostic, and therapeutic services, including administration of drugs, and any other service for treatment of an individual's serious mental illness, serious emotional disturbance, substance use disorder[2], or intellectual and developmental disability.

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[1]As defined by the MDHHS Medicaid Provider Manual
[2]As defined in the Michigan Mental Health Code
[3]As defined by SAMHSA's Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies report
[4]As outlined in NASMHPD's A Safe Place To Be white paper
[5]As defined by SAMHSA's National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit
[6]Modified from the MDHHS Medicaid Provider Manual definition

A Vision for CSUs in Michigan

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 availability and access to care: There is no wrong door to access a CSU. Insurance status, transportation, childcare, and ability to pay are not barriers to accessing care at a CSU. All Michiganders will 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: Children, youth, young adults, and adults are served in a community based, non-institutional setting, in the least restrictive environment and are triaged to the appropriate level of care to support and stabilize them quickly. There is a decrease in inappropriate psychiatric hospitalizations and emergency department use.

Coordinated care: Coordination occurs across systems and agencies, including law enforcement, 9-1-1, 9-8-8, and emergency medical services (EMS), mobile crisis responders (of any type including multidisciplinary response teams [MDRT], Mobile Crisis Stabilization Services [MCSS], Intensive Crisis

Stabilization [ICSS] for children, juvenile urgent response teams [JURT], etc.), child welfare, aging and older adult services, and behavioral health systems and supports.

When working with children, youth, and young adults, and their families, care activities are deliberately organized across systems, and information is shared among all authorized and relevant entities concerned with the child and youth's care. This means the needs and preferences of children, youth, young adults and their families are solicited upon entry and are communicated in a timely fashion to the right people and that this information is used to provide safe, appropriate, and effective care. Children and youth receive coordinated contact around their health from the initial CSU visit to community support follow ups.

Natural Supports: In acknowledgement of the Surgeon General's Advisory, CSUs recognize the impact loneliness has on individuals' health and wellbeing. Joining the effort to combat the rising epidemic of loneliness and isolation, CSUs make an active effort to connect individuals with a natural support system. CSUs seek to maximize the positive impact of family and friends through the promotion of their partnership in stabilization services. CSUs will involve whomever the individual or their parent or caregiver identifies as a support for their recovery. In addition, when a person is in crisis their support network may be as well. With this in mind, CSUs strive to offer education and support to individuals' families and friends. For those without active and supportive family and friends, connections with peer supports and peer recovery coaches will be established during time of service. During the facilitated transition, referrals to peer-led programs, like clubhouses, drop in centers, and support groups, will also be prioritized. CSUs value social connectedness and strive to ensure all individuals will leave the service with an improved sense of belonging.

Family-Driven/Youth-Guided Care: Family and found family are an important, if not the most crucial, part of a youth's support network. Because of the important role of family/found family, treatment of youth optimally occurs as part of a family unit. CSUs provide family-driven/youth-guided care which involves and supports the family as well as the youth. CSUs will involve whomever the child, youth, young adult and their family identify as their supports in the recovery process and resiliency building.

Positive individualized experience: CSUs provide high quality of care for those in crisis. All people, including children, youth, and their families feel safe, respected, and supported in comfortable spaces that maximize privacy. Service intake and discharge are seamless for individuals, children, youth, and their families, and they can expect that there will be linkage to further services beyond the period of crisis.

CSU Model Concept

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 behavioral health diagnosis or health care coverage
• Children, youth, families and adults experiencing a crisis related to mental health, substance use, or both, as defined by the person and/or their family

Meeting the needs of diverse groups

Children, youth, and young adults with their families should be served in physically separate facilities from adults but in a parallel fashion. CSUs should ensure that all care, services, and coordination are offered in a culturally competent and linguistically appropriate manner. CSUs should be prepared to serve diverse populations, including Black, Indigenous, and people of color (BIPOC), people who identify as LGBTQ+, and other historically underserved groups. CSUs must also have interpreters that can speak about mental health and services in the preferred language of the people they serve in a culturally appropriate manner and be available on an as-needed basis to serve all populations. While CSUs are expected to serve all people presenting with a behavioral health crisis, they 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) or autism spectrum disorder (ASD), 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 stabilization service interventions upon arrival
- Conduct an initial psychosocial assessment and psychiatric evaluation
- Ensure timely access to appropriate medical services for physical health needs and provide ambulatory care level support for physical health to prevent unnecessary transfers to the Emergency Department for minor health concerns
- Address crises through stabilization services related to both mental health and substance use
- Ensure meaningful family partnership in the child, youth, young adult, and/or individual's assessment, care, service planning, and care coordination, which may include connecting family members to their own services and supports
- Ensure that services are inclusive and gender affirming
- Provide individualized services based on the specific needs of the child, youth, young adult, or adult

- Stabilize individuals receiving services typically within a few hours but within no more than 72 hours
- Provide stabilization services in the least restrictive manner possible, including providing care for individuals seeking voluntary service, and 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 and accessible level of care, resulting in one of the following:

    - The individual is no longer a person requiring treatment.
    - Referral to outpatient or community-based services for aftercare treatment.
    - Referral to a partial hospitalization program.
    - Referral to a residential treatment center, including crisis residential services.
    - Referral to a psychiatric inpatient hospital.
    - An order for involuntary treatment.

Geographic and Special Population Considerations

Different CSU models may be needed for different geographic locations and 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, other licensed and/or credentialed clinicians, and individuals with lived experience
- Ensure staffing levels and types of staff are adequate to provide required services and meet the needs of the population
- Meet staffing ratios established by MDHHS

Importance of Peers

All individuals seeking help should be informed of the availability of support from certified, specially trained peers and people with relevant lived experience.[*] Individuals with lived experience should be available at each step of the process from intake and service to release and transportation. This type of peer support helps amplify the voice of people served, including children, youth, young adults, adults, and their families while supporting them in navigating a crisis.

[*] Not intended to be the Parent Support Partner or youth Peer Support Medicaid Service

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 the use of telehealth services.

Physical Space Requirements

CSUs must:

- Provide a trauma-informed, comfortable, home-like environment
- Match security and facilities restrictions of the physical space with the acuity of the individuals served, as a secured unit is not a trauma-sensitive environment for low acuity individuals
- Ensure physical space that meets the needs of special populations
- Provide waiting areas and stabilization service spaces for children and their families that are separated from those for adults receiving services
- Ensure individual (not shared) rooms that ensure privacy, are family- and individual-friendly, and provide a trauma-informed, comfortable, home-like setting, and are conducive to recovery and building resiliency
- Provide for individuals' and families' 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 only 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 and accessible 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 MDHHS to CMHSP or contractor

System Collaboration Requirements

CSUs must:

- Ensure linkage and partnership with Michigan Crisis and Access Line (MiCAL/988)
- Ensure a pre-admission screening unit is available on a 24-hour basis to provide crisis services on a voluntary basis
- Establish a formal agreement with a CMHSP or regional entity for services provided to individuals using public behavioral health funds, when operated by a hospital
- Operate within a real-time regional bed registry
- 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

Certification and Accreditation

CSU's must:

- Obtain accreditation from The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), or similar organization accreditation by soonest of 1/12/2023 or 3 years following MDHHS certification

Youth Crisis Stabilization Units in Michigan

An addendum to *Crisis Stabilization Units in Michigan* concept paper

***Note as of 03/21/2024**: This Youth CSU Addendum has been drafted, as shown below, providing a preliminary framework for the model. It should be noted that it is MDHHS's goal to co-create a comprehensive model in partnership with individuals with lived experience and stakeholders who are key to the model's implementation. As revisions have not yet been made to capture the essence of these individuals and stakeholders, this document is subject to changes. Updates will be provided as available and this notation will be removed from the final version.*

The following should be utilized **in addition to** the requirements described in the *Crisis Stabilization Units in Michigan* concept paper when designing Youth Crisis Stabilization Units (CSUs).

Purpose

This document provides high-level overview of the key concepts and stakeholder priorities for Youth CSUs in Michigan and is intended to support the early stages of program design and implementation. Michigan Department of Health and Human Services (MDHHS) will be modifying and refining the Adult CSU Certification Standards to meet the needs of children, adolescents, and their families. The Youth CSU Certification Standards will be utilized independently from those written for Adult CSUs and will define family-driven and youth-guided CSU services in Michigan. These certification standards will provide much greater detail regarding the requirements for the implementation and service delivery. Following requirements provided in the Youth CSU Certification Standards, entities will be individually certified, separately from any intra-agency Adult CSUs.

It should be noted that CSUs are defined separately from psychiatric residential treatment facilities and crisis residential service providers and obtain their own individualized certification. CSUs provide crisis stabilization services which are unique from both outpatient and community-based services, as they focus on reduction of acute symptoms of mental illness, rather than treatment of chronic symptomology.

Youth CSU Model Concept

Michigan recognizes the need for caregivers to be intricately involved in children's crisis care as a child's environment and relationships are core components of a child's life and identity. Therefore, the family role will be honored in all aspects of service delivery; opportunity for family partnership and empowerment will be woven throughout the programming and physical site design, beginning at arrival and continuing through to the aftercare coordination.

In designing this model for Youth CSUs, MDHHS has considered both the barriers and the benefits of requiring the active inclusion of parents', caregivers', and family supports' participation and voice in these critical services. There are many factors to consider, including the family's key role in stabilization, as well as trauma incurred with separations from parents, conflicting responsibilities of parents and caregivers, the family's need for a break, and the licensing realities of programs where parents and caregivers are not always onsite. While weighing these factors, MDHHS has determined that requiring inclusion of families in services will lead to the best long-term stability for the child and the family. The intent of crisis stabilization is to offer care at the precise time of need. When family is not present to provide real-time consent, care is delayed. Parents' and caregivers' presence during the crisis treatment is integral to the success of timely stabilization services. Parents and caregivers offer critical insights into the crisis situation, leading to more comprehensive care and assessment. NASMHPD's literature supports this, suggesting that improvement during site-based stabilization services does not predict future functioning or the ability to sustain clinical and functional improvements after a child is discharged, rather, the most salient factors that sustain positive outcomes following discharge are family involvement and the availability of an array of home- and community-based services (HCBS).[5] The Youth CSU model

has been designed with the understanding that they are only one component of the crisis and post-stabilization service continuum. There is a value for both family-focused stabilization and treatment, as well as child-focused stabilization and treatment, such as crisis respite and crisis residential, in the local crisis continuum.

Michigan Youth CSUs understand that when a child is in crisis, their family is experiencing the crisis as well. To address this and best support the full family unit, Michigan Youth CSUs will engage the child, the child's parents and caregivers, as well as existing providers, in this family-driven, youth-guided service. In working toward resolution of the immediate crisis with an eye toward long-term child and family stability, Michigan Youth CSUs will ensure that not only is the child stabilized, but families receive the supports and services they need as well. This support for the full family unit will promote the longevity of the child's stability.

Michigan also recognizes that many children may either be placed in the care and custody of the State of Michigan or without engaged caregivers. These children will be welcomed and served in Michigan's Youth CSUs, being provided an integrated care team who will seek to coordinate care both during their stay and facilitated transitions to post stabilization services.

Key Components of Michigan crisis stabilization unit services:

Basic Program Requirements

Youth CSU site-based services must:

- Provide accessible receiving services for all children and families in behavioral health crises
- Offer family-driven, youth-guided care that is culturally humble, linguistically competent, and fully accessible to all children and their families.[5] The child should be treated not only as an individual, but as a member of their family unit
- Ensure a safe and secure environment to minimize the risk of suicide and (re)traumatization
- Partner with parents and caregivers throughout the course of CSU services in order to provide trauma-informed care and promote long-term stability
- Provide parent/caregiver education on skills to best support the child after their return to the home
- Facilitate coordination of all available natural and professional supports to best serve the child and family in crisis, such as other family and youth-serving systems, such as education, child welfare, housing, and economic supports, as applicable
- Ensure that all services are strengths-based and individualized[5]
- Provide inclusive and culturally competent stabilization services that empower children and families from arrival to discharge; providers must partner with youth and families for shared-decision making
- Evaluate needs and provide services that are developmentally appropriate for the child and family being served
- Hold a strong focus on the inclusion of peer support services* in stabilization activities
- Provide facilitated transitions to alternative levels of care, such as crisis residential, respite care, inpatient treatment, and post-stabilization community-based care. Facilitated transitions must

include in-home services for aftercare support until a child and family are actively engaged in services in their community

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* Not intended to be the Parent Support Partner or youth Peer Support Medicaid Service

Youth CSU community- and home-based aftercare services must:

- Offer family-driven, youth-guided care that is culturally humble, linguistically competent, and fully accessible to all children and their families[5]
- Facilitate the child and family's connection to natural supports in order to assist in stabilizing not only the child, but also their environment
- Ensure that all services are strengths-based and individualized[5]
- Further engage the child and family in care planning to identify triggers to prevent future crises and maintain the evolution of the safety plan initiated during site-based Youth CSU services
- Provide inclusive and culturally competent stabilization services that empower children and families from arrival to discharge; providers must partner with youth and families for shared-decision making. "The safety plan must be proactive, be written in the youth's and family's own words, define appropriate and inappropriate triggers, and include methods to manage negative reactions to behavior or situation from authorities, peers, and members of the community that could cause further harm or shame to the youth or young adult."[5]
- Offer peer support services that reflect the population being served in relation to race and ethnicity, as well as gender and sexuality

Staffing and Training Requirements

Youth CSUs must:

- Design a 24/7 staffing plan which includes clinicians, para-professionals, and peers who hold expertise in child, adolescent, and family crisis care
- Employ only providers who include and honor the input of the child's family and supports
- Ensure competencies and training in effective and culturally-competent child, adolescent, and family crisis prevention and intervention techniques
- Provide youth and young adult, as well as parent and caregiver, -focused peer supports who reflect the population of the community served, including racial, ethnic, national origin, immigration status, LGBTQI+, physical disability, socio-economic status, and geographical considerations

Physical Space Requirements

Youth CSUs must provide:

- Receiving and service areas that not only allow for, but actively encourage, family to partner and engage in the stabilization services of their children
- Law Enforcement receiving areas that are private and not visibly accessible to other children and families in order to prevent (re)traumatization
- A welcoming space for those children and families with lower acuity needs that allows for triage, assessment, and support exterior to the locked unit.

- A safe stabilization area for children and families with higher acuity needs through the use of a secure unit
- Welcoming and adequate space for at least one caregiver or family member to stay with their children throughout the duration of stabilization services
    - Sleeping rooms are required to measure, at minimum, 120 square feet
    - A pull out bed for caregivers is encouraged, but a minimum of a recliner designed for comfortable sleeping is required in each sleeping room, in addition to the bed designated for the child
    - Private restrooms in each sleeping room are required to ensure that caregivers are able to assist in the supervision of their children
    - Provide food service to caregiver(s) staying with their children in the CSU
- Calm and inviting spaces for families to gather outside of their children's rooms either with their child or independently; this must include communal and private gathering spaces
- A trauma-informed design that protects children from exposure to adults experiencing a behavioral health crisis (i.e. when Youth CSUs are co-located with adult services and CSUs)
- Various service delivery rooms, including a sensory room on each unit in order to best serve children with sensory disorders
- A protected and secure outdoor area for children and their families
- A secured milieu that is locked to prevent child elopement and child abduction. The unit may include features like door alarms and buzzer systems, as well as security or unit personnel stationed to allow for approved entrance and departures

Operational Standards

Youth CSUs must:

- Established supported transitions processes; CSU staff will remain actively engaged with the child and family until they are actively engaged in services in the community
- Establish discharge planning protocols for children, including warm handoffs and referrals, as well as partnership and coordination with families, behavioral health providers, social services, juvenile justice officers, and school interventionists, in cases where consent has been provided

Standards Specific to Child Welfare Involvement

Youth CSU's must:

- Navigate the complexities of serving children involved with the child welfare and juvenile justice systems
- Establish protocols for children's receiving services while engaged in the child welfare and juvenile justice systems; these should include the following at minimum:
    - Providing information and documentation in a timely manner to Children's Protective Services workers, as requested
    - Coordination and engagement of the child's environment in their stabilization services; when the child is in the care and custody of the State of Michigan, this may include kinship supports, placements, and child welfare and foster agency engagement, as permitted

- Develop informational materials about CSU stabilization services in order for Child Welfare workers to discuss with families when they are unable to be present with their children due to child welfare related restrictions. There should be a contact number within the materials where parents may call to ask questions

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[5] *As outlined in NASMHPD's A Safe Place To Be white paper*

Questions and comments regarding the CSU model concept can be submitted to Michigan Department of Health & Human Services at MDHHS-CSU@michigan.gov.