2025

Saginaw County CCBHC Community Needs Assessment Survey Results

A data-driven analysis to guide leadership in shaping FY26 priorities for behavioral health improvements, strategic investments, workforce development, and system partnerships.

Submitted by AmyLou Douglas
November 14, 2025

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This Community Needs Assessment (CNA) identifies priority behavioral health needs in Saginaw County and guides Saginaw County Community Mental Health Authority (SCCMHA) in service design, staffing, partnerships, and quality improvement. Findings will inform near-term access and crisis pathway adjustments and shape multi-year plans for workforce and evidence-based practice adoption.

Between June and September 2025, SCCMHA fielded community surveys (n=143) with individuals with lived experience, family and caregivers, employees, and partner agencies. Survey insights were interpreted alongside local administrative information and public data on demographics, coverage, crisis trends, and substance use.

Saginaw County is metropolitan with substantial rural areas. About one in four residents is enrolled in Medicaid and roughly four percent are uninsured, with higher uninsured rates in the City of Saginaw. Transportation and housing remain significant barriers to care, and overdose mortality and emergency visits exceed state averages, signaling sustained substance use burden.

SCCMHA delivers the full CCBHC core services and operates 24/7/365 crisis access (hotline and triage), Mobile Response and Stabilization Services with countywide one-hour response, and adult crisis residential at Saginaw Meadows. Regional hospitals provide emergency coverage; Great Lakes Bay Health Centers and other partners extend primary care, medications for opioid use disorder (MAT), and dental services. Harm-reduction resources include naloxone distribution and a county naloxone vending option. In addition, SCCMHA partners with law enforcement agencies through the CrisisConnect program, which equips officers with tools such as iPads, iPhones, and a dedicated phone line to facilitate their response to crisis situations. This initiative ensures that law enforcement personnel can connect with mental health professionals 24 hours a day, every day.

Assessment results indicate demand outpaces current capacity in several lines of service, most notably substance use disorder care and care coordination; without additional navigation and outreach, much need will not present to SCCMHA. Substance use remains a top priority: expanding MAT availability, recovery supports, and warm handoffs from emergency departments and justice settings would address the highest-risk points of the continuum. Access and experience can improve through a simpler intake process, added evening and telehealth availability, and clearer public information on crisis pathways. Sustained recruitment and retention in psychiatry, therapy, and SUD counseling, and more integrated youth and co-occurring services, are essential to meet need.

METHODOLOGY

A. Qualitative Data Collection & Analysis

Survey Methods and Analysis. Between June and September 2025, SCCMHA fielded three coordinated surveys to quantify behavioral health needs and system performance: an employee survey (n=65), a community and lived-experience survey (n=61), and a partner-agency survey (n=17), for a total of 143 responses. Instruments shared a common core of closed-ended items on access, crisis services, substance use disorder care, coordination, and barriers, with tailored modules by audience (for example, staffing and workflow for employees and referral knowledge for partners). Open-ended prompts captured context on barriers, ideas for improvement, and populations at risk.

Responses were compiled into a single analytic file and summarized with descriptive statistics. Where cell sizes allowed, we compared results across audiences to identify converging signals. Open-ended comments were coded using a structured codebook aligned to the survey domains, reconciled by two reviewers, and converted to theme counts that informed the findings.

These are non-probability convenience samples and were not weighted; results should be interpreted as directional. The partner-agency sample is small, and the employee response may underrepresent some roles. Even so, the three-survey design produced consistent signals—particularly around substance use, access and throughput, and awareness of crisis pathways—that align with administrative and community indicators reported elsewhere in this CNA.

B. Quantitative Data Collection & Analysis

SCCMHA integrated public datasets, local administrative/EHR records, and survey results to quantify need and project demand. Prevalence for adults with any mental illness (AMI) and serious mental illness (SMI), and for youth with serious emotional disturbance (SED), was drawn from NSDUH 2022–2023 and SAMHSA URS 2023 and applied to Saginaw's population to estimate residents likely to need care.

FY2024 EHR data provided counts by core CCBHC service. From these, SCCMHA calculated per-person utilization rates for adult SMI/co-occurring, adult mild-to-moderate, and youth SED cohorts, then applied those rates to the estimated populations to produce county-level projections across crisis, outpatient MH/SUD, screening/assessment, case management, psychiatric rehabilitation, recovery/peer/family supports, and treatment planning.

Survey items were summarized with descriptive statistics; open-ended responses were coded and mapped to the quantitative indicators. Projections rest on two apply-forward assumptions: (1) FY2024 per-person utilization approximates appropriate practice; (2) with barriers reduced, populations would engage at similar rates.

SERVICE AREA DESCRIPTION & SERVICE SITES

Geographic Description of Service Area

Saginaw County spans 800.8 square miles and has about 190,000 residents. Although classified as metropolitan, roughly one-third of residents live in rural areas. It is the county seat within a mix of 3 cities, 27 townships, and 6 villages, a geography that makes service reach and transportation central to planning.

Behavioral Health and Healthcare Infrastructure

SCCMHA delivers the full CCBHC core services regardless of ability to pay from multiple sites (main campus at 500 Hancock St., Child/Family Services on Bay Rd., Community Ties North and South, Housing Resources, Supports Coordination, and Supported Employment). Designated Collaborating Organizations (DCOs) include Hope Network, Saginaw Psychological Services, SVRC, and Westlund Guidance Clinic.

Two hospital systems (Covenant and MyMichigan – Saginaw) provide 24/7 emergency coverage; HealthSource Saginaw offers inpatient psychiatry. Saginaw Meadows (Hope Network) adds an 8-bed crisis residential alternative to hospitalization. Crisis access is available 24/7/365 (hotline and after-hours at Covenant ECC), with MRSS responding countywide within one hour.

Great Lakes Bay Health Centers (FQHC) operates a broad safety-net footprint (22 sites and mobile teams, including school-based locations) covering primary care, behavioral health, and MAT. SUD services span detox, outpatient (including MAT), residential, and recovery housing through regional providers (DOT Caring Centers, Odyssey Village, Ten16, Victory, Sacred Heart). Harm-reduction assets include naloxone pharmacies, a county vending machine with fentanyl test strips, and syringe/safer-use supply distribution.

Social Supports and Access Considerations

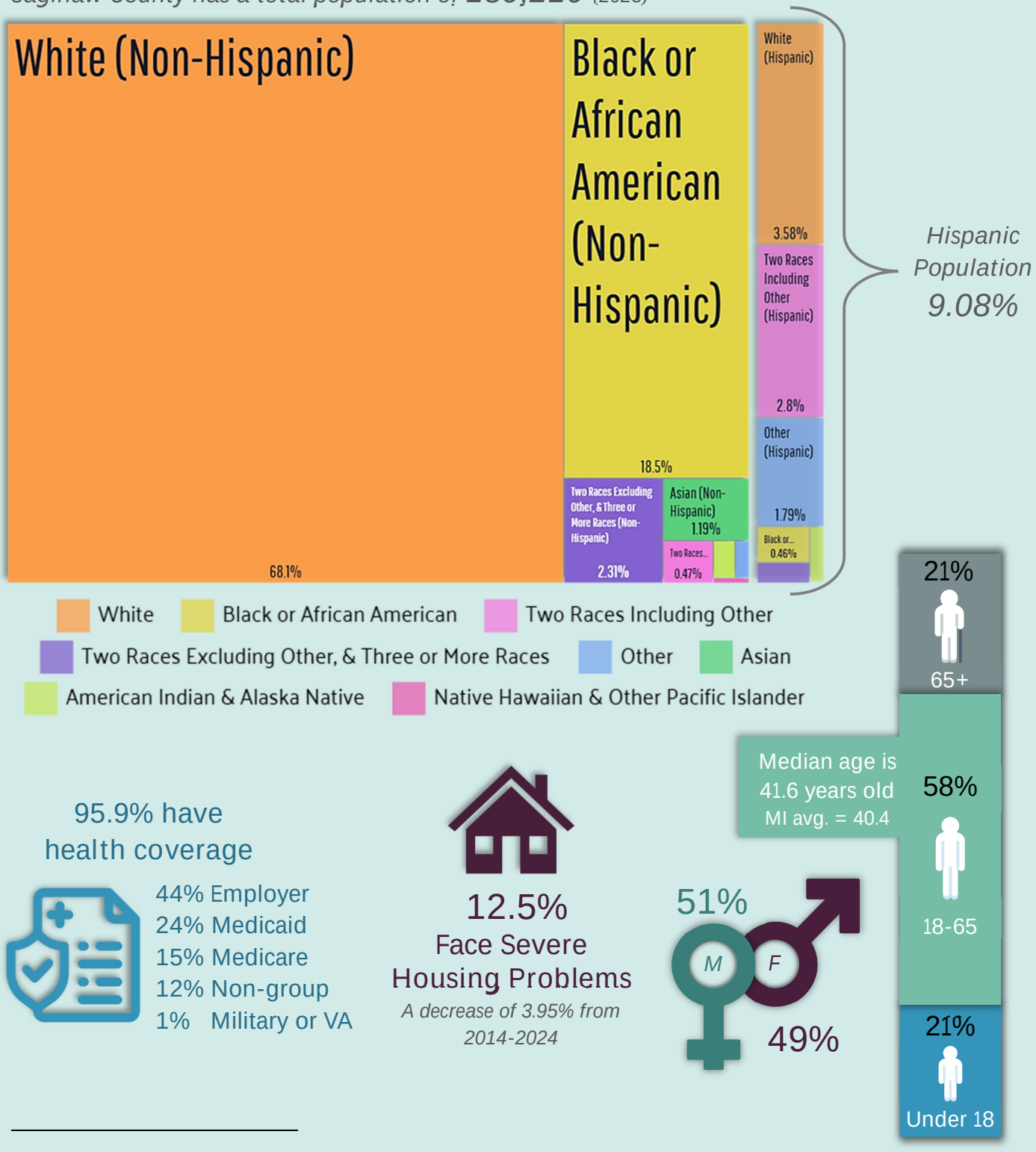
Food, shelter, and emergency assistance are provided by the Saginaw County Community Action Committee, Heart of Saginaw, the YMCA, faith partners, and shelter programs (e.g., Restoration Community Outreach, Mustard Seed, City Rescue Mission, and youth shelters via SCYPC Innerlink and Good Samaritan). Underground Railroad operates the domestic-violence shelter.

Transportation remains a binding constraint: about 9.5% of households lack a vehicle, limiting timely access to behavioral health and primary care, especially in rural townships. SCCMHA's deployment of mobile, crisis, and community-based services is designed to offset these barriers and bring care closer to where people live.

DEMOGRAPHICS

Service Area[1]

Saginaw County has a total population of 189,210 (2023)



[1] Saginaw County, MI | Data USA

*American Indian, Native Hawaiian or other Pacific Islander, and Alaskan Native comprised less than 1% of the population.

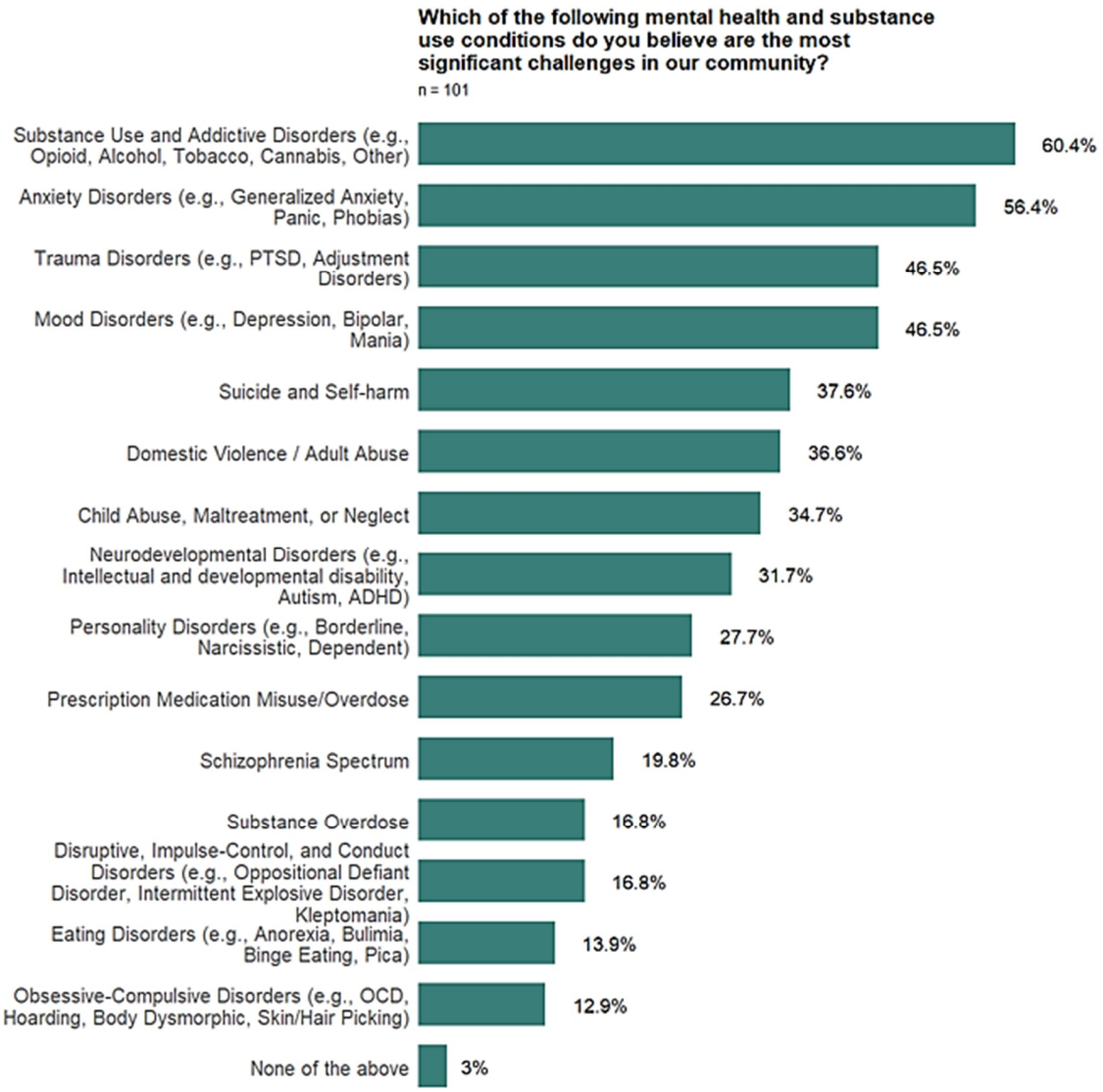
Survey Findings

Major Themes

A. Substance Use Disorders are a Top Community Need

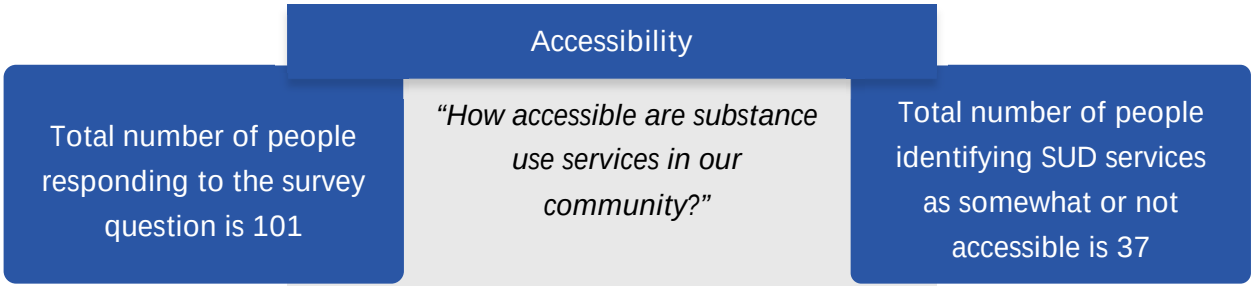
Substance use disorder (SUD) is a top community need. Employees and partner agencies rank SUD among the most significant challenges and lived-experience comments call for more harm-reduction and recovery supports. This convergence strengthens the case to expand medications for addiction treatment (MAT), recovery supports, and warm handoffs from emergency departments and justice settings. In FY2024, SCCMHA served 86 individuals with a *primary* SUD diagnosis, about 0.3% of residents estimated to be experiencing SUD countywide.[2] The following analysis includes data from the survey distributed to individuals with lived experience.

Figure 1

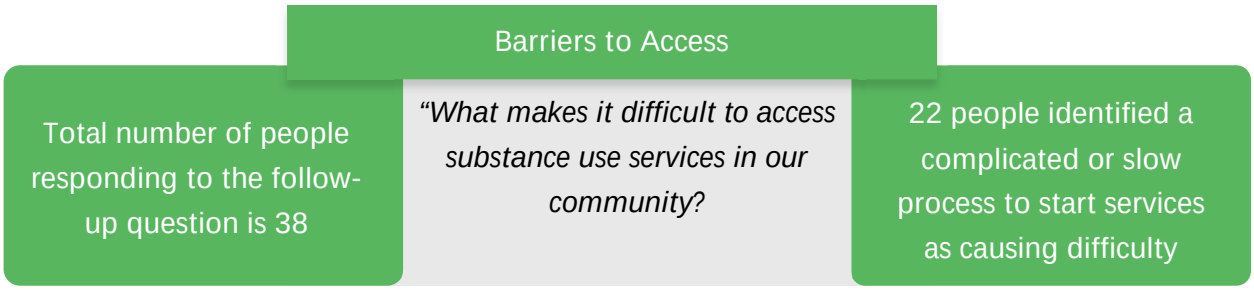


[2] Count reflects clients with a primary SUD diagnosis; SUD care also occurs in co-occurring programs and via MAT in primary care.

Substance Use Disorders are a Top Community Need



Across surveys, respondents consistently surfaced SUD as a leading community challenge and priority for system investment. Employees explicitly identified SUD as the community's most pressing need. Lived-experience responses emphasized stigma, limited SUD options, and the importance of harm-reduction supports like naloxone and fentanyl test strips.



Among respondents who reported problems accessing SUD care (n=38), the most common barrier was a complicated/slow intake (57.9%), followed by cost/insurance hurdles (47.4%), not knowing where to go (42.1%), and stigma/fear of judgment (42.1%). Network and capacity issues also surfaced, not enough providers and providers not accepting my insurance (39.5% each), along with practical obstacles: transportation (36.8% no affordable/reliable rides; 26.3% no public transit), appointments limited to business hours (36.8%), long waits (21.1%), limited internet/phone for teletherapy (21.1%), and language barriers (10.5%).

This pattern points to a targeted access plan:

1. Simplify and speed up the intake with considerations such as single front door, same-day assessment/rapid starts, plain-language forms, and peer navigators.
2. Expand capacity where demand pinches such as evening/weekend and telehealth MAT slots and recruiting/training more in-network SUD clinicians.
3. Reduce cost confusion through efforts like benefits checks, clear copay estimates, and payer engagement to widen networks.
4. Improve wayfinding and stigma-free entry with tools like a one-page "How to Start SUD Care" guide paired with consistent crisis/entry messaging.
5. Remove logistics barriers through the use of ride vouchers/NEMT coordination, mobile visits/phone-first options, as well as translated materials and interpreters.

B. Access Friction throughout Saginaw County

"Access friction" refers to the avoidable steps, waits, and uncertainties that delay or deter people from getting behavioral healthcare, especially first contact and first treatment. In Saginaw County, access friction shows up as slow or complicated intake, unclear wayfinding (not knowing who to call or what to ask for), limited appointment windows, after-hours gaps, cost and insurance hurdles, and logistics barriers such as transportation and technology.

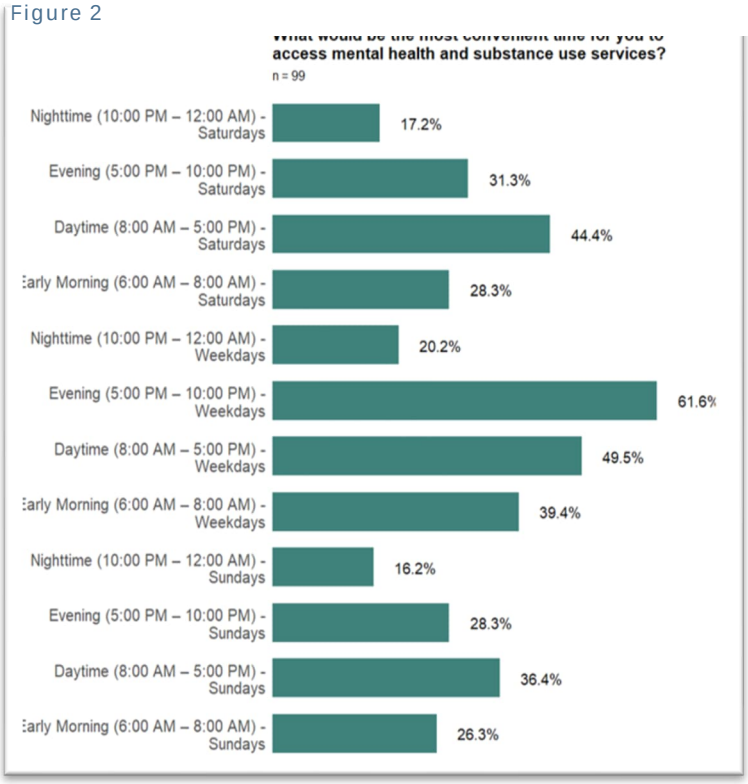
> *"...easy to refer, hard to get the first appointment."*

Across audiences, employees, partner agencies, and community/lived experience, respondents described the same pinch points from different vantage points, which is a strong validity signal. Employees pointed to intake bottlenecks and wait times, noting staff capacity as a contributing factor; community members cited appointment scarcity and paperwork burden; partners called the referral process confusing and reported uneven follow-through or long delays to first appointments.

Partner agencies describe a mixed referral experience: many positive encounters, as well as inconsistent guidance depending on the staff member, and responsibility shifted to clients to initiate or follow up. Several partners asked for online referral options and clearer instructions.

Employees report families are not aware of services until a crisis and cite after-hours limitations (e.g., long hotline waits; limited availability from regional partners) that create avoidable ED use and missed windows for engagement.

Figure 2



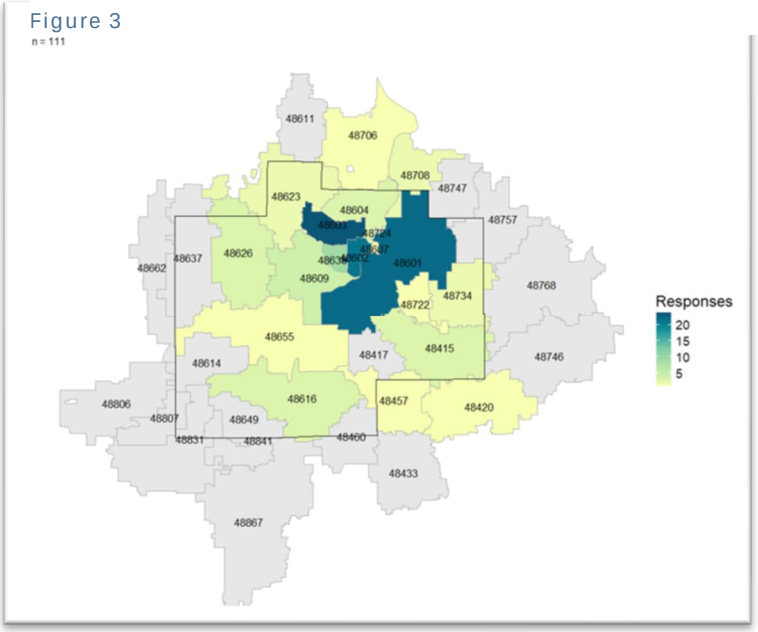
Appointment timing is a key source, and fix, of access friction. A clear majority of respondants prefer weekday evenings (61.6%), with substantial interest in weekday daytime (49.5%) and early mornings (39.4%); on weekends, Saturday daytime (44.4%) and Sunday daytime (36.4%) outpace late-night options (≤20%). In practice, that means shifting capacity out of Monday through Friday business hours into after-work, early-morning, and weekend daytime blocks.

Intake and wayfinding friction are systemic and fixable. Because they occur *before* treatment begins, improvements here lift the entire continuum: faster time-to-first-visit, higher MAT starts, fewer crisis escalations, and better experience for clients and partners.

C. Equity Gaps in Access and Outcomes

Saginaw County's behavioral health needs are concentrated in communities that face structural barriers including poverty, unstable housing, limited transportation, and stigma. These conditions do not impact residents evenly; they cluster by ZIP code and identity (e.g., LGBTQIA+, disability, veterans, older adults), shaping when, where, and whether people get care. Survey responses point to consistent disparities that SCCMHA can address through targeted outreach, tailored service design, and accountability measures.

Figure 3
n = 111



To identify who faces the biggest barriers, we combined three views – the lived-experience, partner-agency, and employee surveys, and then layered on county context about transportation and housing. We flagged groups that appeared in more than one source or whose barriers likely block people at the very first step of care. The same groups surfaced repeatedly: LGBTQIA+ residents; people with disabilities, including autistic adults and 18–25 transition-age youth; people who are justice-involved or experiencing homelessness; and residents in several underserved ZIP codes. Staff also pointed to veterans and older adults. Limited transportation (about 9.5% of households have no vehicle) and elevated homelessness widen these gaps, so outreach, mobile access, and inclusive practices should start here.

Approximately 4% of the Michigan population identifies as LGBTQ+.

LGBTQIA+: Respondents described consistent gaps in inclusive, safe services, with specific concerns about how LGBTQIA+ people are treated in some shelter and faith-based settings. Fear of judgment or coercion discourages help-seeking and interrupts care, especially during first contact. Participants asked for visible signals of inclusion (affirming signage, pronoun use, multilingual materials) and providers trained in trauma-informed, culturally responsive practice. Partnering with trusted community organizations and placing outreach on the east side were also cited as ways to build trust.

People with Disabilities, Including Autism: Community comments highlighted a shortage of adult autism supports and a "transition gap" as youth move into adult services. Families reported difficulty finding clinicians skilled in neurodiversity-affirming care, which can lead to mismatches in treatment and early disengagement. Respondents asked for clear navigation help at the handoff from youth to adult programs, along with sensory-friendly environments and flexible scheduling. Peer support and caregiver education were cited as helpful bridges during the first months of adult care.

People with autism experience higher rates of anxiety, depression, and PTSD.

Veterans: Employees flagged unmet needs for veterans, including difficulty navigating VA eligibility and inconsistent local access through VA channels. Veterans also face cross-cutting barriers including cost confusion, scheduling around work, and transportation as factors that interrupt engagement after first contact to verify the gap is closing.

There are approximately 9,825 Veterans living in Saginaw County.

Justice-Involved Individuals: Justice-involved residents face multiple compounding risks at the exact moments when care is most needed: court disposition and especially jail release. Partner agencies explicitly flagged this population and asked for tighter coordination with courts, noting that referral steps are confusing and slow, which leads to missed first appointments and early disengagement. These transition points intersect with Saginaw's elevated overdose burden—drug poisoning and opioid-related death rates above state averages—so delays after release carry outsized consequences for relapse and mortality. Practical barriers amplify the risk: a meaningful share of households have no vehicle, and homelessness remains elevated, making it harder to keep appointments or be reached for follow-up. Finally, employee survey participants pointed to after-hours gaps in regional support, which is precisely when many releases and crises occur, widening the window for adverse outcomes.

Roughly 9.5% of households lack a vehicle, making standard clinic hours and in-person intakes a high barrier, especially outside the core city.

Mental health significantly impacts underserved populations in various ways:

1. Access to Care: Many underserved communities face barriers to accessing mental healthcare, including lack of insurance, high costs, and limited availability of providers. This often results in untreated mental health conditions.[3]
2. Stigma and Discrimination: Stigma around mental health can be more pronounced in marginalized communities, making individuals less likely to seek help. Discrimination and lack of culturally competent care further exacerbate these issues.
3. Economic and Social Factors: Poverty, unemployment, and unstable housing are more prevalent in underserved populations, contributing to higher stress levels and mental health issues. These factors also make it harder to access and afford care.[4]

[3] Overlooked and Underserved: Promoting Mental Health Equity in Marginalized Communities | Healthiest Communities Health News | U.S. News (usnews.com)
[4] There's a new push to reach underserved communities (apa.org)

4 Health Outcomes: Poor mental health can lead to severe consequences, such as increased risk of substance abuse, homelessness, and involvement in criminal activities. It also negatively affects physical health, leading to a cycle of poor overall health.[5]

Addressing these challenges requires targeted interventions, including increasing access to affordable care, reducing stigma, and providing culturally competent services.

STAKEHOLDER INPUT

SCCMHA conducted three surveys to gather feedback from stakeholders.

Community and Lived Experience Survey: SCCMHA received 61 responses to the Community & Lived Experience survey. Demographic questions were optional, so denominators vary by item; percentages in figures and tables have been calculated only from those who answered each question.

Age: Among respondents who answered the age item, 12% were age 65+. Adults 55-64 (23.1%), 45-54 (29.1%), 35-44 (17.9%), and 25-34 (9.4%) accounted for the largest portion of participants, and 4.3% were 18–24.

Race and Ethnicity: The majority of respondents identified as White (69.2%), followed by Black/African American (20.5%). Smaller shares identified as Hispanic/Latino (9.4%), Native American or Alaska Native (2.6%), Asian (0.9%), or other groups (e.g., Middle Eastern) in write-ins.

Gender Identity: Most respondents identified as female (76.1%), with male (15.4%) next. A small share identified as non-binary or self-described (3.5%).

Other: Beyond basic demographics, respondents showed strong ties to the local system. Many reported that they or a family member have received services through SCCMHA or its contracted network (53.5%), and most indicated they live (88.9%) and/or work (57.8%) in Saginaw County, with ZIP codes spread across the catchment area.

Employee Survey: SCCMHA received 65 responses to the Employee Survey. The survey was anonymous and focused on frontline perspectives; role and job-title questions were included, but some respondents skipped individual items, so denominators vary by question. Percentages shown in figures and tables were therefore calculated only from those who answered each item.

Primary Role: Employees who responded represent a cross-section of SCCMHA functions. Most identified with front-line, direct-service roles (case management, clinical/therapeutic services, crisis/outpatient care), with administrative and coordination roles comprising a smaller share and a handful selecting supervisory/leadership or “Other.” Because this was a single-select item, each respondent chose the one role that best fit their day-to-day work.

[5] Amplifying the Mental Health Needs of Underserved Youth (advancetheseed.org)

Job Title: Job titles track closely with the role distribution and give helpful texture to how work is organized. This was also single-select, and several respondents used the "Other (please specify)" option to clarify titles not listed—examples include Coordinator, Staffing Services, Billing, Provider–CLS/Respite, OBRA Coordinator/Clinician, Self-Determination Coordinator, and Care Management.

Partner Agency Survey: SCCMHA received 17 responses to the Partner Agency Survey. The instrument collected sector affiliation and perspectives on community service challenges, assessed partners' referral knowledge (populations served and services offered by SCCMHA), captured referral destinations and experience with SCCMHA's referral process, and asked partners to rate the accessibility of mental health and SUD services and identify barriers and underserved groups. Several items were multiple-select, and all questions were optional, so denominators vary by item.

Sector/System Represented: Responding organizations span the local continuum—healthcare, human services, housing, education, justice, and related sectors—so the results reflect multiple vantage points on access and coordination. Because this item allows more than one sector, several agencies selected multiple categories to reflect cross-cutting roles such as health and housing.

Referral Experience: This yes/no item functions like an organizational "demographic" of engagement: it shows which partners have direct referral experience with SCCMHA versus those who have not (or are unsure). Yes: [Y] of [N] ([Y/N × 100]%) • No: [Z] of [N] ([Z/N × 100]%) • Unsure: [U] of [N] ([U/N × 100]%).

The three surveys provide triangulated, cross-stakeholder evidence, from community/lived experience, employees, and partner agencies, to inform SCCMHA decision-making. While the instruments used non-probability, optional-response designs and findings should be interpreted as directional, such as identifying patterns and priorities, rather than making exact prevalence claims. SCCMHA can use these inputs to prioritize workflow redesign, capacity deployment (including evening/telehealth access), and partner coordination where the data show the highest yield.

Survey analyses focused on pinpointing where individuals experience delays or disengagement when accessing or continuing care, from initial referral and contact through intake, and the first treatment or medication visit. Respondents evaluated the accessibility of mental health and SUD services and described obstacles and referral experiences, with open-ended feedback offering specific examples of protracted or intricate intake processes, ambiguous referral roles, and after-hours service gaps. By synthesizing these responses, SCCMHA identified the most significant access barriers and recent developments impacting the speed and dependability of care entry.

A. Input from Stakeholders on Access Friction

Surveys highlighted the need to reduce avoidable steps and waits that delay or deter people from starting and staying in care. Respondents described slow or complicated intake, unclear wayfinding and referral

roles, gaps in after-hours coverage, and limited evening/weekend appointment options. Partners also noted variable referral experiences by staff member and long intervals between intake and the first treatment/medication visit. Together, these findings point to front-door processes as a primary lever for improving timeliness and reliability.

Specific barriers included:

- Complicated intake and paperwork that prolong eligibility steps and push first appointments out by weeks.
- Unclear wayfinding and referral responsibilities, causing follow-through to be entirely left to clients.
- Limited appointment windows and after-hour gaps, including hotline holds and daytime-only scheduling that conflict with work and caregiving.
- Transportation and technology constraints that make in-person or telehealth access unreliable for some residents.

Identified improvements:

- Standardized, close-looped referrals
- Extended hours and flexible modalities
- Transparent costs and supports

B. Input from Stakeholders on SUD Treatment Needs

Across all three surveys, substance use disorder (SUD) emerged as a top system priority. Employees explicitly identified SUD as the community's most pressing need; community respondents rated affordable treatment and crisis access as leading gaps; and partners described long waits and unclear placement pathways once someone is ready for care. Together, these inputs indicate that SUD access requires both capacity and process fixes.

Specific barriers included:

- Slow or complicated starts and long intervals from intake to first treatment/medication visit; several partners described variable experiences by staff and uncertainty about outcomes of referrals.
- Placement constraints and after-hours gaps, including reports of increased admissions to medical floors for detox and limited regional support on evenings/weekends.
- Insufficient harm-reduction and recovery supports such as Naloxone, Fentanyl testing strips, and ongoing recovery support services.

Identified improvements:

- Clear placement pathways and closed-loop referrals from emergency departments and courts, with feedback to the referring agency.
- Expand capacity and hours to match demand and work schedules.
- Strengthen harm-reduction options and recovery supports alongside treatment.

C. Input from Stakeholders on Equity Gaps

Across surveys, respondents described disparities in who receives timely, appropriate care and who does not. Themes point to gaps tied to identity (LGBTQIA+, disability/autism), life circumstance (justice involvement, homelessness, veteran status), and place (specific ZIP codes, transportation-limited areas). These disparities are reinforced by stigma and inconsistent cultural responsiveness in parts of the local network.

Who is most affected:

- LGBTQIA+
- Justice-involved individuals
- Veterans
- Older Adults
- People experiencing homelessness
- Individuals with transportation barriers
- People with disabilities, including autistic adults and transition-age youth

Identified Improvements

Advancing equity at SCCMHA means turning the survey signals into concrete, targeted practice. First, respondents called for visible LGBTQIA+-affirming care and for supports that bridge the 18–25 transition, especially for autistic adults who struggle to find neurodiversity-affirming services; building an adult autism navigation pathway alongside clear inclusion standards addresses both needs.

Second, partners emphasized gaps for justice-involved residents and named underserved ZIP codes (specifically 48601 and 48603). Formalizing "justice-to-care" bridges, including scheduling before release, rapid linkage on discharge, and tracking outcomes by geography, reduces place-based inequity and prevents early disengagement.

SCCMHA staff highlighted unmet needs for veterans and older adults. Expanding veteran-specific referral options and geriatric-capable services, while aligning appointment hours and telehealth with these groups' constraints, directly responds to those gaps. Because about 9.5% of households lack a vehicle and homelessness remains elevated, SCCMHA should prioritize mobile and after-hours access, ride supports, and closer partnerships with shelters to stabilize care for people without reliable transportation or housing.

Finally, surveys described stigma, safety concerns (fear of being "locked up"), and the need for more diverse, empathetic providers throughout the entire county. Investing in culturally and linguistically responsive care (including interpreter services) and visible anti-stigma outreach in areas that voiced these concerns will improve first-contact experience and retention.

CURRENT STRENGTHS & CHALLENGES AT SCCMHA

A. SCCMHA Strengths

Strong DCO Network

- Robust network of care coordination agreements
- Coordinated and comprehensive care for indivuduals with behavioral health needs
- Open to evaluating and establishing additional agrements as needs evolve and new providers enter the county

24/7 Crisis Services

- Maintains 24/7 crisis hotline
- Crisis center available during business hours at 500 Hancock
- Mobile Response and Stabilization Services (MRSS)
- Eight-bed crisis residential at Saginaw Meadows
- A full continuum of crisis services: Someone to Call, Someone to Respond, Somewhere to Go

Active Improvement Posture

- Actively training workforce and leadership on access barriers and stigma reduction
- Regional workforce development efforts
- Financial planning to sustain CCBHC

B. SCCMHA Challenges and Gaps

Extended Waits

- Long waits after intake
- Referral process is confusing and varies by staff members
- Limited visibility in referral outcomes

Placement Bottlenecks

- Hospital boarding while waiting for placement
- Care transition gaps
- Limited downstream capacity

Awareness Gaps

- Service and eligibility misunderstood
- Need for community-facing education and informaiton
- Uncertainty of who to call for consultation
- Insufficient linkage and transition knowledge

C. Summary of Findings

SCCMHA enters this planning cycle with a strong foundation. The organization operates a 24/7 crisis backbone and delivers the full CCBHC core services regardless of ability to pay. Robust cross-system partnerships enable warm handoffs across settings. Partners frequently describe positive referral experiences and responsive staff, and SCCMHA demonstrates an improvement posture via training to reduce stigma, workforce development, and attention given to financial sustainability. These assets give SCCMHA a credible platform to expand access, integrate SUD care, and advance equity.

At the same time, surveys and local context point to persistent access friction: complicated intake and paperwork, unclear wayfinding and referral roles, and limited evening and weekend options that delay access to first treatment or medication visits. Placement bottlenecks and SUD capacity and coverage gaps (detox/residential, insured inpatient alcohol treatment) compound delays. Awareness gaps, such as not knowing where to start, who is eligible, or whom to call for consultation, limit timely help-seeking and partner follow-through. Underlying workforce shortages (psychiatry, therapy, SUD counseling) and after-hours pathway complexity further stress throughput and reliability.

APPENDIX A

SCCMHA Community Needs Assessment - Community & Lived Experience Survey

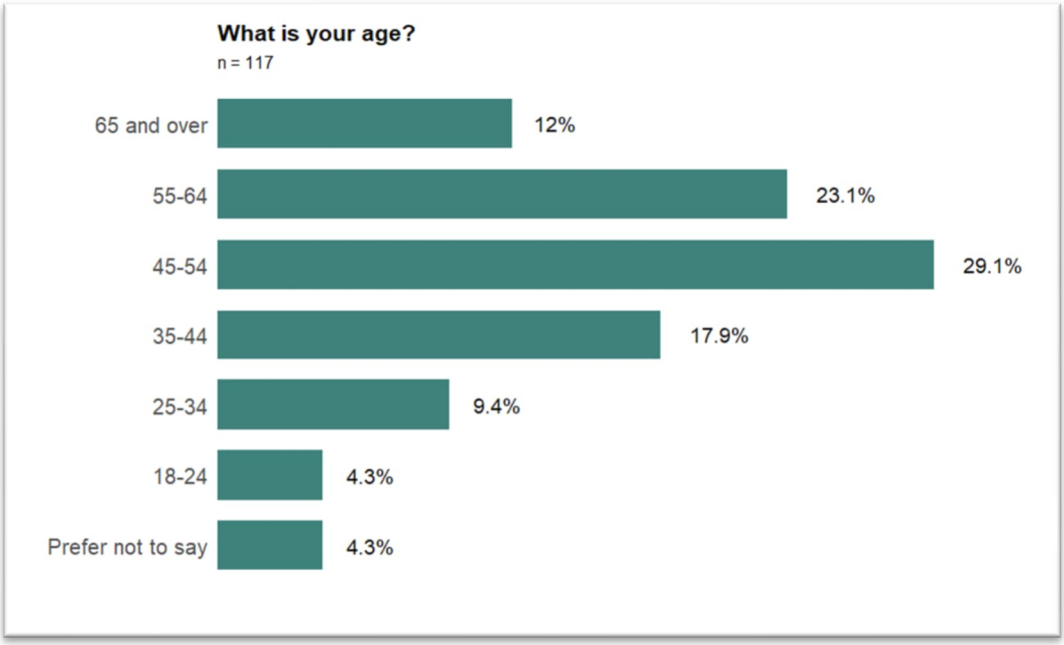
TBD Solutions

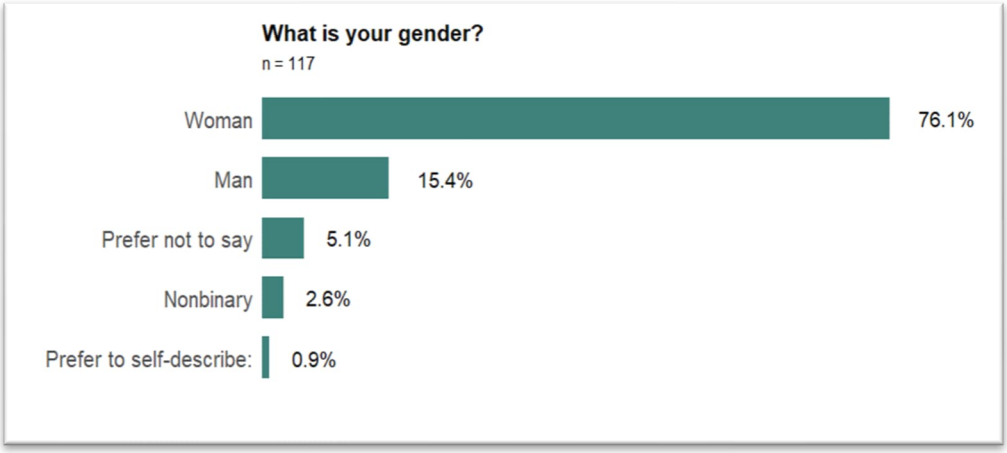
2025-09-25

Whether their experience is in facing behavioral health challenges, supporting a loved one, or simply caring about the well-being of their community, this survey invited those with lived experience to share what they've seen, felt, and learned. Their insight helps to identify what's working and what needs to change, so services can better reflect and respond to the real needs of the people they're meant to serve.

1. What is your age?

Multiple choice question. Only one option can be selected.



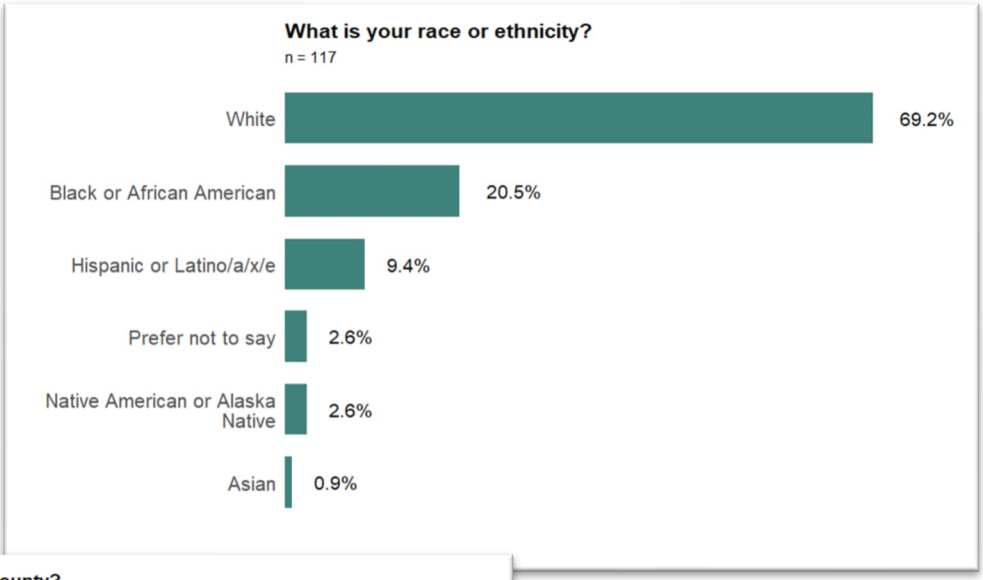


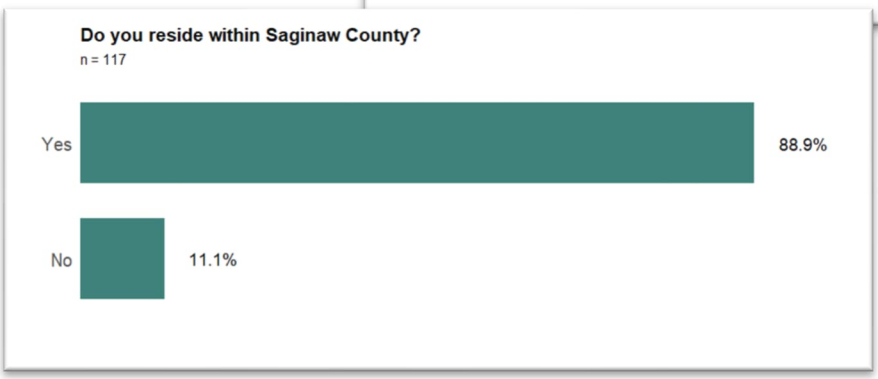
2. What is your gender?

Multiple choice question. Only one option can be selected. Any responses to the "Prefer to self-describe:" follow-up question are shown in the Appendix.

3. What is your race or ethnicity?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



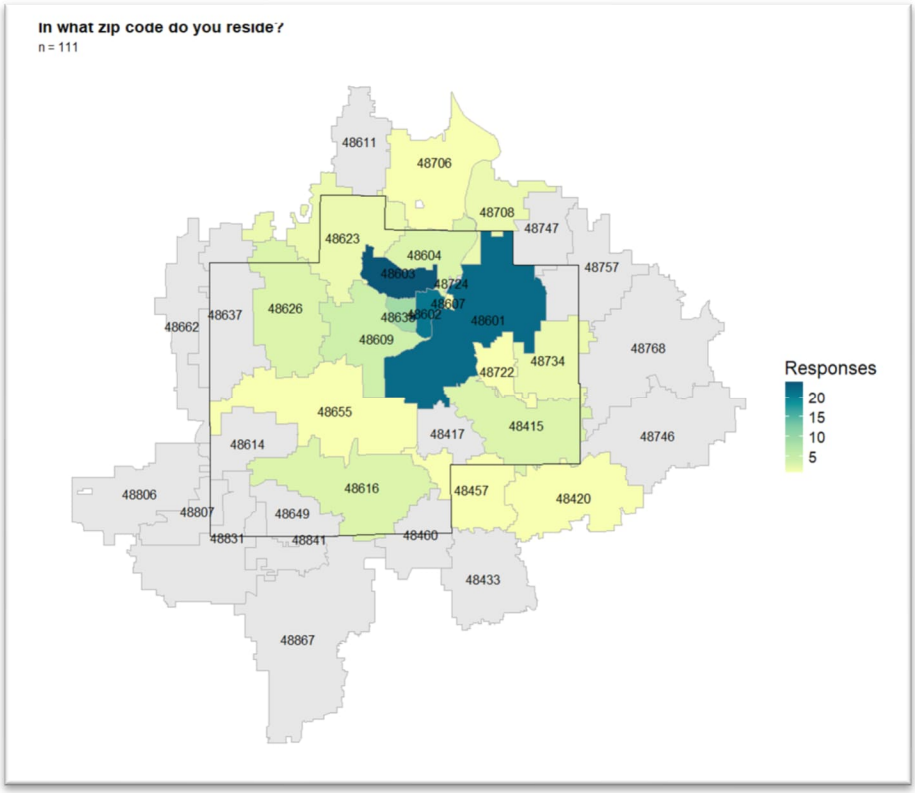


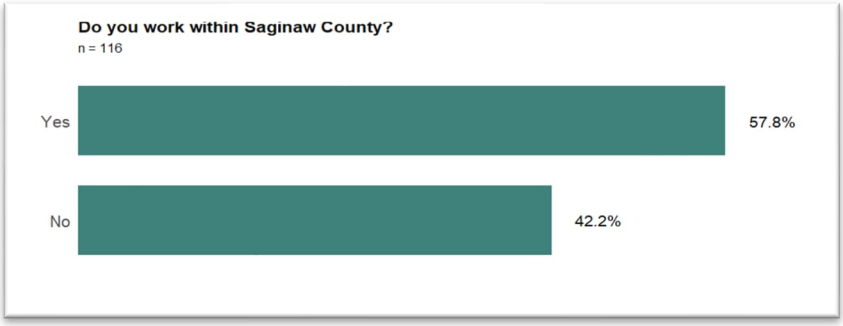
4. Do you reside within Saginaw County?

Multiple choice question. Only one option can be selected.

5. In what zip code do you reside?

Multiple choice question. Only one option can be selected.



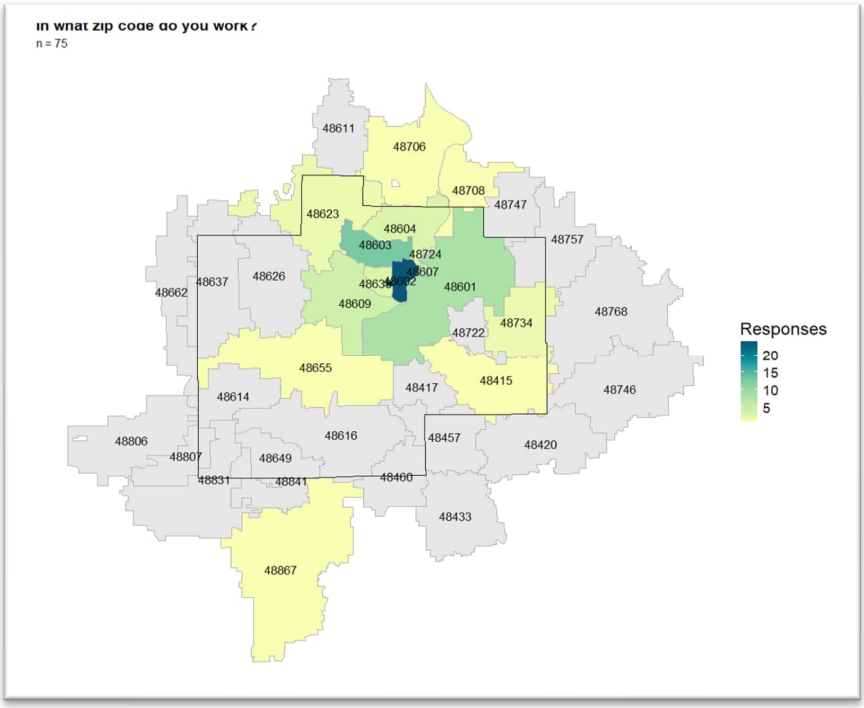


6. Do you work within Saginaw County?

Multiple choice question. Only one option can be selected.

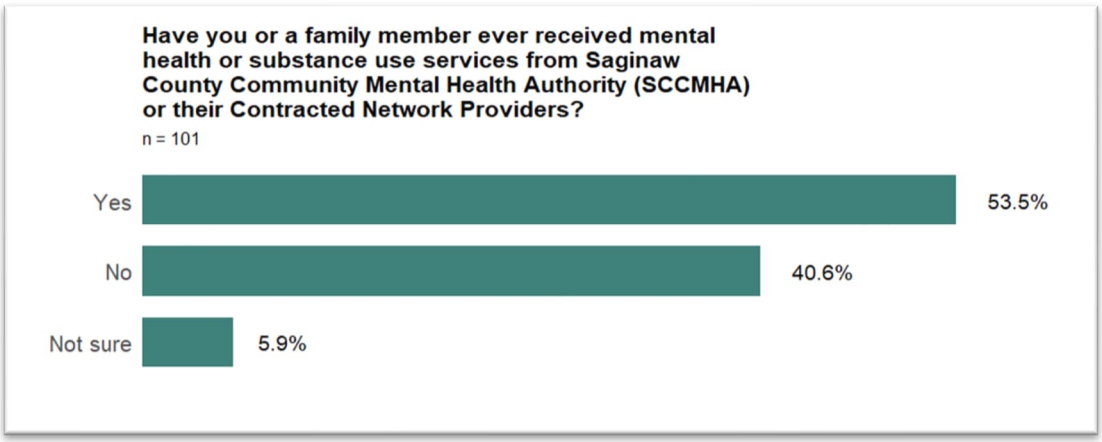
7. In what zip code do you work?

Multiple choice question. Only one option can be selected.



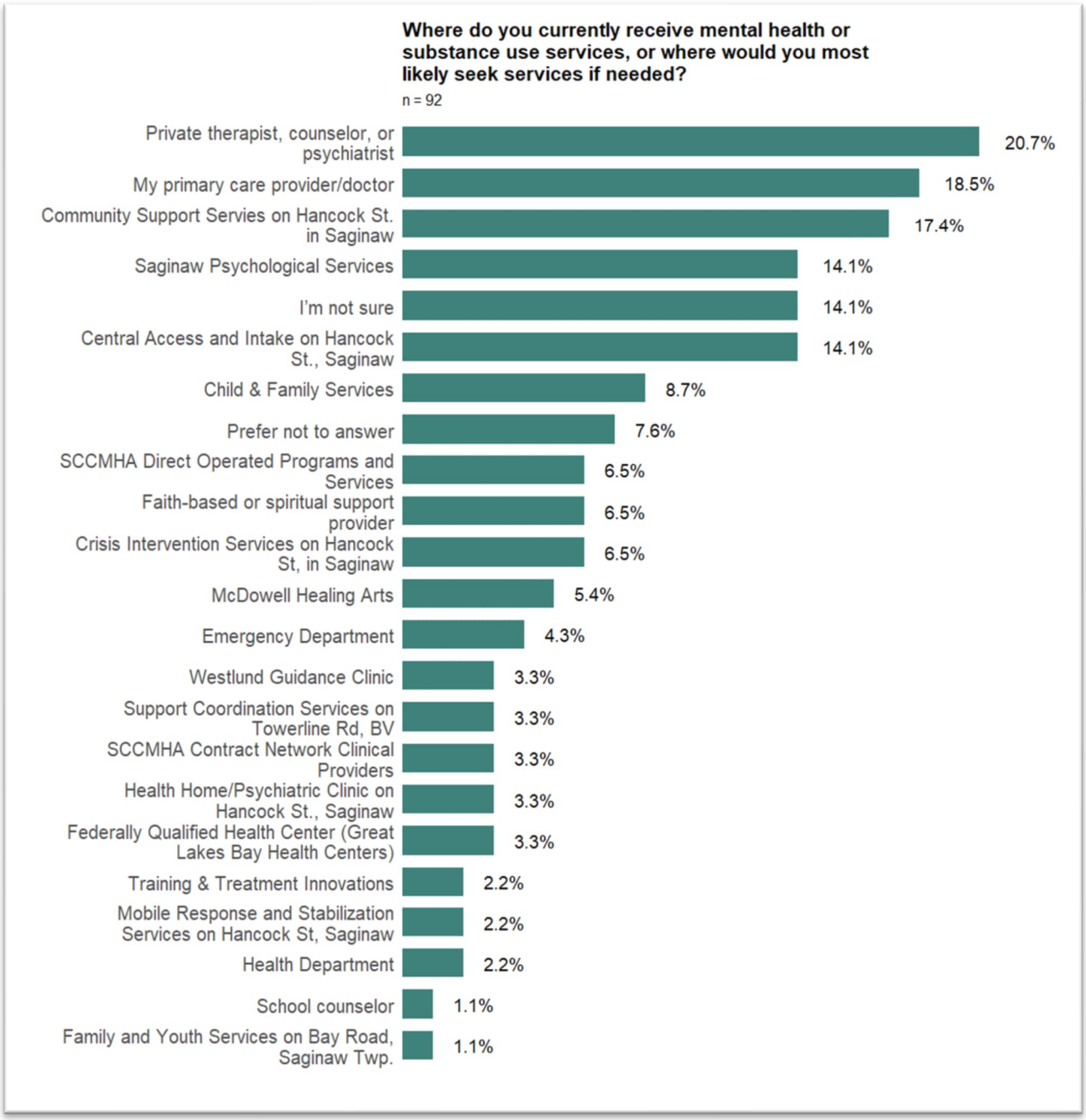
8. Have you or a family member ever received mental health or substance use services from Saginaw County Community Mental Health Authority (SCCMHA) or their Contracted Network Providers?

Multiple choice question. Only one option can be selected.



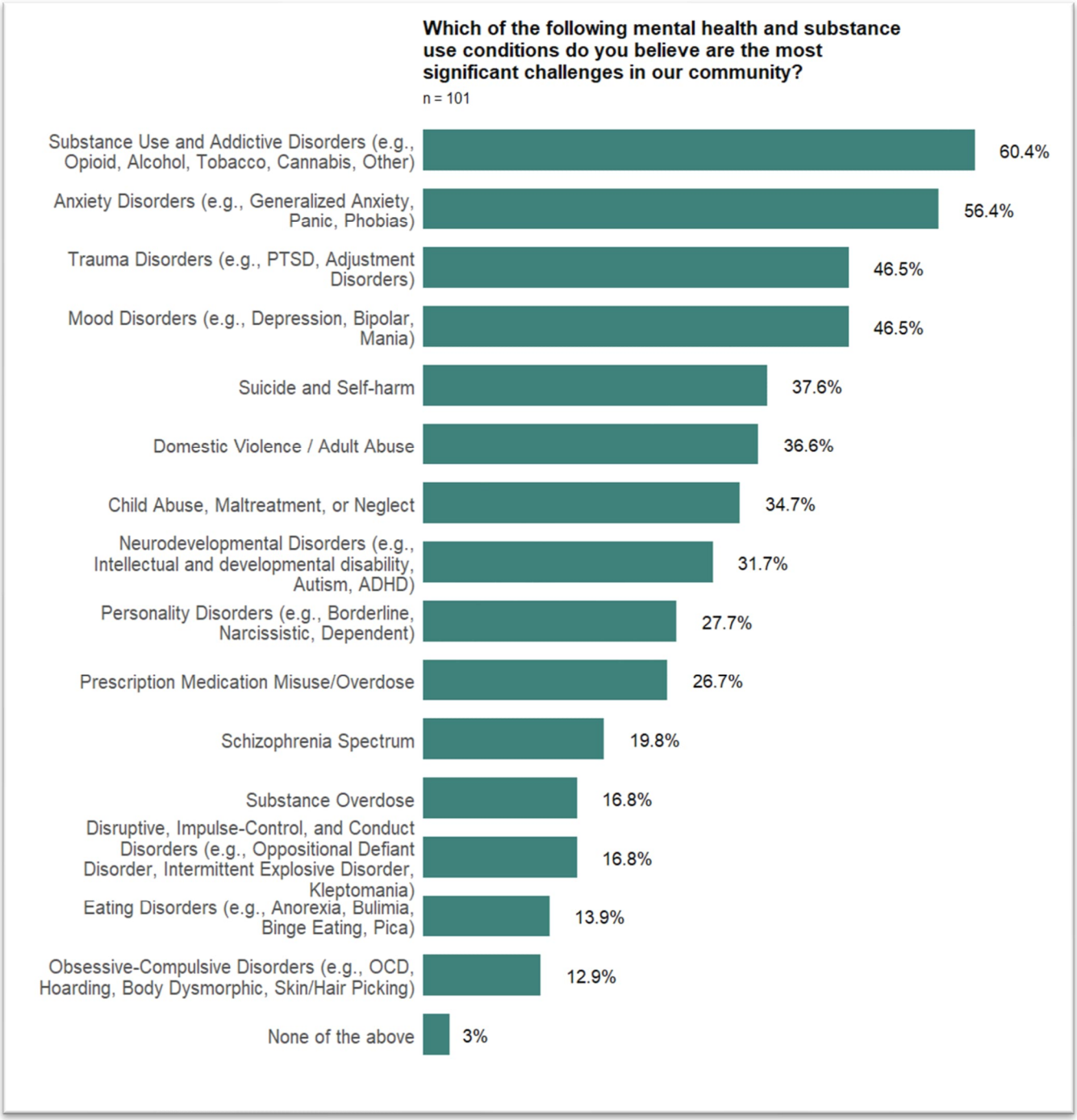
9. Where do you currently receive mental health or substance use services, or where would you most likely seek services if needed?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



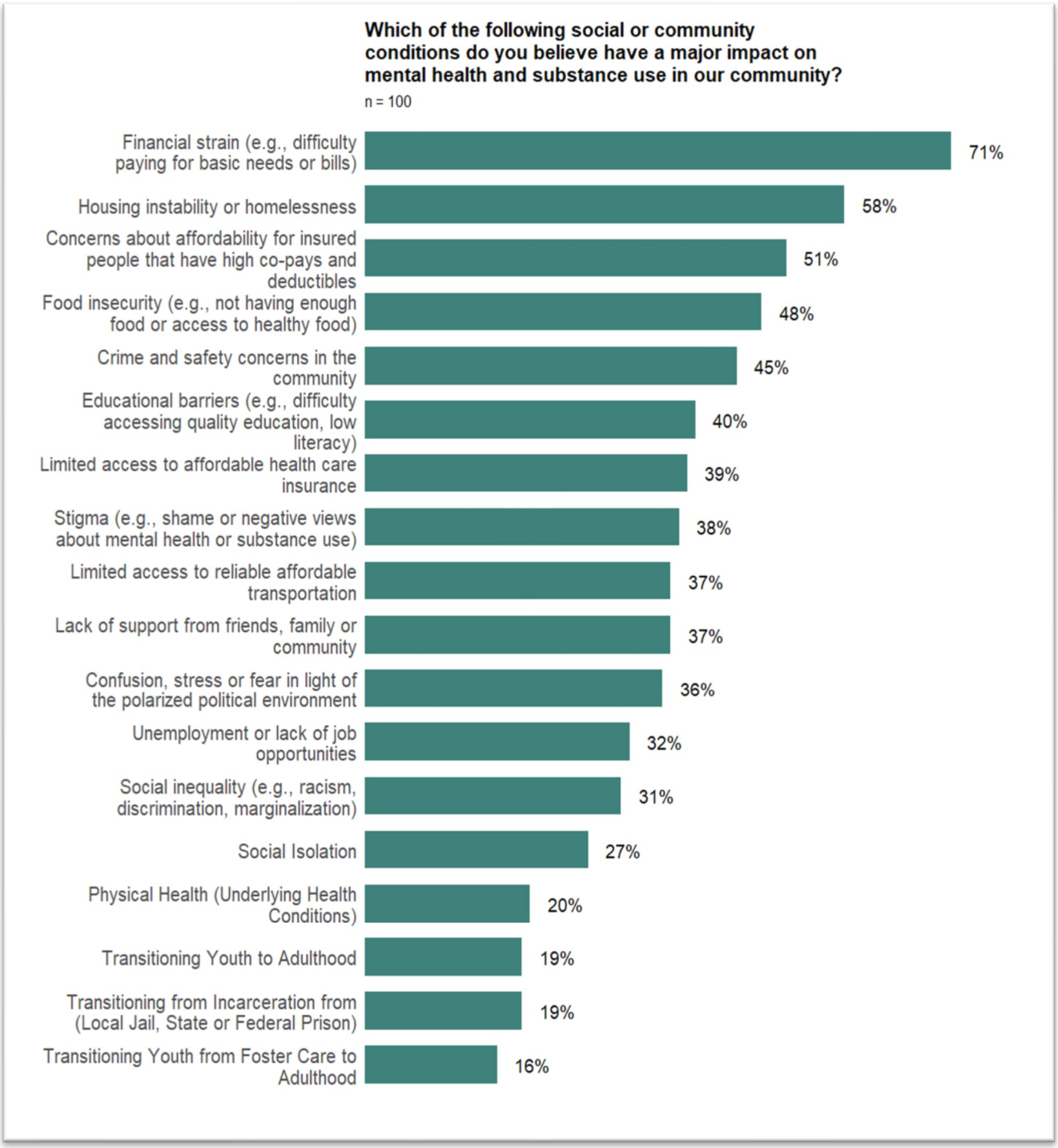
10. Which of the following mental health and substance use conditions do you believe are the most significant challenges in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



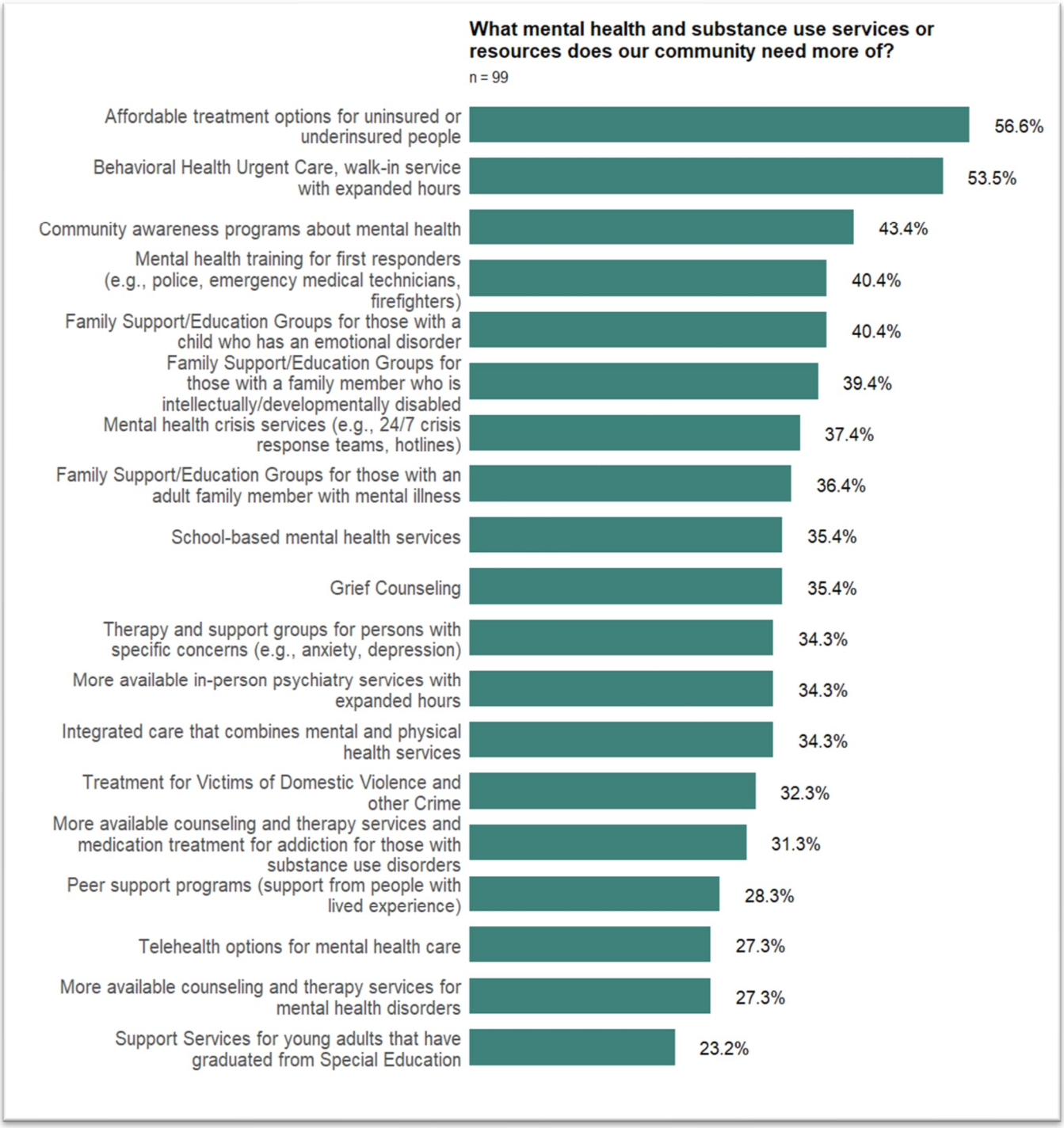
11. Which of the following social or community conditions do you believe have a major impact on mental health and substance use in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



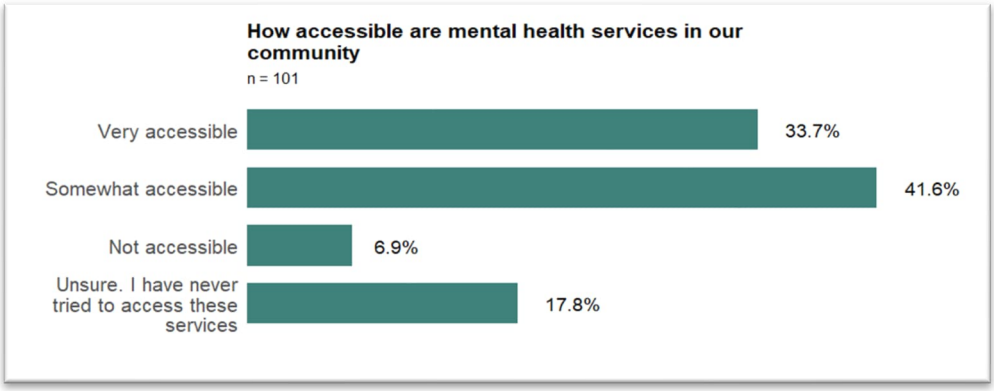
12. What mental health and substance use services or resources does our community need more of?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



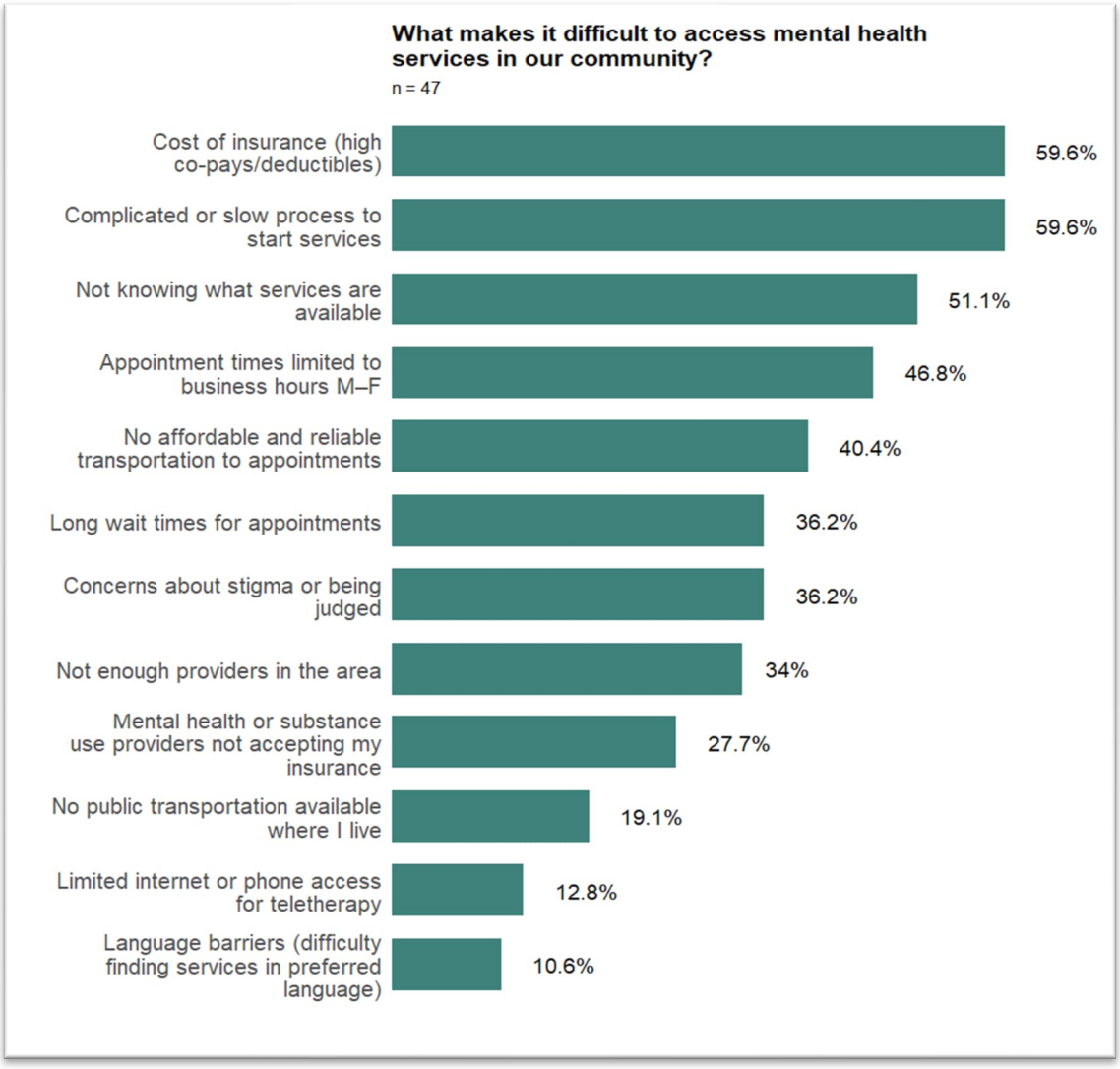
13. How accessible are mental health services in our community?

Multiple choice question. Only one option can be selected.



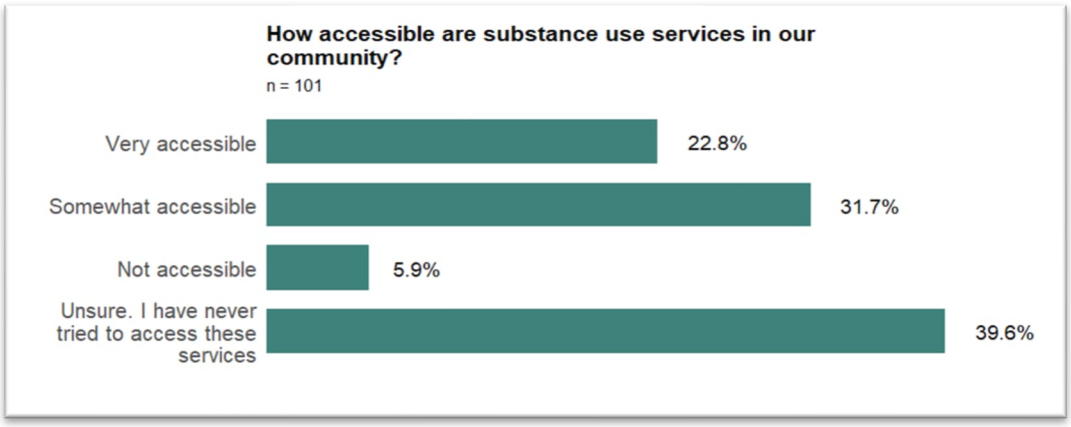
14. What makes it difficult to access mental health services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



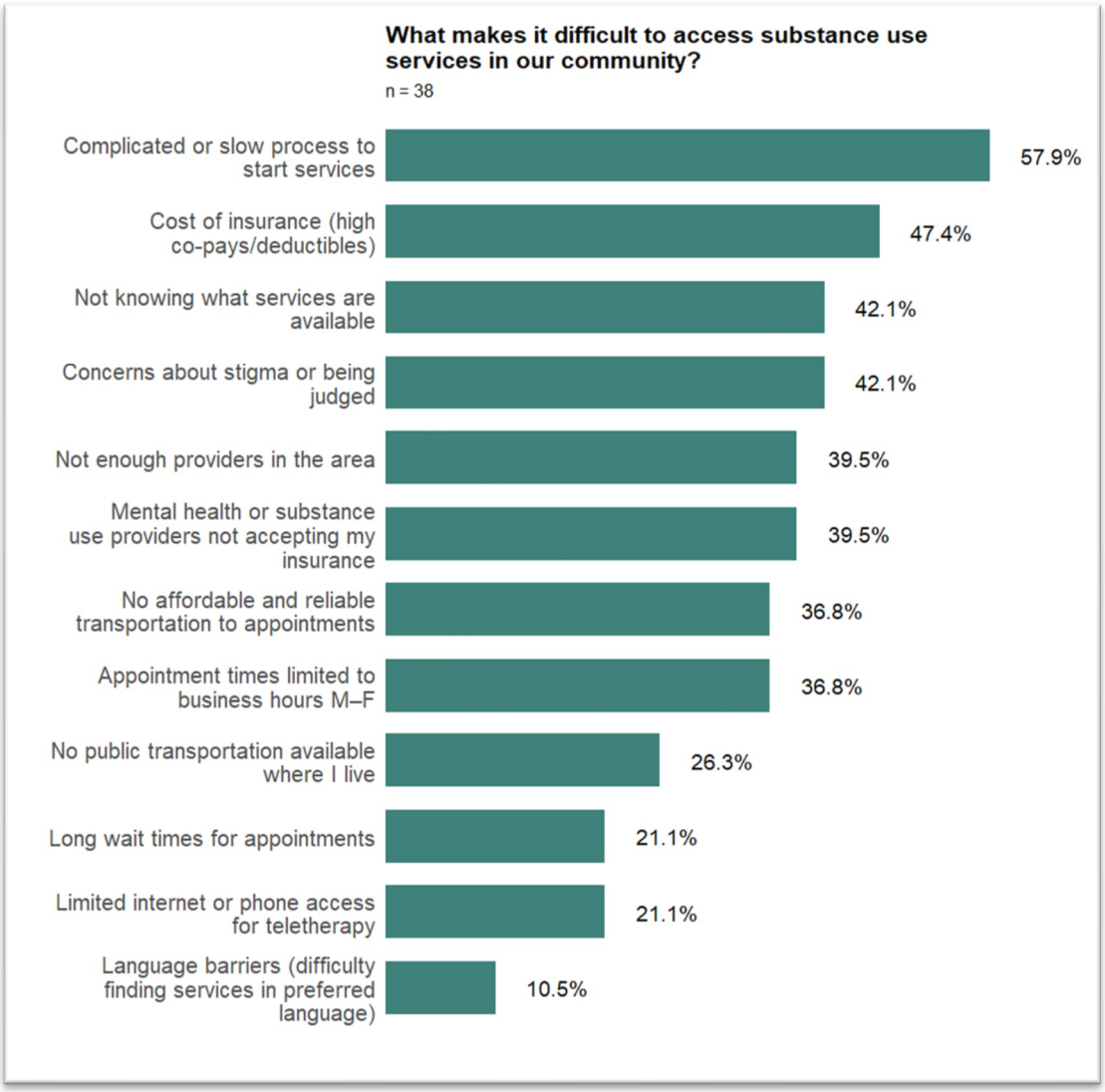
15. How accessible are substance use services in our community?

Multiple choice question. Only one option can be selected.



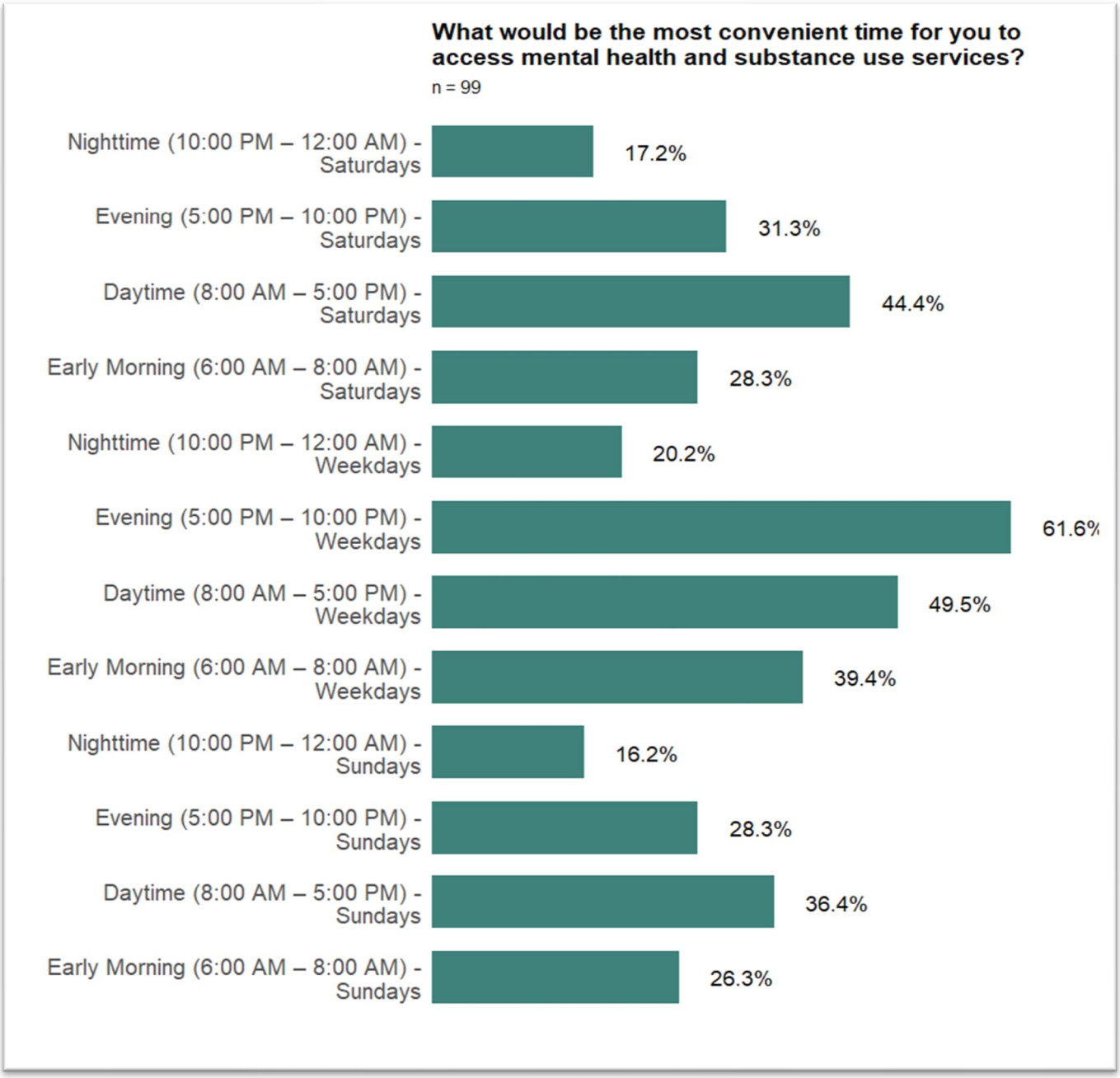
16. What makes it difficult to access substance use services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



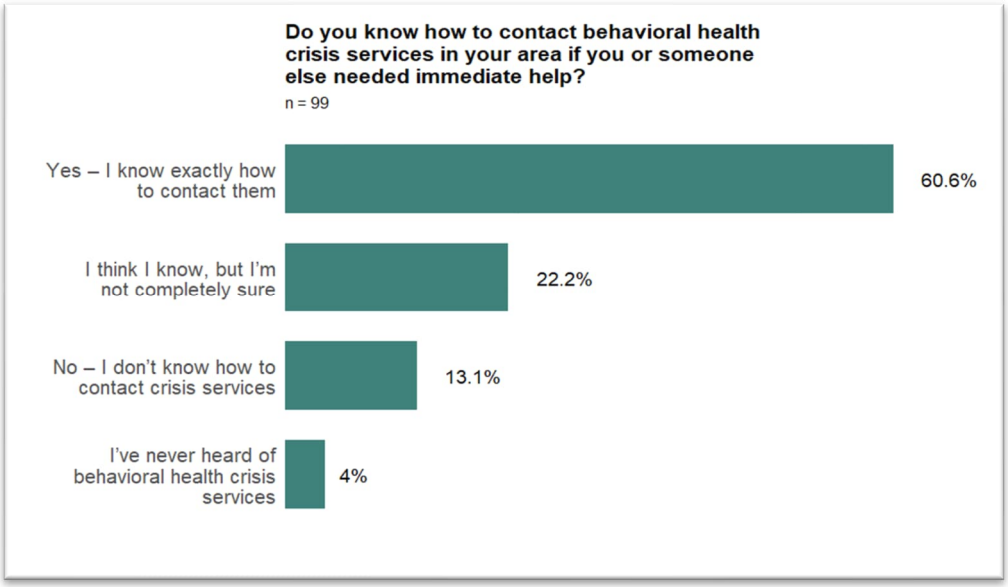
17. What would be the most convenient time for you to access mental health and substance use services?

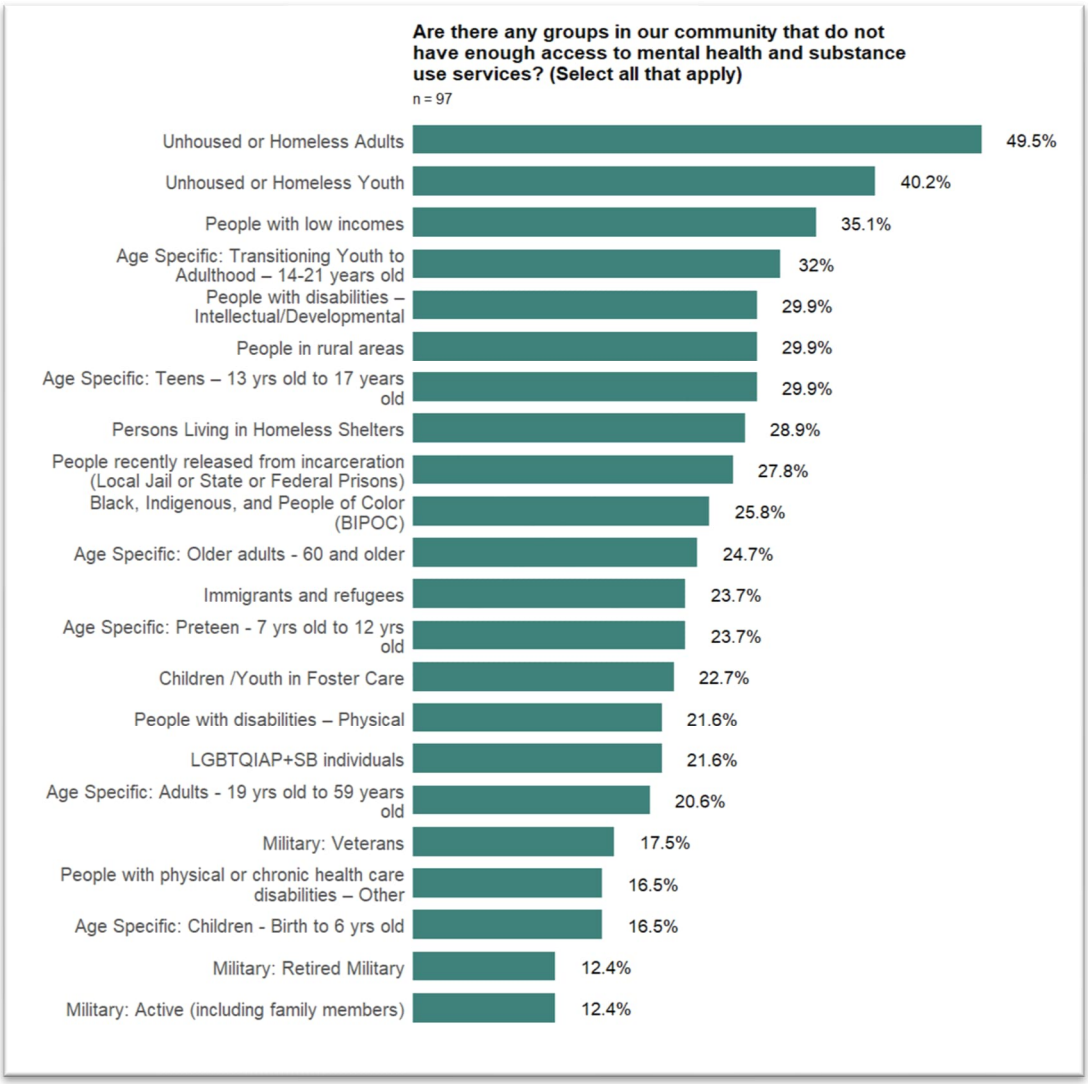
Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



18. Do you know how to contact behavioral health crisis services in your area if you or someone else needed immediate help?

Multiple choice question. Only one option can be selected.



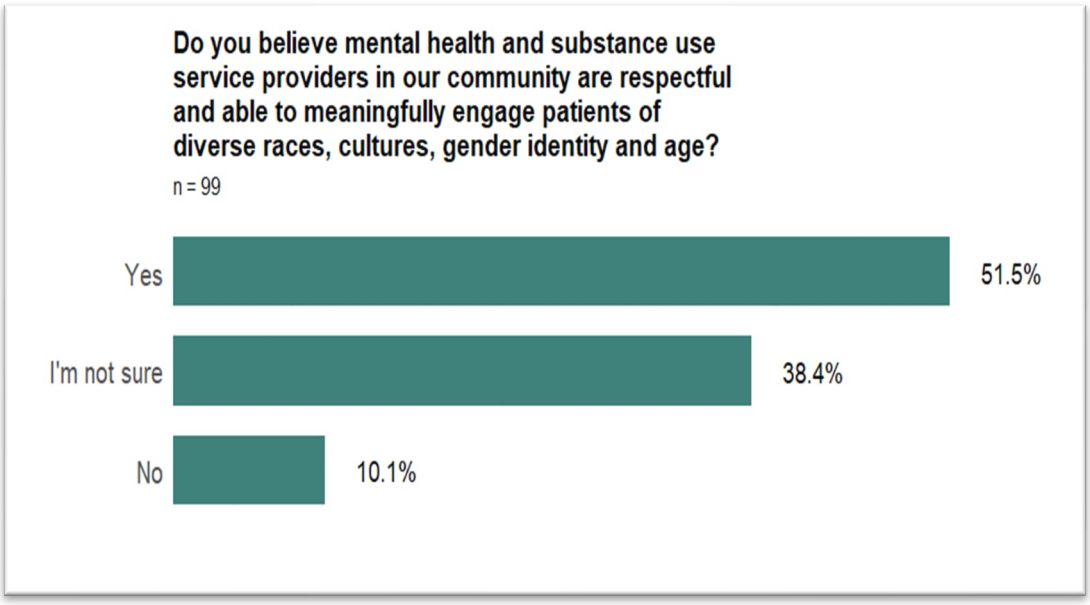


19. Are there any groups in our community that do not have enough access to mental health and substance use services?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.

20. Do you believe mental health and substance use service providers in our community are respectful and able to meaningfully engage patients of diverse races, cultures, gender identity, and age?

Multiple choice question. Only one option can be selected.



21. Please share any additional information related to mental health and substance use service needs in our community

Free text option. All blank and "Don't know" answers are excluded.

Response

1. diverse employees - it's easier to get help from someone who is like you.
2. More talk - less medication
3. It is important to find and seek those who need help for their mental health issues.
4. There aren't enough disability friendly jobs in Saginaw. Lots of transphobia. I have friends in the system & not one has been helped by White Pines.
5. Listen
6. It's much needed
7. More support
8. Need to have some form of therapy for disabled people who live with family to do together
9. Yes, because people need help sometimes
10. adult autism support
11. Specifically mental health services need to be mainstreamed to cover the gap to cover ages 18-25. There is a stop gap of coverage and programs at the local, state and federal levels for this demographic
12. We need more genuine people in these positions don't just help have a heart to understand people don't judge.
13. stigma is a big one especially for suicidal ideation, I would never admit it if it were me because you get locked up against your will just for mentioning it
14. I have concerns that our homeless shelters are not caring for LGBTQIA folks appropriately, especially those that are faith based
15. There's to much stigma. Most people don't really care. There's not enough empathy and not enough education. We have to many people that have never been through deep addiction and mental health issues trying to teach people that have. They don't understand.
16. social work shortage has made it difficult to recruit and maintain social workers
17. Providing Narcan and fentanyl test strips isn't enough but it's a step in the right direction. The need is increasing. Encourage people to don't quit quitting. The Public Libraries of Saginaw would like to work together to be part of the solution. tks
18. MDHHS & SCCMHA drop the ball with a lot of adults needing assistance. SCCMHA and MDHHS both push people off to other services instead of handling their clients as needed. Adults are falling through the cracks.
19. Stigma makes people avoid getting help.
20. You need to make yourself more visible on the EAST side of the river

APPENDIX B

SCCMHA Community Needs Assessment - Employee Survey

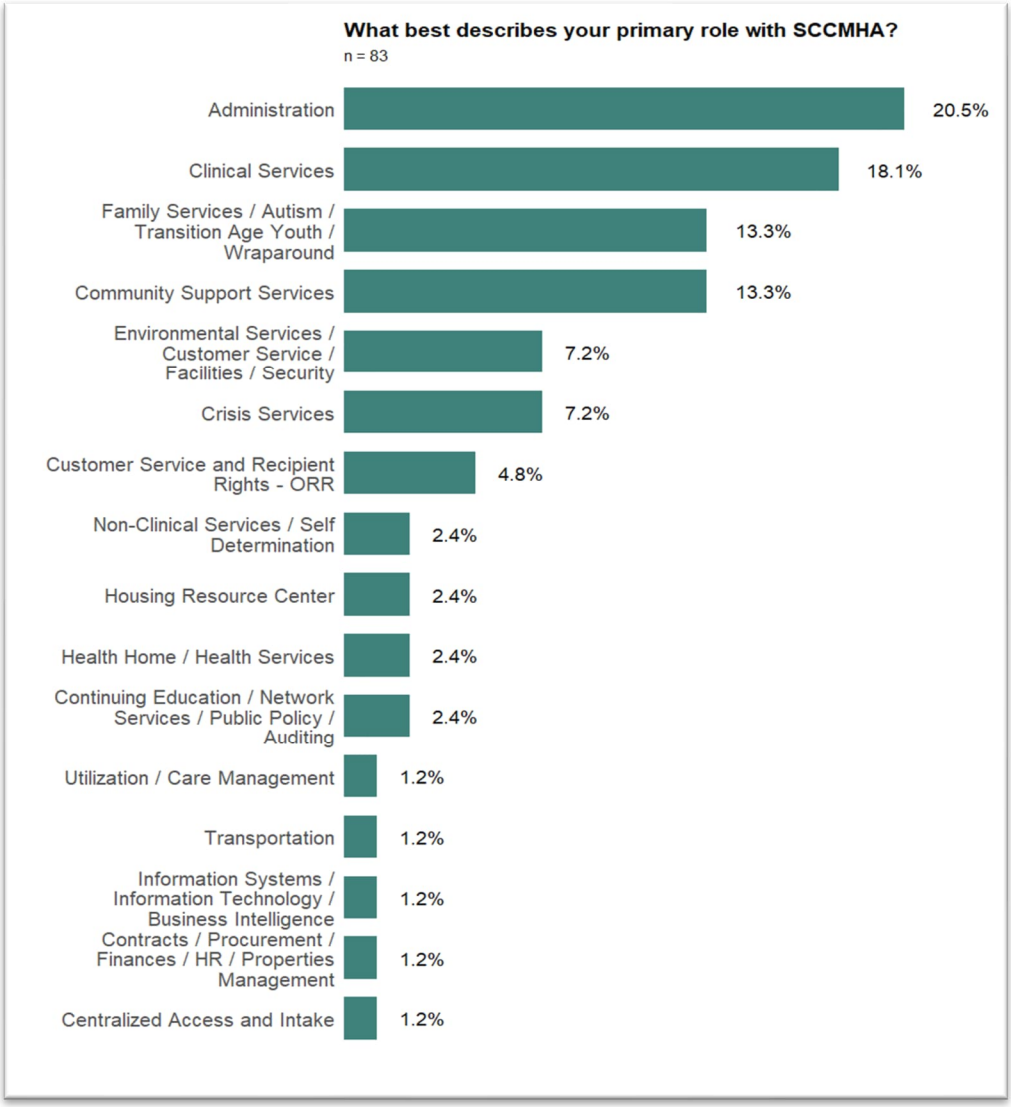
TBD Solutions

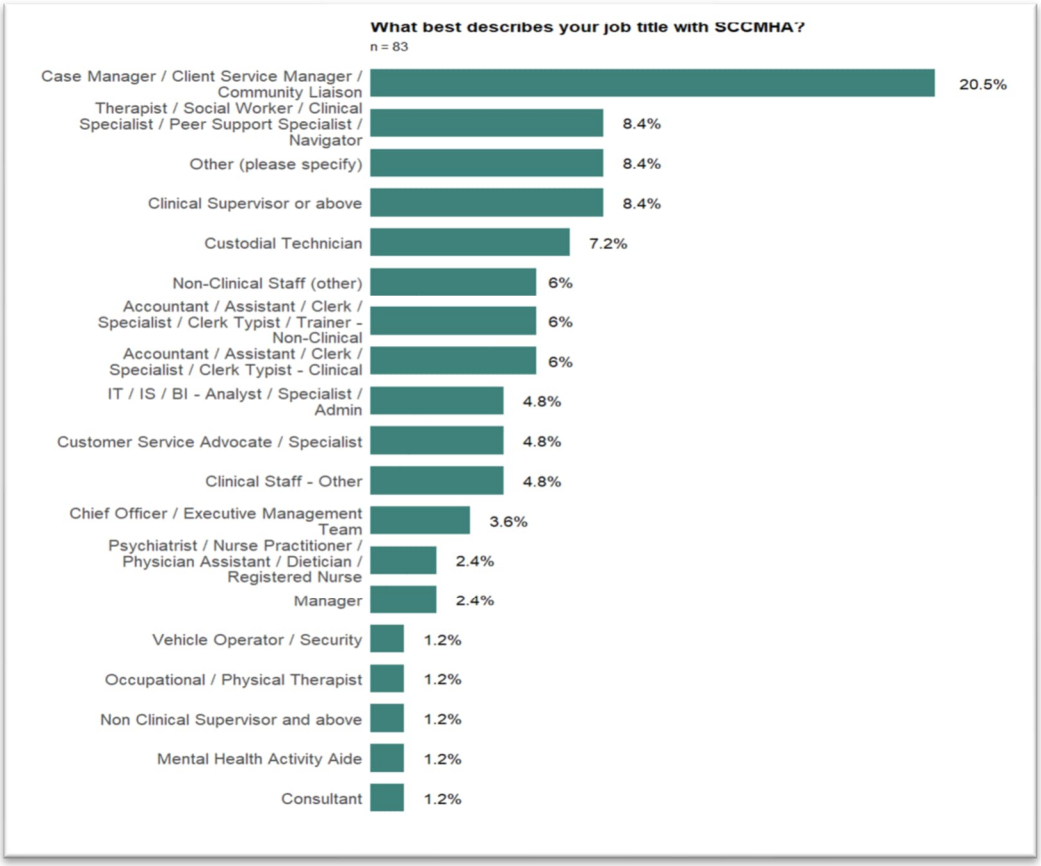
2025-09-25

The insights and experiences of those working on the front lines of behavioral health are critical to understanding how we can better support both our community and the workforce itself. This anonymous survey was designed to gather the front-line workers' perspectives on needs, challenges, strengths, and opportunities within the behavioral health system to help shape a healthier, more responsive system for all, starting from the inside out.

1. What best describes your primary role with SCCMHA?

Multiple choice question. Only one option can be selected.



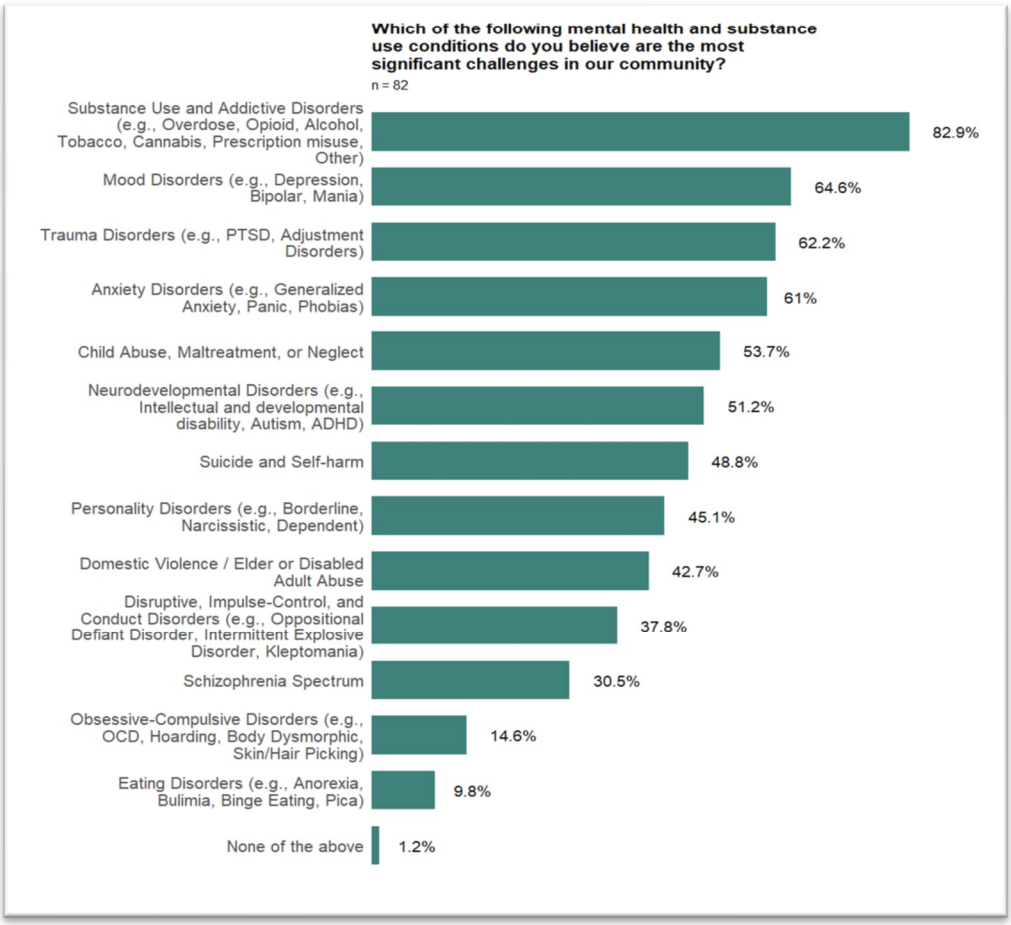


2. What best describes your job title with SCCMHA?

Multiple choice question. Only one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.

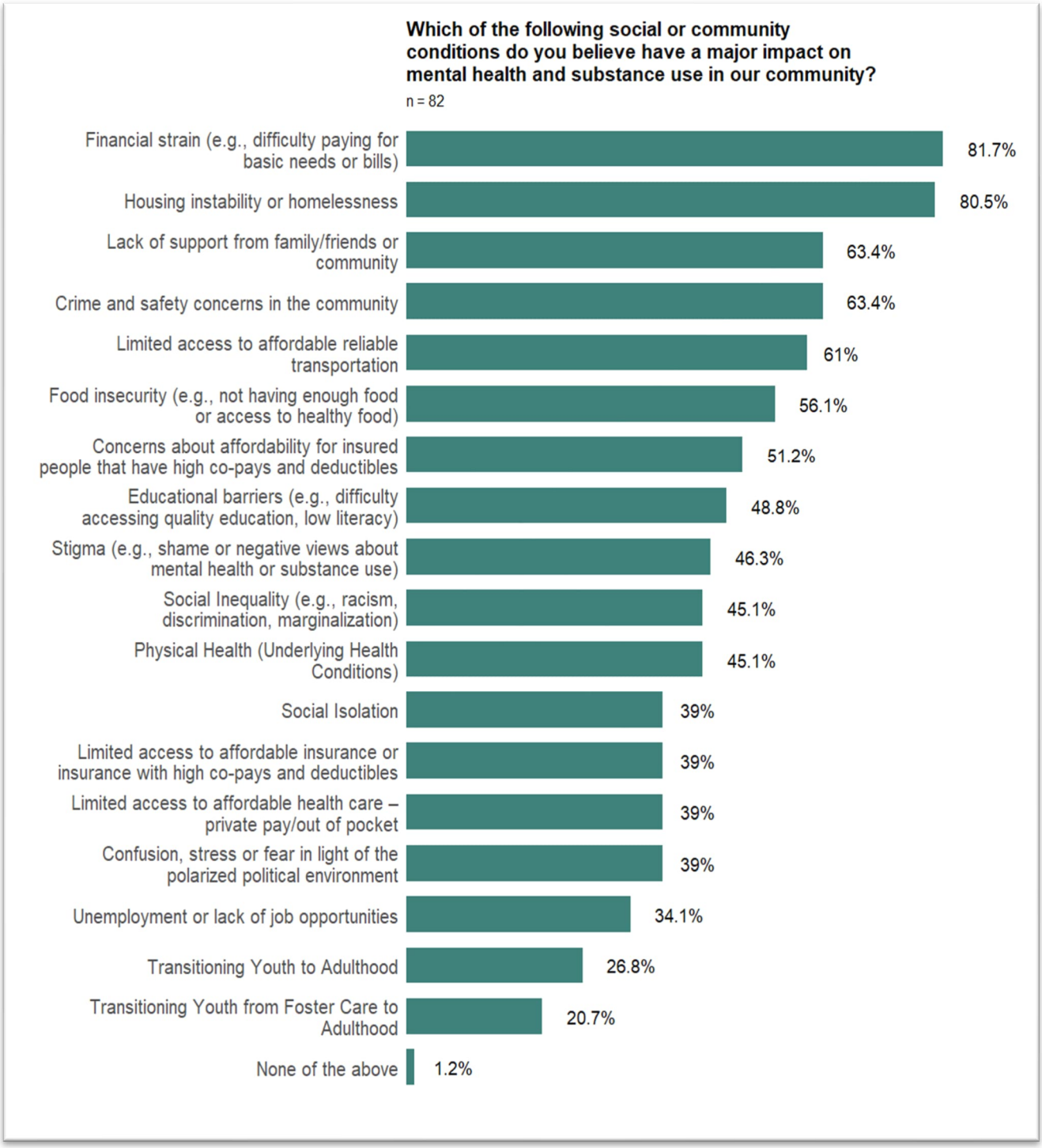
3. Which of the following mental health and substance use conditions do you believe are the most significant challenges in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



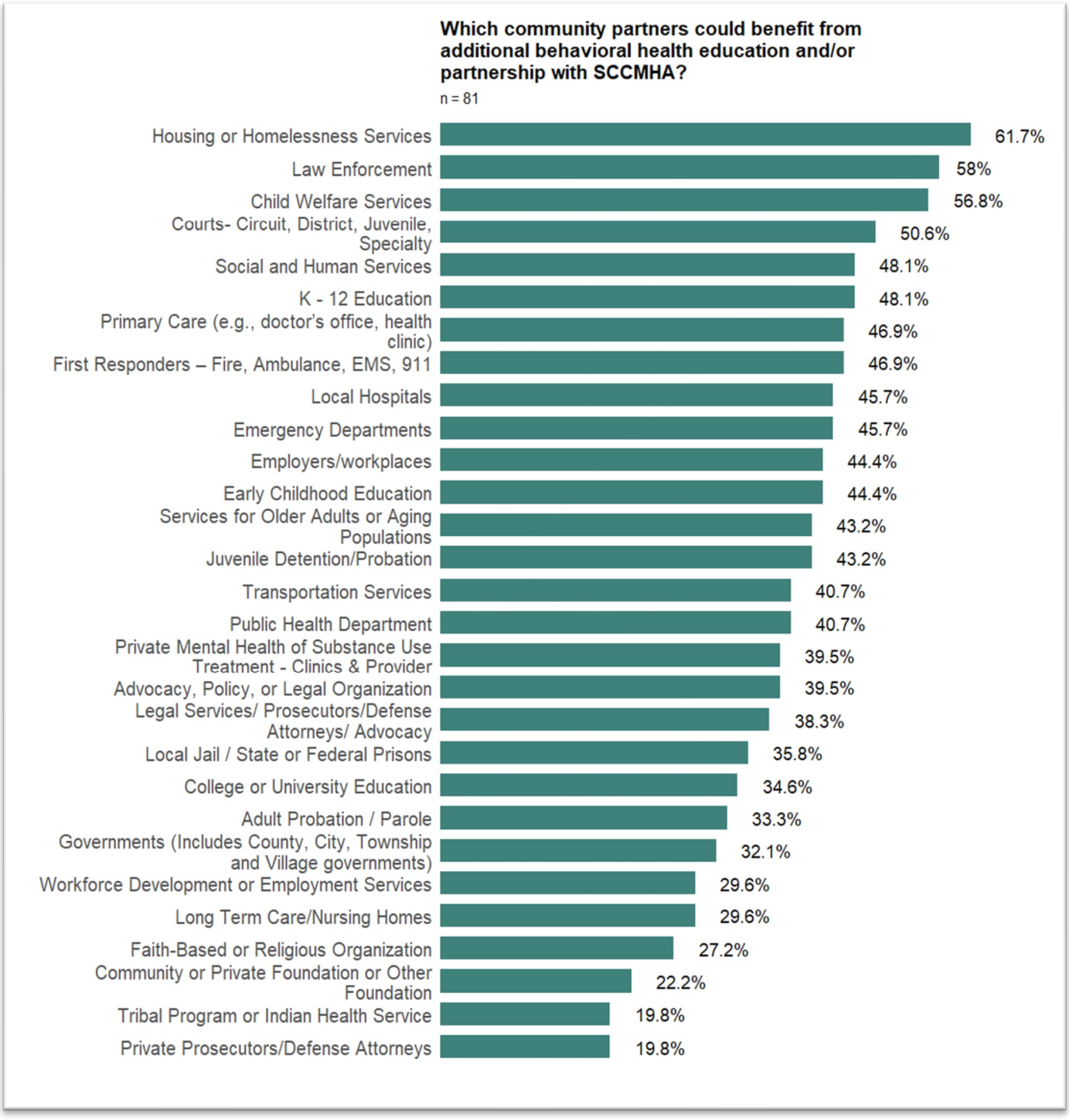
4. Which of the following social or community conditions do you believe have a major impact on mental health and substance use in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



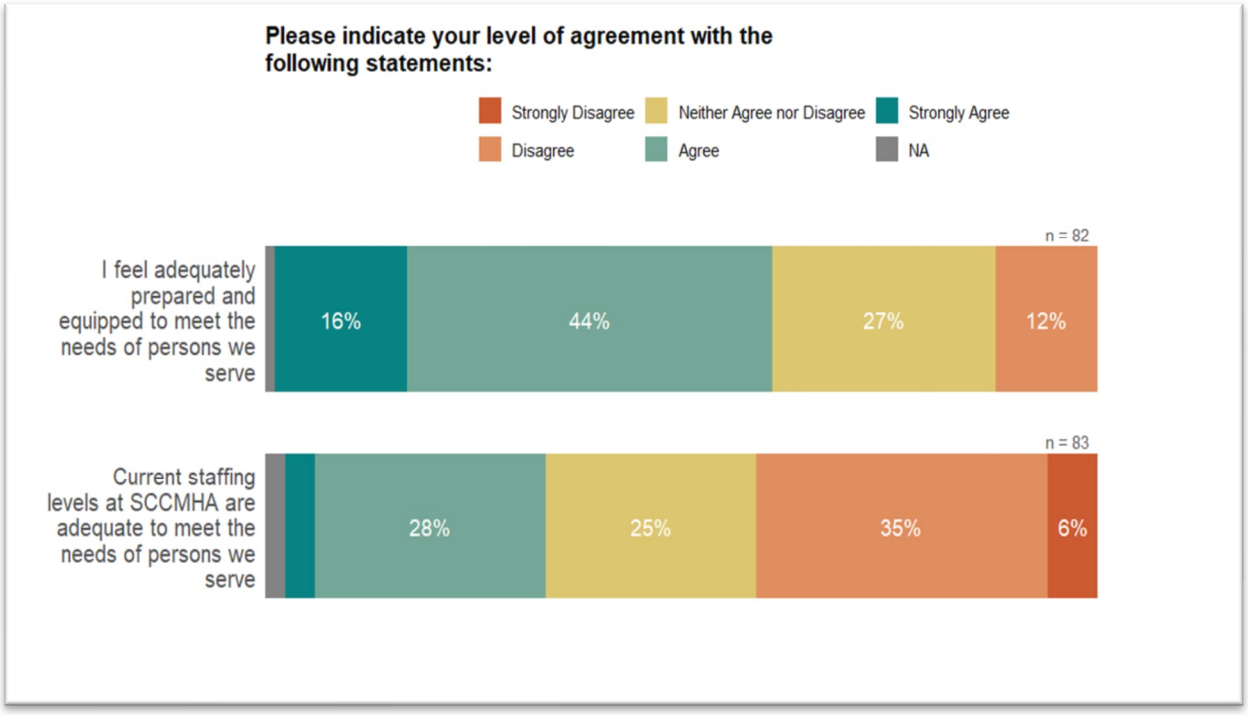
5. Which community partners could benefit from additional behavioral health education and/or partnership with SCCMHA?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



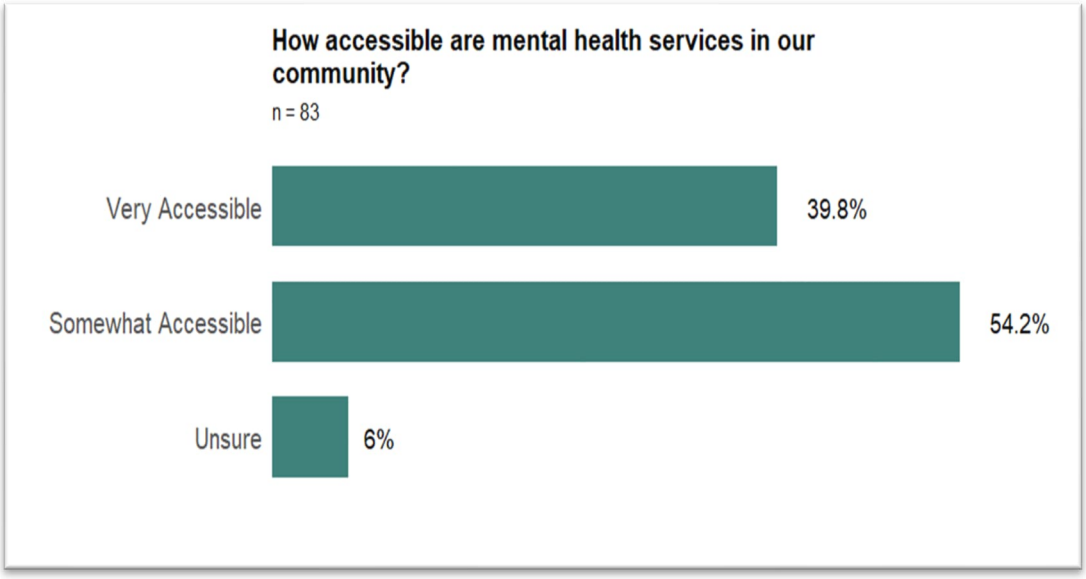
6. Please indicate your level of agreement with the following statements:

Matrix question. Only one option can be selected per category.



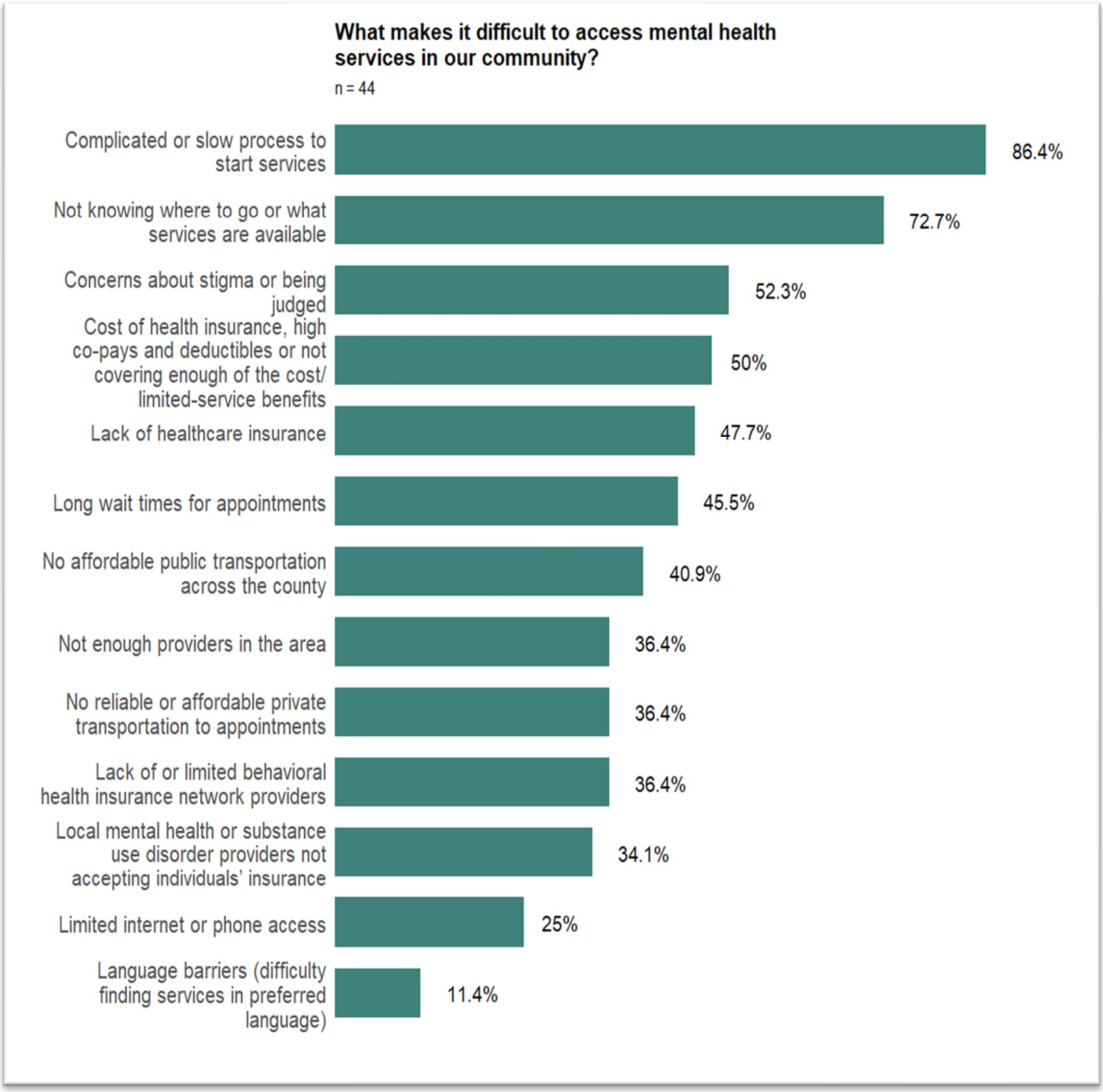
7. How accessible are mental health services in our community?

Multiple choice question. Only one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



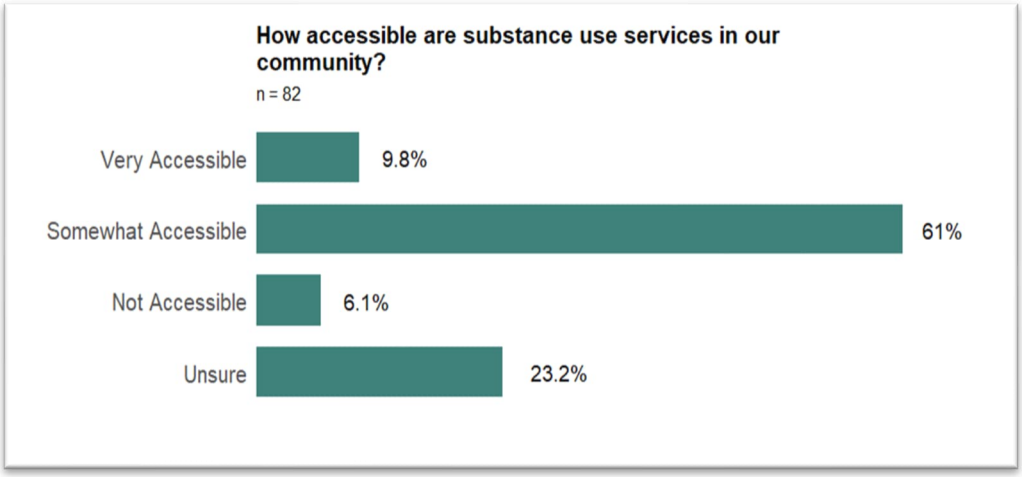
8. What makes it difficult to access mental health services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



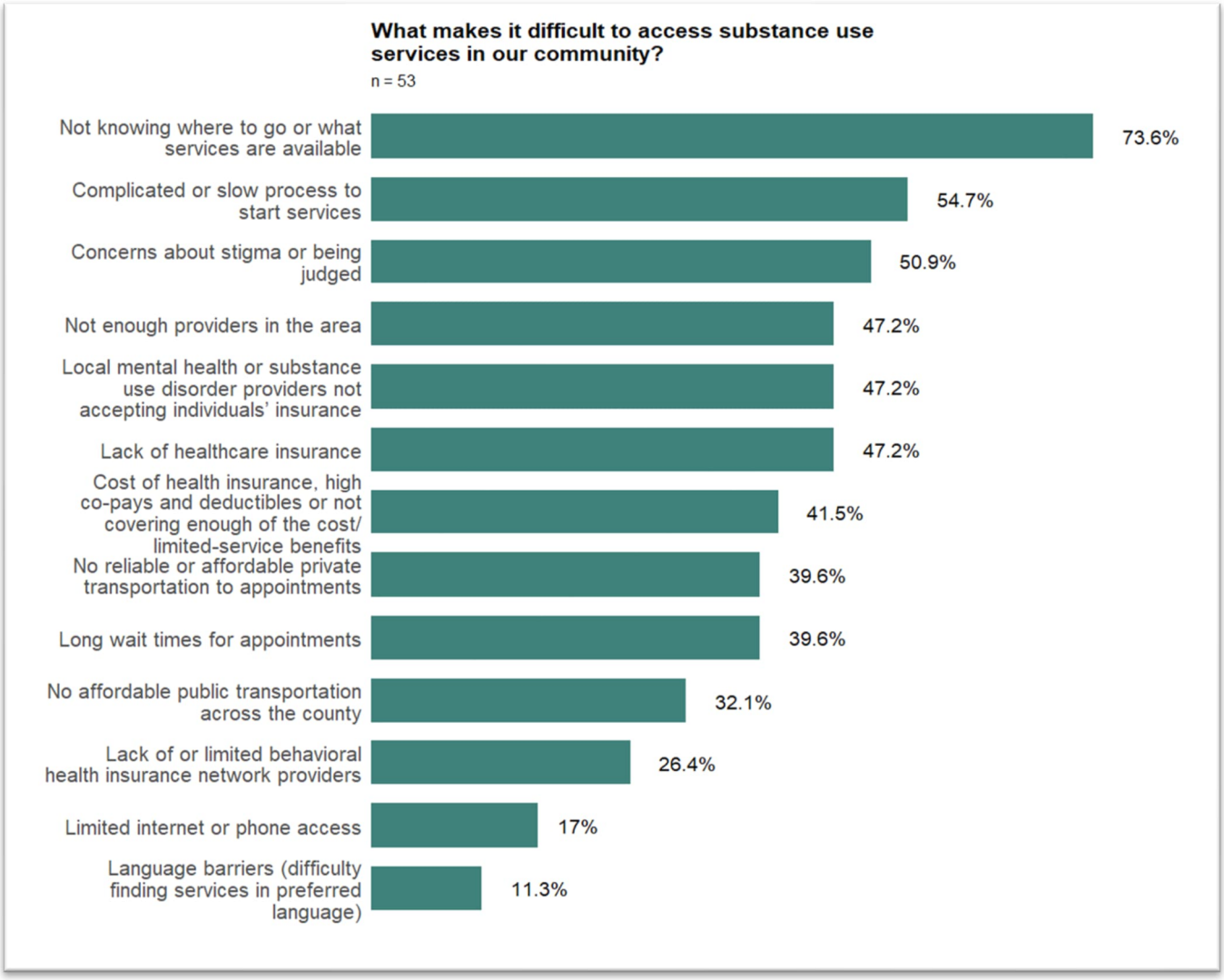
9. How accessible are substance use services in our community?

Multiple choice question. Only one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



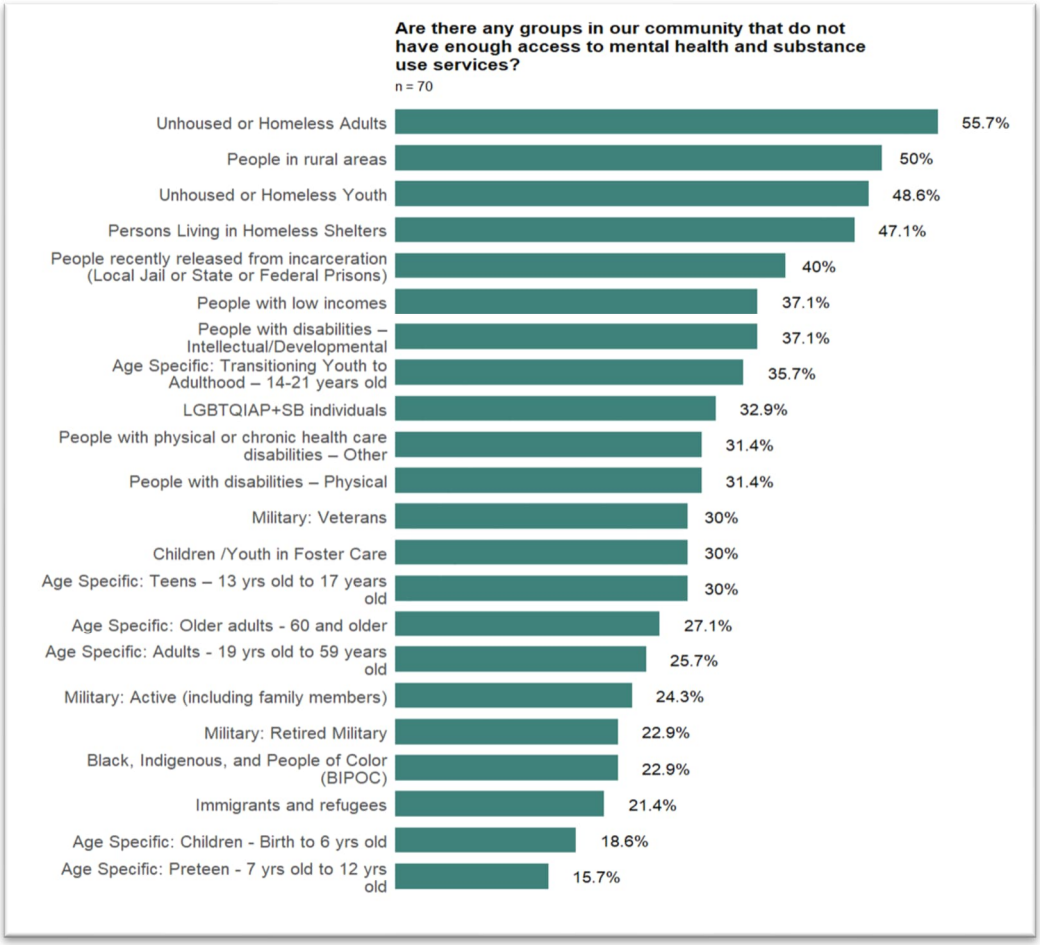
10. What makes it difficult to access substance use services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



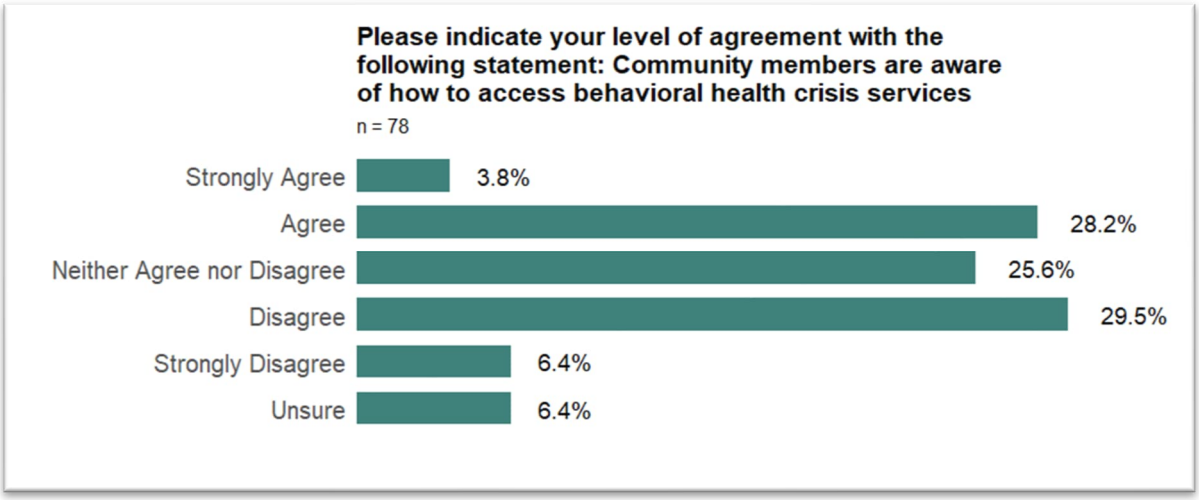
11. Are there any groups in our community that do not have enough access to mental health and substance use services?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



12. Please indicate your level of agreement with the following statement: Community members are aware of how to access behavioral health crisis services

Multiple choice question. Only one option can be selected.



13. Please share any additional information related to mental health and substance use service needs in our community

Free text option. All blank and "Don't know" answers are excluded.

Response

1. group awareness community form monthly platform.
2. Needs to be less initial appointments or set up appointments to deliver services on an ongoing outpatient basis.
3. Many families are unaware how to access resources, or try to access resources for their family members but are denied until something happens to that family member.
4. I don't feel everyone is aware of services whether they are for mental health, crisis, substance abuse, abuse/neglect, exploitation, as I have had many families over the years tell me "if we had known about these services earlier".
5. Education against using drugs and more JOBS are needed to keep people busy and working on themselves.
6. I don't really know much about our community
7. Older adults with medicare are really struggling for finding providers, veterans with VA benefits dont always get the help they need from the VA, but are warehoused into the VA.
8. The new system with Mid State Health Network is very inefficient and has led to a significant increase in people being admitted to medical floors for detox. Mid-State is not available or useful after hours and on weekends.
9. One of my persons served reported calling a suicide crisis number that was provided to him and reported being put on hold for 20 minutes.
10. Probably costs, scheduling, and transportation are general barriers for many people. Even personally, I'd probably enroll in counseling and access healthcare more often if these 3 factors became easier. I'd love if healthcare costs everywhere could be shared upfront - so many times in my life I believed it would be one cost and then 3+ bills show up from a variety of sources for just 1 service.
11. More available options are needed.
12. Limited staffing in some programs makes it difficult for our community to utilize the services that we offer. Leaving them with limited resources/opportunities.
13. I have none.

APPENDIX C

SCCMHA Community Needs Assessment - Partner Agency Survey

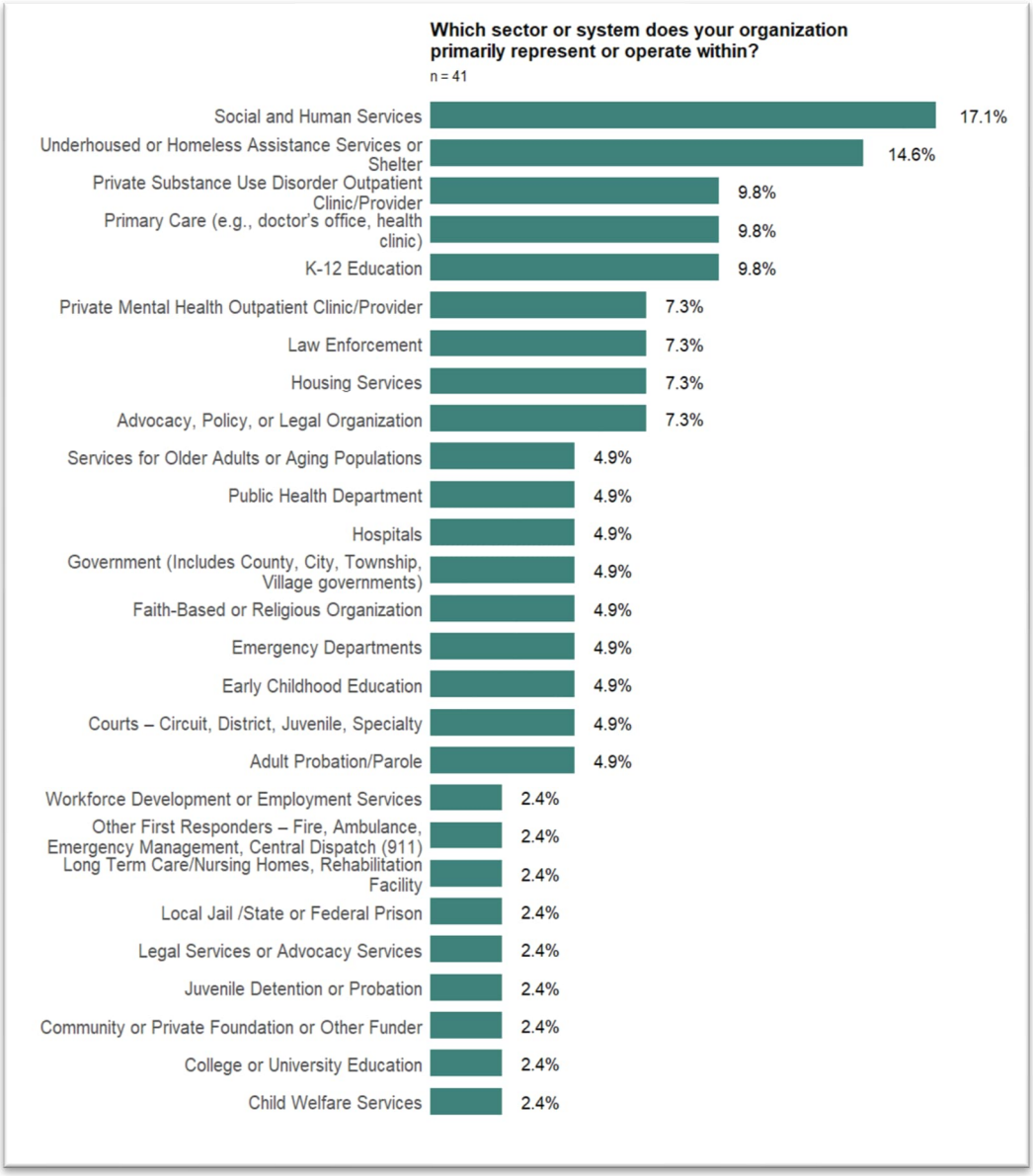
TBD Solutions

2025-09-25

The unique viewpoint of partner agencies helps us build a stronger, more connected behavioral health network. This survey seeks to understand the system-wide needs, gaps, and strengths from the partner agency's professional lens. The responses will guide strategic planning, improve inter agency coordination, and ensure that together, we're providing the most effective support to those we serve.

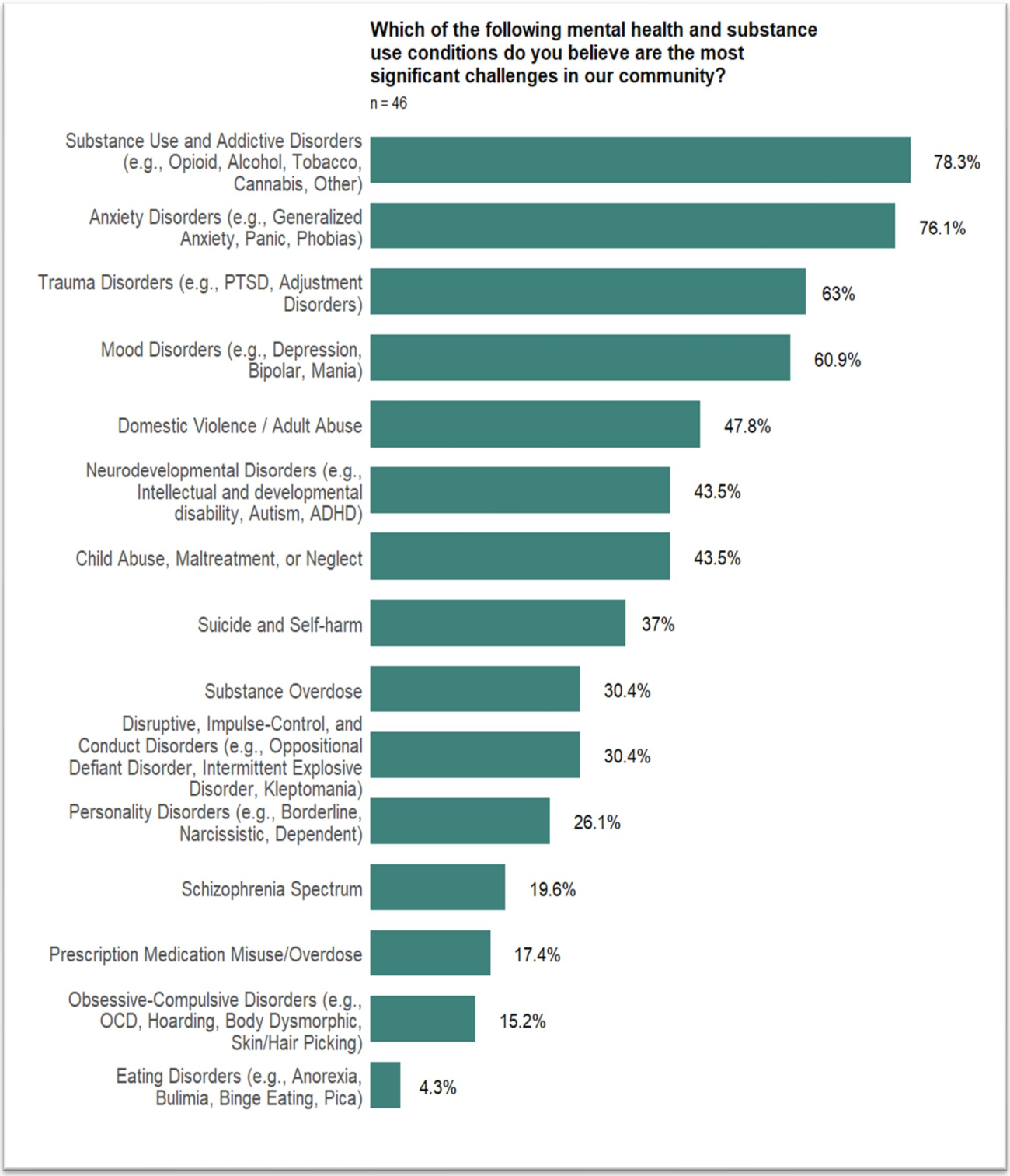
1. Which sector or system does your organization primarily represent or operate within?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



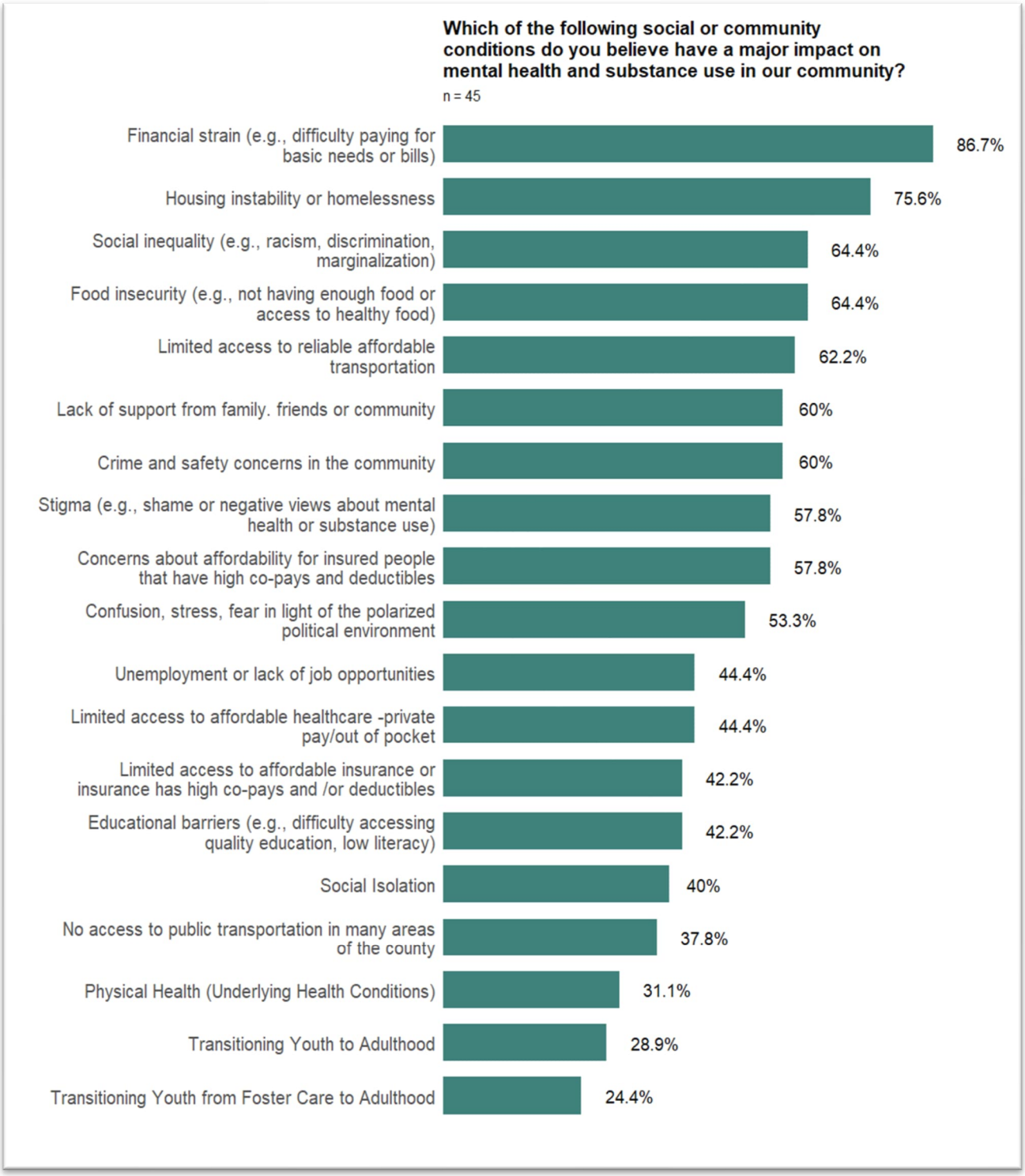
2. Which of the following mental health and substance use conditions do you believe are the most significant challenges in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



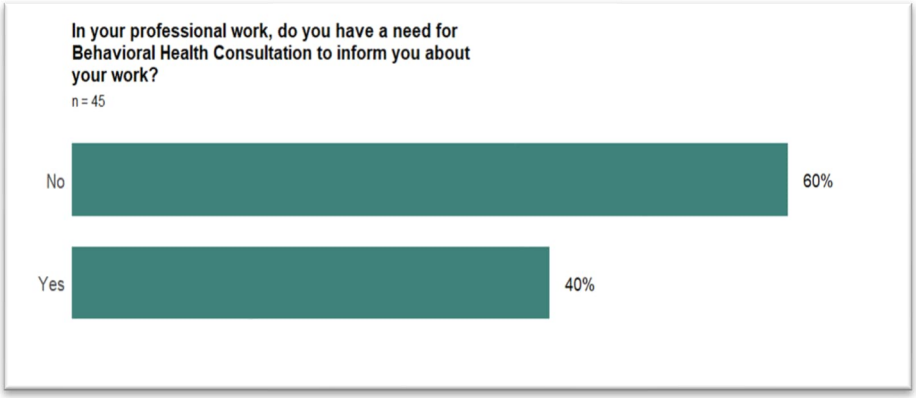
3. Which of the following social or community conditions do you believe have a major impact on mental health and substance use in our community?

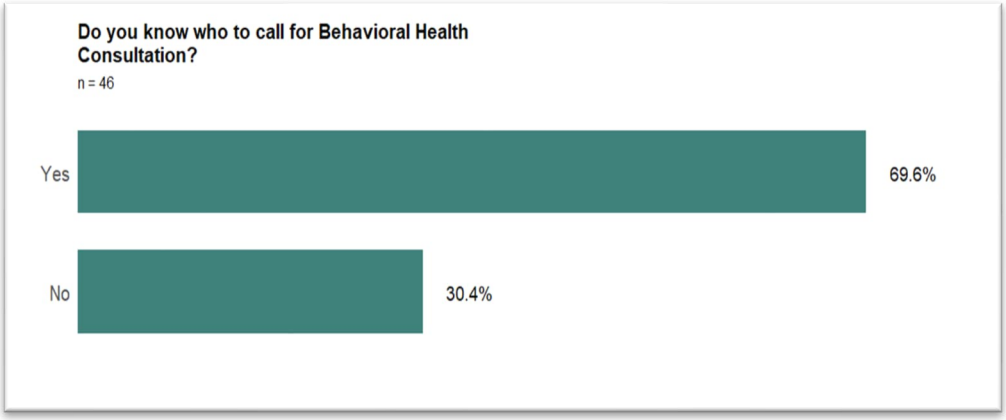
Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



4. In your professional work, do you have a need for Behavioral Health Consultation to inform you about your work?

Multiple choice question. Only one option can be selected.



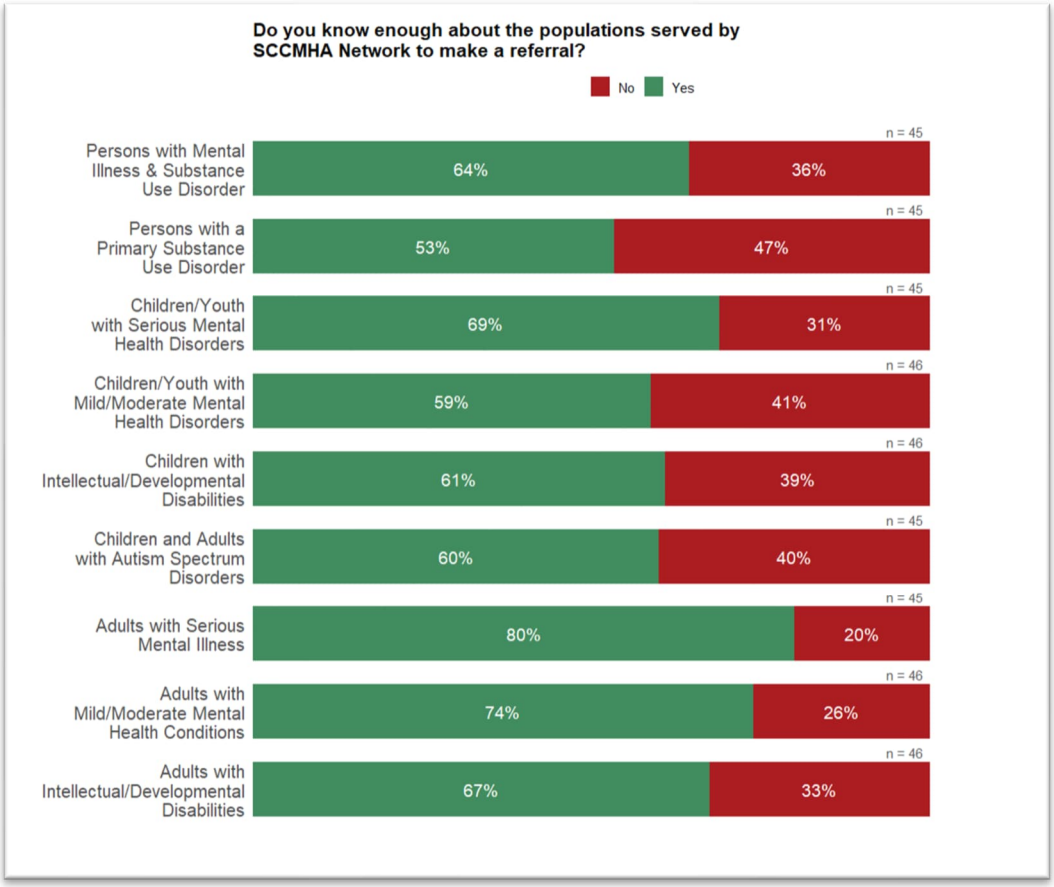


5. Do you know who to call for Behavioral Health Consultation?

Multiple choice question. Only one option can be selected.

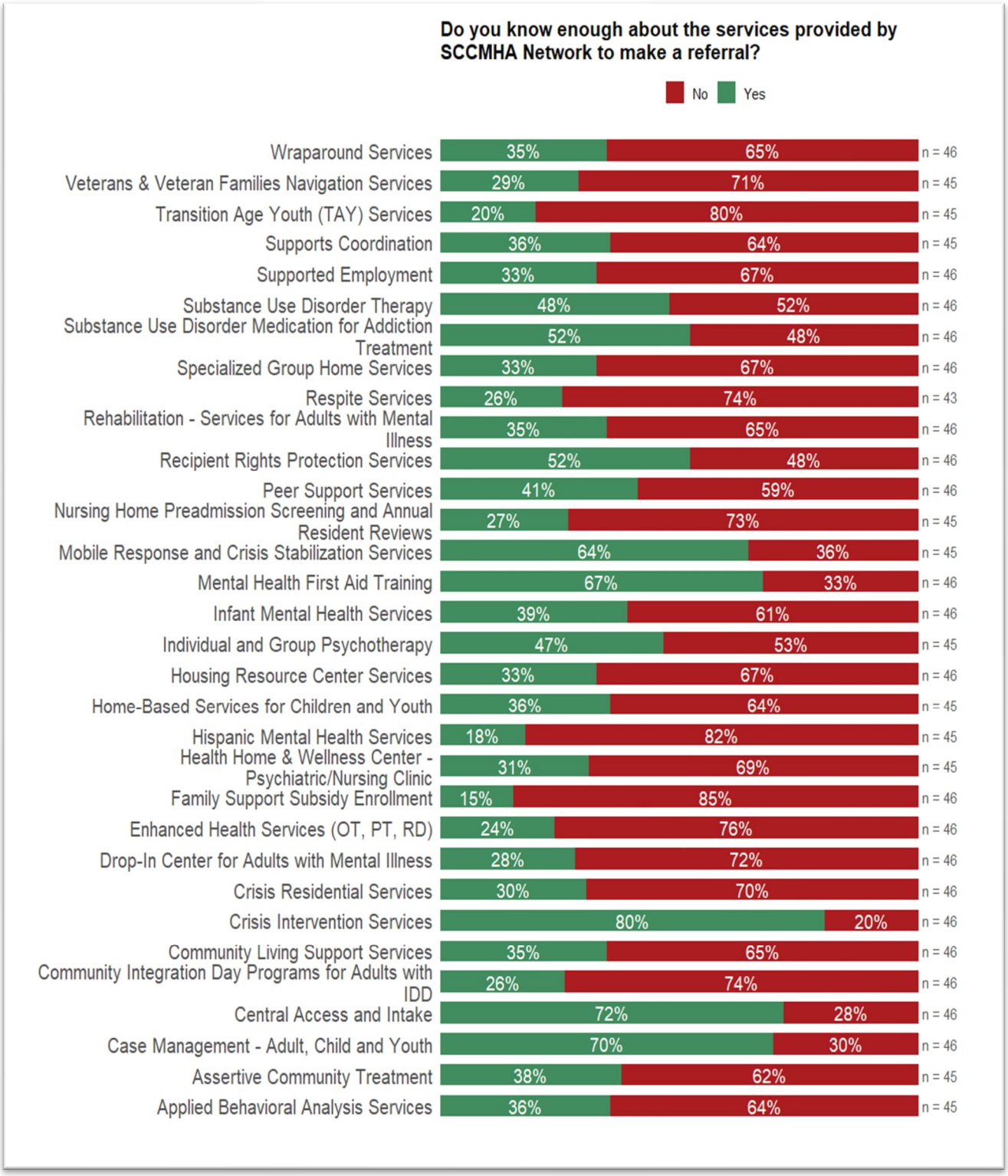
6. Do you know enough about the populations served by SCCMHA Network to make a referral?

Matrix question. Only one option can be selected per category.



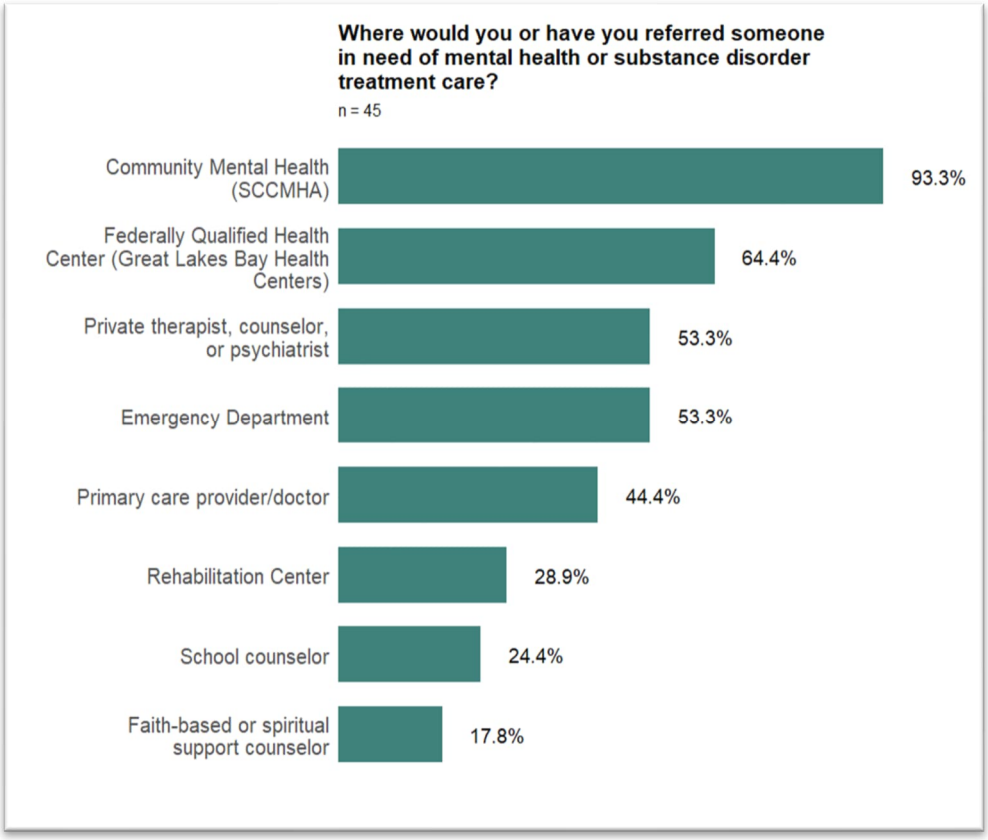
7. Do you know enough about the services provided by SCCMHA Network to make a referral?

Matrix question. Only one option can be selected per category.



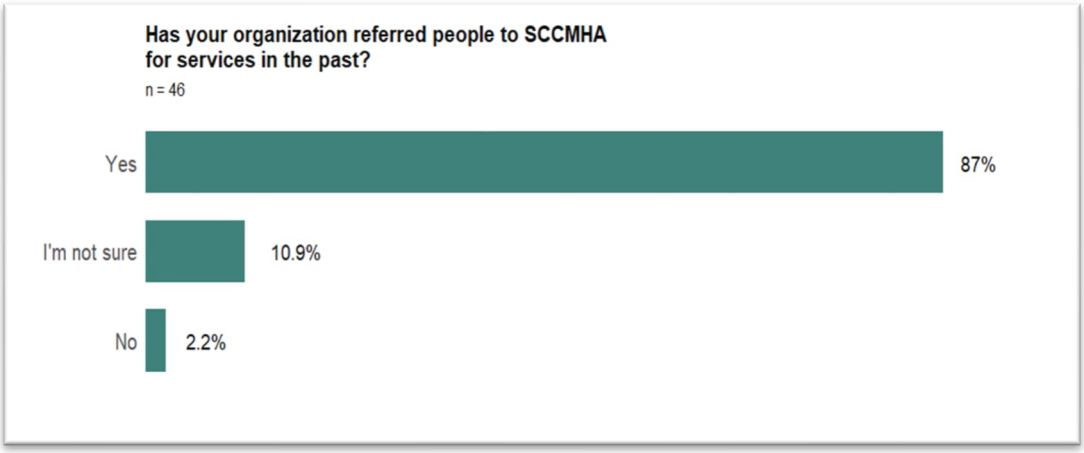
8. Where would you or have you referred someone in need of mental health or substance disorder treatment care?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



9. Has your organization referred people to SCCMHA for services in the past?

Multiple choice question. Only one option can be selected.



10. Please describe your experience with SCCMHA's referral process.

Free text option. All blank and "Don't know" answers are excluded.

Response

1. Worked with SCCMH thru Barb Smith.
2. SCCMHA staff have followed through with referrals, even if unable to provide services for families.
3. Helpful but lengthy time to receive services beyond the intake.
4. It is easy to refer but the wait time for a first appointment is disappointing.
5. It's been quite a while since I have had a chance to refer someone, so I'm not sure of any other processes than contacting Central Access and Intake with someone.
6. In the past, we have called with our person in need however, at times, we are told that we can't by certain intake workers. We do complete the referral form provided by CMH.
7. Average
8. Depending on the staff, it can go smoothly or be very frustrating.
9. Not sure what came of patient or if they went
10. We didn't make a forma referral. I spoke with someone at a meeting and she followed up for me. We need information on the normal process
11. I usually ask my clients to reach out to CMH
12. Not experienced, haven't used it formally.
13. We have not had issues with the referral process.
14. Experience has been limited and I believe there are many aspects of services that are not well known to our staff. We would certainly provide more referrals if we knew what services could be provided and when.
15. Had a client who was in need of a DD guardianship.
16. I have engaged inn training through SCCMHA
17. I have instructed patients to call the access number to call to inquire about services.
18. The referral process is unclear. We were informed only a certain amount of time would be allocated to our referrals for service.
19. Took family member to the SCCMHA in a they received service through the intake department.
20. Have not referred
21. Sometimes good and sometimes bad
22. I believe that the referral process and initial appointment with SCCMHA was easy.
23. Very positive
24. From my experience in the hospital setting, we have been informed that patients themselves need to call intake to complete a referral for services. Intake information is provided on the patients discharge summary. Sometimes, we will sit with patients to complete the intake or help them with calling prior to discharge, to ensure that patient actually calls.

Response

25. It has been challenging for individuals with commercial insurance to be enrolled even though they meet the severity of their diagnosis or current issues. Also, referring people who are on court orders has been challenging
26. Generally issue free
27. Usually very smooth.
28. I have had good experiences with this and have heard the same from my colleagues
29. Mostly it is talking with patients about calling for services.
30. In my work, I have not had to refer anyone to SCCMHA.
31. very good
32. Lengthy
33. Direct referals and referals through central intake.
34. Overall our communities referral processes between organizations is often lost to follow up. We have provided numbers to call for community members.
35. Clear and defined. I know what to expect each call.
36. We have an open line of communication with Nancy Johnson, which is helpful for crisis scenarios, but I am unsure of how to refer someone who is not currently in crisis.

11. What worked well?

Free text option. All blank and "Don't know" answers are excluded.

Response

1. Families getting connected to services in a timely manner
2. Getting to the right department.
3. Warm hand-off and coordination of services by SCCMHA have worked well for those I'm helping in the past.
4. The staff were kind.
5. Assisting clients with making the calls so the client is better served.
6. Case Managers are very good at communicating with me
7. Not much experience
8. The client was allowed to restart service after not being active with the agency for at least a year.
9. Sharing information to community partners on behalf of others
10. Listening and providing resources immediately and not letter
11. It's normally easy to contact someone
12. How quickly an appointment was available.
13. The collaboration between the agencies
14. We work very well with our CRISIS team.

Response

15. Referring those who have Medicaid only
16. Easy to notify
17. Contact and getting follow up with patient
18. Ease of finding the number, ease of answering the questions asked
19. Patients are able to ask questions, and a few want the more intensive services offered.
20. all
21. Ultimately got there
22. Responsiveness of the SCCMHA has been great. When staff make contact SCCMHA provides direction and guidance for appropriate referral.
23. The format.
24. open line of communication, working together and getting and giving updates.

12. What could be improved?

Free text option. All blank and "Don't know" answers are excluded.

Response

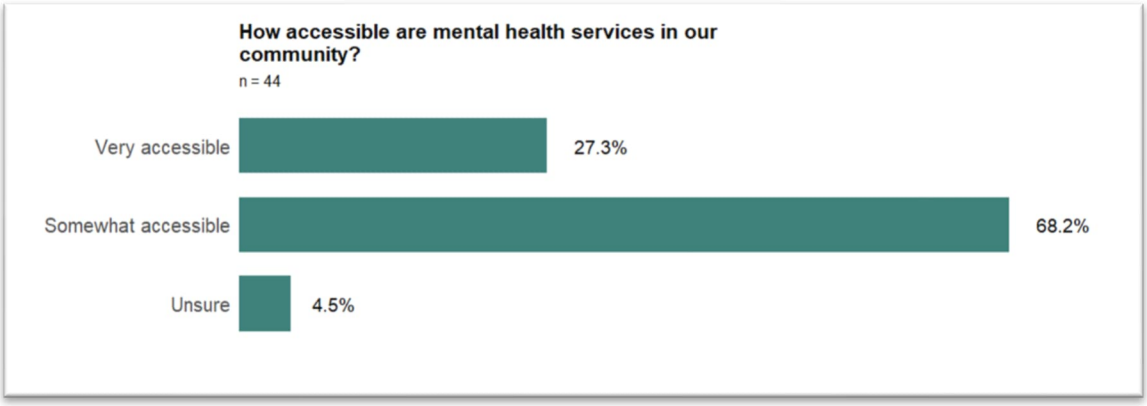
1. More staff to provide services.
2. Decrease the time between intake and treatment/ medication management.
3. I guess maybe a 7 day window for an intake instead of 14 days.
4. Intake process can be lengthy, although understandably so to make sure each referral is handled appropriately and directed to necessary services. Education to the community surrounding the intake process may be helpful to eliminate friction in potential wait-times.
5. Follow up on if that patient actually set up services or came since an ROI is sent with them.
6. I would like to meet more often in person with both CMH CM and client
7. Not enough experience to comment.
8. The process for guardianship was far too long.
9. The process works well for my organization
10. Improve collaboration and communication
11. Being more culturally competent when providing services
12. We need placement facilities!!!!
13. The initial intake could improve slightly for individuals that will require services with outside providers.
14. Unknown
15. Communication with case managers in SCCMHA. Patients established with CMH services who need AFC Home placement from the Hospital.. This process is typically very long and patients sit in our hospital medically stable for extended periods of time waiting for CMH to approve and find placement.

Response

16. The referral process if confusing for many people in the area
17. Better online referral resources (submitting referals online)
18. Some patients don't necessarily want the level of commitment to enroll in CMH services. Some don't want to be referred because they experienced frequent staff changes with CMH and with contract providers.
19. Eliminate red tape and streamline the process
20. Having SCCMHA enrolled in the community information exchange, when developed to receive and send referrals amongst others providers and partners servicing our residents.
21. Offering or discussing services that may work better for the needs of the caller.

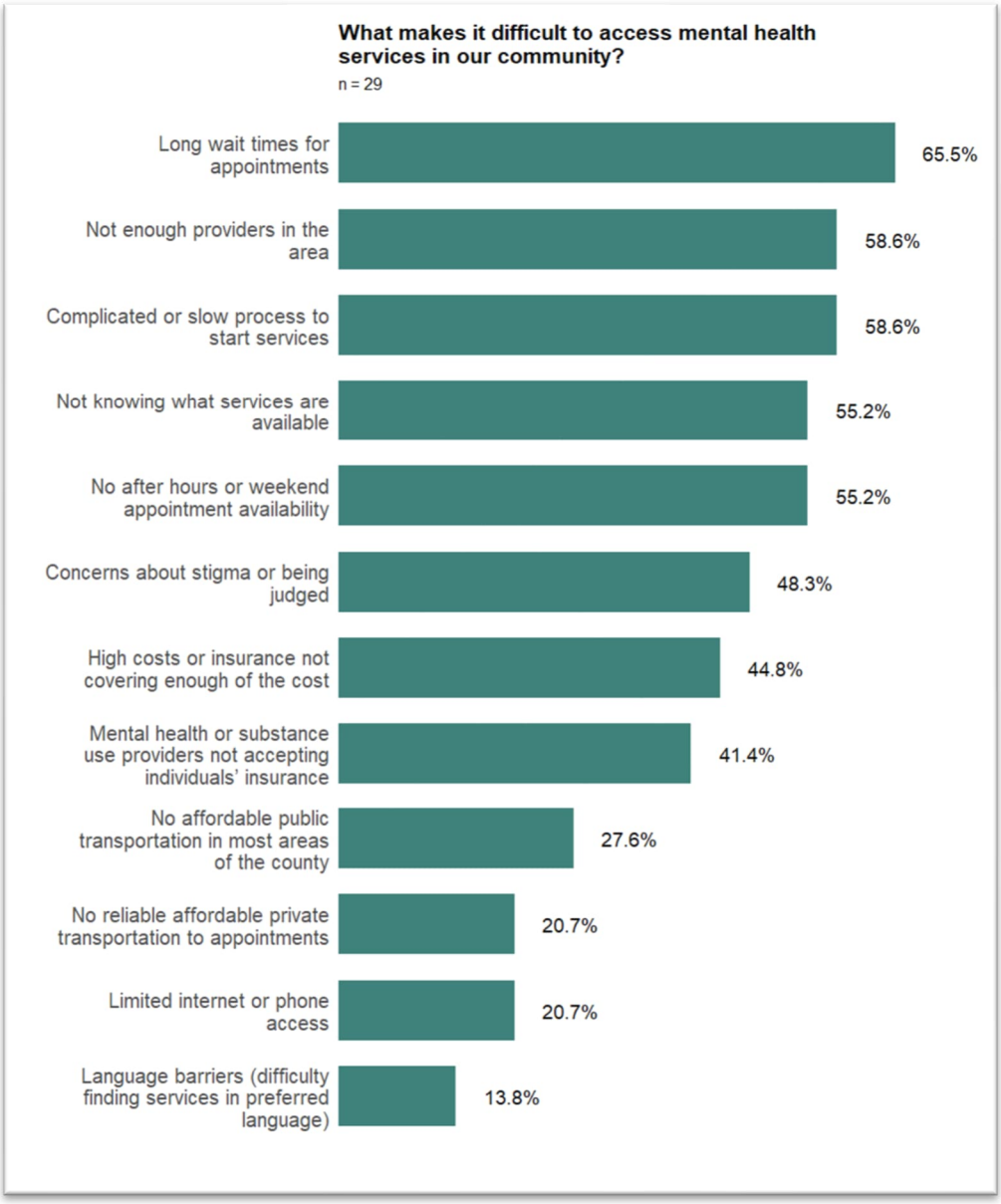
13. How accessible are mental health services in our community?

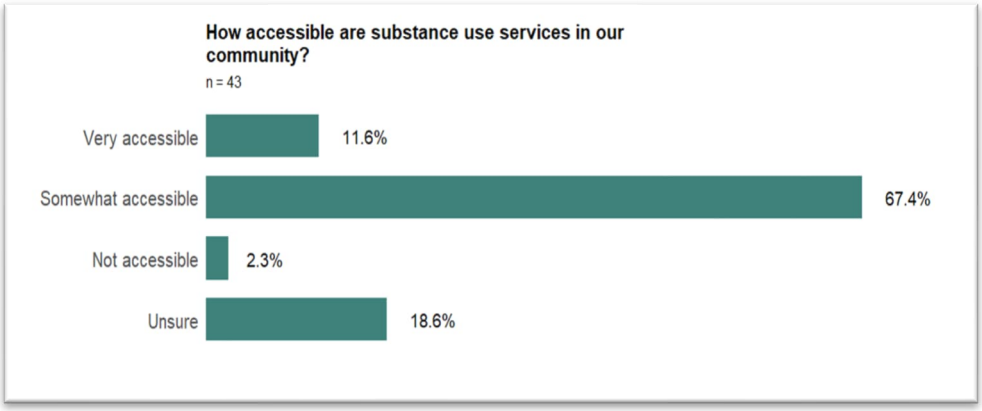
Multiple choice question. Only one option can be selected.



14. What makes it difficult to access mental health services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



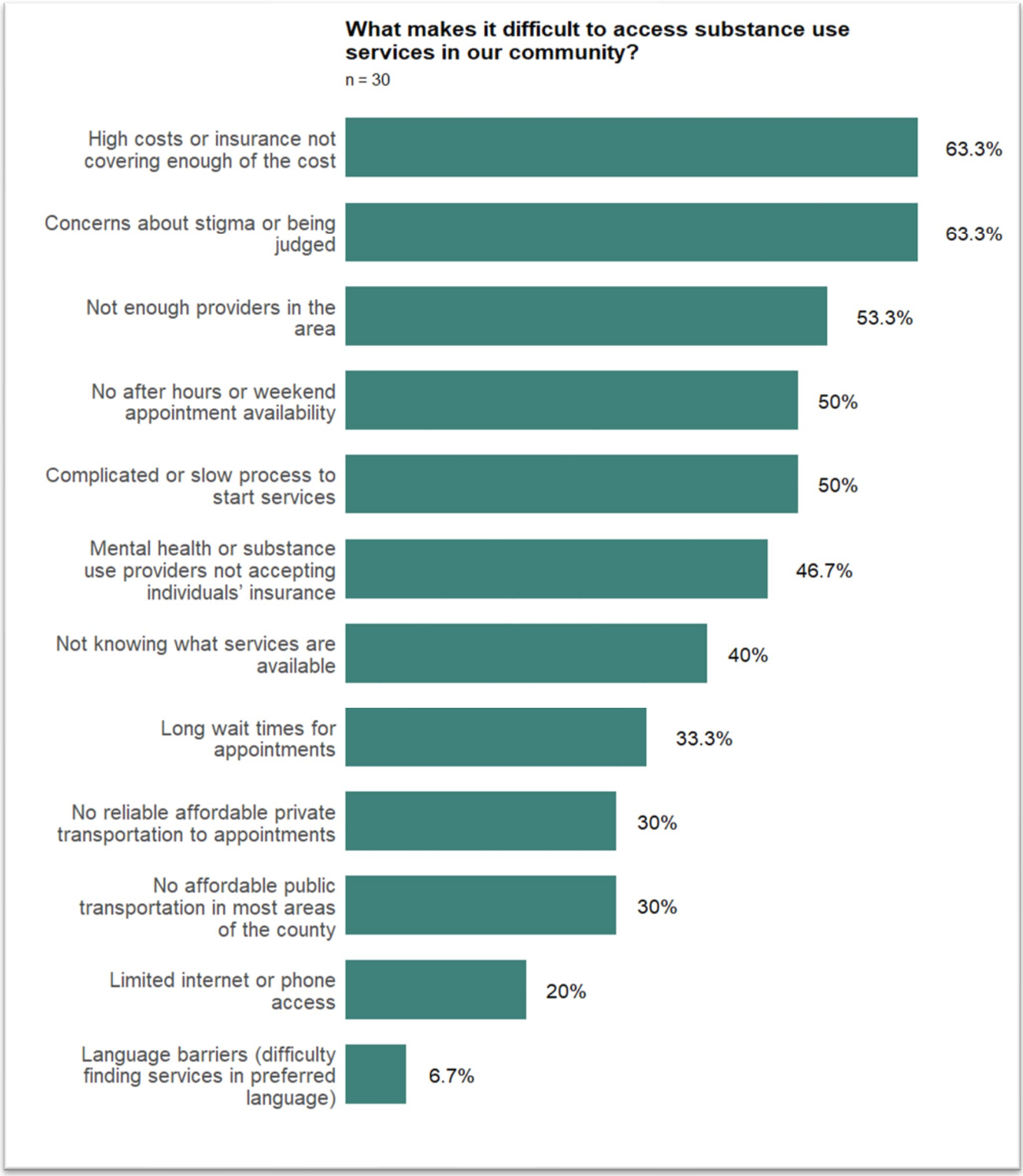


15. How accessible are substance use services in our community?

Multiple choice question. Only one option can be selected.

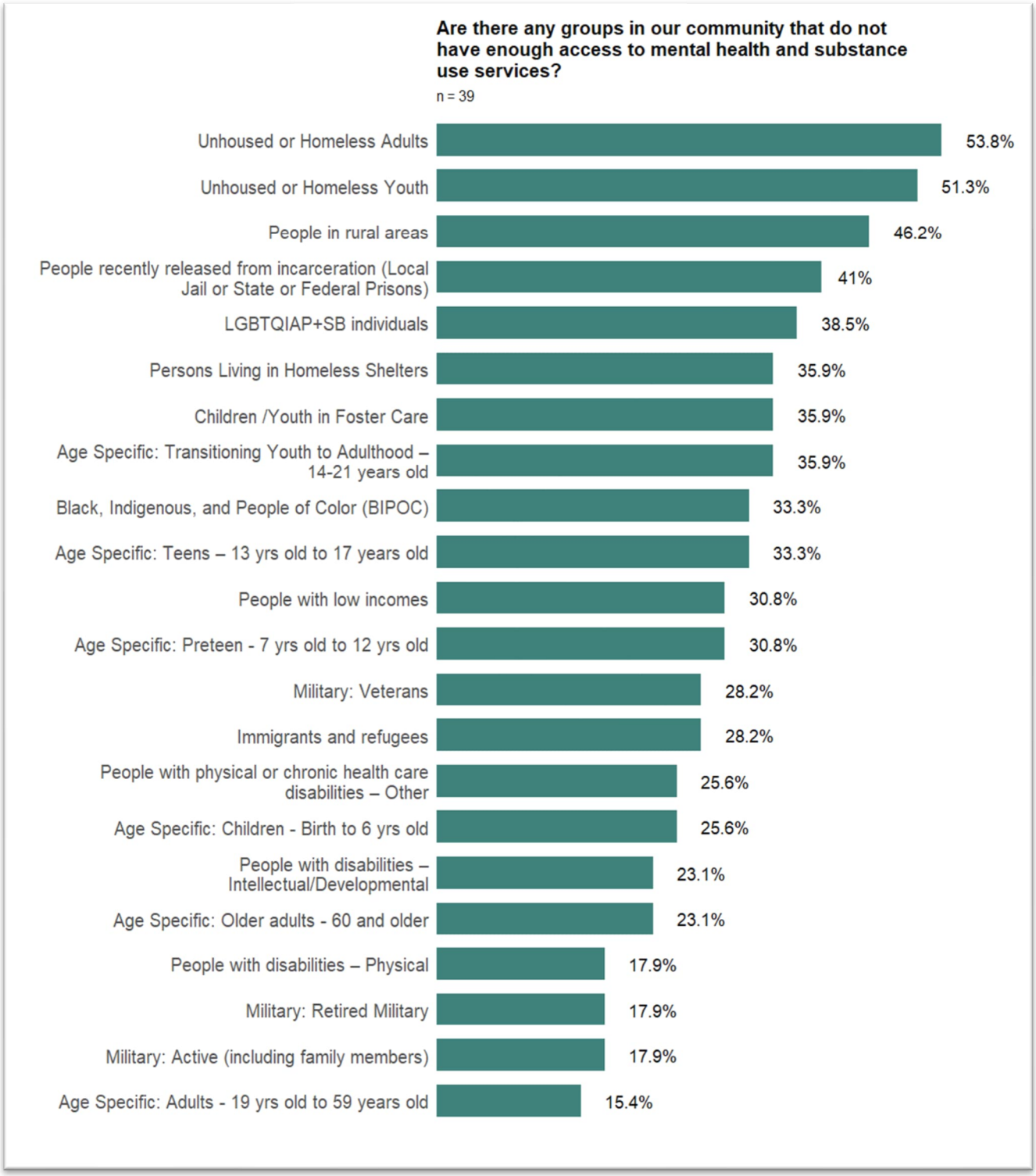
16. What makes it difficult to access substance use services in our community?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



17. Are there any groups in our community that do not have enough access to mental health and substance use services?

Multiple select question. More than one option can be selected. Any responses to the "Other (please specify)" follow-up question are shown in the Appendix.



18. Please share any additional information related to mental health and substance use service needs in our community

Free text option. All blank and "Don't know" answers are excluded.

Response

1. More community wide information on the actual process to reach out and receive services. I think this process is still very overwhelming and complicated for many families.
2. Specific mental health/substance use services for various populations to eliminate barriers and meet them where they're at. (Or expansion of education within the community on these services, if they're already available)
3. need for inpatient treatment
4. Assistance is need for our more severe people in therapy. It is hard at times to know what the next steps are because CMH is able to offer way more than we are able to and is better equipped with the resources, but we are told that they are not "severe" enough even after the person has had multiple hospitalizations.
5. People in jail need more services and should be easily referred to SCCMHA when they are released. They would benefit if CMH would give them appointments prior to release or not close their case while they are incarcerated.
6. More residents especially in the 48601 and 48603 communities rarely see the services offered by SCCMHA, from my viewpoint.
7. I have walked through some scary mental health issues with one of our people. Getting the proper services was incredibly difficult, especially getting an appointment to begin with. I also noticed that she was sent home over and over again before improving or being ready to be discharged.
8. This is affect people across regardless of socioeconomic status, but too many services are being geared towards others , than Medicaid clients when this is a social issue.
9. More beds for treatment
10. Right now I feel like the thinking is the easy answer is to call the police. Then the easiest thing to do is take these people to jail. The jail staff are not mental health care providers they are corrections officers. It's not fair to them to keep inundating the jail with people with mental health care needs
11. Lack of therapist, unaware of any mental health services available for homeless or homeless in shelters. Most Military and Veterans has Tri-care which is rarely accepted by agencies for mental health services. Lack of therapist who have experience or training treating the I/DD population for mental health therapy.
12. With being a CCBHC, access should be easier on the community to get the services they need.
13. Many would say that there aren't enough services for all categories. There might be services, but not everyone will take advantage of them due to stigma, perceived cost, bad experience with "the system" turnover of providers and not wanting to start over.
14. Better coordination with courts