State Support for Crisis Stabilization Services, 2024

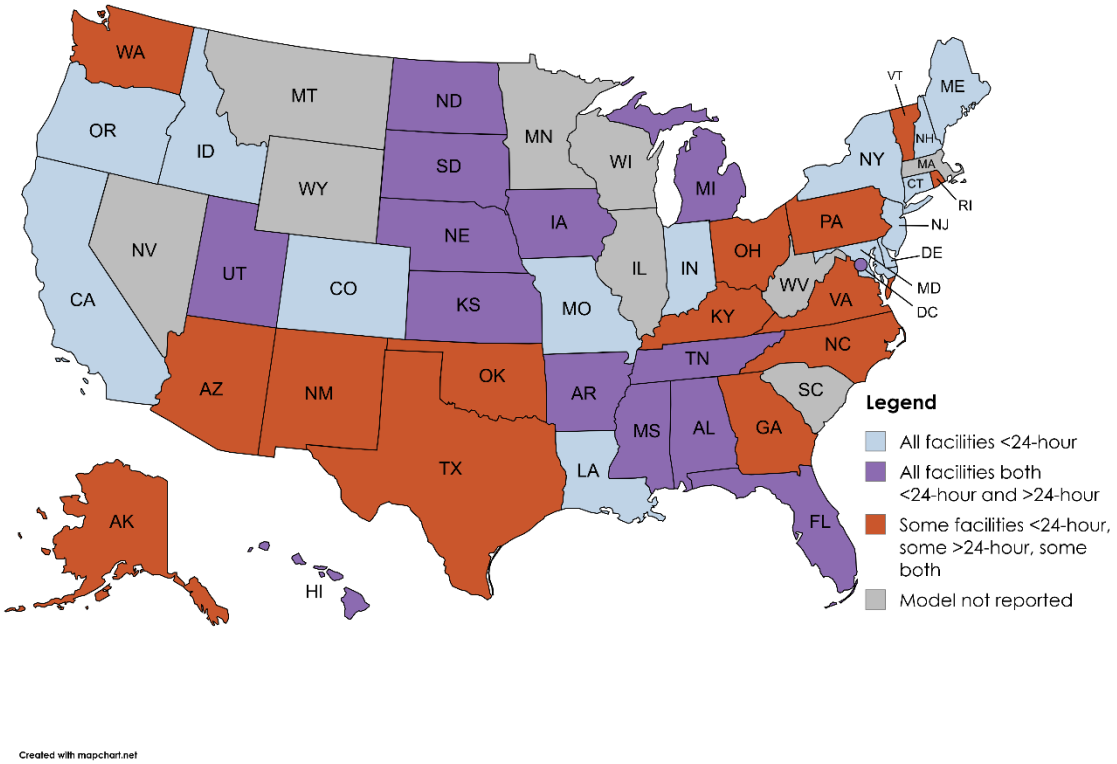
NRI 2024 State Profiles

Revised August 2025

Crisis Stabilization Services: A Safe Place for Help

Crisis stabilization facilities help individuals experiencing behavioral health crises avoid going to emergency departments (EDs) or psychiatric hospitals by providing a safe, dedicated place for observation and specialized crisis stabilization services. Crisis stabilization facilities provide short-term (frequently under 24 hours) observation and crisis stabilization services in a home-like, non-hospital environment. Many crisis stabilization facilities have recliners instead of beds, and staff facilitate the quick drop-off of individuals in crisis by law enforcement, emergency medical services (EMS), and mobile crisis teams (MCTs). Crisis stabilization facilities have demonstrated effectiveness in helping address crises and reduce use of emergency rooms, psychiatric hospitalizations, and adverse criminal justice system interactions.

Figure 1: Crisis Stabilization Models Supported by States, 2024



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807

Crisis stabilization facilities operating

(47 states reporting)

630,776

Individuals served in crisis stabilization

(36 states reporting)

89% (median)

Of crises resolved at crisis stabilization facility

(14 states reporting)

In 2024, 47 states operated 807 crisis stabilization facilities, including 96 such facilities in 19 states specialized for serving children and adolescents. Twenty-three states reported plans to open at least 110 additional crisis stabilization facilities during this year. Eighty-nine percent of crisis stabilization facilities were either entirely less-than 24-hour programs or were a combination of less-than 24-hour and over 24-hour units. See Figure 1.

Types of Crisis Stabilization Facilities:

In 2025, SAMHSA adopted new definitions for a typology of crisis stabilization facilities (https://library.samhsa.gov/sites/default/files/model-definitions-pep24-01-037.pdf). NRI's 2024 Profiles asked states to indicate how many facilities their state has based on the definitions of: hospital-based emergency stabilization units, high-intensity behavioral health emergency centers, high-intensity behavioral health-extended stabilization centers, medium-intensity behavioral health crisis centers, medium-intensity behavioral health extended stabilization centers for voluntary admissions only. Table 1 shows the number of states reporting having each type of service and the number of facilities of each type.

Of 39 reporting states, 27 states reported only having a single type of crisis stabilization facility. Eight states indicated having two types of facilities, while three states reported having three types, and one state reported having four different types of crisis stabilization facilities. No state reported having all five types. High-intensity extended stabilization centers (11 states) is the model that has the most number of programs (228 programs). Medium-intensity behavioral health crisis centers are the most widespread, across 19 states, with 119 programs of this type across states. Ten states report having 119 high-intensity behavioral health emergency centers, while eight states report having 40 hospital-based emergency stabilization units. See Table 1.

Table 1: Types of Crisis Stabilization Facilities

Type of Facility	Number of States with This Facility	Number of Programs of Each Type
Hospital-Based Emergency Stabilization Units	8	40
High-Intensity BH Emergency Centers	10	119
High-Intensity BH Extended Stabilization Centers	11	228
Medium-Intensity BH Crisis Centers	19	119
Medium-Intensity BH Extended Stabilization Centers (voluntary only)	8	71

Number of Individuals Served by Crisis Stabilization Facilities:

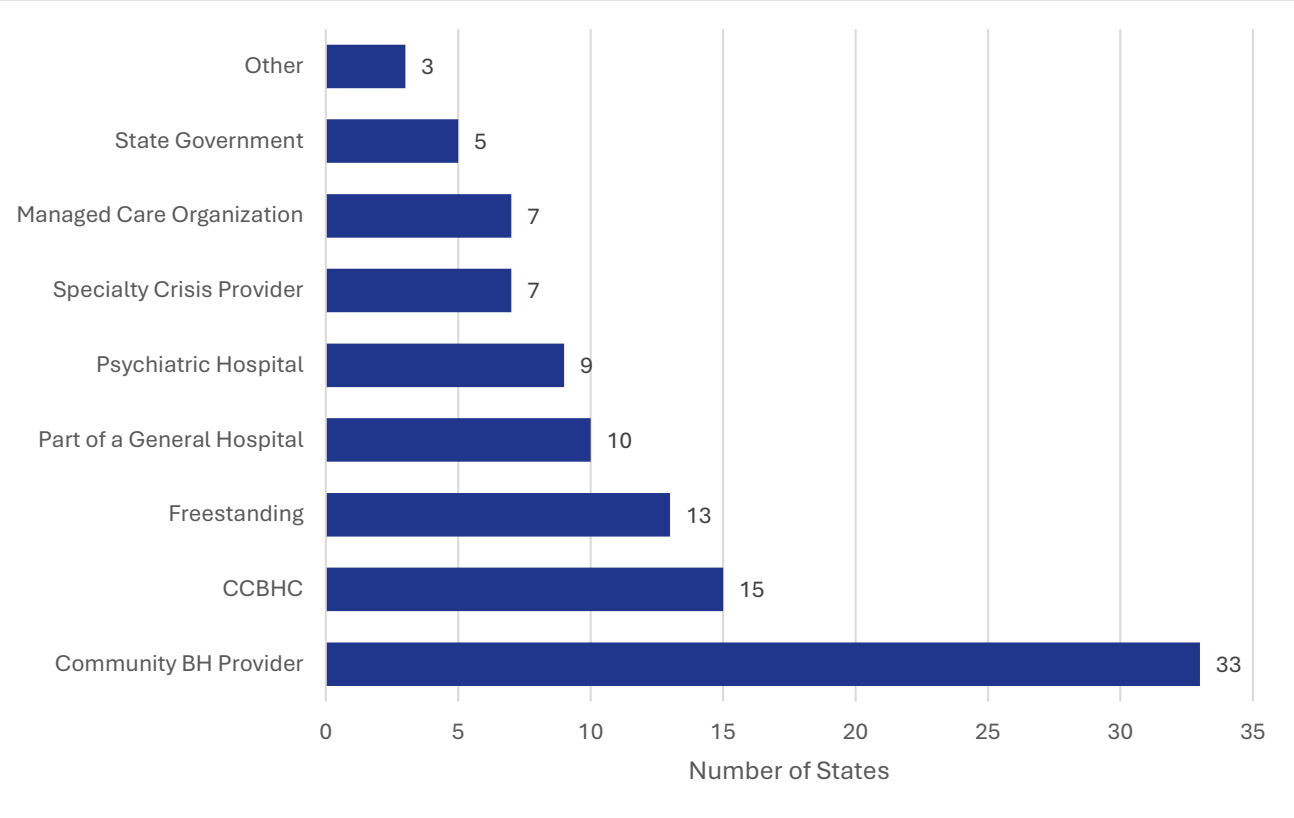
Not all states with crisis stabilization services are able to report how many clients were served during the past year. The 36 states able to report the number of individuals who received a crisis stabilization service during the last year reported 630,776 individuals served in 2024. These states averaged 17,522 individuals served by crisis stabilization services (the median was 4,420), ranging from a high of 164,413 in Florida to a low of 57 in Nevada. Only eight states reported a count of indviduals receiving crisis stabilization services were experiencing a

substance use related crisis and they reported 16,149 and seven states reported 6,736 individuals had a co-occurring mental health and substance use crisis.

Crisis Stabilization Facility Operations:

Community mental health providers are the most frequent type of organization that operates crisis stabilization facilities (33 states). Certified Community Behavioral Health Clinics (CCBHCs) operate crisis stabilization facilities in 15 states. State Mental Health Authorities (SMHAs) operate their own crisis stabilization facilities with state employees in five states. In 13 states, at least some of their crisis stabilization facilities are free-standing (not part of any other organization). In 10 states, they are part of a general hospital system. In nine states, they are part of a psychiatric hospital system. Multiple types of organizations may operate crisis stabilization facilities in states. See Figure 2.

Figure 2: Organization of crisis stabilization facilities, by Number of States, 2024



Characteristics of Crisis Stabilization Facilities:

In most states, crisis stabilization facilities are expected to accept all individuals experiencing crises. This includes those transported by MCTs, law enforcement officers, EMS, and individuals who walk in on their own, or are brought there by friends or family. However, states vary greatly in how they organize and structure the services provided by crisis stabilization facilities.

Table 2 shows that while crisis stabilization facilities in almost every state accept voluntary legal status clients, in 20 states at least some crisis stabilization facilities also serve involuntary status individuals.

Table 2: Characteristics of Crisis Stabilization Services, 2024

	Number of States	
	All in State	Some
Crisis Stabilization Facilities Accept Walk-in Clients		
Accept walk-in clients	32	9
Have dedicated drop off entrance for LE/EMS	19	13
Legal Status of Clients Served		
Voluntary only	18	10
Involuntary only	0	1
Both voluntary and involuntary	8	11
Crisis Stabilization Involuntary Patient Treatment Area		
Shared space	11	6
Separate space for involuntary	5	2
Crisis stabilization facilities have locked units	10	9
Medical Staff		
Crisis stabilization has on-site medical staff	23	12
Crisis stabilization has on-call medical staff	18	11
Other (RN on site or agreement with local hospital)	1	3
Workforce		
Use Peer Specialists	19	15
Use Licensed Behavioral Health Workers	33	5
Use Discharge Planners	27	7
On-Site Pharmacy		
Crisis stabilization facilities have on-site pharmacy	6	12
Access to Medications through Pyxis type device	9	12
Partner with off-site pharmacy	9	16
Crisis Stabilization Programs do not provide medications	3	6

To serve involuntary status individuals or individuals who may require close supervision, all crisis stabilization facilities in 10 states have locked units available, and some facilities in eight states have locked units. All Crisis stabilization facilities in five states have separate areas for involuntary patients and in two states some stabilization facilities have separate spaces.

To address potential medical issues and diagnose behavioral health issues, in 23 states all their crisis stabilization facilities have on-site medical staff available, while at least some crisis

stabilization facilities in 12 have on-site medical staff. In 18 states, all crisis stabilization programs use on-call medical staff, and in 11 states some facilities use on-call medical staff. In one state their crisis stabilization facilities use nurses, and three states have crisis stabilization programs with relationships with local general hospitals for medical staff.

In six states, all crisis stabilization facilities have on-site pharmacies that can be accessed for either prescribed or emergency medications and 12 states some crisis stabilization facilities with on-site pharmacies. In nine states all crisis stabilization facilities have an on-site Pyxis type device to dispense medications and in 12 states some crisis facilities use Phyxis types of devices.

Peer specialists are part of the staffing model in 34 states, with all crisis stabilization facilities using peer specialists in 19 states and some crisis stabilization facilities using peer specialists in 15 states. Only five states reported that their crisis stabilization facilities do not use peer specialists.

Discharge Planners are used to connect individuals leaving crisis stabilization facilities to ongoing services in 34 states, with all facilities having discharge specialists in 27 states and some facilities in seven states.

In 19 states, every crisis stabilization facility offers a dedicated entrance or drop-off area for law enforcement and EMS. In 13 states, some, but not all, crisis stabilization facilities have such an entrance or area, and in eight states no crisis stabilization facilities have such an area.

Populations Served by Crisis Stabilization Facilities:

Crisis stabilization facilities may serve different populations, including clients with mental health needs, substance use disorders (SUDs), and/or intellectual and developmental disabilities (ID/DDs). Table 3 shows the number of states that serve a given population.

Table 3: Populations Served in Crisis Stabilization Facilities

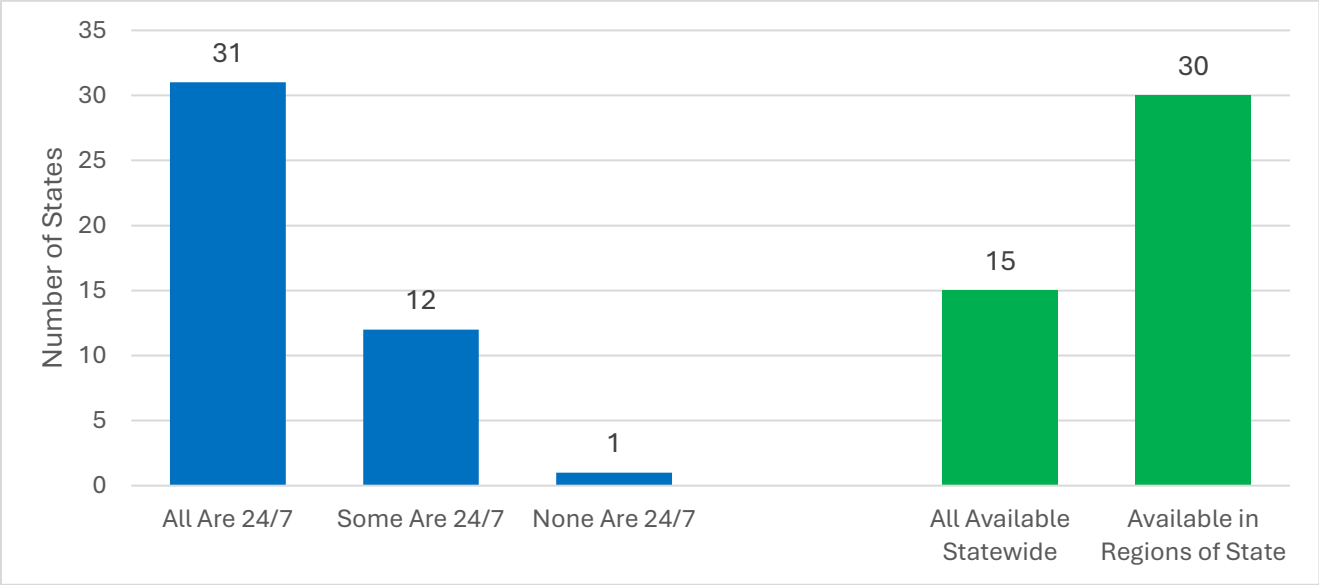
	Either MH or SUD	MH only	MH and co-occurring SUD	ID/DD	SUD Only
All facilities	28	4	9	11	0
Some facilities	9	8	6	7	2
No facilities	4	11	9	8	19

Among states that served clients with SUDs in their crisis stabilization facilities, nine states indicated that all of their facilities include withdrawal management or medications for opioid use disorder (MOUD). Sixteen states reported that some of their facilities have such an offering, and in 12 states, none of their facilities offered withdrawal management or MOUD.

24/7 Availability of Crisis Stabilization Services Statewide:

While 47 states have established crisis stabilization services, making these services available to all residents in a state remains a challenge. Only 15 states report that crisis stabilization services are available statewide, and 30 states report that crisis stabilization services are only available in regions of their state, typically in urban and suburban areas. The majority of crisis stabilization facilities operate 24 hours per day/7 days per week (all crisis stabilization facilities in 31 states, and some crisis stabilization facilities in 12 states operate 24/7). Only one state reported that none of their crisis stabilization facilities operate 24/7 to help individuals experiencing a behavioral health crisis. See Figure 3.

Figure 3: Number of States with Crisis Stabilization Facilities Available State-wide and 24/7, 2024



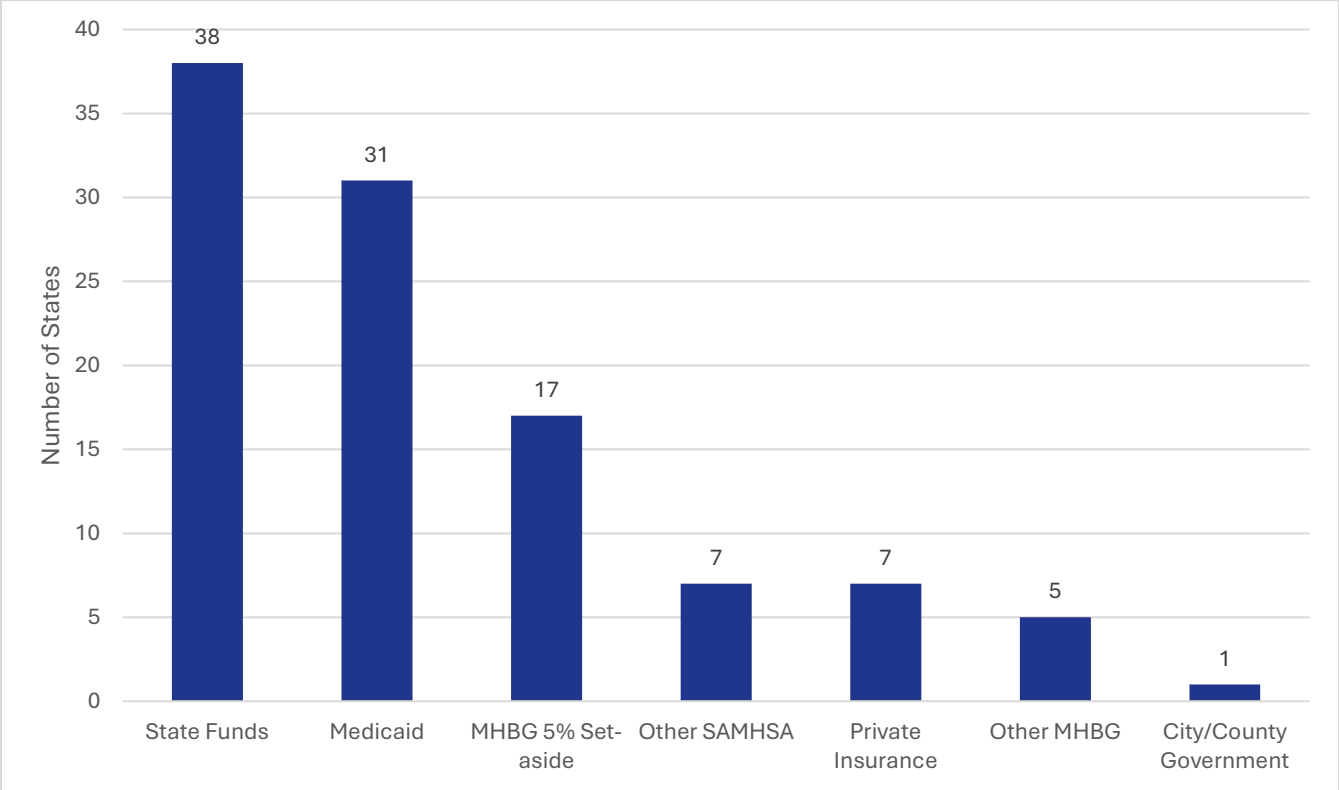
States report that major challenges to statewide, 24/7 crisis stabilization facilities are workforce (36 states), financing (26), issues operating 24/7 (15 states), in the unique context of rural and remote areas (three states), difficulty providing services to children (three states), lack of awareness of crisis stabilization facilities (two states), and transportation to services (two states). Other challenges included constructing new facilities, structure of behavioral health service provision in the state, lack of provider interest in providing the service, and requirements related to the storage of medications.

Financing Crisis Stabilization Services

Thirty-seven states reported expending a combined total of $1.1 billion for crisis stabilization facilities last year, averaging $28.9 million per state and ranging from a high of $176.3 million in Georgia (with 24 crisis stabilization facilities averaging $7.3 million per facility) to a low of $583,615 in Iowa (with seven crisis stabilization facilities averaging $83,374 per facility). The average expenditures per crisis stabilization facility across the reporting states was $1.8 million per facility (with the median cost of $1.1 million per crisis stabilization facility).

States are supporting crisis stabilization facilities through a variety of funding sources, including state, federal, and local government funds. As Figure 4 shows, most states fund crisis stabilization facilities using state general and special funds (38 states). Most states also reported billing Medicaid (31 states), and a significant number of states reported using the Mental Health Block Grant (MHBG), including the 5% set-aside for Crisis Services. Although crisis stabilization facilities work with any individual in a crisis, only seven states reported that their crisis stabilization facilities are currently supported by private insurance.

Figure 4: Major Funding Sources for crisis stabilization facilities, 2024



Data/Outcomes from Crisis Stabilization Services:

Several states are starting to collect and report data on how crisis stabilization facilities help individuals experiencing behavioral health crises. Only some states were able to report outcomes for crisis stabilization facilities. Fourteen states were able to report on outcomes for crisis visits to crisis stabilization facilities. The majority of individuals served at crisis stabilization facilities had their crises resolved sufficiently to the point where they did not need to move on to a more intensive level of treatment. Almost two-thirds of individuals left a crisis stabilization visit with an appointment for outpatient behavioral health services. Less than 20 percent of individuals seen at a crisis stabilization facility required transfer for additional behavioral health treatment at a psychiatric hospital, detoxification unit, SUD treatment facility, or sobering center. Only 4.2 percent, on average (median of 4 percent) were transferred for care at an ED (see Table 4).

Table 4: Crisis Stabilization Facility Outcomes Being Tracked by States, 2024

	Number of states reporting	Average*	Median	Minimum	Maximum
Percentage of individuals who go to a crisis stabilization program whose crisis is **successfully resolved during the initial encounter** (do not need to move to more intensive care)	14	81.0%	88.5%	53.9%	97.8%
Percentage of individuals at a crisis stabilization program who **leave with a BH outpatient appointment**	9	63.0%	81.8%	6.7%	100%
What percentage of individuals at crisis stabilization programs who require additional care at **EDs**	9	4.2%	4.0%	1.5%	8%
What percentage of individuals at crisis stabilization programs who require additional care at **Detox program or psychiatric hospitals**	8	12.8%	8.1%	2.0%	48.0%
What percentage of individuals at crisis stabilization programs who require additional care at a **SUD treatment agency**	8	7.6%	8.6%	0.3%	13.4%
What percentage of individuals at crisis stabilization programs who require additional care at a **Sobering Center**	4	6.3%	2.5%	0.0%	20.0%

** Average is the average of reported state rates–not weighted by the number of individuals served in crisis stabilization facilities in each state.*

Medical Clearance and Limitations on Transporting Individuals Directly to Crisis Stabilization Facilities:

Eighteen states reported having rules or practices requiring medical clearance, which may limit the ability of individuals needing intensive crisis services to directly access crisis stabilization services.

For example:

- **Pennsylvania:** While the state does not currently require medical clearance, the majority of crisis facilities require medical clearance before providing crisis treatment. New regulations will prohibit Emergency BH Walk-In Centers from requiring external medical clearance prior to treatment. Grant funded projects are required to work towards this goal now.
- **Rhode Island:** Individuals who are severely impaired by substance use must be medically cleared by the ED in order to go to any CSU.
- **South Dakota:** Crisis stabilization facilities are working together to streamline the medical clearance process to have the same requirements for admission. There has been success in some facilities to medically clear them in house, but some still require medical clearance at an ED prior to admission.

Other 2024 NRI State Profile Reports on Crisis Services

This report on Behavioral Health Crisis Services is one of a series of reports that NRI is producing for states on Behavioral Health Crisis Services in 2024. Other Profile Highlight reports will focus on:

- State Support for Crisis Service Continuum (Contact Centers, Mobile Crisis, Crisis Stabilization)
- State Support for Mobile Crisis Services
- State Support for Crisis Contact Centers
- Crisis System Technology and Outcomes

Please contact NRI at profiles@nri-inc.org with any questions or comments about this and other State Profiles reports.