State Support For <24-Hour Crisis Receiving & Stabilization Facilities, 2023

NRI's 2023 State Profiles

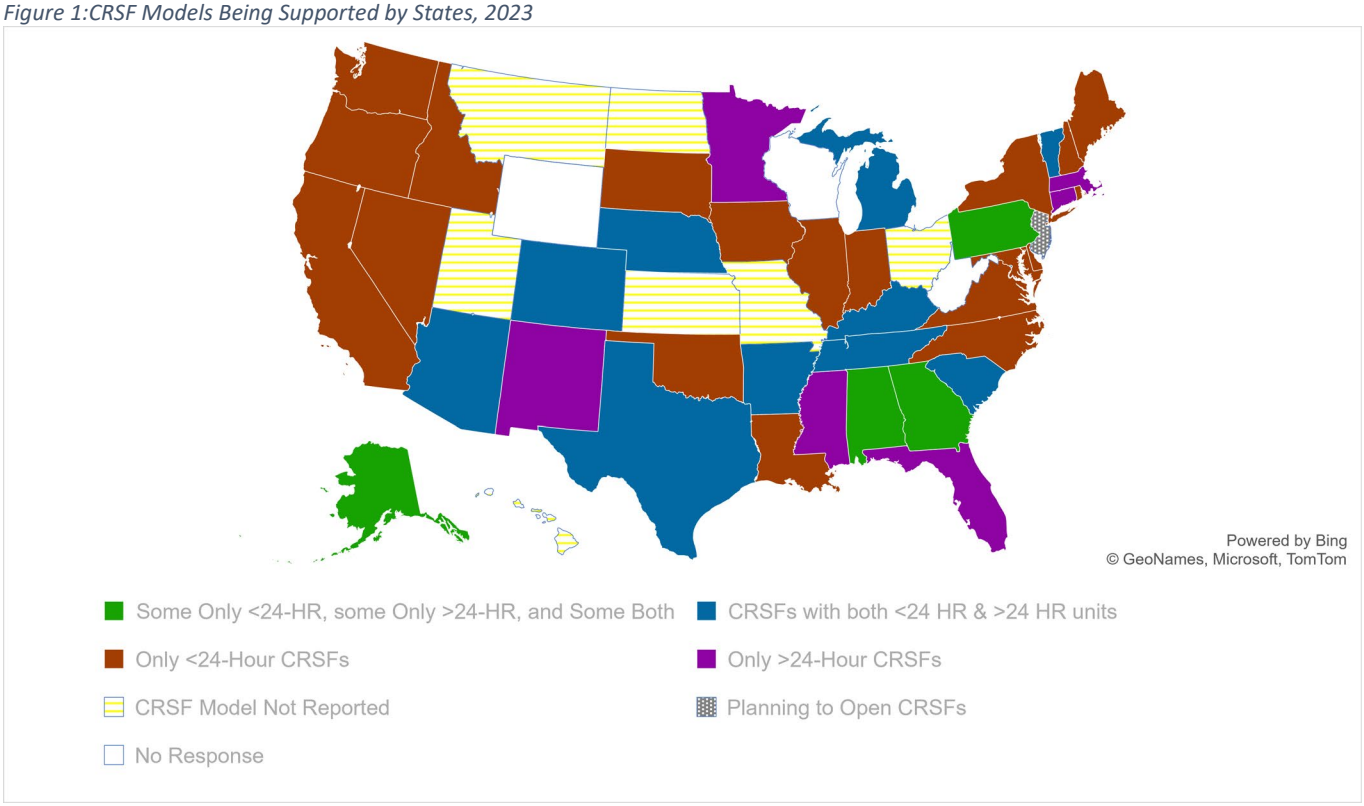
July 2024

Crisis Receiving and Stabilization Facilities (CRSFs): A Safe Place for Help

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 (frequently 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.

In 2023, 44 states were operating 576 CRFS facilities, including 46 CRSFs in 13 states that are specialized for serving children and adolescents. Thirty-five states reported plans to open at least 180 additional CRSFs during 2024. Sixty percent of CRSFs are either entirely less than 24-hour programs (<24 Hour) or have a combination of <24 Hour and over 24 Hour units (see Figure 1 for map of CRSFs by state).

Figure 1:CRSF Models Being Supported by States, 2023



576
CRSFs Operating
(45 states reporting)

633,673
Individuals Served At CRSFs
(33 states reporting)

69% (median)
Successfully Served at CRSFs
(7 states reporting)

To learn more about what states count as a CRSF, the 2023 Profiles asked states to report if their CRSFs were all <24-hour programs, all >24-hour programs, or had a combination of <24 programs and >24 hour programs.

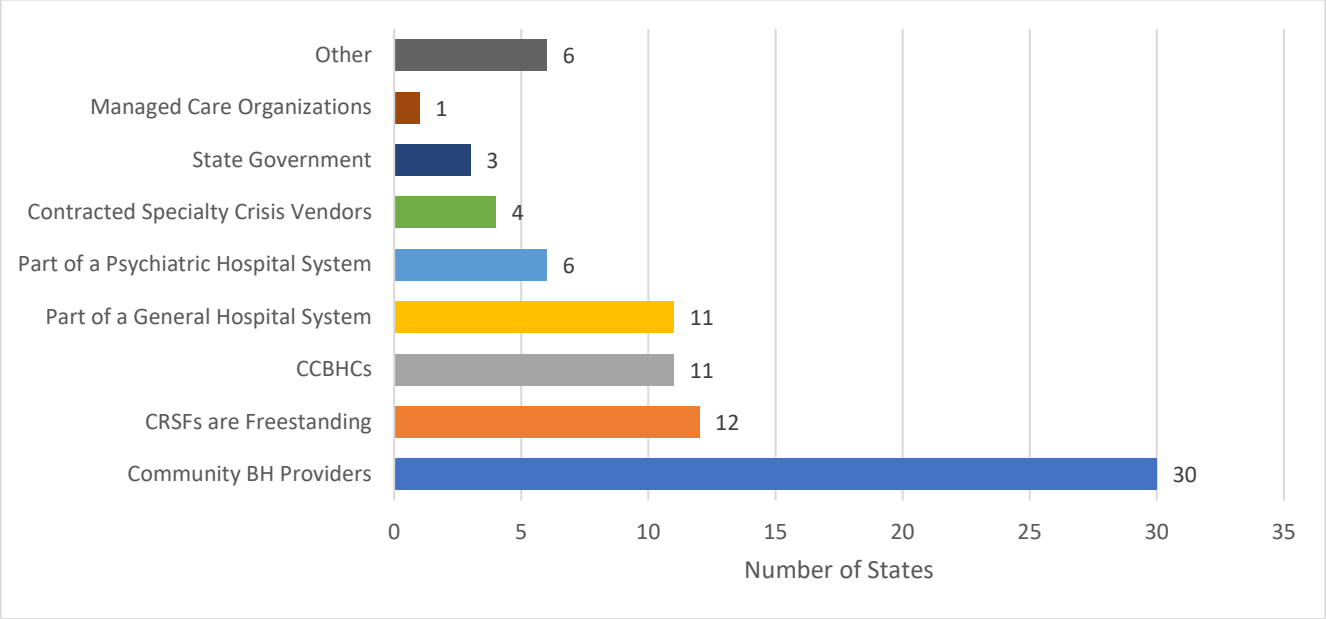
- 24 States reported they have CRSFs that are only <24-hour programs (with 209 CRSFs operating in these states)
- 21 states (representing 127 CRSFs) reported their CRSFs operate a combination of <24-hour units and also >24 hour ('short stay') crisis units
- 11 states (representing 226 CRSFs) reported having CRSFs that are very short term crisis programs of >24-hour units
    - Note: nine states (included in the counts above) reported they have a mixture of some CRSFs being only <24-hour programs (51 CRSFs), combination of both <24-hour and >24-hour units (25 CRSFs), and only >24-hour programs (37 CRFSs).

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 32 states able to report the number of individuals who received a CRSF service during the last year reported 633,673 individuals served in 2023 (every visit to a CRSF by one individual is counted separately). These states averaged 19,802 individuals served by CRSFs (the median was 4,956) ranging from a high of 163,438 in Florida to a low of 798 in Iowa.

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 30 states). Certified Community Behavioral Health Clinics (CCBHCS) operate CRSFs in eleven states and the State Mental Health Authorities (SMHAs) operate their own CRSFs with state employees in three states (see Figure 2). In 12 states, at least some of their CRSFs are free-standing (not part of any other organization), in 11 states they are part of a general hospital system and in 6 states they are part of a psychiatric hospital system. States may use multiple types of organizations to operate CRSFs.

Figure 2: Organization of CRSFs, by Number of States, 2023



Characteristics of CRSFs

In most states, CRSFs accept all individuals experiencing crises. This includes those transported by MCTs, law enforcement officers, EMS, and individuals who walk-in on their own or how are brought there by friends or family. However, States vary greatly in how they organize and structure the services provided by CRSFs. Table 1 shows, that while CRSFs in almost every state accept voluntary legal status clients, in 15 states CRSFs also serve involuntary status individuals.

To serve involuntary status individuals or individuals who may need close supervision, CRSFs in 17 states have locked units available and CRSFs in 2 states have separate areas for involuntary patients.

To address potential medical issues and diagnose behavioral health issues, CRSFs in 23 states have on-site medical staff available, while CRSFs in 18 states have medical staff on-call as needed. Five states described alternatives, such as using Registered Nurses or having agreements with a local hospital to provide medical staff.

Table 1: CRSF Program Units/Services, 2023

	Number of States
CRSFs Accept Walk-in Clients	
Walk-in Clients Treated	33
No Walk-in option	1
Legal Status of Clients Served	
Voluntary Only	19
Involuntary Only	1
Both Voluntary and Involuntary	14
CRSF Involuntary Patient Treatment Area	
Shared Space	12
Separate space for Involuntary	2
CRSF has Locked Units	
CRSF has Locked Units	17
No Locked Units	10
Medical Staff	
CRSF has On-Site Medical Staff	23
CRSF has On-Call Medical Staff	18
Other (RN on site or agreement with local hospital)	5
On-Site Pharmacy	
CRSFs have on-site pharmacy	10
No on-site pharmacy	22
Use of Peer Specialists	
All CRSFs use Peer Specialists	24
Some CRSFs use Peer Specialists	5
No CRSFs use Peer Specialists	5

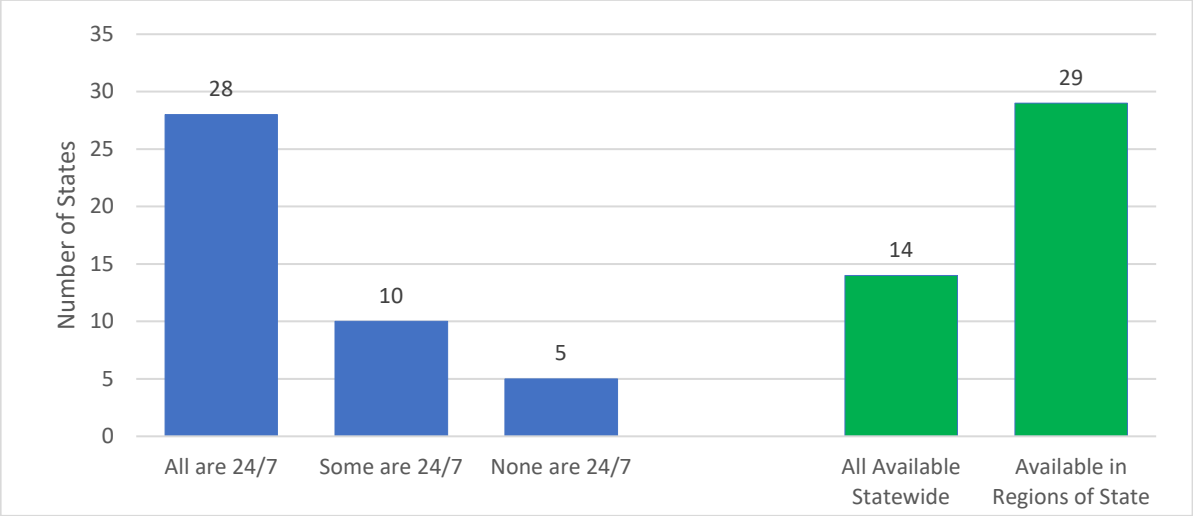
CRSFs in 10 states have on-site pharmacy that can be accessed for either prescribed or emergency medications.

Peer Specialists are part of the staffing model in 29 states, with all CRSFs using Peer Specialists in 24 states and some CRSFs using Peer Specialists in 5 states. Only five states reported their CRSFs do not use Peer Specialists.

24/7 Availability of CRFS Services Statewide:

While 44 states have established CRSFs operating, making these services available to all residents in a state remains a challenge. Only 14 states report that CFSFs are available statewide and 29 states report that CRSFs are only available in regions of their state (typically in urban and suburban areas). The majority of CRSFs are operating 24 hours per day/7 days per week (all CRSFs in 28 states and some of the CRSFs in 10 states are operating 24/7). Only five states report none of their CRSFs are currently operating 24/7 to help individuals experiencing a behavioral health crisis. (See Figure 3).

Figure 3: Number of States with CRSFs Available State-wide and 24/7, 2023



States report that major challenges to having CRSFs available statewide and 24/7 are workforce (33 states), operating 24/7 (21 states), financing (17), and issues related to operating CRSFs in rural and remote areas (11 states).

Behavioral Health Crisis Workforce Shortages at CRSFs:

Twenty-three states report reported workforce shortages at their CRSFs. Social Workers (MSW and above) and Registered Nurses were the staff category with the most states (22) reporting shortages. Fifteen states reported moderate levels of shortages of RNs, two states reported catastrophic shortages (shortages that result in reductions of services), and five states reported minor shortages. Psychiatrists were the next more frequently listed shortage workforce category for CRSFs, with 21 states reporting shortages (five with catastrophic shortages, 10 with moderate shortages and five with minor shortages). Nurse Practitioners were identified as a shortage group by 19 states, with two states reporting catastrophic shortages, 13 states moderate shortages and four states reporting minor shortages (see Table 1).

States report a variety of initiatives to address CRSF workforce shortages, including:

- **California:** DHCS has multiple initiatives to support workforce expansion across behavioral health services, including crisis intervention and stabilization services. Specifically, DHCS administers the Behavioral Health Workforce Development project that expands the behavioral health workforce statewide by continuing support for peer support specialists, analyzing the state of the current behavioral health workforce, and funding workforce development activities.
- **Louisiana:** Office of Behavioral Health (OBH) has developed a partnership with the LSUHSC Center for Evidence to Practice to support the development of LA's BH workforce.
- **Maine:** Workforce development and retention support includes financial supplements, workforce marketing campaigns, and workforce training support.
- **New Hampshire:** The Division for Behavioral Health is developing a crisis certification program for individuals with lived experience, or other non-related degrees to become certified in providing crisis services.
- **New York:** In discussion with prospective providers to discuss sustainability, providing a learning collaborative for implementation. Use of telehealth where appropriate. Discussion of creative and flexible staffing when necessary, within regulation and statute limits.
- **Pennsylvania:** Working on a crisis worker certification program, regionalization efforts as a way of stretching resources between counties, regulations to address standards, ARPA funds, looking at other funding resources.

- **Texas:** HHSC is providing direction on the credentialing process to clarify who can be credentialed as a Qualified Mental Health Professional-Community Services.
- **Vermont:** Allocating state funds to community mental health centers for workforce recruitment and retention. Partnering with hospital and community health centers to provide non-emergency healthcare support onsite.

Table 1: Number of States Reporting Workforce Shortages Among CRSFs, by Discipline and Shortage Level, 2023

	Catastrophic Shortage	Moderate Shortage	Minor Shortage	Any Shortage	Position not used at Contact Centers
Social Workers (M.S.W. and above)	2	13	7	22	1
Registered Nurses	2	15	5	22	3
Psychiatrist	5	11	5	21	1
Peer Specialist	1	14	4	19	2
Nurse Practitioner	2	13	4	19	3
Bilingual/Multilingual Staff	2	11	4	17	1
Licensed BH Workers	2	12	3	17	1
Case Managers	1	7	8	16	5
MH Aids/Technicians	1	6	10	17	4
Other Nurses	2	12	2	16	4
Psychologists (Ph.D. Level)	0	8	5	13	9
Psychologists (Masters)	1	6	4	11	7
Support Staff	1	5	6	12	3
Social Workers (Other)	2	6	3	11	4
Prevention Specialists	0	1	4	5	17

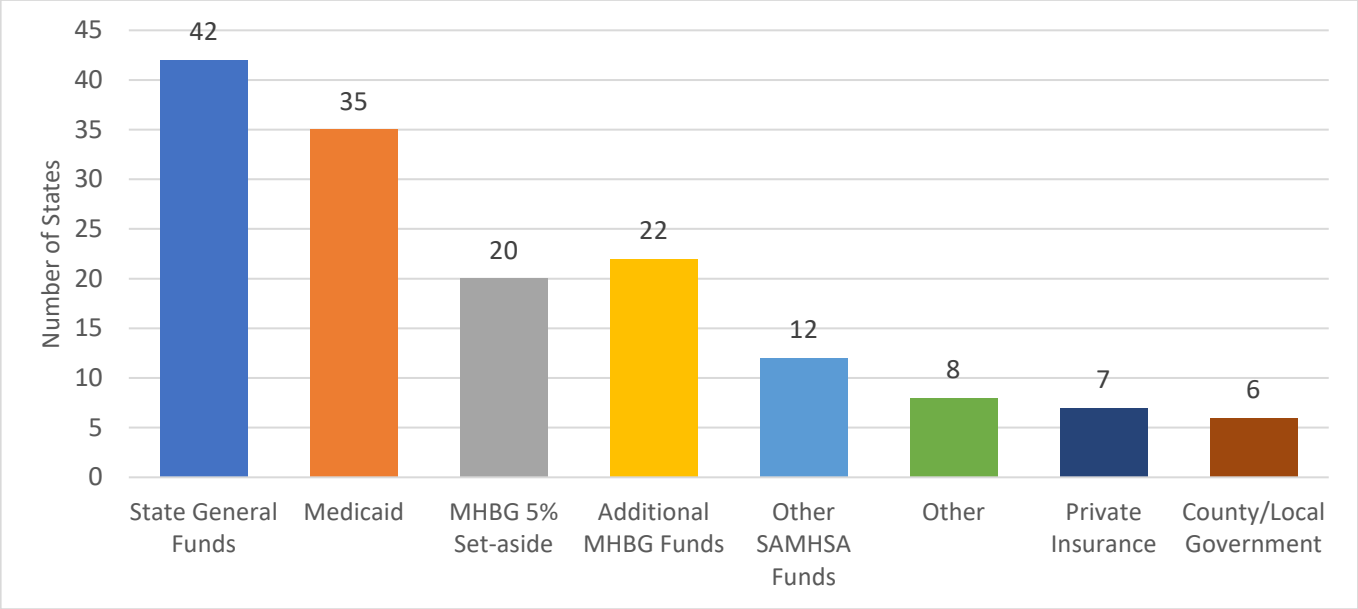
Shortages from 2023 Profiles Workforce Component: 43 states reporting

Financing CRSFs

Thirty-fix (36) states reported expending $832.5 million for CRSFs last year, an average of $22.3 million per state, ranging from a high of $196.5 million in Georgia (with 15 CRSFs averaging $7 million per CRSF) to a low of $601,357 in New Mexico (with 3 CRSFs averaging $200,452 per CRSF). States reported average expenditures per CRFS was $3.99 million (with the median cost of $1.5 million). Thirty-four 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 4 shows, most states are using state general and special funds (42 states), but Medicaid (35 states) is being used by many states. The SAMHSA Mental Health Block Grant (MHBG), including the MHBG 5% set-aside for Crisis Services, are being used by many states (see Figure 4). Although CRSFs work with any individual in a crisis, only seven states reported their CRSFs are currently being reimbursed or supported by private insurance.

Figure 4: Major Funding Sources for CRSFs, 2023



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. Eight states were able to report on outcomes for crisis visits to CRSFs. The majority (average of 63.7 percent and median of 73.2 percent) of individuals served at CRSFs had their crisis resolved sufficiently to the point where they did not need to move on to a more intensive level of treatment. Over half (average of 59.6 percent, and median of 45 percent) of individuals left a CRSF visit with an appointment for outpatient behavioral health services. Less than 20 percent of individuals seen at a CRSF required transfer for additional behavioral health treatment at psychiatric hospital care, detoxification, or sobering center. Only 5.2 percent on average (median of 4.5 percent) were transferred for care at an ED (see Table 3).

Table 3: Crisis Receiving & Stabilization Facility Outcomes Being Tracked by States, 2023

	Number of states reporting	Average	Median	Minimum	Maximum
Percentage of individuals who go to a CRSF program whose crisis is successfully resolved during the initial encounter (do not need to move to more intensive care)	8	63.7%	73.2%	24.0%	85%
Percentage of individuals at a CRSF program who leave with a BH outpatient appointment	3	59.6%	45.0%	43.9%	90%
What percentage of individuals at CRSF programs who require additional care at EDs	6	5.2%	4.5%	0.9%	12%
What percentage of individuals at CRSF programs who require additional care at Detox program or psychiatric hospitals	7	13.7%	14.7%	1.0%	32%
What percentage of individuals at CRSF programs who require additional care at a Sobering Center	1	4.0%	4.0%	4.0%	4%

Several states highlighted that a lack of available inpatient or detox services can delay an individuals leaving a CRSF for appropriate levels of continuing treatment.

Medical Clearance and Limitations on Transporting Individuals directly to CRSFs

In some states, rules or practices requiring a "medical clearance" may limit the ability of individuals needing intensive crisis services being able to be taken directly to a CRSF. In 35 states, Mobile Crisis Teams (MCTs) can transport an individual to a CRSF, in several states a level of "medical clearance at an ED is required for some individuals before they can go to a CRSF. If Law Enforcement or EMS are involved in transporting an individual, there are often limitations on where they can transport a person to.

In 10 states, EMS are usually required transports clients to hospital EDs instead of a CRSF. Several states are currently working to change these policies to permit EMS to transport individuals to behavioral health crisis providers: For example:

- **Arkansas:** Currently only to ERs. However, this will be changed in 2024.
- **Missouri:** DMH is collaborating with the Missouri Department of Health and Senior Services (DHSS) to update the code of state regulations (CSR) to allow for ambulance districts/EMS to transport voluntary individuals to BHCCs

Other 2023 NRI State Profile Reports on Crisis Services

This report on Behavioral Health Crisis Services is one of a series of reports that NRI is producing for states on Behavioral Health Crisis Services in 2023. Other Profile Highlight reports will focus on:

- State Support for Crisis Service Continuum (Contact Centers, Mobile Crisis, Crisis Receiving & Stabilization)
- State Support for Mobile Crisis Services
- State Support for Crisis Contact/Call Centers
- Behavioral Crisis Information Systems and Outcomes
- Crisis Workforce Issues
- Funding Crisis Services
- Behavioral Health Crisis Outcomes and Technology

Please contact NRI at profiles@nri-inc.org with any questions or comments about this and other State Profiles reports.