



OCTOBER 2023

Leading State Priorities and Considerations for Youth Crisis Receiving and Stabilization Facilities

Youth are experiencing unprecedented behavioral health needs, which have steadily increased over the past decade. At the same time, behavioral health systems continue to experience strain due to provider shortages, limited residential treatment options, and few early intervention options. Consequently, youth in crisis are increasingly seeking treatment in emergency departments or other high-acuity settings.

To support the behavioral health needs of youth, states are establishing youth-specific crisis receiving and stabilization facilities to provide immediate assessment, stabilization, and connection to appropriate services. See the case studies on [New York](#) and [Wisconsin](#) models to learn more about two states' approaches.



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Recent Trends in Youth Mental Health Needs

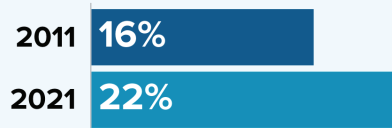
States are exploring strategies to improve access to comprehensive community-based mental health services, including the use of crisis receiving and stabilization facilities, to better meet the growing behavioral health needs of youth. Rates of poor mental health and suicidal thoughts among youth have increased dramatically over the past decade.¹ Nearly 30 percent of youth experienced persistent feelings of sadness and hopelessness in 2011 compared to over 40 percent in 2021.² During this same period, the rate of youth who seriously considered attempting suicide increased approximately 40 percent.³ Among these alarming trends, there are significant disparities. Nearly 60 percent of female youth and nearly 70 percent of LGBTQ+ youth experienced persistent feelings of sadness or hopelessness.⁴ Black and American Indian or Alaska Native youth reported significantly higher rates of attempted suicide compared to their White peers — approximately 50 to 80 percent greater, respectively.⁵ In addition, as many as 80 percent of youth in foster care⁶ and up to 70 percent of youth involved in the juvenile justice system⁷ experience serious behavioral health needs.

Rates of poor mental health and suicidal thoughts among youth

Experienced persistent feelings of sadness and hopelessness



Seriously considered attempting suicide



[“Youth Behavior Survey: Data Summary and Trends Report 2011-2021,”](#) U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2023.

At the same time, the rate of pediatric mental health hospitalizations increased by over 26 percent between 2009 and 2019.⁸ Among these hospitalizations, approximately 65 percent involved suicidal or self-harming behaviors.⁹ Similarly, the number of mental health-related emergency department (ED) visits among youth has increased over 50 percent from 2011 to 2020.¹⁰ The rate of youth presenting to EDs for suicide-related needs rose fivefold during this period.¹¹

Overview of Youth Crisis Receiving and Stabilization Facilities

Youth in crisis have historically been served in hospital EDs due to a variety of factors, including insufficient early intervention options (e.g., school-based mental health services and mobile response teams) and few pediatric inpatient beds.¹² ED settings are not well-equipped to properly respond to behavioral health crises and are often associated with longer stays and subsequent ED visits and higher health care costs.^{13,14} To best support the unique needs of youth in crisis, there is a priority to provide de-escalation and stabilization services within the home and community.¹⁵ However, this is not always possible for a variety of reasons, including limited availability of home- and community-based stabilization services or the need for a higher acuity of behavioral health care, such as inpatient psychiatric hospitalization or residential treatment.¹⁶



Crisis receiving and stabilization facilities are a critical component of the crisis care continuum (see graphic “Core Components of Child, Youth, and Family Crisis Continuum of Care”) and offer an intermediary option between home- and community-based stabilization and hospitalization. Crisis receiving and stabilization facilities may include crisis stabilization facilities, 23-hour observation units, and the Living Room Model (see text box “Types of Crisis Receiving and Stabilization Facilities”).¹⁷ These types of stabilization facilities primarily work to triage youth in crisis, connect them to outpatient services, and help them return home as quickly as possible.¹⁸ Crisis receiving and stabilization facilities vary in their design and structure, generally offering a home-like setting with a limited number of beds (i.e., 16 beds or fewer to comply with the [Institutions for Mental Diseases Exclusion](#)). Most of these types of facilities also have a maximum length of stay ranging from less than a day up to two or three weeks.¹⁹

Crisis receiving and stabilization facilities can help youth when they require more intensive care and safety measures than can be provided through home and community-based options.^{20,21} Relatedly, they may also help to divert youth from costly and unnecessary hospitalizations or can serve as a step-down service post-hospitalization to support youth to safely transition back into their communities, by offering short-term care in a safe environment.²² Most of these facilities are staffed by non-clinical providers (e.g., peer support providers, other crisis response providers), with psychiatrists or other credentialed clinical providers offering supervision and medical consultation as needed.²³

Crisis Receiving and Stabilization Facilities: Common Services and Settings

Common services provided by crisis receiving and stabilization facilities include, but are not limited to, assessment, rapid stabilization, observation, medication management, peer support, brief individual and family counseling, care coordination, linkages to outpatient services, and discharge planning.²⁴

23-Hour Observation Units: 23-hour observation units offer an alternative to EDs by providing 23-hour crisis respite and observation in a community-based setting in a home-like environment. These units are designed to provide short-term triage (i.e., fewer than 24 hours) to relieve crisis symptoms and connect those in crisis to an appropriate level of care (e.g., outpatient or inpatient services).

Living Room Model: The Living Room Model is a walk-in approach where individuals in crisis can work with multidisciplinary professionals and peers with lived experiences to receive immediate treatment services that provide relief. The Living Room Model provides crisis stabilization services longer than 23-hour observation units and provides more intensive treatment.

Crisis Stabilization Facility: Crisis stabilization facilities or centers offer a limited number of beds (i.e., six to 16) in a home-like environment in a community-based setting or as a separate unit of a hospital. These facilities operate 24 hours, seven days a week, allowing them to provide services to a youth in crisis at any time. Crisis stabilization facilities are more comprehensive than 23-hour observation units or the Living Room Model and are often secure settings (e.g., locked doors), but less restrictive than an inpatient setting.

Source: Saxon, et al., “Behavioral Health Crisis Stabilization Centers: A New Normal,” *Journal of Mental Health and Clinical Psychology*, 2018.

To learn more about state-specific approaches to youth crisis receiving and stabilization facilities, see [“Supporting Youth Behavioral Health through Crisis Receiving and Stabilization Facilities: New York Case Study”](#) and [“Supporting Youth Mental Health through Crisis Stabilization Facilities: Wisconsin Case Study.”](#)

States’ Priority Areas and Interests in Crisis Receiving and Stabilization Facilities

Crisis receiving and stabilization facilities are not a substitute for robust prevention and early intervention services. Rather, they are one component of a comprehensive system of behavioral health programs, services, and supports to prevent the escalation of need, promote mental health well-being, and improve outcomes. To best address the need for crisis care in behavioral health systems and other child-serving systems (e.g., child welfare and juvenile justice), states are working to ensure crisis stabilization and receiving facilities are fully integrated and aligned with the entire continuum of care and used only as appropriate. States are simultaneously prioritizing youth and family engagement and designing crisis receiving and stabilization facilities in accordance with the needs and strengths of those served in these settings.²⁵

As youth crisis receiving and stabilization facilities become more prevalent, states are establishing specific admission criteria, thoughtful licensure and provider requirements, and robust post-discharge planning.²⁶ In doing so, states are focused on ensuring these facilities are used appropriately and judiciously, including not being used to board youth or become a stand-in for inpatient and/or EDs. Even as states continue to invest in crisis receiving and stabilization facilities, the goal remains to connect youth to home- and community-based options whenever possible.²⁷

There is also a need to ensure youth crisis receiving and stabilization facilities are accessible. Several states are interested in designing crisis receiving and stabilization facilities using a “no wrong door” approach. Under this approach, youth and their families experiencing a crisis may present to a crisis receiving or stabilization receiving facility under any circumstances (e.g., transported by mobile crisis, law enforcement, or self-transported) without advanced approval. States are developing policies and procedures in which crisis receiving and stabilization facilities can provide supports and services on-site, or connect those with more intensive needs (e.g., active suicidal ideation) to a higher acuity setting, depending on the youth’s unique needs or circumstances.²⁸

Key Challenges and Barriers Operationalizing Crisis Receiving and Stabilization Facilities

As states continue to operationalize crisis receiving and stabilization facilities, several key challenges persist, primarily related to staffing, sustainable funding, and transportation. A central component of crisis receiving and stabilization facilities is that they can provide services to youth in crisis on a 24/7 basis. This requires facilities to be staffed at all times, including during periods of low or no utilization. To support 24/7 staffing, many crisis stabilization and receiving facilities operate a “firehouse model.” The specific structure of a firehouse model can vary, but it generally works to ensure staff are available for blocked periods of time during peak, off-peak, and on-call hours.^{29,30,31}

Despite these efforts, many states are experiencing significant staffing shortages. As a result, crisis receiving and stabilization facilities cannot open in certain locations or may need to operate under reduced hours (e.g., daytime only), creating disruptions in services to those in crisis. Additionally, states typically have specific provider requirements (e.g., licensure or certification) for crisis receiving and stabilization facilities. While these requirements provide important quality and safety controls, they can be a barrier for providers, prompting some facilities to seek waivers or variances in the certification process to maintain operations.³²

While crisis receiving and stabilization facilities operate on a 24/7 basis, there are fluctuations in demand for services. It is not uncommon to have open beds and/or periods of low utilization. However, crisis receiving and stabilization facilities are typically only able to receive Medicaid reimbursement for health-related services rendered.^{33,34} Maintaining the infrastructure, staffing, and administrative activities (i.e., nontreatment costs) are not usually billable expenses by Medicaid or other third-party payers.³⁵ As a result, states often use a complex arrangement of funding sources, including federal grants (e.g., Community Mental Health Services Block Grant), state general purpose revenue, and Medicaid — each paying for different components of crisis stabilization and receiving facilities (e.g., services versus administrative costs).³⁶ Identifying the most appropriate funding source for a given cost takes considerable time and cross-sector alignment.

Many states also face challenges transporting youth to and from youth crisis receiving and stabilization facilities. These facilities are not typically available in every community, which can result in long transfer times and additional strain on mobile crisis teams, law enforcement, and families, particularly in rural areas.³⁷ Relatedly, some states report difficulty discharging youth back to their homes due in part to the limited availability of home- and community-based behavioral health providers and services needed to support families caring for their children’s mental health needs.³⁸

Emerging Opportunities and Strategies to Effectively Implement Crisis Receiving and Stabilization Facilities

States are applying innovative strategies, such as providing services for the whole family, seeking input from those with lived experiences, implementing Medicaid managed care (MMC) program flexibilities, and building comprehensive post-discharge services. Some states are using a whole-family approach to mental health care whereby services consider health-related social needs together with mental health services. Applying a whole-family approach within behavioral health settings, including crisis receiving and stabilization facilities, may also address the caregiver's trauma associated with their child being in crisis or other pre-existing trauma with the caregiver.

Similarly, states recognize needs beyond basic services for youth in crisis and are working to ensure that crisis settings are informed by families and youth with lived experience of mental illnesses and substance use disorders. Increasingly, states are seeking input and guidance on ways to incorporate child and family lived experiences to help ensure crisis receiving and stabilization facilities are fully integrated and aligned with other child-serving systems. Some states are including family representation on advisory boards. Wisconsin's Office on Children's Mental Health requires that its [Advisory Council](#) membership is comprised of individuals with lived experience. Kentucky's Cabinet for Health and Family Services created the [State Interagency Council for Services and Supports to Children and Transition-age Youth \(SIAC\)](#). The SIAC includes a parent of a child or transition-age youth with behavioral health needs.

To address financial challenges, many states use a multi-pronged approach to fund crisis stabilization and receiving facilities, braiding various federal and state funding sources, including Medicaid. One such strategy is the use of specialized MMC programs to help establish and sustain these facilities as they can offer more flexibility than standard managed care or fee-for-service (FFS) systems. [Foster care-specific MMC programs](#) in particular are being used by states to provide additional supports for youth in foster care in need of youth crisis stabilization and receiving facilities. For example, at least one state contracts with a specialized MMC entity that provides start-up funds to crisis receiving and stabilization providers to support the continuum of care across systems. Specialized foster care MMC plans may pay for empty beds in some crisis-type facilities to support enhanced capacity (e.g., as [a value-added benefit](#)). States are also working to identify alternative approaches to transportation, such as allowing foster care parents and others to be reimbursed as non-emergency medical transportation (NEMT) providers.

States are also incorporating evidence-based practices and policies in the development of youth crisis receiving and stabilization facilities to ensure a continuum of crisis services. Select policies include closely monitoring the average length of stay and providing post-discharge planning, including connection to intensive care coordination services to support a successful transition from crisis stabilization facilities.

Key Considerations for Effectively Implementing Crisis Receiving and Stabilization Facilities

As states continue to design and implement youth crisis receiving and stabilization facilities, they may want to consider several key strategies to ensure these settings align with the broader crisis continuum of care and meet the comprehensive needs of youth and their families. Select considerations for states include:

Building sustainable financing mechanisms:

As discussed earlier, there is no one dedicated funding source that can adequately support crisis receiving and stabilization facilities. As such, states will need to carefully weigh which financing mechanisms (e.g., state general revenue, federal grants, Medicaid) are best suited to fund these facilities. Given that Medicaid covers over 27 million children³⁹ and is the single largest payer for mental health services in the U.S.,⁴⁰ it is a core financing consideration for most states. To use Medicaid to support crisis receiving and stabilization facilities, states may want to assess which federal authority is best suited to their needs (e.g., [state plan amendment](#) versus a [Medicaid waiver](#)).

States may then want to consider how Medicaid reimbursement is structured for youth crisis stabilization and receiving facilities, such as FFS or capitated payments. Many states offer reimbursement for crisis receiving and stabilization facilities on an FFS basis using a daily (e.g., crisis per diem) or hourly rate (e.g., crisis hourly professional billing) given the time-limited nature of services provided. However, to help address reimbursement challenges and align with the firehouse model, states are increasingly exploring the role of MMC programs to support crisis receiving and stabilization facilities under a capitated payment. Under this capitation approach, crisis services are reimbursed on a per-member, per-month basis that is based on the total number of Medicaid beneficiaries in a particular area at the time rates are established, not based on the number of people receiving services. In selecting an approach, states will want to weigh the relative advantages and disadvantages of these Medicaid policy levers to determine the most cost-effective approach with the least administrative burden, while ensuring stable, continuous, and accessible coverage for youth crisis services.

Ensuring appropriate 24/7 access to services:

States vary in how they establish criteria for the design and implementation of youth crisis receiving and stabilization facilities. Yet, all states strive to make these facilities available 24/7 to ensure services are accessible to those in need. To optimize access, states may want to consider how to support staffing capacity and transportation. To ensure adequate staffing capacity, states will need to consider the level of care (e.g., high intensity/high acuity versus low intensity/low acuity) that will be offered, which can impact staff qualification and certification requirements and staff ratios. Relatedly, states may want to explore strategies to ensure adequate transportation, including [guidance from the Centers for Medicare and Medicaid Services to states](#) that allows Medicaid reimbursement for mobile teams to transport individuals to crisis stabilization units, as well as other flexibilities available through Medicaid (e.g., gas reimbursement to nontraditional NEMT providers).⁴¹

States may want to consider how crisis stabilization and receiving facilities can meet the unique needs of specific populations, such as youth with intellectual and developmental disabilities (I/DD). Youth with I/DD often have greater behavioral health needs and may require specific interventions beyond the basic level of services,⁴² which may impact staffing needs, treatment options and approaches, and operational policies, among other aspects.

Integrating crisis receiving and stabilization facilities into the crisis continuum of care:

Crisis receiving and stabilization facilities are one component of the crisis continuum of care. These facilities may be used as a stepdown option for youth who do not require hospitalization or inpatient care following a crisis episode. States may want to consider how to ensure these settings are fully integrated to streamline connection to appropriate services. To support this, states may explore evidence-based practices such as post-discharge planning, intensive wraparound services, and follow-up supports. Ongoing mental health care may be needed for youth once they return home, and these services can be provided in various settings, including the home. States may want to prioritize efforts to establish and ensure the continued provision of adequate [home- and community-based services](#) for youth and families to improve mental health outcomes and reduce youth readmissions to crisis receiving and stabilization facilities.⁴³ Beyond integration, states may also want to consider how crisis receiving and stabilization facilities can be used to better align with broader efforts of the comprehensive system of behavioral health programs and services to improve outcomes and overall well-being.

Because many youth who experience behavioral health crises often are involved with multiple systems,⁴⁴ states may want to consider how to coordinate and align crisis services, including crisis receiving and stabilization facilities, with child welfare and juvenile justice systems to prevent duplication of services and strengthen care coordination. States may consider implementing specific policies or procedures within crisis stabilization facilities for children in foster care or at risk of out-of-home placement.

Integrating lived experience and family-centeredness:

States may want to consider how to meaningfully engage and partner with youth and families with lived experience (e.g., [strategy to support integrated care coordination](#) for children and youth with special health care needs) during the design, implementation, and ongoing operationalization of youth crisis receiving and stabilization facilities. In doing so, states can design programs that reflect the needs of families and the community, as well as foster trust and supportive relationships between service providers and youth and their families. States may also consider exploring how crisis stabilization and receiving facilities can incorporate a family-centered approach. Because child emotional and behavioral health depends on a healthy family environment,⁴⁵ assessing and addressing the mental health needs of the whole family, not just the youth in crisis, can provide families important tools, strategies, and resources to support their child's care post-discharge. Select efforts may include providing trauma supports for parents and caregivers during the intake process and connecting families with peer support specialists.

States are increasingly implementing youth crisis receiving and stabilization facilities to support youth in crisis who require more intensive care and safety needs than can be provided through home and community-based options. As states continue to explore opportunities to address the growing youth behavioral health crisis, they may want to consider, in conjunction with families and youth with lived experience, how crisis receiving and stabilization facilities can be effectively integrated within a comprehensive system of behavioral health programs, services, and supports and as part of a crisis continuum of care. In doing so, states can optimize available resources to ensure crisis receiving and stabilization facilities align, and are responsive to, those experiencing a behavioral health crisis while also connecting youth to other critical services and supports to promote their overall well-being.

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Acknowledgements

This policy brief was written by Veronica Thompson and Robin Buskey. Several NASHP staff contributed to the brief through input, guidance, or draft review, including Karen VanLandeghem and Heather Smith. NASHP wishes to thank officials at the Health Resources and Services Administration, Maternal and Child Health Bureau, for their review.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UD3OA22891, National Organizations of State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the U.S. government.



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