PRA
POLICY RESEARCH ASSOCIATES

FROM PLANNING TO PRACTICE:

Insights from a Survey of Crisis Stabilization Centers

April 2024

Context

Crisis stabilization or crisis triage centers are facilities designed to provide immediate, typically short-term care and support for individuals experiencing mental health, substance use disorder, and other co-occurring needs. There is a wealth of recent public-facing resources focused on creating a robust behavioral health care continuum and the integral role that crisis centers play for individuals who may need a physical location to access care. However, minimal information exists comparing individual crisis centers and their operations. This resource builds on existing publications by highlighting data from a survey of 31 U.S. jurisdictions planning and implementing crisis centers. It contains specific and practical data regarding centers' service capacities, data collection and evaluation, staffing, funding, partnerships and collaborations, and critical challenges and lessons learned.

Background

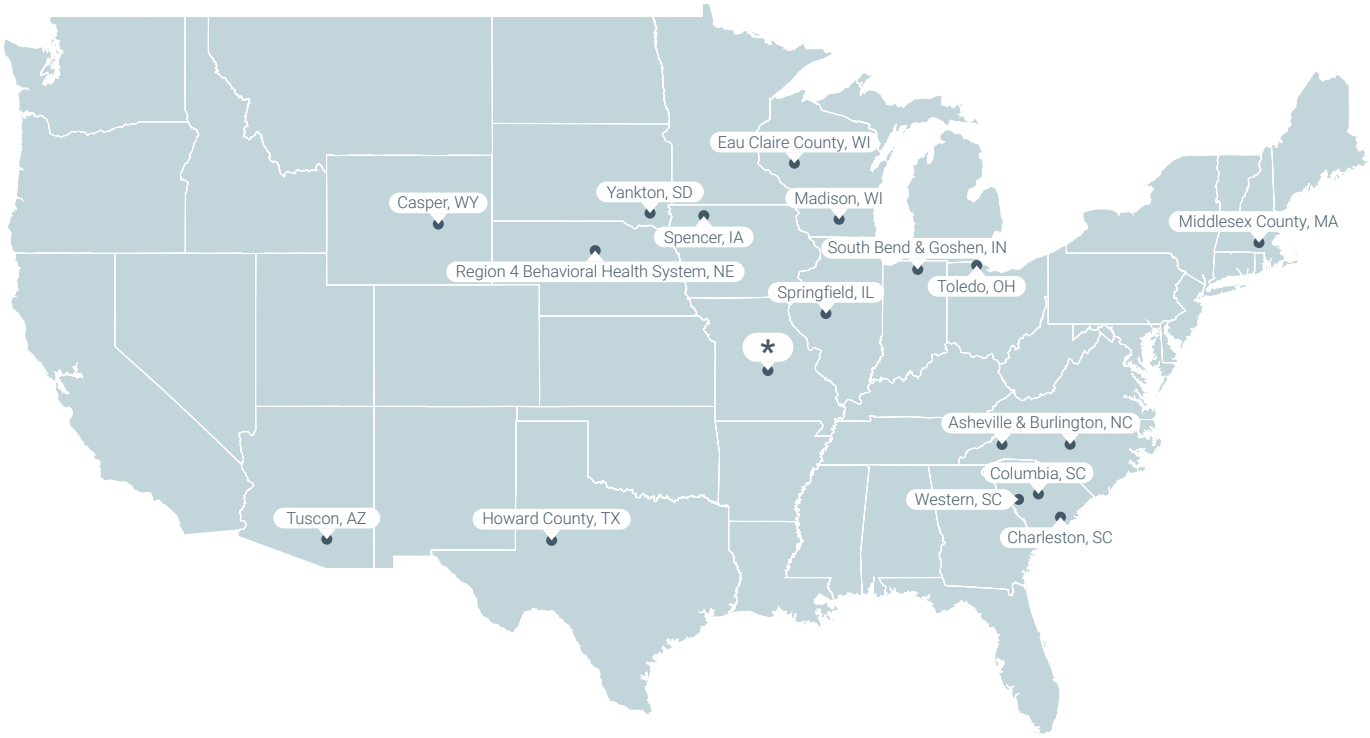
Beginning in early 2022, Policy Research Associates, Inc. (PRA) facilitated a virtual learning community of cities and counties planning and operating crisis stabilization centers. The group originated at the request of a single site and has grown to over 65 representatives from 20 states as of February 2024.

Between March and May 2023, PRA conducted a voluntary survey of the virtual learning community participants to learn more about their crisis centers. The survey's goals included facilitating peer-to-peer learning across centers, developing a "state of the service" snapshot, and building justification for ongoing work across sites. PRA received 31 total responses across 15 states, although individual question responses varied and are indicated below. About half of the responses were from crisis centers already in operation and half from sites still in the planning process.

Where are the sites?

Most (68%) of the 31 respondents serve or plan to serve jurisdictions with less than 500,000 residents, with about one-quarter (26%) serving jurisdictions between 500,000 and 1 million residents. Only one center is/will serve jurisdictions between 1 million and 1.5 million residents, and one in a jurisdiction including more than 1.5 million residents.

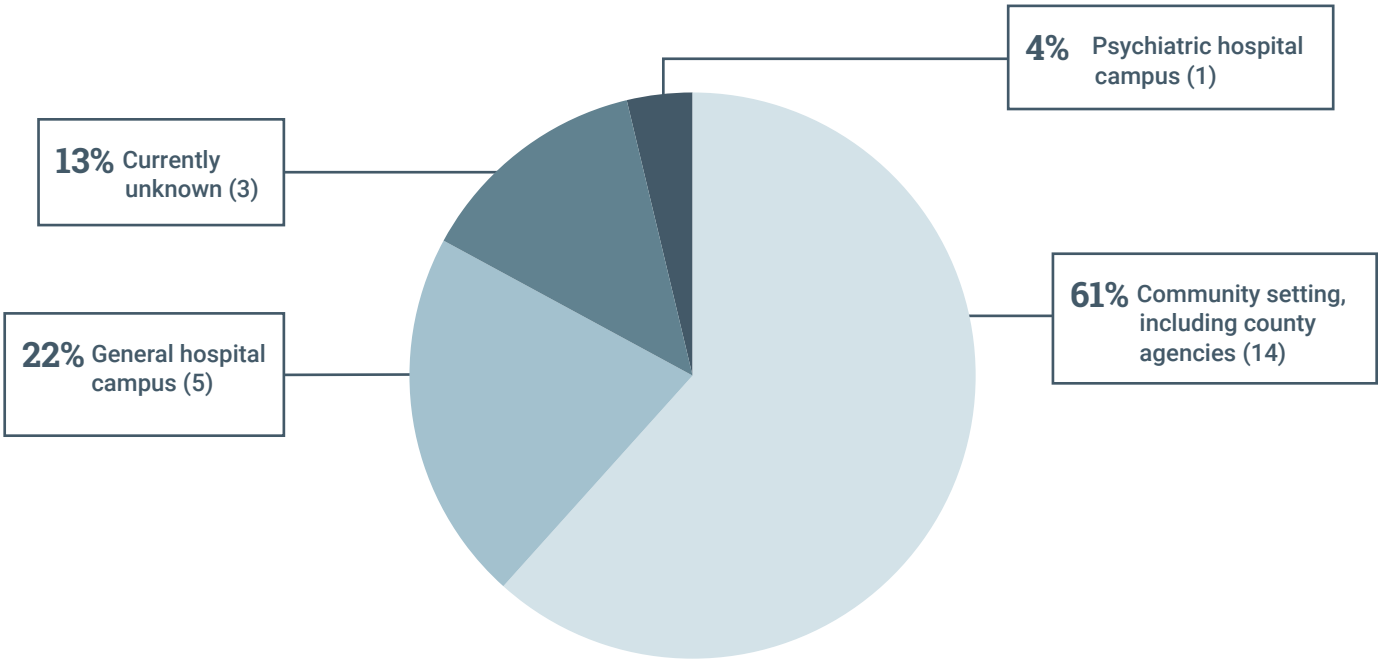
? Where is your crisis center located, or where will it be located? (N=31)



1. 14 cities/counties across Missouri*
2. Tucson, AZ
3. Spencer, IA
4. Springfield, IL
5. South Bend & Goshen, IN
6. Baton Rouge, LA
7. Middlesex County, MA
8. Asheville and Burlington, NC
9. Region 4 Behavioral Health System, NE
10. Toledo, OH
11. Charleston, SC
12. Columbia, SC
13. Western SC
14. Yankton, SD
15. Howard County, TX
16. Eau Claire County, WI
17. Madison, WI
18. Casper, WY

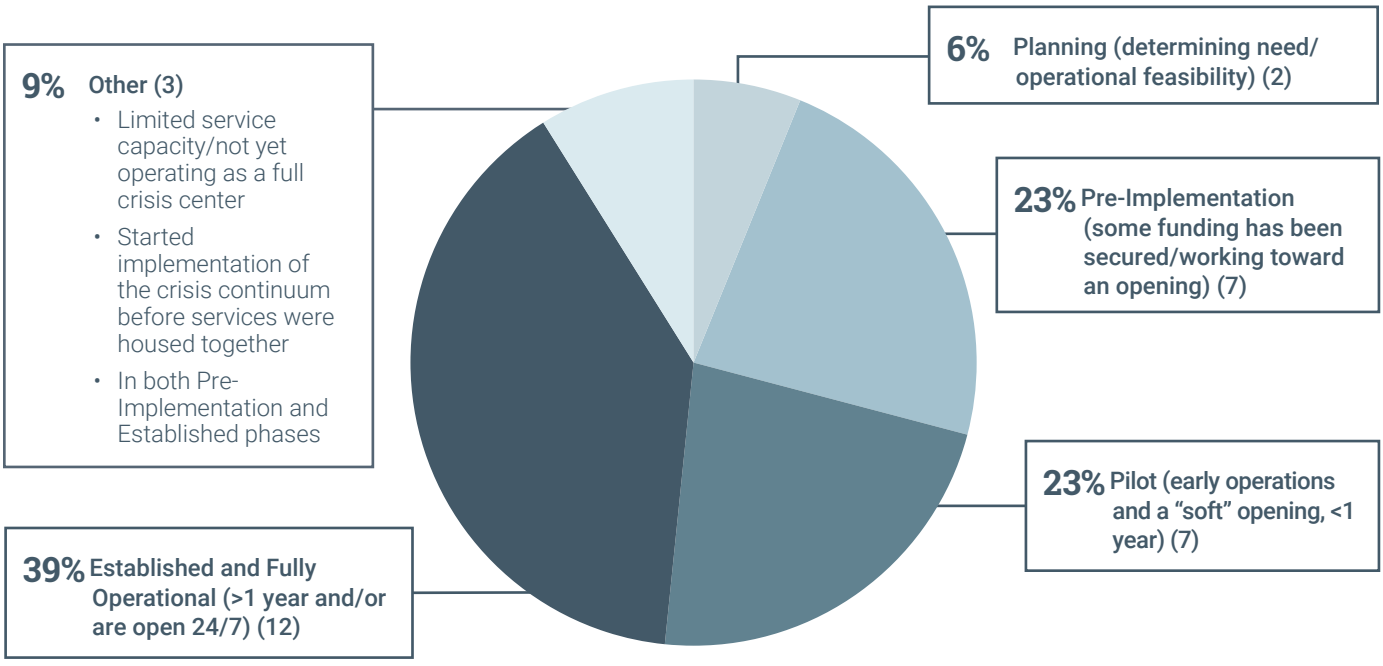
**Missouri jurisdictions include St. Joseph, Wentzville, St. Louis, Kirksville, Hannibal, West Plains, Rolla, Jefferson City, Raymore, Kansas City, Cape Girardeau, Joplin, Columbia, and Springfield.*

In what setting is your crisis center based? (N=23)

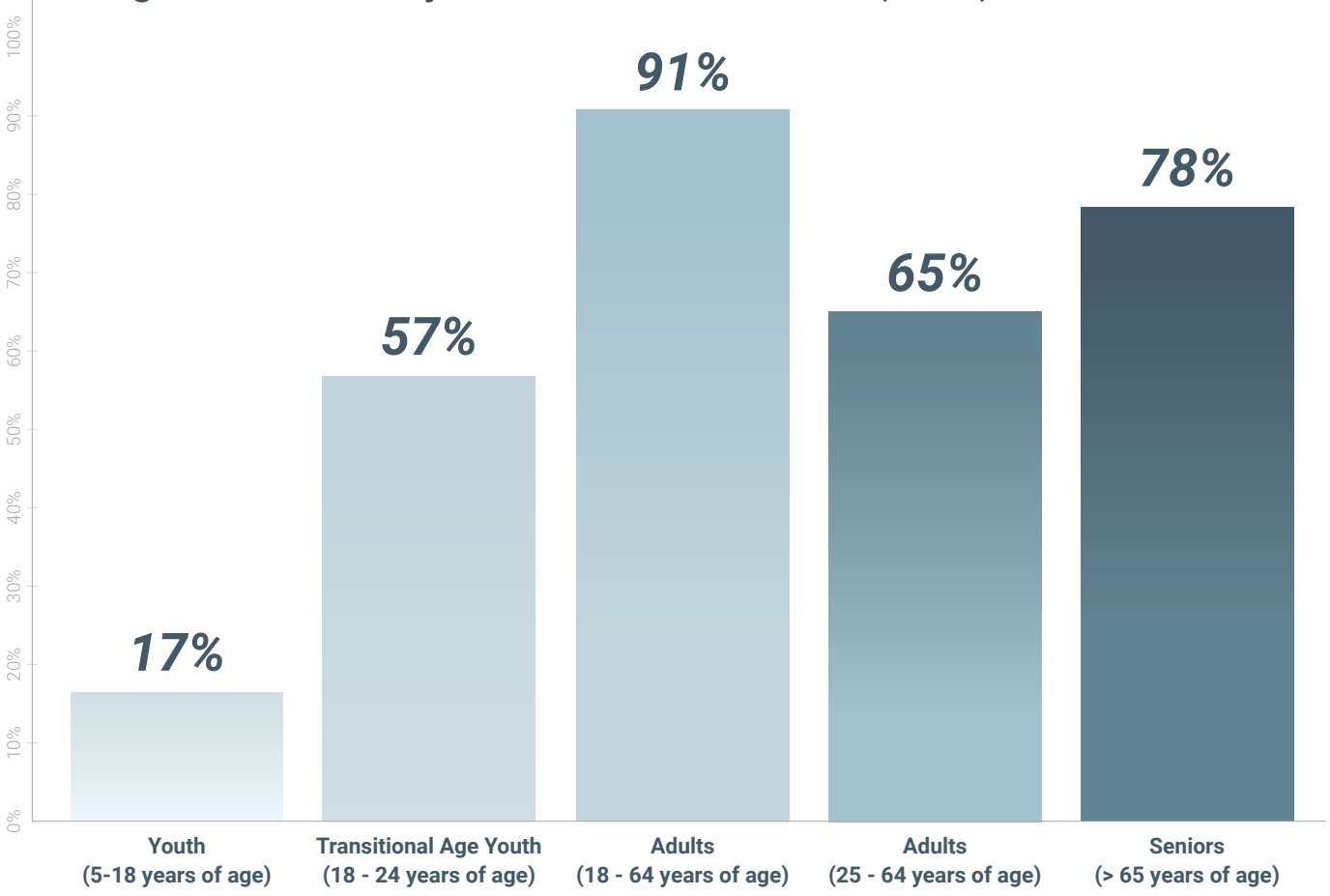


Service Capacity

What phase do you consider your crisis center to be in? (N=31)



What ages does or will your crisis center serve? (N=23)

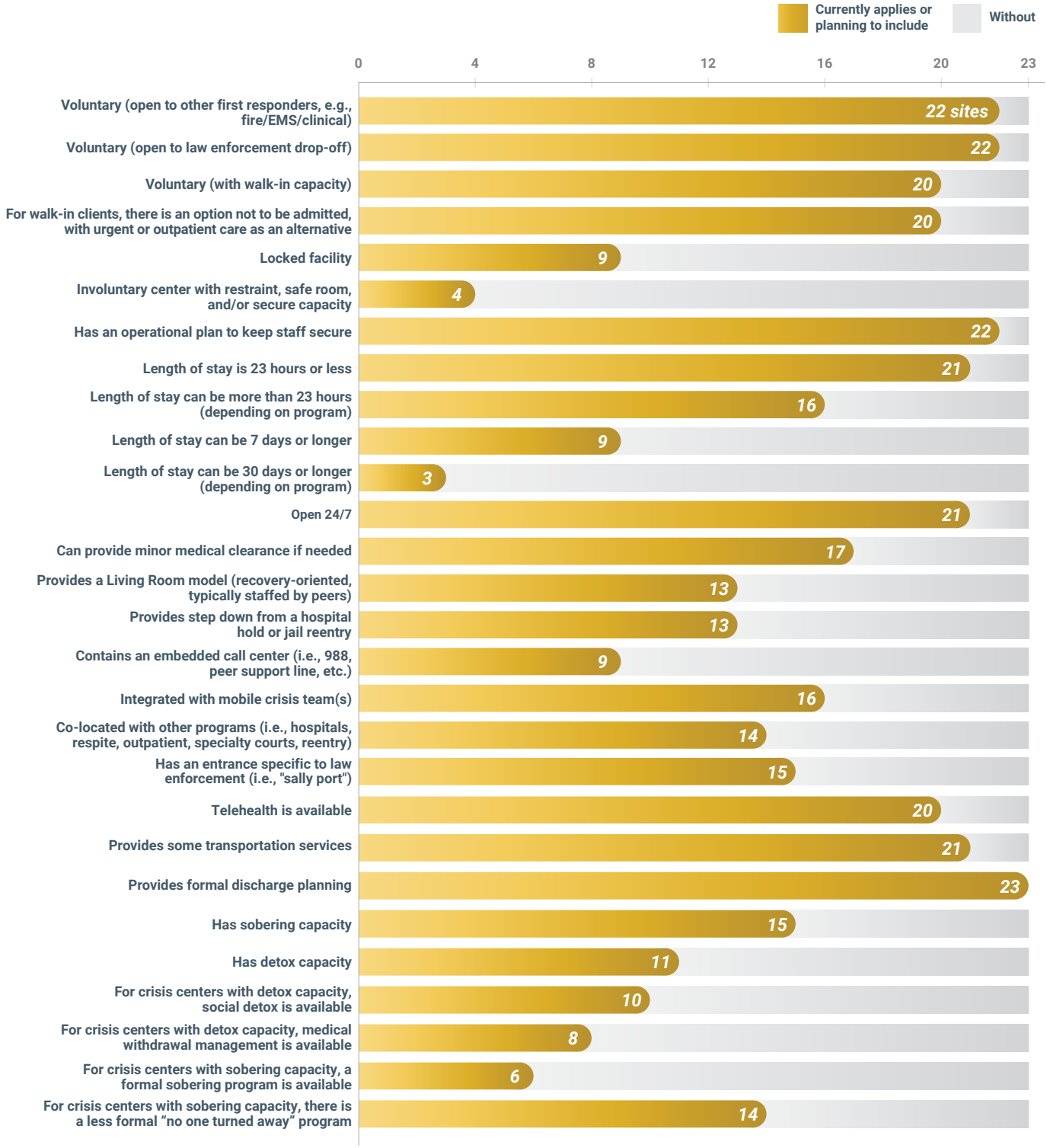


What are or will be your crisis center's exclusionary criteria, if any?

About half of 23 respondents' crisis centers would exclude individuals exhibiting or at risk of violent behavior (57%) or who were non-ambulatory/unable to walk without assistance (52%). Twenty-two percent (22%) of centers would exclude individuals who were intoxicated (often referring to a hospital or detoxification center, if available), with one location listing a specific BAC limit of over 0.3%.

Some centers may exclude individuals with an intellectual or developmental disability as their primary diagnosis (17%) or who have a previous criminal history (9%), including sex offense convictions. However, no responding centers stated they would exclude individuals based solely on active community supervision on probation or parole. Other less common exclusions were medical or behavioral conditions that could not be safely managed or stabilized within the center, as well as if the individual had made a suicide attempt requiring medical attention or been "kicked out" of other centers.

Which features below apply or will likely apply to your jurisdiction's crisis center? (N=23)



Describe your bed capacity, or planned capacity, according to the services provided.

The crisis centers surveyed ranged from four total beds to 32. Specific designations included:

- Exam rooms
- An observation room for medication management
- Community rooms for quiet space
- Withdrawal management/detox/recovery beds
- Crisis unit lounge chairs or rooms, often for up to 23 hours
- Longer-term stabilization/residential beds
- Separate beds for harm reduction units
- Separate beds for respite care

How are you handling, or planning to handle, transportation to or from your center?

When asked about transportation options to or from the crisis centers, most facilities reported using center-owned vehicles (74%), providing public transportation passes/fares (52%), and offering taxi or rideshare assistance (52%) (in addition to most sites offering walk-in capacity). A smaller percentage utilize contracted transportation services (13%) or other health plan-funded services such as ambulance transport to higher levels of care.

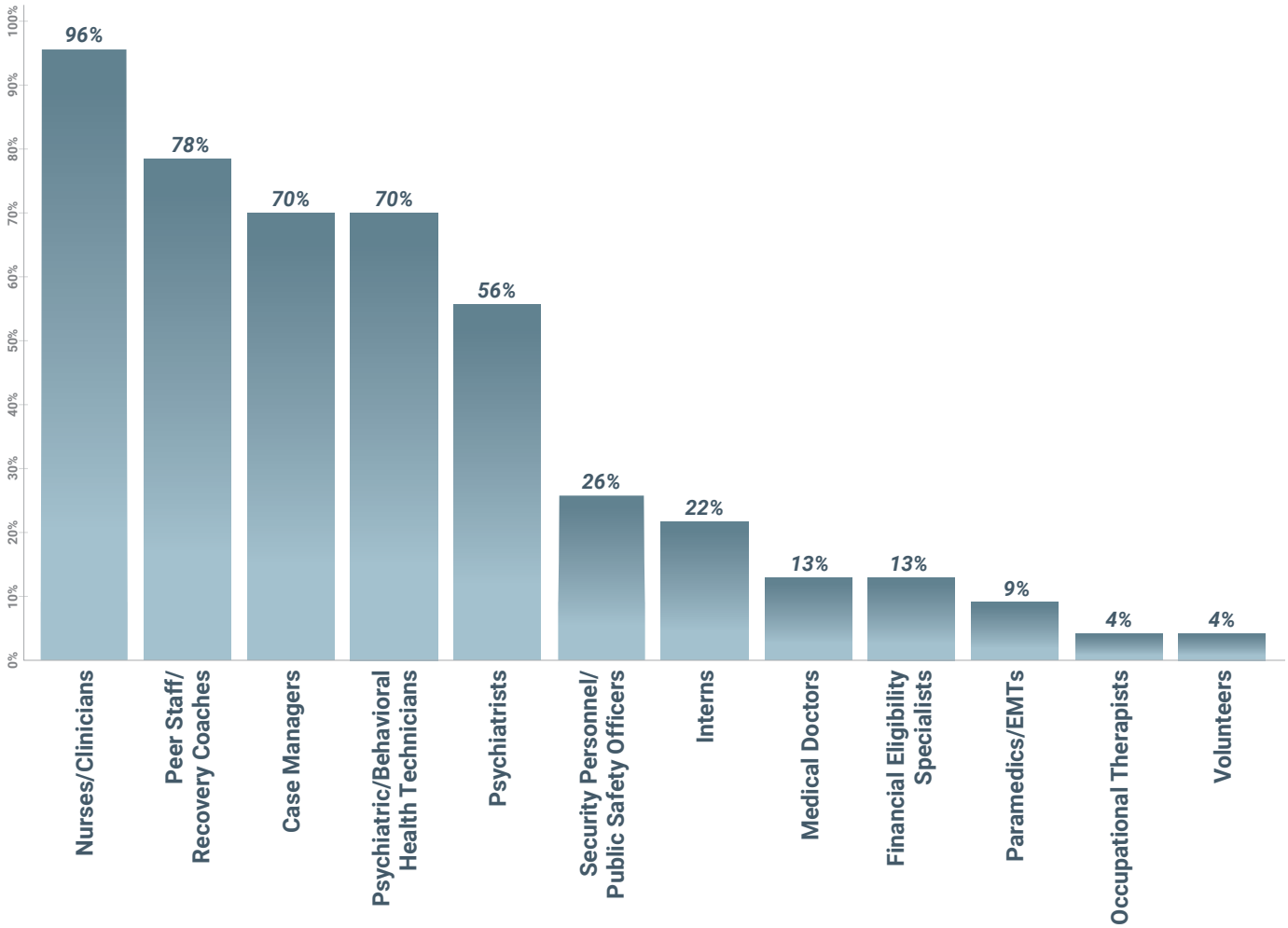
Staffing and Partnerships

What entity is or will be your center's behavioral health and/or medical provider?

About half (57%) of 23 respondents currently contract or plan to contract with a non-profit organization or certified community behavioral health clinic (CCBHC) to provide behavioral health and/or medical services. One quarter (26%) engage or plan to engage in hospital or university collaborations. One center utilizes its state mental health department as a provider, while another twenty-two percent (22%) of respondents have not yet determined who their provider(s) would be.

How is the crisis center staffed, or how do you anticipate it will be?

As reported by 23 respondents, crisis center staffing shows a significant diversity in roles. Almost all centers (96%) employ or plan to employ nurses and clinicians (such as LCSWs, LMFTs, and QMHPs). Additionally, a high percentage reported including peer staff or recovery coaches (78%), case managers (70%), psychiatric or behavioral health technicians (70%), and psychiatrists (56%). One quarter (26%) of centers employ or plan to employ security personnel or public safety officers, and 22% of centers include interns. A few centers also employ medical doctors (13%), financial eligibility specialists (13%), paramedics/EMTs (9%), occupational therapists (4%), and volunteers (4%). Individual respondents also mentioned community health workers, physician assistants, navigators, medical assistants, community support specialists, and aftercare follow-up staff.

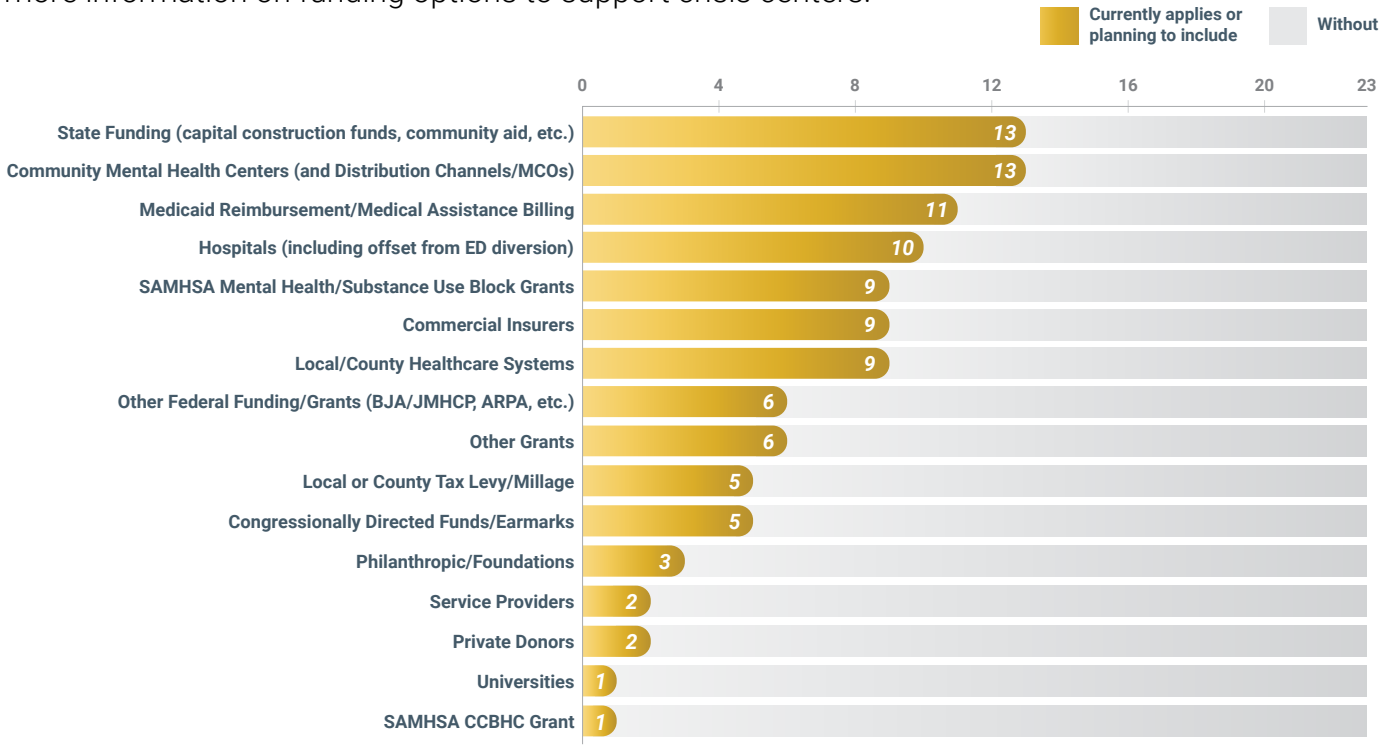


Which groups are or will likely partner with the crisis center (formally or informally)?

All respondents collaborate with law enforcement (or expect to). Additional common partners are hospitals/emergency departments (91%), local community providers such as mental health or substance use (91%), mobile crisis teams (78%), and EMS (74%). Most respondents also partner or plan to partner with crisis lines (70%), county behavioral health agencies (65%), state mental health or substance use services (56%), and city and county governments (each 56%). State Medicaid, fire departments, housing providers, and the judiciary were less common partners (all 48%). Some crisis centers also collaborated with law enforcement/behavioral health co-responder teams (44%), advocacy groups such as the National Alliance on Mental Illness (NAMI, 44%), regional behavioral health authorities (39%), and other relevant organizations such as food banks (4%).

Funding

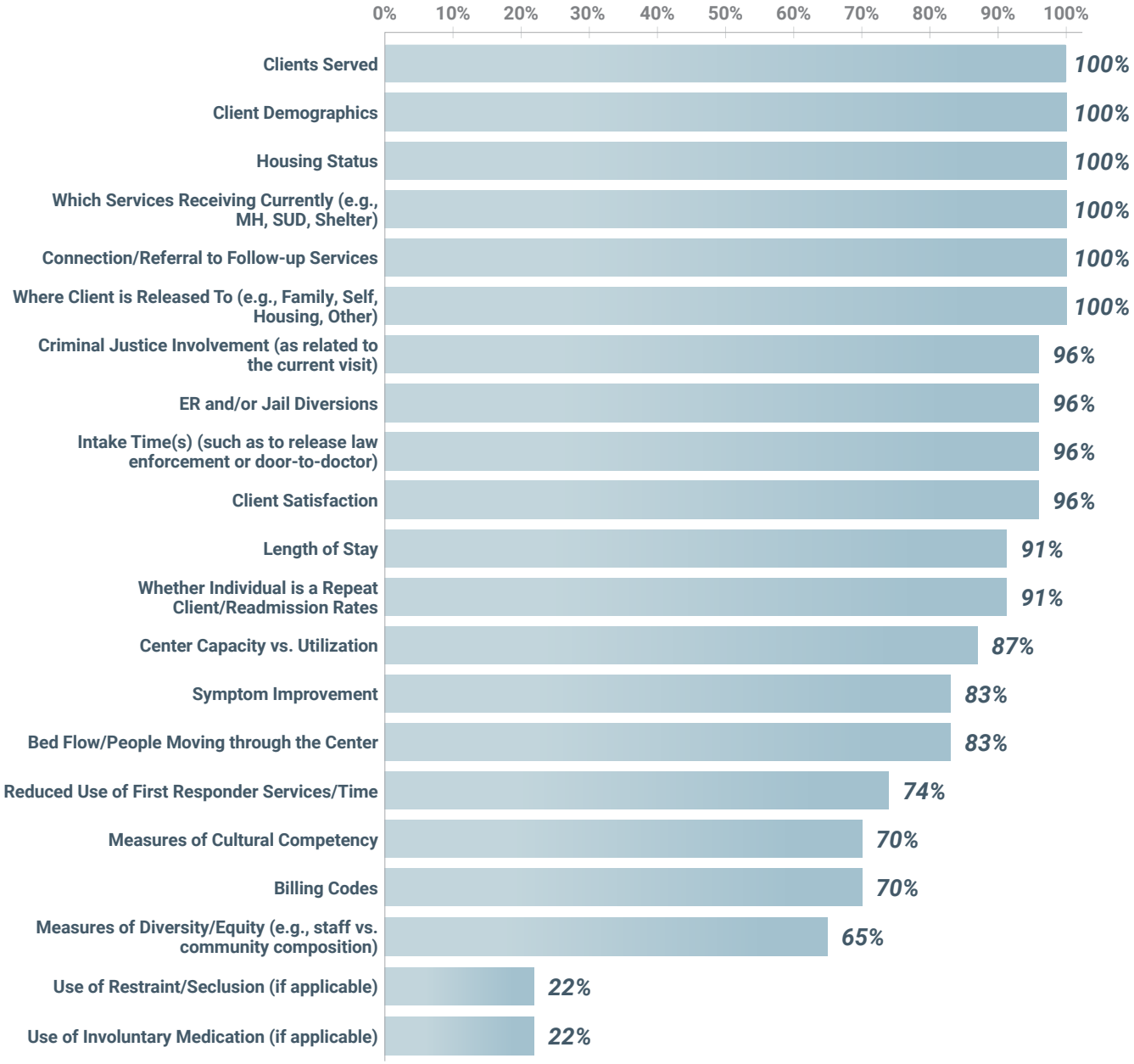
Securing start-up and ongoing funding is a crucial aspect of operationalizing crisis centers. The chart below shows how many crisis centers are receiving or exploring funding across various potential sources. Braiding and blending of funding streams, otherwise known as collaborative funding, is common across crisis centers. See *Additional Resources: Funding-Specific* below for more information on funding options to support crisis centers.



Data Collection and Evaluation

Almost all (91%) respondents' centers collect or will collect data via electronic health records. About 17% utilize customized software such as iCentrix, myAvatar, and other provider- or state-dependent data collection systems. A small percentage (4%) of centers report using health information exchanges.

Respondents were also asked about specific data metrics and performance indicators. The chart below shows how many crisis centers are collecting or planning to collect each indicator.

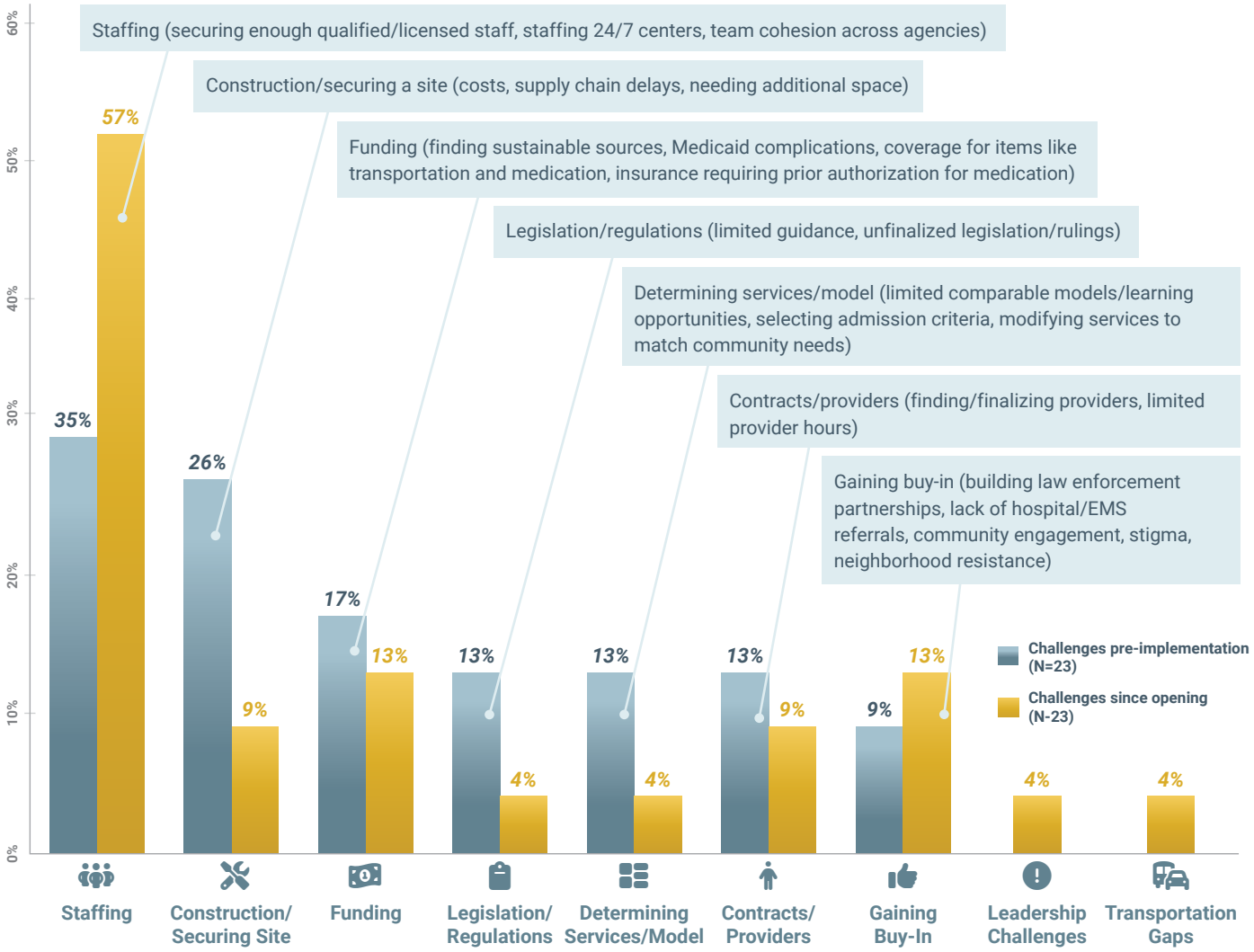


Twenty-three respondents provided insights into how their crisis center programs are evaluated and audited. Various methods are employed internally and externally, including:

- Utilization of reporting software like iCentrix for data gathering
- Weekly chart and staff audits
- Oversight by state departments, including health and mental health
- Accreditation via the Commission on Accreditation of Rehabilitation Facilities
- Yearly audits conducted by the health systems region overseeing the contract
- Monthly review of patient satisfaction surveys
- Internal Quality Improvement/Assurance/Management audits
- Supervisor fidelity to evidence-based practice monitoring

Lessons Learned

We asked sites about their most significant "pain points" or challenges both in planning and since implementation (if applicable) and found commonalities across several categories.



> "Keeping the unit staffed is our most significant issue right now. We are not taking police drop-offs until we get fully staffed, and we've had huge challenges getting enough staff to work evenings and weekends."

> "Not having peer learning groups such as these to learn and grow."

> "Making sure we think of "everything" before opening."

We also asked operational sites to describe any changes they would like to see in their centers. The most common responses centered around staffing, which is consistent with earlier data. Specific changes included covering staff shortages, increased staffing ratios, higher wages, and better staff integration and communication across multiple agencies. Several respondents talked about expanding current services, which in some cases was tied to staffing capacity. They would like to see additional substance use-specific resources such as medical detox and residential beds and increased housing resources for individuals who are displaced. Additional desired service expansion included for juvenile populations, offering an onsite pharmacy and Medicaid specialist, and better coordination with medical needs. Funding, increased education for community members, and transportation capacity were also mentioned.

Some sites offered specific advice for jurisdictions planning or implementing crisis centers:

> **Make sure the state Medicaid plan has sustainable rates in place before opening.**

> **Create ongoing connections to other centers for support and education.**

> **Make sure you are speaking to your neighbors, HOAs, and business groups constantly to avoid potential NIMBY and negative press effects.**

> **Peer support is crucial!**

> **If you build it or offer it, they will come.**

> **Develop trusting relationships with your community partners and hospitals.**

Additional Resources

General

- National Council for Mental Wellbeing. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.
- Arnold Ventures. (2020). Behavioral Health Crisis and Diversion from the Criminal Justice System: A Model for Effective Community Response.

Funding-Specific

- Crisis Now. (2022). Overview of Crisis Funding Sources Available to States and Localities.
- Crisis Now. (2022). Sustainable Funding for Mental Health Crisis Services: Healthcare Crisis Service Coding Guidelines to Support Standardized Billing and Access to Coverage from All Insurers.
- National Association of State Mental Health Program Directors. (2022). States' Options and Choices in Financing 988 and Crisis Services Systems.
- Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.

Learn More

If your jurisdiction is planning or implementing a crisis stabilization center and is interested in joining PRA's bimonthly Operationalizing Crisis Centers virtual learning community, please contact Ashley Krider at akrider@prainc.com.

Citation

Policy Research Associates, Inc. *From Planning to Practice: Insights from a Survey of Crisis Stabilization Centers*. Troy: Policy Research, Inc., 2024. https://www.prainc.com/resources/survey-crisis-stabilization-centers.

Acknowledgments

This report was created with support from the John D. and Catherine T. MacArthur Foundation as part of the Safety and Justice Challenge initiative, which seeks to address over-incarceration by changing the way America thinks about and uses jails. More information is available at www.SafetyandJusticeChallenge.org