

State Mental Health Agency Support for Less than 24 Hour Crisis Receiving and Stabilization Facilities (CRSFs), 2022

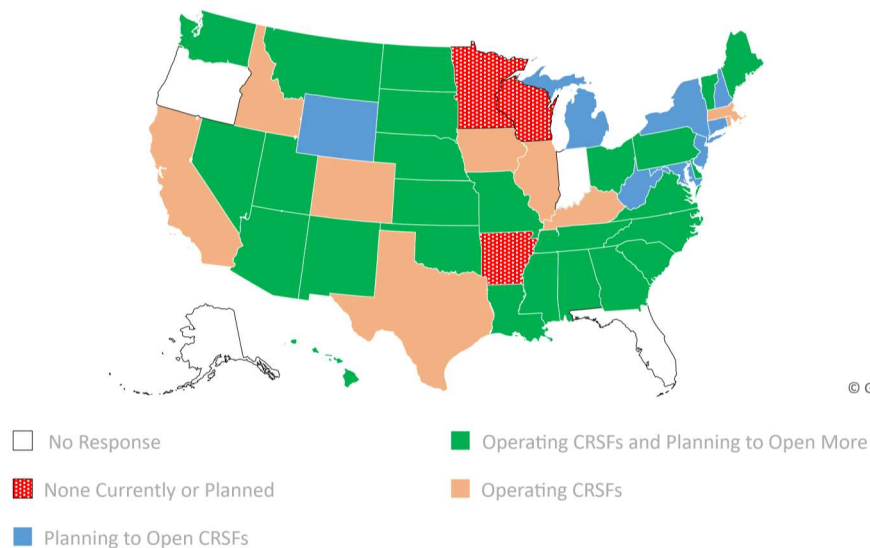
Highlights Based on 48 States Responding to the Crisis Component of NRI's 2022 State Profiles

Note: although 48 states responded to the Crisis Component, not all states provided answers to all questions; therefore, some of the information presented in this report is based on responses from less than the total number of reporting states.

Less than 24-Hour CRSFs: **SOMEWHERE TO GO**

Short term (less than 24-hour) Crisis Receiving and Stabilization Facilities (CRSFs) are one of three core components of the behavioral health crisis care continuum described by SAMHSA's National Guidelines for Behavioral Health Crisis Services. CRSFs are designed to help individuals experiencing behavioral health crises avoid having to go to Emergency Departments or psychiatric hospitals by providing a safe, dedicated place for individuals needing observation or stabilization services to receive specialized services. CRSFs provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, non-hospital environment. Many CRSFs have recliners (instead of beds) and are staffed to facilitate the quick drop-off of individuals in crisis by law enforcement, EMS, and mobile crisis teams. CRSFs have demonstrated effectiveness in helping address crises and reduce use of emergency rooms, psychiatric hospitalizations, and adverse criminal justice system interactions.

Figure 1: Status of States Operating or Planning to Open Crisis Receiving and Stabilization Facilities, by State, 2022



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CRSFs are currently operating in 75% of responding states (36 of 48 states) and nine additional states are planning to open CRSFs this year. Most (30) states with CRSFs are staffing and funding CRSFs to respond to both mental health crisis and substance use crises, while in three states, CRSFs are staffed and organized to only respond to mental health crises and in four states CRSFs are focused on individual with mental health crises or individuals with co-occurring mental health and substance use crises.

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36 States

Have Operating <24-Hour Crisis Receiving & Stabilization Facilities

129,574

Individuals Were Served by a Crisis Receiving & Stabilization Facility

237

Crisis Receiving & Stabilization Facilities were Operating

In 16 states, CRSFs accept both voluntary and involuntary clients experiencing behavioral health crises (involuntary clients are individuals brought to the CRSF by a Mobile Crisis Team, Law Enforcement, or EMS involuntarily due to potential risk of harm to themselves or others during their crisis). In 20 states, CRSFs only provide services to voluntary individuals (individuals who do not volunteer to go to the CRSF may be transported by law enforcement, EMS, or mobile crisis to an emergency room instead of a CRSF).

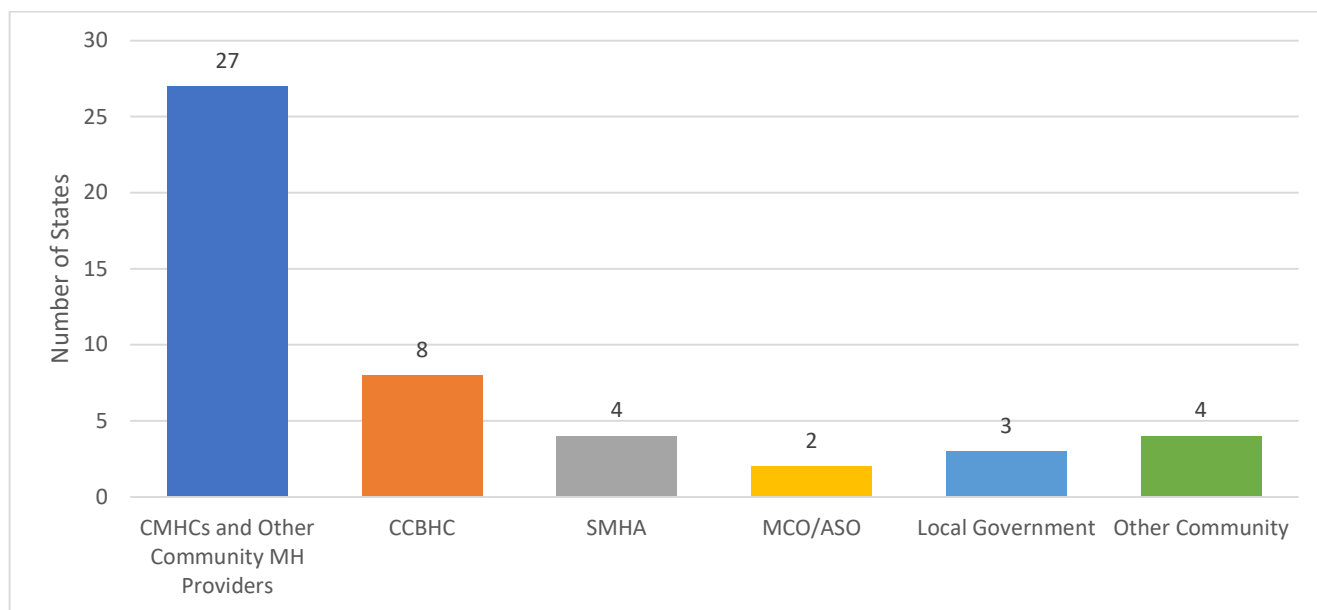
In 2022, 34 states reported they have 237 CRSFs operating. The median state reported six CRSFs, with a range from a high of 48 CRSFs (in Pennsylvania) to a low of one operating CRSF in 12 states. In seven states a total of 21 separate CRSFs have been established to work with children and adolescents in crisis, but in most states the same CRSFs work with both children and adults experiencing crises.

CRSFs are a relatively new service in many states and several states with CRSFs were not yet able to report how many clients were served at CRSFs during the past year. The 19 states able to report the number of individuals who received a CRSF service during the last year reported 129,574 persons served. These states averaged 6,820 individuals served by CRSFs (the median was 3,868) ranging from a high of 53,219 in Arizona to a low of 73 in Hawaii. Only two states were able to report on the number of children receiving crisis services at CRSFs, and in those states only 4% of individuals served by CRSFs were under age 18 (and 96% were age 18 and over).

Crisis Receiving and Stabilization Facility Operations:

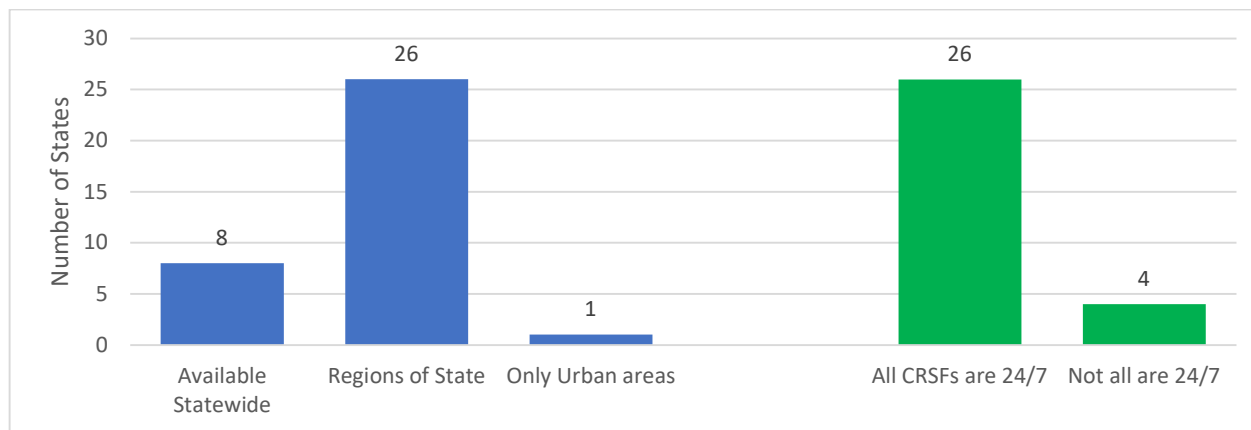
Community mental health providers (such as community mental health centers (CMHCs)) are the most frequent type of organization that operates CRSFs (used in 27 states). Certified Community Behavioral Health Clinics (CCBHCS) operate CRSFs in eight states and the State Mental Health Authorities (SMHAs) operate their own CRSFs in four states (see Figure 2). Other organizations that operate MCTs include county/local governments in three states, local hospitals in one state, and private providers contacted by the state’s MCO in one state. States may use multiple types of organizations to operate CRSFs.

Figure 2: Number of States Funding CRSFs, by Type of Organization Operating CRSFs, 2022



The goal of states is to have CRSFs available to all individuals experiencing a crisis anywhere in a state, at any time of day or night. However, as states expand their CRSF services, most states do not have CRSFs available statewide (only eight states report having CRSFs available statewide, 26 states report CRSFs are available in some regions of their state and one state reported CRSFs are only available in urban areas). In 25 states, CRSFs are open to provide crisis services 24-hours a day, 7 days a week (24/7), however, almost all states with CRSFs (27 states) reported they are experiencing challenges to staffing and operating CRSFs 24/7 (see Figure 3).

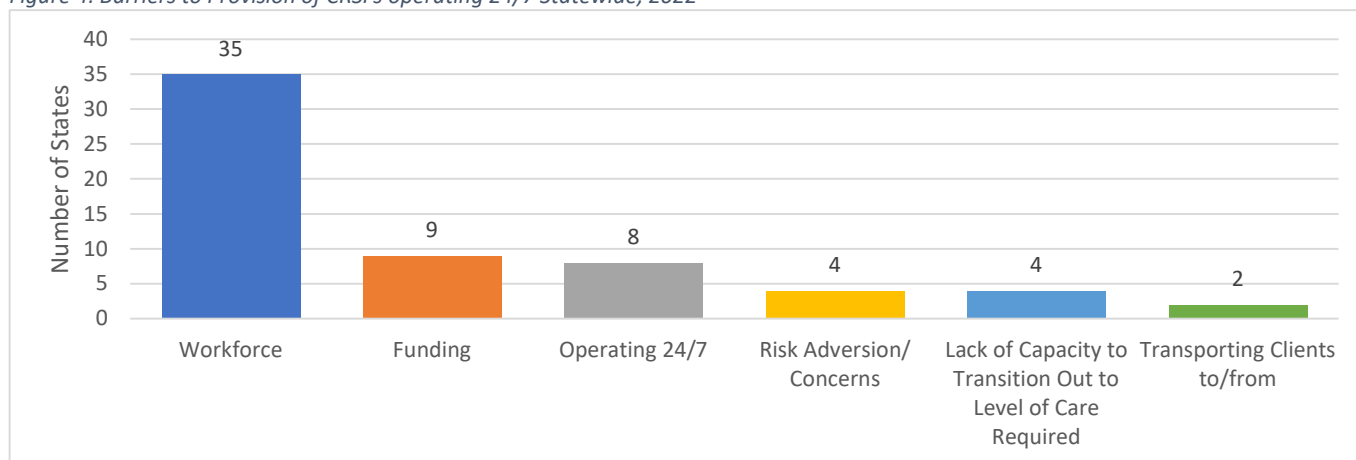
Figure 3: Number of States with Crisis Receiving and Stabilization Facilities Available State-wide and 24/7, 2022



Challenges to Having CRSFs available 24/7 to all Clients in all Regions:

Every state with CRSFs reported having difficulties providing CRSF services in all regions of a state and providing services any time of any day or night. The most frequently identified barriers to providing 24/7 CRSF services across all regions of a state were the workforce shortages, including recruiting, training, and retention of skilled workers (35 states), developing sustainable funding and reimbursement for CRSF services (9 states), and issues of operating CRSFs 24/7 (8 states). Other challenges include transportation of clients to CRSFs (especially in rural/remote areas), reluctance by other systems to transport individuals in crisis to CRSFs, and behavioral health systems lacking capacity to transition clients from CRSFs to appropriate next levels of care. (See Figure 4).

Figure 4: Barriers to Provision of CRSFs operating 24/7 Statewide, 2022



Steps to Address Challenges to CRSF 24/7 Availability:

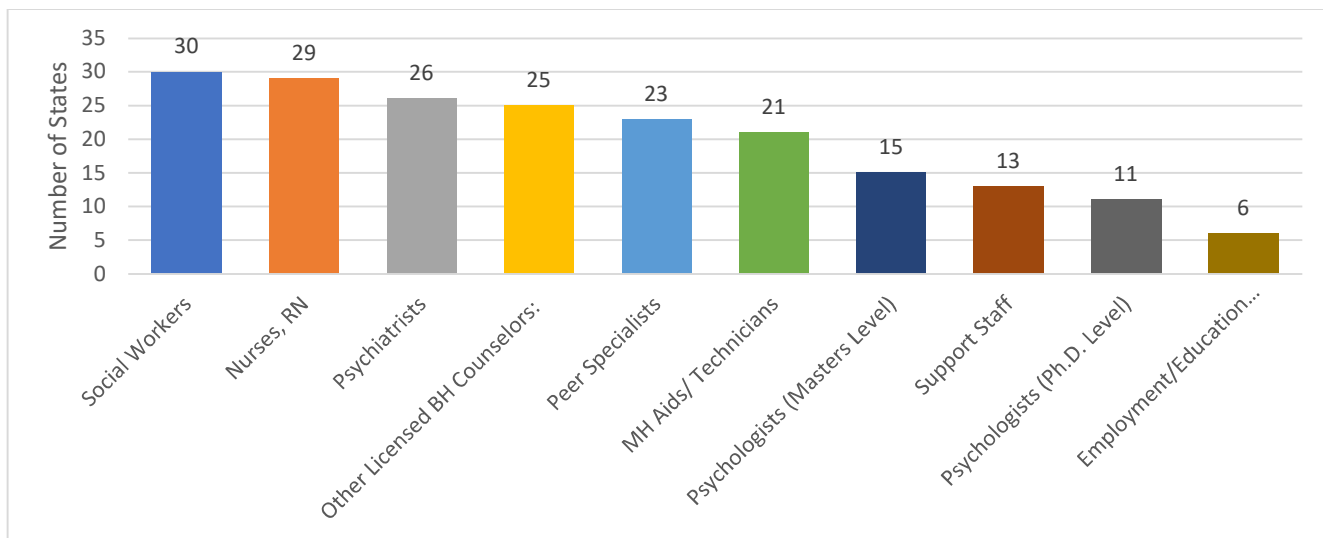
Many (25) of the states provided examples of work they are undertaking to address barriers to CRSFs being available 24/7. Approaches to increase CFSF availability include increasing the use of Medicaid, increased state funding, supporting growing and training the workforce to work in CRSFs, changing credentialing requirements to staff CRSFs. State initiatives to expand CRSF services include:

- Iowa: The state works with providers to address education and experience requirements that may prohibit hiring otherwise qualified staff.
- Montana: The state is undergoing a rate study to ensure that reimbursement rates are competitive with other health care providers. The state is working with the CRSF to work towards qualifying to bill for crisis stabilization services through Medicaid.
- Nebraska: The state is considering modifications to staffing requirements. The Behavioral Health Education Center of Nebraska is a legislatively mandated program dedicated to training and increasing the behavioral health workforce in Nebraska.
- New Mexico: The SMHA is working with the CRSF licensing entity the Department of Health, to change medical staff regulations to address workforce concerns. The CRSF continues to work with local stakeholders to address other concerns.
- Ohio: The state has introduced a workforce development plan. The planned investment of \$85 million of federal funds gives the state an opportunity to make education more attainable and affordable for students committed to behavioral healthcare careers. The funding will be dedicated to enhancing paid internship and scholarship opportunities for students working to achieve behavioral health certifications and degrees at Ohio's two- and four-year colleges and universities and other educational career development settings. It will also help remove financial barriers from obtaining licenses, certifications, and exams necessary for employment in these careers; support providers in their ability to supervise and offer internships and work experiences; and establish a Technical Assistance Center to help students navigate the federal and state funding opportunities available to them. This investment will also fund recruitment and retention bonuses for students who commit to employment with Ohio's community mental health and addiction centers which provide care, treatment, and services to Ohio's Medicaid-eligible population.
- South Carolina: The State is working closely with legislators, community partners to secure locations for programs that need limited physical plant issues. The state is exploring investing State and other dollars that can contribute to operational expenses.
- Virginia: The SMHA assisted two programs (<24 hour) in developing an innovative pilot project through the Virginia Board of Pharmacy to allow the APS Passport (an automatic dispensing device" to be installed in two programs. Both sites were granted a three-year waiver of multiple pharmacy regulations to allow this device to be installed and managed by a pharmacy so that these units will have access to over 176 oral solid medications as well as injectables and inhalers. This will eliminate the barrier of timely access to medications in these three sites and increase the acuity of the individuals these sites may serve. DBHDS is examining the crisis system as a whole and working to re-write licensing regulations for these new services in the state.

Crisis Receiving and Stabilization Facility Workforce Shortages

Thirty-five (35) SMHAs reported that CRSFs in their state were experiencing workforce shortages, Masters-level Social Workers, Registered Nurses, Psychiatrists and Other Licensed Behavioral Health Counselors are the types of staff with the most states reporting shortages (see Figure 5).

Figure 5: Number of States Experiencing Workforce Shortages for CRSFs, by Type of Staff, 2022



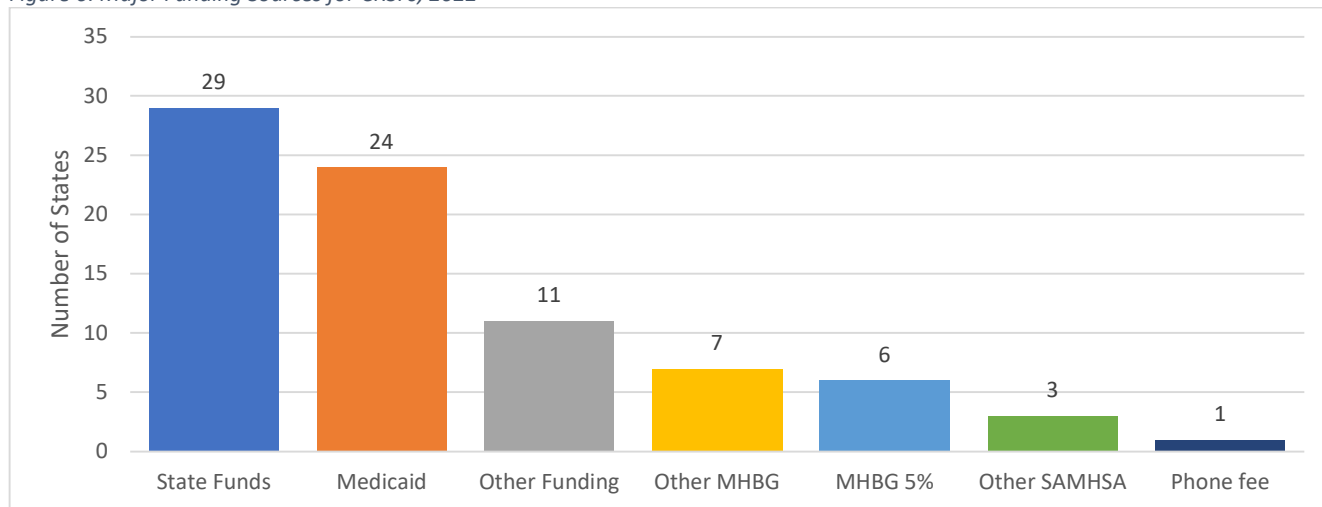
Twenty-two (22) SMHAs have developed special training to prepare peer specialists to work as part of MCT or at a Crisis Stabilization Center. For example, Oklahoma developed a Peer Specialist Crisis Training for peer specialists working in a crisis level of care. A webinar about the Oklahoma Peer Recovery Support Specialist Training program is available online: <https://www.nasmhpd.org/content/presentation/ta-coalition-webinar-oklahomas-peer-recovery-support-specialist-crisis-track>

Financing CRSFs

Twenty-one (21) States reported expending \$307.9 million for CRSFs last year, an average of \$147 million per state, ranging from a high of \$155.8 million in Arizona (with 15 CRSFs averaging \$10.4 million per facility) to a low of \$161,000 in Maryland (with 1 CRSF). States reported that the average expenditures per CRFS was \$2.5 million (with the median cost of \$1.1 million). Eighteen (18) states reported both number of CRSFs and expenditures.

States are supporting CRSFs through a variety of funding sources, including state, federal, and local government funds. As Figure 6 shows, most states are using state general and special funds, but Medicaid and the Mental Health Block Grant (MHBG) including the 5% set-aside for Crisis Services, are being used by many states (see Figure 6).

Figure 6: Major Funding Sources for CRSFs, 2022



Medicaid is used to pay for some CRSF services in most states with CRSFs (24 states). The Medicaid Rehabilitation option is currently being used by 15 states, the 1115 Medicaid waiver is used by 6 states, while four states use a 1915(b) waiver, four states use the Medicaid Clinic Option, 2 states use the Medicaid Targeted Case Management Option, and six states use other Medicaid options/waivers to support CRSF services. (Many states use a combination of Medicaid waivers and options to fund CRSFs).

One issue that can impact CRSFs receiving Medicaid reimbursement, is the Medicaid Institution for Mental Disease (IMD) rule that prohibits Medicaid reimbursement for adults (ages 21 to 64) in behavioral health inpatient and residential programs with more than 16 beds (they are considered an Institution for Mental Disease (IMD)). Although SAMHSA recommended model for CRSFs is that they work with individuals experiencing a behavioral health crisis for less than 24 hours, in 19 states rules permit CRSFs to retain clients over 24 hours if responding to an individual’s crisis requires their remaining at the CRSF beyond 23 hours (13 states have rules that CRSFs must discharge individuals before they are at the program for 24 hours). In two states, because CRSFs can served clients in crisis more than 24 hours, they report that the Medicaid IMD rule has resulted in their CRSFs being defined as IMDs and thus are unable to bill Medicaid.

Examples of why states permit CRSFs to retain clients over 24 hours include:

- Clients are allowed to stay longer than 24 hours to allow them improve stability and this leads to increased success in the community.
- Extra time in a CRSF can benefit the stability of a client to allow for transitions to appropriate levels of care in areas where subacute programming does not exist.
- They are able to stay over 24 hours if they are in an Involuntary commitment and are awaiting placement in a 24-hour facility.
- Less than 1% of all clients served (approximately 430 during the reporting period) remain past 24 hours, this can range from a couple of hours to a few days depending on the unique discharge needs of each client. Due to the small overall numbers of cases where discharge planning exceeds the 24-hour period the financial and programmatic impact for our CSU programs is minimal.

Data/Outcomes from CRSFs

Several states are starting to collect and report data about how CRSFs are helping individuals experiencing a behavioral health crisis. Use caution when interpreting reported outcomes as only a few states were able to report outcomes for CRSFs. Table 1 below shows that for states that could report outcome, that about half of clients who go to a CRSF had their crisis addressed during their stay at the CRSF. About 5% of clients required further care at an Emergency Department and 13% were transferred to either a psychiatric inpatient or substance abuse detox program for further care.

Table 1: CRSF Data on Outcomes at End of Stay at CRSF, 2022

CRSF Metrics being Measured	Number of States Reporting	Average	Median	Low	Max
Percentage of crises successfully resolved during the stay in the CRSF	7	50.5%	55.0%	0.6%	94.7%
Percentage of individuals who leave a follow-up outpatient visit scheduled	5	72.7%	57.5%	50%	100%
Percentage of individuals who are transferred to an Emergency Department	8	4.9%	4.8%	0.9%	9.6%
Percentage of individuals who move to a substance abuse detox or psychiatric inpatient facility for additional care	7	13.1%	9.8%	0%	40%

Other 2022 NRI State Profile Reports on Crisis Services

This report on Crisis Receiving and Stabilization Facilities is one of a series of reports that NRI is producing for states during the fall of 2022. Other Profile Highlight reports will focus on:

- State Crisis Services Continuum of Care
- States Support for Crisis Call Centers (988 and other call centers)
- State Support for Mobile Crisis Teams
- Crisis Workforce Issues
- Crisis Technology and Outcomes
- Financing Crisis Services
- Alternative Transportation for Crisis Services

**For Additional Information About this Report, or the SMHA Profiles Project,
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National Association of State Mental Health Program Directors Research Institute (NRI)