CALIFORNIA INITIATIVE
FOR HEALTH EQUITY
AND ACTION

Crisis Stabilization Units: A Community-Based Alternative for Inpatient Mental Health Care

Section 1: Background/Overview

Crisis stabilization units (CSU) are "front doors" to public behavioral health care by providing assessment, outpatient therapy, telephone hotline, referral to follow-ups and community resources, and mobile outreach in facilities that cover a specific geographic region [1]. CSUs aim to reduce the impact of mental health emergencies through immediate response to crisis situations and through coordination with local public safety organizations, hospitals, and other community organizations.

The goal of CSU is to stabilize and reintegrate individuals with crises into the community quickly. During an individual's time in a CSU, staff provide supportive care and attempt to secure referrals for appropriate long-term services or inpatient care. CSUs provide services that are particularly important because the availability of inpatient mental health care and reliable access to outpatient care have diminished over time [2]. As such, without CSUs to support communities, patients with mental illness experience acute psychiatric crises, which unnecessarily shifts mental health care to the criminal justice system and emergency departments (ED).

Patients with severe mental illness are high utilizers of EDs, have high hospitalization rates, long lengths of stay, and frequent return visits to EDs [3, 4]. From 2009 to 2014, there were 846,867 ED visits by adult patients with mental illness to EDs in California, of which 28.2% were frequent ED utilizers. Patients with substance use disorders, homelessness and public healthcare coverage are more likely to be frequent users of EDs for mental illness [5]. Moreover, between 20% to 50% of incarcerated individuals suffer from a serious mental illness, and outpatient mental health services would have prevented them from committing a crime in the first place [6].

Section 2: Research Findings

Funding Sources

The most commonly described funding sources for crisis services in the U.S. are state and county

general funds and Medicaid waivers [1]. Though states finance crisis services in diverse ways, many use a combination of funding mechanisms to assure that patients receive support, regardless of their insurance status. Through California's 1915(b) SMHS Waiver, 56 local county mental health plans (MHPs) are responsible for the local administration and provision of substance and mental health services (SMHS).[1] The Department of Health Care Services contracts with each of the 56 MHPs to provide or arrange for the provision of SMHS.

In 2004, California voters passed Proposition 63, which created the Mental Health Services Act (MHSA) and places a 1% tax on the adjusted gross income of earnings over $1 million [7]. The MHSA offers augmented funding, personnel and other resources to support county mental health programs and monitor advancement toward statewide goals for families, children, transition age youth, adults, and older adults [8]. Moreover, SB 82 established the "Investment in Mental Health Wellness Act of 2013", which requires that counties have sufficient community-based resources to meet the mental health needs of eligible individuals [9], which expands the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs. Starting in 2015, counties applied for mental health funding through SB 82 to create Crisis Stabilization Units (CSU), Crisis Residential Units (CRU), Mobile Crisis Programs (MC), Peer Respite Services (PRS) across the State [10].

Table 1. 2016 Funding Awarded by California Health Facilities Financing Authority (CHFFA)

	Crisis Stabilization Units	**Crisis Residential Units**	**Mobile Crisis Programs**	**Peer Respite Services**
# of Beds	281	901	63 (vehicles)	
Total Funds	$36,407,735	$94,036,991	$3,016,171 + $3,998,943 for personnel	Capped at $3,000,000

Source: (2016). CHA Summary: Investment in Mental Health Wellness Act of 2013 - SB 82. 2014-2016. California, California Hospital Association. https://www.calhospital.org/sites/main/files/file-attachments/sb_82_grants.pdf?1466786478

Moreover, for grant period 2014-2017, the Mental Health Services Oversight and Accountability Commission (MHOAC) awarded a total of $117,228,640 of Triage Personnel Funding [10]. The purpose of the Triage Funding was to increase the number of personnel to provide crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services. Individuals experiencing a mental health crisis were assisted in various settings such as schools, shelters, clinics, jails, and in the community [11]. These funds provided an opportunity for counties and city behavioral health departments to reduce the costs associated

[1] https://www.dhcs.ca.gov/services/Documents/CA-Public-MH-SUD-Services-Overview.pdf

with long stays in EDs, linked services for those released from jails, and reduced the time spent by law enforcement on mental health crisis calls [11]. A second round of triage grants was awarded in 2018 for a 3-year period. As seen in Table 2 there are currently 30 triage programs operating in 20 California counties.

Table 2. Triage Grant Round 2 Recipients

Alameda County	Adult/Transition Age Youth	$ 3,759,492.06
Berkeley City	Adult/Transition Age Youth	$ 614,834.50
	Children and Youth	$ 216,098.53
Butte County	Adult/Transition Age Youth	$ 514,743.27
The California Association of Health and Education Linked Professions	School/County Collaborative	$ 5,293,367.35
Calaveras County	Adult/Transition Age Youth	$ 212,070.65
	Children and Youth	$ 366,562.87
Humboldt County	Adult/Transition Age Youth	$ 690,935.48
	Children and Youth	$ 512,712.74
	School/County Collaborative	$ 5,293,367.35
Los Angeles County	Adult/Transition Age Youth	$ 17,558,366.98
	Children and Youth	$ 13,755,073.37
Merced County	Adult/Transition Age Youth	$ 718,033.99
Placer County	Adult/Transition Age Youth	$ 799,922.38
	Children and Youth	$ 1,036,123.02
	School/County Collaborative	$ 5,293,367.35
Riverside County	Children and Youth	$ 1,436,318.53
Sacramento County	Adult/Transition Age Youth	$ 2,837,194.79
	Children and Youth	$ 1,684,568.99
San Francisco County	Adult/Transition Age Youth	$ 1,660,526.51
San Luis Obispo County	Children and Youth	$ 371,233.73
Santa Barbara County	Children and Youth	$ 882,415.63
Sonoma County	Adult/Transition Age Youth	$ 1,194,097.57
Stanislaus County	Adult/Transition Age Youth	$ 893,320.67
	Children and Youth	$ 422,127.70
Tulare Office of Education	School/County Collaborative	$ 5,293,367.34
Tuolumne County	Adult/Transition Age Youth	$ 461,370.50
Ventura County	Adult/Transition Age Youth	$ 1,754,732.93
Yolo County	Adult/Transition Age Youth	$ 207,908.65
	Children and Youth	$ 207,921.35

Source: (2019). "Triage Services." What We Do from https://www.mhsoac.ca.gov/what-we-do/triage/triage-program-overview

Along of with the aforementioned community-based services funded through SB 82, DHCS also funds Community-Residential Treatment Systems (CRTS). CRTS program services include a full-day treatment program with an active prevocational and vocational component, special education services, outreach and counseling. The mental health program components of CRTS are certified by the DHCS.[2]

There are currently 150 CRTS that are certified by DHCS with a total of 1,738 beds. In May 2019, the California Department of Developmental Services (CDDS) released its payment range rates for community-based day programs and in-home respite agencies effective for May 1, 2019 to April 30, 2020. Moreover, CDDS also released it Community Care Facility Rate for facilities with four or less beds. Facility rates vary by county, by the number of consumers served, and by the staffing ratio at each facility.

According to DHCS, adult Crisis Residential Services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The adult crisis residential programs provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

DHCS also funds Residential Treatment Services, which are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral.

DHCS also funds Crisis intervention and Crisis Stabilization services. The former last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community. Crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a timelier response than a regularly scheduled visit. Both intervention and stabilization service activities include but are not limited to one or more of the following: assessment, collateral, and therapy.

[2] https://www.dhcs.ca.gov/services/MH/Pages/MentalHealthTreatmentProgramscertifiedbyDHCSare.aspx

In Table 3 through Table 6, the number of Medi-Cal clients, units of mental health service, cost per unit, and approved amounts by service type are provided for 2013 through 2018 for adult crisis residential services, residential services, crisis stabilization, and crisis intervention services. Medi-Cal claims data are used for all years until 12/31/2018, with a forecast provided for FY 2019-20.

Table 7 and Table 8 provide figures on the number of Medi-Cal beneficiaries who were hospitalized in an inpatient psychiatry unit, along with the number of days and the cost per day for the hospitalization. Medi-Cal claims data are used for all years until 12/31/2018, with a forecast provided for FY 2019-20.

Table 3. Adult Crisis Residential Services Approved Claims Data

	Adult Crisis Residential Services - SMA(1) $345.38				
FY	Number of Clients	Number of Days	Days Per Client	Cost Per Day	Approved Amount
2013-14	5,704	94,271	16.52	$ 334.80	$ 31,561,687
2014-15	7,306	120,470	16.49	$ 339.44	$ 40,892,508
2015-16	7,343	130,265	17.55	$ 358.38	$ 46,763,571
2016-17	8,039	141,749	17.59	$ 371.83	$ 52,709,740
2017-18	8,314	152,684	18.80	$ 375.19	$ 56,982,378
2018-19	8,473	162,132	20.17	$ 378.93	$ 61,304,522
2019-20	8,510	174,452	21.28	$ 382.66	$ 66,797,642
Change	0.44%	7.60%	5.50%	0.98%	8.96%

(1) The State Maximum Allowance (SMA) for FY 11/12 is noted here as a historical reference and was removed as maximum rate for computing federal reimbursement for dates of service beginning July 1, 2012 per AB 1297.
Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

Table 4. Adult Residential Services Approved Claims Data

	Adult Residential Services - SMA(1) $168.46				
FY	Number of Clients	Number of Days	Days Per Client	Cost Per Day	Approved Amount
2013-14	1,330	116,144	87.33	$ 174.61	$ 20,279,367
2014-15	1,541	127,702	82.87	$ 184.99	$ 23,623,998
2015-16	1,514	135,244	83.86	$ 186.99	$ 25,462,736
2016-17	1,585	148,641	93.69	$ 197.80	$ 29,393,748
2017-18	1,587	160,196	100.08	$ 199.66	$ 31,810,857
2018-19	1,634	170,106	107.41	$ 201.64	$ 34,236,092
2019-20	1,667	183,030	113.33	$ 203.61	$ 37,300,149
Change	.02%	.60%	5.51%	0.98%	8.95%

(1) The State Maximum Allowance (SMA) for FY 11/12 is noted here as a historical reference and was removed as maximum rate for computing federal reimbursement for dates of service beginning July 1, 2012 per AB 1297.
Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

Table 5. Adult Crisis Stabilization Services Approved Claims Data

	Crisis Stabilization Services - SMA(1) $94.54				
FY	Number of Clients	Number of Hours	Hours Per Client	Cost Per Hour	Approved Amount
2013-14	34,235	794,878	23.22	$108.03	$85,870,355
2014-15	47,568	1,117,043	23.48	$114.20	$127,562,659
2015-16	50,580	1,251,290	24.53	$112.28	$141,496,734
2016-17	54,773	1,323,620	24.11	$107.93	$154,106,894
2017-18	54,950	1,425,680	25.75	$117.53	$166,639,473
2018-19	55,923	1,513,760	27.63	$118.70	$179,178,437
2019-20	56,581	1,628,651	29.15	$119.87	$195,230,908
Change	.18%	7.59%	3.57%	0.99%	8.96%

(1) The State Maximum Allowance (SMA) for FY 11/12 is noted here as a historical reference and was removed as maximum rate for computing federal reimbursement for dates of service beginning July 1, 2012 per AB 1297.
Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

Table 6. Adult Crisis Intervention Services Approved Claims Data

	Crisis Intervention Services - SMA(1) $3.88				
FY	Number of Clients	Number of Minutes	Minutes Per Client	Cost Per Minute	Approved Amount
2013-14	35,939	8,188,687	227.85	$ 4.35	$ 35,657,233
2014-15	46,625	10,569,517	226.69	$ 4.61	$ 48,683,642
2015-16	47,558	11,357,589	236.58	$ 4.82	$ 54,619,014
2016-17	51,967	13,147,551	251.13	$ 5.09	$ 66,947,806
2017-18	52,105	14,115,280	268.24	$ 5.14	$ 72,124,714
2018-19	52,627	14,987,478	287.89	$ 5.19	$ 77,554,770
2019-20	53,793	16,125,160	303.67	$ 5.24	$ 84,499,435
Change	2.22%	7.59%	5.48%	0.96%	8.95%

(1) The State Maximum Allowance (SMA) for FY 11/12 is noted here as a historical reference and was removed as maximum rate for computing federal reimbursement for dates of service beginning July 1, 2012 per AB 1297.
Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

Table 7. Adult Psychiatric Inpatient Hospital Services - FFS/MC Approved Claims Data

	Psychiatric Inpatient Hospital Services - FFS/MC				
FY	Number of Clients	Number of Days	Days Per Client	Cost Per Day	Approved Amount
2013-14	18,433	226,387	12.28	$ 686.09	$ 155,321,773
2014-15	23,971	275,944	11.51	$ 731.94	$ 201,973,987
2015-16	25,871	304,756	11.78	$ 761.41	$ 232,043,950
2016-17	26,896	327,468	12.18	$ 785.53	$ 257,235,054
2017-18	28,830	342,785	11.89	$ 833.55	$ 285,729,505
2018-19	31,417	365,567	11.64	$ 854.98	$ 312,551,954
2019-20	33,999	388,348	11.42	$ 873.89	$ 339,374,402
Change	8.22%	6.23%	-1.89%	2.21%	8.58%

Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

Table 8. Adult Psychiatric Inpatient Hospital Services - Short-Doyle Medi-Cal (SD/MC) Approved Claims Data

	Psychiatric Inpatient Hospital Services - SD/MC - SMA (1) $1,213.75				
FY	Number of Clients	Number of Days	Days Per Client	Cost Per Day	Approved Amount
2013-14	7,908	78,687	9.95	$1,281.45	$ 100,833,142
2014-15	10,196	94,872	9.30	$1,436.62	$ 136,294,610
2015-16	9,319	96,795	10.31	$1,241.44	$ 120,309,211
2016-17	8,863	91,718	10.33	$1,229.57	$ 113,466,732
2017-18	8,690	106,728	11.95	$1,224.68	$ 130,234,909
2018-19	9,028	113,317	12.83	$1,236.82	$ 140,103,284
2019-20	9,175	121,910	13.53	$1,248.95	$ 152,634,256
Change	1.63%	7.58%	5.46%	0.98%	8.94%

(1) The State Maximum Allowance (SMA) for FY 11/12 is noted here as a historical reference and was removed as maximum rate for computing federal reimbursement for dates of service beginning July 1, 2012 per AB 1297.
* The daily rate for SD/MC hospitals includes the cost of any needed professional services.
Source: https://www.dhcs.ca.gov/Documents/SMHS-Supplement-May2019.pdf

In California, the FY 2019-2020 projected cost for adult crisis residential services is $382.66 per patient per day; $203.61 residential services per patient per day; $119.87 for crisis stabilization per patient per day; and $5.24 for crisis intervention services per patient per day. On the other hand, the FY 2019-2020 projected cost for psychiatric inpatient hospital services is $873.89 and $1,248.95 per patient per day for fee for service hospitals and Short-Doyle Medi-Cal hospitals. For FY 2019-2020, Medi-Cal is projected to pay $492,008,658 for in-patient psychiatric care compared to a combined $383,828,134 for crisis residential services, residential services, crisis stabilization, and crisis intervention services.

Medicaid is expected to finance a large and growing share of mental health treatment spending. Nationally, public funding sources for mental health, represented as a percentage of total mental health expenditures, were distributed as follows: 27% Medicaid, 13% Medicare, 15% state and local and 5% other federal [12]. Public funding for substance abuse expenditures were more heavily distributed towards state and local funding with the following distribution: 31% state and local, 21% Medicaid, 11% federal and 5% Medicare [12].

Quality and Satisfaction

Along with the cost-savings aspect of CSUs, important satisfaction indicators specified by participants include freedom, safety, less coercion, lower levels of disturbance, mutual support and friendship from other service users, the homelike environment, and access to staff found in these units [13].

Cost-Effectiveness

Various studies have found that acute residential mental health services offer treatment outcomes equivalent to those of inpatient units, with users reporting high satisfaction and offer a cost-

effective alternative to inpatient services [14]. Below, cost-effectiveness and return on investment (ROI) are specified for different components of CSU services.

Crisis Stabilization Cost-Effectiveness

In a 2013 study by Wilder Research (2013), Medicaid claims data were used to calculate ROI of mental health crisis stabilization programs in the metropolitan area of Minnesota. The authors examined the impact of the program on utilization of health care including ED use, outpatient services, and inpatient psychiatric services [15].

- For every $1 spent on CSUs, there is a savings of $2.00 - $3.00 in hospitalization costs;
- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients.
- Significant decreases in mental health-related admissions were observed for patients;
- ED utilization decreased significantly post-crisis stabilization for all patients, including "high-frequency" patients; and
- Total costs for all-cause inpatient hospitalization decreased from $2.9 million prior to crisis stabilization to $1.7 million post stabilization.

A 2016 study evaluated the effects of the decrease in behavioral health services resulting from the 2009 Sacramento county CSU closure on the use of ED services at the adjacent UC Davis Medical Center [16]. After the closure of the CSU and the overall decrease in county mental health services,

- The number of psychiatry consultations in the adjacent university ED tripled,
- ED psychiatric visits doubled;
- ED length of stay for the patients requiring this service increased from 12.1 hours before the closure and 21.9 hours afterward, a difference in means of 7.9 hours;
- There was a 64% increase in wait times for psychiatric evaluation;
- The frequency of both high- and low-severity psychiatric complaints increased; and
- A 5-fold increase occurred in daily ED bed hours occupied by a patient receiving psychiatry consultation.

Residential Crisis Care Cost-Effectiveness

- A study by Fenton et al., (2002) found that residential care was less expensive for both the period of admission and the six-month period of community service use after discharge from residential care, with average acute treatment episode costs in residential crisis settings were 44% lower than in general hospitals [17].
- Hawthorne et al., (2005) found that a Short-Term Acute Residential Care program for veterans aged 18–59 years with a diagnosis of affective disorder, bipolar disorder, or psychosis was 65% less costly than regular hospital care; while outcomes where similar to hospital care [18].

Mobile Crisis Care Cost Effectiveness

- Scott, (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention [19]. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23% lower average cost per case, and 55% of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28% of the emergencies handled by regular police intervention.

The California Legislature has found that approximately 70% of people taken to ED for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care[3]. If at least 50% of Medi-Cal patients seen in the psychiatry inpatient hospital were transferred to a less intensive level of care, such as crisis residential services, residential services, crisis stabilization, and crisis intervention services, the state could save upwards of $2,4600,4329 in FY 2019-2020. These findings reinforce the value of CSU's in providing cost-effective behavioral health care.

Section 3: Current Federal/State Policy

Under current California law, the responsibility for providing specialty mental health services has been realigned to the counties and is provided by county mental health plans that contract with the Department of Health Care Services. CSU services are required to be provided on-site at a licensed 24-hour health care facility, hospital-based outpatient program, or a provider site certified by DHCS or a county mental health provider [20].

Factors Exacerbating Shortage of Behavioral Health Services

- According to a 2018 psychiatric bed annual report by the California Hospital Association, since 1995 California has lost 37 facilities, either through the elimination of psychiatric inpatient care or complete hospital closure, denoting a nearly 20% decrease in facilities [21].
- In California, there is a 24-hour restriction of CSU usage that forces behavioral health workers to stop care for their patients. Individuals in an acute mental health crisis can only receive up to 24 hours of supportive care [20]. Moreover, referring patients to outpatient and community services is hindered by the time limit.
- Recent reports have highlight the continuing problem of inappropriate and unnecessary utilization of ED in California hospitals due to limited community-based services for individuals in psychological distress and acute psychiatric crisis [21].

[3] See Senate Bill No. 82, approved by the Governor and filed with the Secretary of State on June 27, 2013; Welf. & Inst. Code § 5848.5(a)(4).

- Behavioral health crisis services that exclusively rely on transitional funding such as grants are negatively impacted by the uncertainty of the program's sustainability, particularly in rural communities with smaller populations [1, 2].
- Furthermore, based on a Kaiser Family Foundation and California Health Care Foundation poll, over half of Californians surveyed thought their communities lacked mental health providers and that most people with mental health conditions are unable to get the services they need [22].
- Private insurance providers have wrongly restricted treatment for patients with mental health and substance abuse disorders in order to cut costs, in violation of federal law.[4]

Section 4: Policy Recommendations

- AB 1550 Crisis stabilization units: psychiatric patients by Asm. Bonta would help reduce unnecessary emergency room visits by granting CSUs 48 hours, instead of the 24-hour limit**,** to be able to find appropriate and effective care for their patients.
- The State should facilitate implementation AB 680 by Asm. Chu which seeks to provide emergency dispatchers with mental health awareness and identification training as part of their basic training course to ensure that first responders are aware of CSU services in their region and avoid resorting to ED and county jails.
- Given that CSU services includes referral services in the community, outpatient substance use treatment and housing services need to be available in the first place. These are important factors to address in this population.
- Increased funding for CSU services is needed across the State for these centers to be part of the continuum of care for clients who experience a behavioral health crisis.

Section 5: Contact Information

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