An Imperfect Guide to Crisis Stabilization Units: Matching the Right Level of Care to Individual Needs

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Article

Here's how having a clear understanding of the services different crisis stabilization units provide can help communities serve the unique needs of each individual in crisis without unnecessarily restrictive or intensive levels of care.

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CRISIS CONNECTIONS

Bipartisan support and increased funding have led to unprecedented interest in and expansion of behavioral health crisis services. As described in my recent feature, "Behavioral health crisis care's carpe diem moment,"[1] this interest has only increased with the launch of the 988 Suicide & Crisis Lifeline, the impact of the COVID-19

pandemic on mental health, and reform efforts to create alternatives to police response to mental health emergencies.

The Substance Abuse and Mental Health Services Administration (SAMHSA) national guidelines for crisis care[2] outline a vision in which an individual in crisis always has "someone to call, someone to respond, and a safe place to go." Many communities across the United States have subscribed to this vision and made strides in bringing it to life, but most communities are lacking the critical third pillar of the vision: a safe place to go.

According to a RAND survey[3] on preparedness for 988 throughout the United States, 81% of surveyed agencies stated they did not have sufficient psychiatric bed capacity in their jurisdiction, and 93% of surveyed agencies stated the emergency department (ED) at a general hospital served as the major entry point for someone to receive mental health care.

Specialized crisis facilities provide a safe and therapeutic alternative to hospital EDs, inpatient psychiatric units, and jails, and many communities are in various stages of creating crisis stabilization units to fulfill this need. However, crisis facilities vary widely in scope, capability, and populations served, and facility licensure and nomenclature differ from one state to another, and even within some states.

Some facilities are designed for individuals with low acuity who primarily need peer support and a safe place to spend the night, whereas others can treat individuals with the highest acuity presenting with suicidal behaviors, acute agitation, and substance intoxication/withdrawal. Some are freestanding, whereas others are embedded in or attached to hospital EDs.

Lack of a shared understanding of the capabilities of each type of facility can lead to unsafe conditions (eg, when an individual with high acuity is sent to a facility that is unable to safely address their needs), delays in treatment (eg, disputes over whether a facility should accept a referral), and ineffective system planning (eg, creating a system unable to serve certain populations).

As the crisis field continues to develop, a standard classification system for facility-based crisis services is needed to distinguish between the range of facilities currently encompassed by the term *crisis stabilization unit*. The emergency medical field learned

long ago that the ability to differentiate hospitals based on their capabilities is critical for developing well-organized systems of care.

For example, trauma center classification into Levels I through IV provides a foundation for regional governing bodies to coordinate patient flow, geographic access, and outcome measurement. An analogous national standard for crisis facilities would:

1. Improve safety and quality of care by ensuring that individuals are matched to facilities that can meet their needs.
2. Support sustainable financing by providing a framework for reimbursement to reflect the intensity of the services provided.
3. Aid in organizing regional crisis systems that serve all populations—rural and urban, high acuity and low acuity, voluntary and involuntary—across a geographical region.
4. Lay the foundation for consistent licensing, accreditation, and outcome measurement.

An Imperfect Guide to Crisis Stabilization Facilities

As a starting point, we have created this "imperfect guide to crisis stabilization facilities" to begin to differentiate the types of crisis facilities that currently exist. The guide categorizes facilities by the acuity of the population they serve and the intensity of the treatment the facility is designed to provide.

We reference the Level of Care Utilization System (LOCUS)[4] and American Society for Addiction Medicine (ASAM) criteria[5] as standard frameworks for defining acuity and service intensity. These frameworks assess needs based on multiple dimensions (eg, risk of harm, engagement/motivation for change, acute behavioral and physical health needs, living environment) and then describe the level of care needed to address those needs.

In practice, these differences are manifested by differing levels of psychiatric, nursing, programming, and physical plant capabilities. We then categorize different facility types along a high, medium, or low acuity/intensity continuum. An overview of each category is described in the **Figure**, along with a list of the types of facilities typically included in each category.

A more detailed description of each type of facility can be found in the *Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards, and Best Practices for Behavioral Health Crisis Response*6 and in this recent review.[7]

Figure. *An Imperfect Guide to Facility-Based Crisis Services*

Core Capabilities

All crisis facilities should be able to provide care that is recovery-oriented and focused on helping the individual return to community-based care. Other core capabilities include:

- Safe and therapeutic milieu
- Peer support and engagement
- Care coordination and help with social determinants of health
- Trauma-informed approaches
- Ability to address co-occurring mental health and substance use disorder needs

As a general rule, crisis facilities should be able to care for individuals who, if not for their behavioral health crisis, would be able to return home without the need for home health or other specialized nursing care. Crisis programs should have clear admission criteria and the capability to screen for medical conditions that need further evaluation and treatment. They should not require all referrals to receive screening evaluations in the ED prior to admission.

High Intensity/High Acuity Crisis Facilities

LOCUS Level 6: Medically Managed Residential Services

ASAM 3.7-WM: Medically Supervised Withdrawal Management

High intensity/high acuity crisis stabilization units are designed to provide services for individuals who are actively suicidal, intoxicated, experiencing withdrawal, acutely agitated, and/or violent. They are the crisis equivalent of a Level 1 trauma center. Without this level of care, individuals who are too acute for other crisis programs have no other options but the ED or jail.

High intensity/high acuity facilities must be available to serve as a "receiving center" for law enforcement and first-responder drop-offs and have the capability to accept both voluntary and involuntary individuals. To incentivize emergency responders to bring individuals to treatment instead of utilizing jail or emergency departments, the facility must be available 24/7/365, accept 100% of first responder drop-offs, and have rapid drop-off times ideally under 10 minutes.[8,9]

These facilities provide intensive treatment to individuals who meet hospital inpatient criteria and are highly monitored to keep individuals receiving care and staff safe. They are not simply holding areas for boarding patients awaiting transfer to an inpatient unit—rather, they provide short-term intensive treatment focused on rapid assessment, early intervention, and proactive discharge planning. Most individuals can be stabilized and discharged within 24 hours, resulting in reduced inpatient psychiatric hospitalization, ED boarding, and arrests.

Care is provided onsite 24/7/365 by an interdisciplinary team that includes psychiatrists, nurses, behavioral health technicians, case managers, social workers, and peers. Ideally, these facilities blend hospital-level safety standards (eg, anti-ligature design) with the more holistic and person-centered aspects of the recovery model to create a safe and therapeutic milieu. Lengths of stay are typically designed to be short (under 24 hours). An affiliated subacute unit can provide brief inpatient-like care for individuals needing additional short-term stabilization, which could last up to several days.

Facility types in this category: Crisis receiving centers, 23-hour observation units, and comprehensive psychiatric emergency programs (CPEPs) can be free-standing or associated with/attached to a psychiatric hospital or ED. Psychiatric emergency services (PES) and emergency psychiatry assessment treatment and healing (EmPATH) units are typically, but not always, ED/hospital associated.

Low Intensity/Low Acuity Crisis Facilities

LOCUS Level 5: Medically Monitored Residential Services

Clinically Managed Withdrawal Management (ASAM 3.2-WM)

On the opposite end of the continuum are facilities that are designed to provide services to individuals of lower acuity who are non-violent, not acutely suicidal, and

motivated to receive help, and who may need help with social stressors like unstable food, social supports, income, or housing. Without this level of care, individuals may end up in care settings more restrictive and resource-intensive than needed or wait until the situation escalates to a higher acuity crisis before seeking care.

These facilities are typically unlocked, have more "home-like" environments, and are primarily staffed by peers with lived experience and social services staff. Individuals may access these facilities directly or via transfer or step-down from higher levels of care such as high intensity/high acuity crisis centers, inpatient units, or EDs. Some of these programs accept direct police or mobile team drop-offs if people meet admission criteria.

With a lower acuity population, medical and nursing staff are not required onsite 24/7/365; instead, they will meet with individuals receiving care once a day or on an as-needed basis. For individuals needing withdrawal management, these facilities may provide clinically managed "sobering" or "social detox." Lengths of stay can be short (under 24 hours) or longer (days to weeks).

Facility types in this category: living rooms, crisis respite, peer respite, social detox, and sobering centers

Medium Acuity/Medium Intensity Crisis Facilities or "The Zone of Variability"

LOCUS Level 5: Medically Monitored Residential Services

Clinically Managed (ASAM 3.2-WM) or Medically Managed (3.7) Withdrawal Management

In between high and low acuity programs is a "zone of variability" in which it is difficult to determine the capabilities of the program by its name alone. The acuity of the individuals who can be safely served in each setting depends on the level of medical and nursing involvement.

Psychiatric coverage is typically a mix of onsite and on-call coverage, and nursing involvement can range from 24/7 onsite nursing care to various combinations of onsite and on-call coverage. Staffing often includes a combination of peers, social workers, therapists, behavioral health technicians, and sometimes emergency medical

technicians (EMTs). Lengths of stay can be short (under 24 hours) or longer (days to weeks).

Until classification standards are developed, it is critical for communities to have a clear definition and understanding of the clinical capabilities and admission criteria for crisis programs in this zone. Specific considerations include the level of psychiatric/nursing support, level of agitation/behavioral acuity that can be managed in the facility, and level of withdrawal management.

Lack of a clear understanding of the capabilities of each type of facility can lead to unsafe conditions (eg, when an individual with high acuity is sent to a facility that is unable to safely address their needs), delays in treatment (eg, disputes over whether a facility should accept a referral), and suboptimal system planning (eg, creating a system unable to serve certain populations such as involuntary patients).

Facility types in this category: crisis residential, medically managed detox centers, clinically managed sobering and social detox centers, some crisis receiving centers, and some living rooms/peer respite

Looking Forward

With increased funding and bipartisan support for crisis services, it is our hope that more communities will be able to develop sustainable systems that provide safe and effective emergency response and treatment for individuals experiencing mental health and substance use disorder emergencies. Having a clear understanding of what services different crisis stabilization units provide enables communities to serve the unique needs of each individual in crisis without unnecessarily restrictive or intensive levels of care.

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