CHEAT SHEET

for the entire health care ecosystem

The Role of Crisis Care in Behavioral Health Care

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Key takeaways

- Crisis care services are often patients' first entry point for behavioral health care, especially for the most marginalized and at-risk patients. After a crisis evaluation, patients are routed to clinical or non-clinical environments to receive follow-up care.
- Despite the importance of crisis response services, much of the services are funded through a patchwork system of state and local government funding and are expensive to maintain. Many U.S. communities do not currently have the crisis response infrastructure to meet demand.

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What is it?

Crisis care providers include call centers, clinics, psychiatric urgent care centers, mobile response teams, short-term care facilities, and emergency departments. These organizations offer services for patients who need immediate support for a behavioral health crisis to prevent them from hurting themselves or others. Behavioral health crises can arise from many circumstances including environmental stressors, an experience of violence or trauma, or changes in treatment or medication access or adherence.

Crisis response services are integral because they are often patients' first entry point for behavioral health care. And these services contribute to advancing equity because they are designed as "no-wrong-door" services. This means that the most marginalized and at-risk patients can receive services at no cost and avoid the burden of waiting for an appointment or navigating the confusing health care system. With that said, patients who receive crisis response services are receiving care at the last possible moment. A more equitable system would provide the most marginalized and at-risk patients with more accessible, affordable options prior to escalation.

To determine the level of crisis care needed, clinical staff conduct assessments in the following settings:

- **Regional crisis call center***:* 24/7 state or locally operated and clinically staffed crisis call centers that provides crisis intervention services through phone call, texting, or chatting services. The 988 lifeline, which was rolled out in July 2022, connects callers to the existing network of regional call centers around the United States.
- **Walk in crisis services***:* Clinics or psychiatric urgent care centers that offer immediate attention to resolve crisis (or recommend hospitalization as needed).

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WHAT IS IT?

Patients are then routed to crisis response services that can be delivered in either non-clinical or clinical environments. Non-clinical environments include:

- **Crisis receiving and stabilization facilities**: Provide short-term (less than 24 hours) observation and crisis stabilization services.
- **Family-based crisis home supports**: Deliver home-based practical and emotional support and treatment.
- **Crisis respite and apartments**: Offer 24-hour observation and support from crisis workers, trained volunteers, and peer support specialists. Patients can also receive this type of care at home if they do not need to be removed from their everyday environment.
- **Crisis mobile team response**: Meet individuals in need where they are located (e.g., home, workplace, other community-based locations) in a timely manner.

Clinical environments for crisis care include:

- **Crisis stabilization units (CSUs)**: Include inpatient facilities with 16 beds or less designed for patients with high acuity needs whose needs cannot be met in non-clinical environments.
- **Emergency departments (EDs)***:* Offer treatment to patients whose conditions may create safety concerns or for patients who don't know where else to go for care. Patients can then be triaged to the appropriate setting across the care continuum.

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How does it work?

Financial overview

Despite the importance of crisis response services, much of the services delivered in non-clinical environments are funded through a patchwork system of state and local government funding and are expensive to maintain. At the higher end, Arizona spends around $163 million per year, while Tennessee at the lower end spends around $45 million per year. Many states also fund these services through Medicaid (for example, Medicaid pays for 82% of Arizona's services). And while Medicaid can help cover these services, states must elect into such programs. Further, because the needs of crisis response care extend beyond Medicaid beneficiaries, it is insufficient to rely on Medicaid funding alone.

There are 326 U.S. cities with populations of over 100,000 that do not have the necessary crisis response infrastructure (or the finances in place) to meet patient need. There's concern that demand for crisis care will only increase due to the launch of the 988 lifeline in 2022 without the appropriate infrastructure to meet this demand. The Biden administration dedicated $432 million towards local and backup call centers to support the increased demand for services. However, research showed only 16% of 180 public health officials around the United States reported had planned a budget for 988 operations.

For many patients, that leaves only the ED as an option for crisis care. In 2017, the average cost to patients for an ED visit for mental health and substance use disorders was $520 per visit, similar to the average cost of $530 per visit for other ED visits. And according to the Agency for Healthcare Research and Quality, "the share of costs for ED visits resulting in admission to the hospital was larger for mental and substance use disorder ED visits than for all ED visits," at around 12% compared to 9%.

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