August 2025


# Alabama Commission on the Evaluation of Services

## ADMH Crisis Centers

A Preliminary Report

ALABAMA COMMISSION ON THE
EVALUATION OF SERVICES

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**September 4, 2025**

**Members of the Commission,**

I am pleased to transmit the report, An Evaluation of Mental Health's Crisis Centers, to the Commission. The evaluation examined the following:

1. What impacts do Crisis Centers have on the communities they serve?
2. How have Crisis Centers improved the quality and access to care?
3. Is the program delivered to fidelity across all Crisis Centers?
4. What costs are associated with the Crisis Centers?

The evaluation concluded on August 18th, 2025, with the Department of Mental Health, and Crisis Center representatives, participating in a stakeholder meeting to discuss the findings and offer recommendations.

The Commission has historically been dedicated to grounding its decisions in data and evidence. At this time, there is insufficient data to draw conclusions to the effectiveness or impact that Crisis Centers are having. Accordingly, I recommend the Commission consider this a preliminary report and continue working closely with the Department of Mental Health to collect and analyze the data needed to measure outcomes more accurately.

This ongoing collaboration between the Commission and the Department of Mental Health will reflect a shared commitment to understanding the long-term and evolving mental health needs in Alabama.

We very much appreciate the cooperation and assistance of the Department of Mental Health, the Crisis Center representatives, and the many other community partners that contributed to this preliminary evaluation. I respectfully request that they be given an opportunity to respond at the Commission meeting on September 4th, 2025.

Sincerely,

M. Morgan

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Director

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# ACKNOWLEDGMENTS

The Alabama Commission on the Evaluation of Services would like to express our sincere gratitude to the researchers, practitioners, and professionals that assisted in this evaluation. In particular, we would like to acknowledge the efforts of the following organizations and individuals that contributed significantly to this report.

**State Agencies**

Alabama Department of Mental Health
Alabama Department of Public Health
Alabama Medicaid

**Other States**

Georgia Department of Audits and Accounts
West Virginia Department of Health, Office of Emergency Medical Services

**Organizations**

AltaPointe Health
Carastar Health
CIT Regional Hub 1
CIT Regional Hub 2
CIT Regional Hub 3
CIT Regional Hub 5
Foley Police Department
Indian Rivers Behavioral Health
JBS Mental Health Authority
NAMI Alabama
Regional Paramedical Services
Robertsdale Police Department
SpectraCare Health Systems
WellStone Emergency Services

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ACES
Alabama Commission on the Evaluation of Services

# An Evaluation of the Alabama Department of Mental Health Crisis Centers

REPORT SUMMARY — AUGUST 2025

**CONCLUSION: Although Crisis Centers largely follow the recommended guidelines, the Department of Mental Health has deficient strategic control, which leads to a lack of accountability. To determine the effectiveness of Crisis Centers and the impact on the communities they serve, better and more consistent data collection is necessary. Additionally, logistical barriers such as transportation and EMS reimbursement should be addressed to improve the quality and access to crisis care. Finally, the equal-funding model does not account for the specific needs of each center. Modifications to the Crisis Center funding model may allow for efficiencies to be gained.**

## Crisis Center Background

Crisis Centers were established to give individuals with a mental health or substance use crisis an appropriate place to receive care (24/7/365) while reducing strain on jails and hospitals. Centers accept individuals through walk-ins and drop-offs by family, friends, law enforcement, or EMS. Crisis Centers provide stabilization, evaluation, psychiatric services, as well as referrals to community resources.

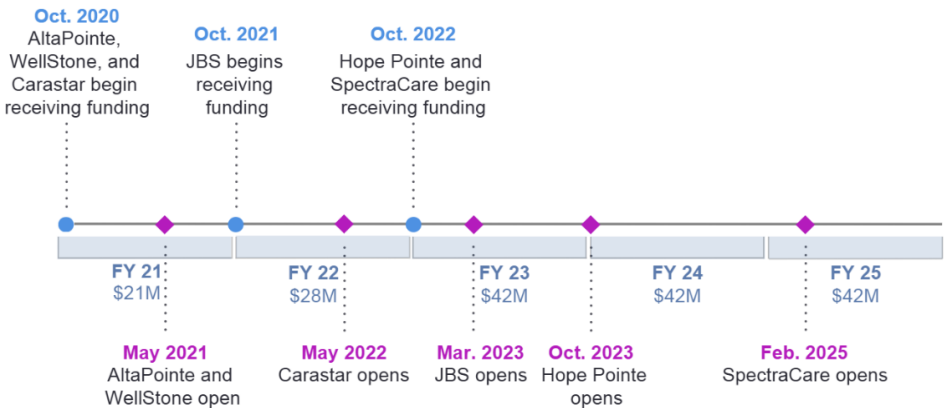
## RECOMMENDATIONS

- ***Provide*** clear reporting methodology for each data point reported by Crisis Centers.
- ***Implement*** a quality control process to ensure data accuracy.
- ***Require*** Medicaid and private insurance to reimburse EMS drop-offs at the emergent rate at state-funded Crisis Centers.
- ***Create*** a needs-based funding model that accounts for the number of individuals served, geographic factors, and capacity for each facility.
- ***Differentiate*** funding between start-up and annual operations.

## Key Findings

- There are deficiencies in the Department of Mental Health's strategic control.
  - Monthly data reports contain inconsistencies, suggesting a lack of quality control and accountability in reporting.
  - Consistent methodology is needed to determine Crisis Centers effectiveness and impact.
- Adequate financial reimbursement for EMS providers is a barrier to bring consumers to the Crisis Center.
- Transportation barriers exist for consumers after leaving the Crisis Center.
- Crisis Centers ***consistently*** operate with fidelity to the guidelines.
- The equal funding model does not consider capital expenditures, operational costs, or differences in needs of populations.
- Capital expenditures drive early Crisis Centers costs but differ significantly.
- For most centers, operations and administration make up over 85% of total expenditures by the fourth year of funding.
- Utilization drives cost-effectiveness because of large, fixed costs.

**Crisis Centers funding and operational status timeline by fiscal year. Total funding since FY21 is $175,000,000.**



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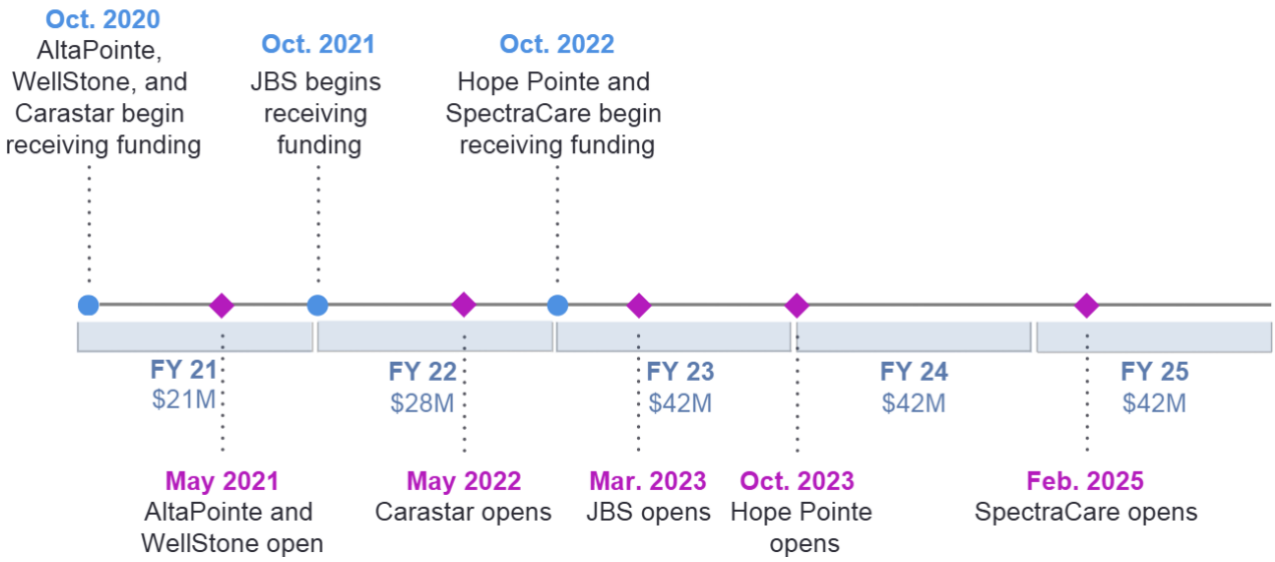
## An Evaluation of the Alabama Department of Mental Health's Crisis Centers

Behavioral health issues are prevalent across the nation. In Alabama, around 931,000[1] adults are living with a mental illness, which is higher than the national average.[i] Furthermore in 2024, 72% of Alabamians with a substance use disorder (SUD) did not receive the treatment they needed.[ii] Since FY21, the state of Alabama has dedicated $175,000,000 in state funding to open and operate six Crisis Centers. Currently the six existing Crisis Centers receive $42,000,000 per year ($7,000,000 per center).

**FIGURE 1|** Crisis Centers funding and operational status timeline by fiscal year.




Crisis Centers are designated places for anyone who is experiencing a mental health or substance use crisis to receive care year-round, 24 hours a day, seven days a week (24/7/365). Crisis Centers accept individuals through walk-ins and drop-offs by family, friends, law enforcement, or emergency medical services (EMS). The Crisis Centers provide stabilization, evaluation, psychiatric services, as well as referrals to community resources. The Crisis Center model was established by the Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines*[2] *for a Behavioral Health Coordinated System of Crisis Care: Best Practice Toolkit*.[iii] This model requires each center to have at least a temporary observation unit with a maximum stay of 24 hours and an extended observation unit with a maximum stay of seven days. After receiving care at the Crisis Centers, discharge

[1]Data from the Mental Health America Report was derived from SAMHSA's National Surveys on Drug Use and Health dataset.
[2]"SAMHSA Guidelines" throughout this report will refer to the model best practice toolkit on which Crisis Centers were built.

planners organize the next steps in a consumer's recovery journey by integrating them within the continuum of care.

It is important to note, establishment and expansion of Crisis Centers in Alabama coincided with the unprecedented challenges of the COVID-19 pandemic. Supply chain disruptions, workforce shortages, and operational constraints are only a few of the challenges the Department faced as Crisis Centers began to open. Despite these challenges, the Department and its community partners continued to make progress toward building a sustainable network of Crisis Centers. These efforts represent an important step in ensuring that individuals in crisis have access to care. By the end of 2024, 16,414 interactions[3] had taken place across all operating Crisis Centers since the first opening in 2021. For more information on interactions see Monthly Report Analysis.

## Purpose and Scope of the Evaluation

In 2022, the 9-8-8 Study Commission determined the state would need a total of 11 Crisis Centers to adequately ensure individuals in a behavioral health crisis have "somewhere to go." [iv] As of the 2025 Legislative Session, Alabama is currently funding each of the six centers at $7,000,000 per year. The main source of funding comes from the state General Fund ($6,000,000 per center). An additional $1,000,000 per center comes from the Special Mental Health Fund. Although minimal, Crisis Centers do receive reimbursement from Medicaid, Medicare, and private insurance. Some centers receive additional funding from community partners.

This evaluation seeks to analyze the following:

1. What impacts do Crisis Centers have on the communities they serve?
2. How have Crisis Centers improved the quality and access to care?
3. Is the program delivered to fidelity across all Crisis Centers?
4. What costs are associated with Crisis Centers?

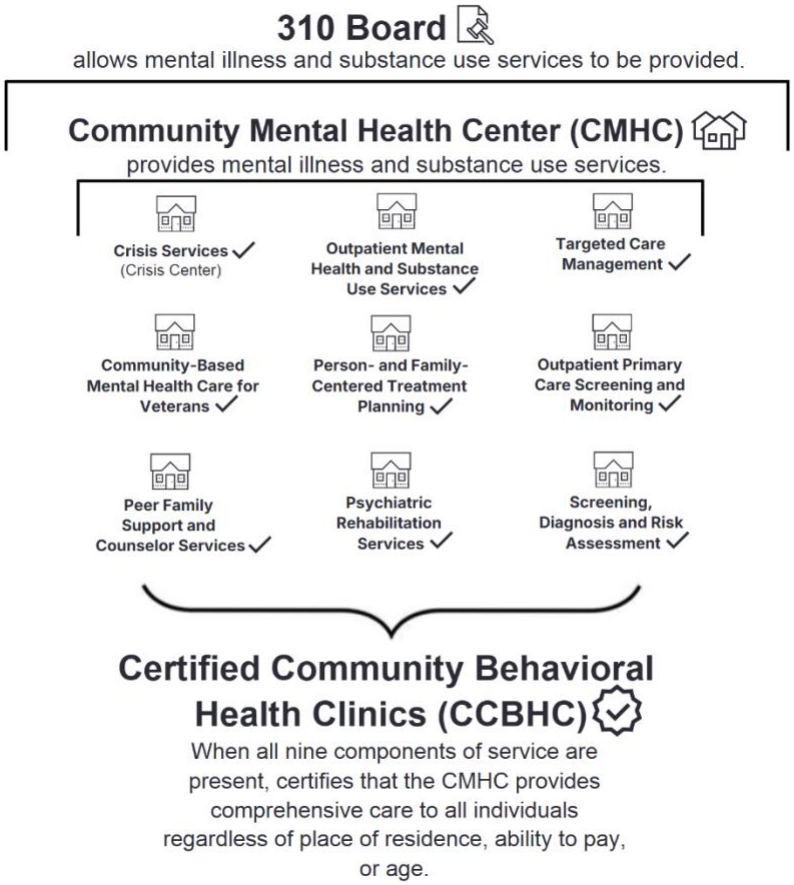
### Understanding the Behavioral Health Continuum in Alabama

The Department is designed to oversee, provide, and support available services for Alabamians with mental illnesses, developmental disabilities, and SUDs. The Department and its partners offer many different services such as inpatient treatments, rehabilitation, peer support, crisis services, outpatient treatments, and counseling for individuals with mental illness or SUD. Services offered by the Department and its partners are intended to have an integrated approach and work in tandem with the overall behavioral health continuum in Alabama.

[3] An interaction is any encounter that may or may not have led to an admission into the center.

Community Mental Health Centers (CMHCs) are the primary providers of mental health and substance use services. They may offer outpatient, day, residential, and crisis services in their catchment area. Alabama has 21 CMHCs across the state that provide mental health and substance use services. While this evaluation will focus on Crisis Centers, they are just one of the services that may be provided in a CMHC.

According to the Department, Crisis Centers are an important piece in the plan for CMHCs to become Certified Community Behavioral Health Clinics (CCBHC) through SAMHSA. Crisis Centers help accomplish this by providing one of the required components – crisis services.




## Detailed Findings and Recommendations

### 1.0 Impact | What impacts do Crisis Centers have on the communities they serve?

Crisis Centers were designed to improve access to behavioral healthcare services for individuals who are experiencing a mental health, substance use, or suicidal crisis. Additionally, they seek to reduce the burden on jails and hospitals by providing a more appropriate alternative to incarceration or emergency room visit for individuals in need of crisis services rather than physical health services or detainment.[v] Although Crisis Centers collect and report data, the current data does not measure impact on these outcomes and is not uniformly collected across all the Centers.

**There are deficiencies in the Department's strategic control of Crisis Centers.** Strategic control is a process for determining the extent to which the organization or agency's strategies are successful in meeting its goals and objectives. It should address the gaps between intent and realized goals.[vi] After the Department awarded funding for CMHCs to establish a Crisis Center, the Department allowed the CMHCs to take on much of the operational management. Although Crisis Center operations are primarily the CMHCs' responsibility, the Department continues to play a key role in approvals, investigating complaints, and oversight. Despite the Department's role in oversight, there is a lack of clarity surrounding the processes and procedures that are taken to ensure data is collected to uniform standards. Without clear oversight and strengthened strategic control, there is limited information to reliably evaluate performance.

The following findings reflect key issues with the data collection that could be improved to increase strategic control:

**Crisis Centers' monthly data reports contain inconsistencies, suggesting a lack of quality control and accountability in reporting.** The Department requires each center to submit monthly reports that align with metrics found in the SAMHSA Guidelines. While the Department does provide a data dictionary for these metrics, Crisis Centers' reports, at times, deviate from the definitions. Additionally, some of the provided definitions are broad, leaving room for interpretation, creating inconsistencies in how a metric may be reported. For example, there were inconsistencies in the reporting of temporary observation discharges, where reporting differed among centers *and* differed within the same center from month-to-month. Variations in data and differences in reporting methodologies among centers suggest other data points such as presenting symptoms, emergency department or jail avoidance, and ambulatory follow-up rates are also affected. Currently, there are not any quality control measures in place to ensure monthly reports are reliable.

It should be noted that SAMHSA also emphasizes the importance of evaluating performance metrics through connected, real-time data systems. ***See Monitoring System and Provider Performance.*** [vii] According to the Department, developing a data system specifically for Crisis Center data was thought to be inefficient as the centers shift into the CCBHC model which may require different data reporting metrics. However, the current method of collecting monthly reports is also inefficient and susceptible to inconsistencies and errors.

**Consistent methodology is needed to determine Crisis Center effectiveness and impact.** One of the Department's key performance indicators of effectiveness is the number of individuals who avoided emergency department and/or jail admission. Even though these are designated outcomes, there is no consensus among centers in the way

**Monitoring System and Provider Performance**

"In addition to monitoring fidelity to the *National Guidelines of Crisis Care*, funders, system administrators, and crisis service providers should continuously evaluate performance through the use of shared data systems. System transparency and regularly monitoring of key performance indicators supports continuous quality improvement efforts. It is highly recommended that systems connect data in a manner that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches focused on value."

individuals who avoided jail admission is collected. One center has never tracked or reported avoidance of jail admission, always submitting zeros for this metric. Despite the consistent reporting of zero jail avoidances, this issue has not been addressed by the Department. While these examples largely influence the credibility of monthly reporting data, they also call into question the objectivity of these metrics. **When objective metrics are collected subjectively, they are unable to serve as key performance indicators of a program's success.**

Because of the subjective and inconsistent nature of current data collection, the Department cannot determine the extent to which the program's strategies are successful in meeting its goals and objectives. Additionally, ACES cannot verify the accuracy of key performance indicators or determine whether Crisis Centers are reducing the strain on emergency rooms and jails. Since the methodologies used to track these performance metrics and outcomes are unreliable, they do not support a robust evaluation of effectiveness.

## RECOMMENDATIONS

To measure impact of the Crisis Centers, the Alabama Department of Mental Health should:

- *Provide* clear reporting methodology for each data point reported by Crisis Centers, including:
  - Uniform and objective criteria for Crisis Centers to determine if an individual has avoided emergency department or jail admission.
- *Implement* a quality control process to ensure data accuracy.

### 2.0 QUALITY & ACCESS TO CARE | HOW HAVE CRISIS CENTERS IMPROVED THE QUALITY AND ACCESS TO CARE?

The Department and CMHCs began addressing a need within the coordinated system of crisis care by opening Crisis Centers. As previously noted, this process began before the 9-8-8 Study Commission identified the need for 11 centers across the state. Prior to the six Crisis Centers opening, there was no designated place where anyone experiencing a mental health, substance use, or suicidal crisis could receive immediate, specialized care 24/7/365. The extent of gaps filled has not been identified, but opening centers gives consumers the ability to have somewhere to go that was not previously available. While Crisis Centers have expanded access to care, there are some logistical barriers that exist within the behavioral health continuum that can affect a center's ability to further expand access to care. Crisis Centers are an integral part in Alabama's behavioral health continuum, and it is essential for the continuum to support consumers getting to the center, while at the center, and once leaving the center.

**There are reimbursement barriers for EMS providers.** Crisis Centers are equipped as a prime spot for individuals in a mental health crisis, without need of medical intervention, to receive care.[viii] In 2022, EMS protocols were updated and the Alabama Department of Mental Health confirmed with the Alabama Department of Public Health that EMS drop-offs could be made, due to the Crisis Center's designation as a definitive care facility. While this designation allows paramedical services to drop-off consumers at a Crisis Center,[ix] Medicaid and private insurance are not required to reimburse those drop-offs. They only reimburse emergent EMS drop-offs at a hospital or for a hospital-to-hospital transfer. Without a process to ensure adequate reimbursement for EMS drop-offs, Crisis Centers may be missing opportunities to provide services to consumers and alleviate burdens on hospitals. It is important to note that although financial reimbursement can be a barrier statewide, some Crisis Centers have worked to create partnerships with their local EMS providers. ***See Crisis Center Spotlight.***

### *Access to Care Findings from Peer Interviews*

Due to the sensitive nature of consumers' protected health information and multiple barriers, ACES did not directly interview consumers who have used Crisis Center services. As an alternate approach, ACES interviewed peers at the operating Crisis Centers. Certified Peer Specialists and Certified Recovery Support Specialists[4] have a unique viewpoint into Crisis Center operations as they play a significant role in a consumer's time at the center.

**Overall, peers expressed pride in the quality and access to care Crisis Centers offer to consumers.** Many peers said that if a Crisis Center had been available when they were in crisis, they would have benefitted from it. In addition to positive feedback regarding the centers, peers shared concerns about Crisis Center operations and the recovery process. The following findings review the prevalent themes that multiple peers discussed. For additional methodology and observations that did not rise to the level of findings, see Thematic Analysis of Peer Interviews.

**Transportation barriers exist for consumers after leaving the Crisis Center.** Before leaving the Crisis Center, many consumers are scheduled for rehab, treatment, or therapy services. Making the next scheduled appointment is essential for consumers to continue on a pathway to success. Many times, these appointments come with medication refills that are necessary to a consumer's recovery. Some consumers do not have their own means of transportation or the money to pay for public transportation and are unable to make their follow-up appointments. Peers stated when consumers are unable to make their follow-up appointments after leaving the Crisis Center, they are more likely to experience setbacks in their recovery.

**Crisis Center Spotlight**

Before opening the JBS Craig Crisis Center, JBS leadership met with Regional Paramedical Services to address the barrier of EMS transports to their Crisis Center. After collaboration with multiple organizations, the Crisis Center deemed that it would need to be classified as an "H-modifier" to support the transport of a consumer to the center. This modifier allows the reimbursement of Emergency Department to Crisis Center transports. Additionally, JBS entered into a memorandum of understanding with Regional Paramedical Services to become the payor of last resort for consumers that needed transportation but were uninsured. While this places an additional cost on JBS, consumers are able to receive care at a more appropriate facility.

[4] Certified Peer Specialists are unique individuals who have lived experience of mental illness. Certified Recovery Support Specialists are individuals in recovery from SUD. Both types of peers work to provide support to consumers who are seeking assistance.

**Consumers need the proper assessments that facilitate timely access to care.** All peers at one center noted consumers who are seeking SUD treatment face barriers to receive care after leaving the Crisis Center.[5] Part of the Crisis Center process for those with SUD is to complete a criteria assessment developed by the Department. This assessment aligns with the criteria developed by the American Society of Addiction Medicine (ASAM).[x] This is a mandatory requirement for consumers to be admitted into a treatment facility that receives state funding after leaving the Crisis Center.[xi] The peers stated that their center's criteria assessment would not transfer to the treatment facilities. Consumers have to call or visit outside resources to have the correct criteria assessment completed for admission into treatment. Many consumers feel discouraged when they are required to take an additional assessment, especially when they believe they have already taken that specific assessment. At times, this could be a big enough hurdle for them to stop the recovery process completely.

## RECOMMENDATIONS

The Governor and the Legislature should consider:

- *Requiring* Medicaid and private insurance to reimburse EMS drop-offs at state-funded Crisis Centers under the emergent transportation rate.

### 3.0 FIDELITY | IS THE PROGRAM DELIVERED TO FIDELITY ACROSS ALL CENTERS?

The Crisis Centers were implemented based on the SAMHSA Guidelines. As is common with emerging programs and services, guidelines get updated over time to reflect new standards and best practices. The original guidelines in place when the Crisis Centers first opened established the following minimum expectations and best practices:[xii]

**"Minimum Expectations:**

- Accepts all referrals.
- Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program.
- Design their services to address mental health and substance use crisis issues.
- Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed.

[5] When ACES was made aware of this barrier, the finding was reported to the Department. At the stakeholder workgroup meeting on 8/18/25, ACES was informed that the Crisis Center has since changed their assessment to the Department approved assessment, eliminating the barrier.

- Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community including:
    - Psychiatrists or psychiatric nurse practitioners (telehealth may be used).
    - Nurses.
    - Licensed and/or credentialed clinicians capable of completing assessments in the region.
    - Peers with lived experience similar to the experience of the population served.
- Offer walk-in and first responder drop-off options.
- Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders.
- Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated.
- Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

**Best practices:**

- Function as 24 hours or less crisis receiving and stabilization facility.
- Offer a dedicated first responder drop-off area.
- Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support.
- Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources.
- Coordinate connection to ongoing care."

After the start of this evaluation, SAMHSA published new *National Guidelines for a Behavioral Health Coordinated System of Crisis Care* and *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services*.[xiii] While the previous expectations and best practices were largely incorporated into these new guidelines, they also provide levels of intensity for which Crisis Centers may operate. Since the release of these new guidelines in January 2025, the Department established that temporary observation units would be categorized as "Moderate-Intensity Behavioral Health Crisis Centers" and the extended observation units would be categorized as "Moderate-Intensity Behavioral Health Extended Stabilization Centers,"[xiv] both of which require only voluntary admissions.

**Crisis Centers consistently operate with fidelity to the guidelines.** All six centers have been operational 24 hours a day, seven days a week since opening. They are staffed with the appropriate professionals, receive walk-ins and first responder drop-offs, and provide care coordination which includes referrals to other community services. Finally, all centers maintain low barriers

to admission.[6] Consumers are not excluded for inability to pay for services nor denied admission based on Medicaid or private insurance criteria.

It should be noted that original guidelines maintain a "Significant Role for Peers" as a "transformative element of recovery-oriented care" that "supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible."[xv] Peer staffing is one area that many of the Crisis Centers are not able to have 24/7/365. Peer staff members range from one peer at a Crisis Center to four peers at other centers. For the centers without a full staff of peers, it is not possible to have a peer at the centers 24/7/365. If consumers were to show up at a time when peers are not at the center, consumers would miss out on this critical component of crisis care.

**Consumers occasionally exceed the maximum duration for length of stay.** Alabama's crisis center model calls for temporary observation unit stays of less than 24 hours and extended observation unit stays of less than seven days. Based on the monthly averages reported to the Department, one center has exceeded the 24-hour maximum for temporary observation in 8 out of 14 months (57%). Another center's average length of stay in extended observation exceeded the seven-day maximum in two of the months reported. Since these are aggregate reports and length of stay was reported as an average for all consumers, it is not known if there were specific drivers for these instances that could be remedied.[7]

**Involuntary holds have occurred at some Crisis Centers.** In addition to the SAMHSA Guidelines, the Department described voluntary admissions as a key element of a Crisis Center. While the 2020 SAMHSA guidelines do not refer to voluntary admissions as a minimum expectation or best practice, the 2025 SAMHSA Guidelines state that Moderate-Intensity Behavioral Health Crisis Centers and Extended Stabilization Centers "accept only individuals who are ***voluntarily*** seeking services and are unable to provide services for individuals on involuntary holds."[xvi]

One center does accept consumers on an involuntary hold due to Act No. 353, 1975 Ala. Acts. This act "provides a procedure by which a law enforcement officer can have an individual placed in psychiatric care prior to the filing of a petition for involuntary commitment if there is clear and convincing evidence that a person is a danger to themselves or others. This applies to counties in Alabama with populations of 600,000 or more."[xvii] Only one Crisis Center in Alabama has a county within its catchment area with a current population that meets the requirements of this act.

[6] There are occasionally instances where a consumer is violent or requires physical health care that prevents them from immediately being admitted.
[7] ACES was unable to validate the data in monthly reports due to various missing elements or inconsistencies within the currently unusable Limited Data Sets.

## 4.0 Costs | What are the costs associated with Crisis Centers?

As previously reported, Crisis Centers each receive $7,000,000 annually. This is based on an equal funding model that does not account for actual needs. This is evidenced by vast differences in initial capital expenditures and current per bed day costs[8] for each center.

**Capital expenditures drive early Crisis Center costs but differ significantly.** Most centers incur the largest capital expenditure costs within the first two years of receiving funding. The amount of those costs varies due to whether a center purchased a new building, renovated an existing building, or both. Capital expenditures ranged between centers from as little as $3,342,309 to as much as $12,566,013. In total, capital expenditures represent 35% of all Crisis Center expenditures between FY21 and FY24.

**For most centers, operations and administration make up over 85% of total expenditures by the fourth year of funding.** In FY24, three centers received their fourth year of state funding. According to the unaudited financial reports provided to ACES, operations and administration accounted for nearly all their expenditures in that year. A fourth center is on the same pace after its third year of funding. ***See Table 1.***

**TABLE 1 |** While *Capital Expenditures* are high in early years, Crisis Center expenses shift to mostly *Operations and Administration* by year four.

| Fiscal Year | AltaPointe | CaraStar | Wellstone | JBS | Hope Pointe | SpectraCare |
|---|---|---|---|---|---|---|
| | Operations and Administration | | | | | |
| **2021** | 51.6% | 42.7% | 25.5% | | | |
| **2022** | **96.3%** | 34.7% | 21.8% | 22.0% | | |
| **2023** | **95.7%** | 50.4% | 83.8% | **97.2%** | 68.4% | 10.5% |
| **2024** | **95.9%** | **94.3%** | **87.3%** | **97.2%** | 40.0% | 32.4% |
| | Capital Expenditures | | | | | |
| **2021** | 47.0% | 57.3% | 74.5% | | | |
| **2022** | 1.4% | 65.3% | 78.6% | 77.5% | | |
| **2023** | 1.5% | 49.6% | 15.7% | - | 31.6% | 87.8% |
| **2024** | 1.4% | 0.2% | 6.6% | - | 58.8% | 65.4% |
| | Non-Cash Items | | | | | |
| **2021** | 1.5% | - | - | | | |
| **2022** | 2.4% | - | -0.5% | 0.5% | | |
| **2023** | 2.9% | - | 0.5% | 2.8% | - | 1.7% |
| **2024** | 2.7% | 5.6% | 6.1% | 2.8% | 1.2% | 2.2% |

The amounts in Table 1 do not distinguish between actual operational expenses and administrative overhead expenses. Based upon the submitted

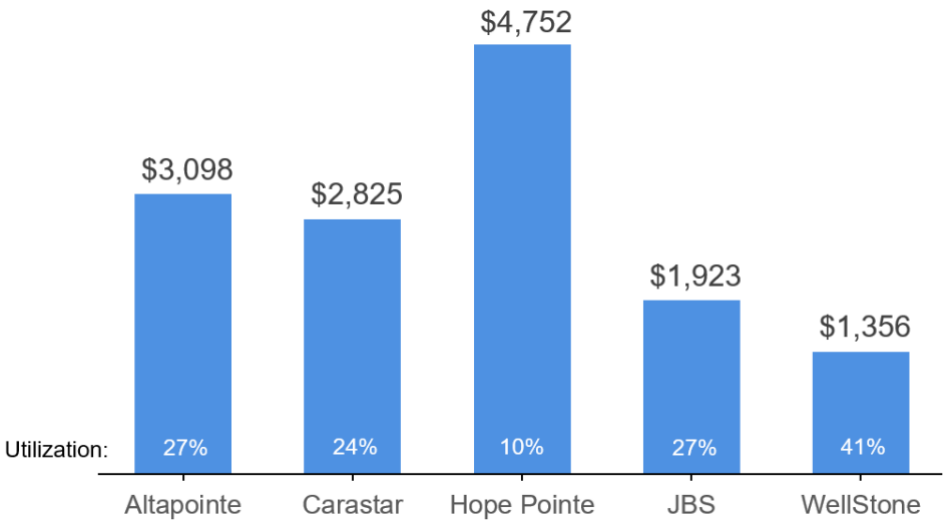
[8] For more information regarding bed day calculations, please see *Data and Methodologies.*

financials, ACES could not readily distinguish between operations and administration. The amounts do exclude ***Non-cash Expenses*** which increased year-over-year for the five operational centers.

**Capital expenditures and annualized operational costs are not considered in the current funding model.** Since the initial RFP awards, the time for Crisis Centers to become fully operational has ranged from 7 to 28 months. Of the six centers that have opened, five established temporary facilities shortly after receiving funding. One center, however, did not establish a temporary site and remained non-operational for two full years. The Department continued to allocate the full amount annually to the non-operational center before it became fully operational in its third year. This resulted in the center retaining over $6,600,000 (47.7% of state funding). Another center has accumulated over $4,400,000 across four years of state funding (16% of state funding). These discrepancies indicate a need for a dynamic funding model with capped administrative expenses.

**Utilization drives cost-effectiveness because of large fixed costs.** Most centers have variable costs of less than 5% due to the staffing costs associated with being open 24/7/365. With such high fixed costs, the cost-effectiveness of the centers is driven by utilization. In FY24, the centers had an average utilization rate of 27% between temporary and extended observation units. This utilization rate produced an average cost per bed day of $2,193. However, the cost per bed day differs significantly based upon each center's overall bed capacity and utilization. ***See Figure 2.***

**FIGURE 2 |** Average cost per bed day in FY24 varies significantly based on the number of admissions into each center and the average length of stay.




***Note:*** *FY24 represents the only complete year of monthly reports from the five centers. It should also be noted that this was Hope Pointe's first full year of operations.*

As Figure 2 demonstrates, two centers with the same utilization rate have a 38% difference in cost per bed day. In this instance, Altapointe admitted more consumers to the crisis center (2,552) than JBS (2,244). However, Altapointe

**Non-cash Expenses**

All centers reported non-cash items such as depreciation and bad debt in their expenditures. These are accounting entries that do not reflect actual spending. For example, depreciation spreads the cost of equipment over time, even though the money was spent up front. While these entries are standard in financial reporting, they do not show how funds were actually used. This matters because it can make it seem like more money was spent than truly left the bank. While the total amount is small (<2% of all expenditures), it is worth noting because it creates some ambiguity of how state funds are actually being spent.

has fewer total beds, and its consumers spent less overall time in the crisis center. With high fixed costs associated with operating the centers, consumer need and access determine cost-effectiveness.

**Equal funding for Crisis Centers does not account for differences in needs of populations across the state.** Currently all Crisis Centers receive equal funding despite noticeable differences in population size, service demands, facility capacity, and community needs. With this funding model, there is an imbalance between current funding and actual needs of each center. One Crisis Center serves the most populated area in the state and operates 48 beds, almost double the capacity of any other center. In comparison, another center has 20 beds[9] with a catchment area consisting of mostly rural communities. Even though these two centers face different challenges, they are given the same amount of funding.

### *State Funding Comparisons*

Other states, such as Texas and Georgia, use a needs-based funding model that allocates money based on each center's individual circumstances. Texas requires each mental health authority to fill out a Local Service Plan detailing number of beds, staff, services offered, community needs, provider networks, and performance goals. The Local Service Plan also includes budget details, crisis protocols, and stakeholder inputs.[xviii] This information is then used to allocate funding for each center's specific needs. Georgia regulations allow for reduced funding if crisis services start after the expected date. The state used this provision in 2020 when a crisis stabilization unit was delayed in opening.[xix]

## RECOMMENDATIONS

The Alabama Department of Mental Health should:

- *Create* a needs-based funding model that accounts for the number of individuals served, geographic factors, and capacity of each facility.
- *Differentiate* funding between start-up and annual operations.

## CONCLUSION

Crisis Centers were established to give individuals with a mental health or substance use crisis an appropriate place to receive care while reducing strain on jails and hospitals. Although Crisis Centers largely follow the recommended guidelines, the Department of Mental Health has deficient strategic control, which leads to a lack of accountability. To determine the effectiveness of Crisis Centers and the impact on the communities they serve, better and more consistent data collection is necessary. Additionally, there are logistical barriers such as transportation and EMS reimbursement that should be

[9] In February of 2025, this center moved into a new facility and now has 28 beds.

addressed to improve quality and access to crisis care. Finally, the equal-funding model does not account for the specific needs of each center. Modifications to the Crisis Center funding model may allow for efficiencies to be gained.

# DATA & METHODOLOGIES

## INTERVIEWS

ACES conducted interviews throughout the evaluation with the Department staff who work with Crisis Centers. Individual site visits and interviews were also conducted with each Crisis Center to better understand Crisis Center operations.

ACES interviewed 13 peers, including Certified Recovery Support Specialists and Certified Peer Specialists. SpectraCare peers were not included in these interviews due to the center opening after the beginning of fieldwork. See Thematic Analysis of Peer Interviews for more information.

ACES also interviewed multiple jails, CIT hubs, EMS providers, and EMS associations.

## MONTHLY REPORTING DATA

ACES obtained the data from which the Department derives its monthly reports and 'Crisis Center Report Cards.' Monthly reports did not include any protected health information and were in aggregate format. SpectraCare monthly reporting data was not included in analysis due to the center opening after beginning fieldwork and not having enough data to analyze.

## COST PER BED DAY CALCULATION

Cost per consumer bed day for FY24 was calculated by dividing each center's FY24 operational expenditures (excluding capital expenditures and non-cash expenses) by the total number of consumer bed days in FY24.

The number of total consumer bed days was defined as the sum of temporary OBS bed days and extended OBS bed days during FY24. For each month of FY24, consumer bed days were calculated as:

(Number of admissions in the month × Average length of stay in minutes for the month) ÷ 1,440

These monthly values were summed across all twelve months to determine the annual number of consumer bed days.

It is important to note that cost per bed day is based off a combined utilization rate of both types of observation units because costs could not be differentiated in a meaningful way to reflect a true separate cost to operate each unit type.

## UTILIZATION CALCULATIONS

Utilization was calculated from monthly report data by multiplying the number of admissions by the average length of stay (in minutes) and dividing that value by capacity.

Capacity was defined as the number of days the center was open in a given month multiplied by the number of beds available during those days, then multiplied by 1,440 (the number of minutes in a day) to convert available bed days into available bed minutes. Summing across all twelve months provided the total annual capacity.

Consumer bed minutes were calculated by multiplying the number of admissions in each month by the average length of stay in minutes for that month, then summing across the year.

The annual utilization rate was then determined as the ratio of total consumer bed minutes to total annual capacity.

To adjust for reporting methodology, extended observation admissions were recalculated when appropriate.

### Limited Data Set

Due to the sensitive nature of protected health information, ACES requested a "HIPAA Limited Data Set," which would include de-identified patient-level data to conduct analyses.[xx] The Department approved a data sharing agreement between ACES and the individual centers on May 2, 2025. ACES received all Limited Data Sets by July 24th, but there was not enough consistency or accuracy to complete analysis. Due to the known issues with the data, ACES did not incorporate analysis of the Limited Data Sets into this report. Any analysis would potentially be incomplete or an inaccurate representation of the Crisis Centers and therefore is inappropriate.

### Financial Information

ACES conducted analysis of annual revenues and expenditures of each Crisis Center. It is important to note that the financials that were received were not audited and could possibly be missing some revenues from community sources. SpectraCare was included in this analysis due to the center receiving funding beginning in FY23.

# Thematic Analysis of Peer Interviews

ACES coded peer interview notes using a thematic analysis methodology. The coding was then analyzed and summarized for prevalence between peers at each Crisis Center and overall. The information from peers that was highly prevalent rose to the level of findings and can be found within the body of the report. The observations in this appendix are important but may not be as prevalent.

## Stabilization

Consumers come through the doors of Crisis Centers experiencing a variety of crises. They may be severely intoxicated, suicidal, paranoid, or actively delusional. Even though the centers are voluntary, they may be afraid of what is to come next, reluctant to stay, and unsettled or destabilized by whatever series of events immediately preceded their arrival. Peers manage these symptoms in a variety of ways. Many peers greet consumers as they walk in. If the consumer is at all receptive, peers seek to build trust by explaining that they have personally experienced similar crises. Peers are trained in various de-escalation tactics which they utilize as needed. Peers affirmed that, most of the time, de-escalation tactics were successful to achieve initial stabilization.

Some consumers in crisis find the material and administrative realities of entering the Crisis Center intolerable. Peers noted that consumers may become distressed when they learn they will have to part with valuables or items that give them comfort, such as phones or radios. Sometimes, this distress is overwhelming causing the consumer to leave.

## Provision of Psychiatric Services

Peers delineated between what they can do in the temporary observation area (<24 hours) as compared to the extended observation area (up to seven days). In temporary observation, many consumers are still experiencing acute symptoms and may be in physical distress if they are detoxing or adjusting to new medications. While many are not up for prolonged interaction and relationship-building, peers do spend time in temporary observation units to check on consumers. In extended observation units, some centers run peer groups or do one-on-one activities with consumers such as talking and coloring. Peers advocate for accommodations they think will improve consumer engagement and wellness such as providing coffee to morning groups, moderating TV or film content in shared spaces, or adapting schedules to a consumer's needs. Peers find outdoor spaces useful both as a change of scenery and as a place where some consumers are more likely to engage. Interestingly, at a facility where consumers are allowed to smoke cigarettes (outdoors only), a peer noted consumers who were otherwise not talkative opened up during outdoor cigarette breaks.

## Discharge and Referral to Community Resources

According to the interviewed peers, all centers analyze the treatment and recovery landscape in their areas and build knowledge about and relationships with resource providers, including homeless shelters, recovery support operations (including 12-step programs), and direct service organizations that offer food, clothing, job training, and other forms of support. They also work to cultivate and maintain relationships and knowledge that can be used to the benefit of the consumer. Most centers provide departing consumers with a week or more of medication for free so they can maintain stability long enough to attend follow up appointments.

Peers also acknowledged **bed scarcity** as an issue. Bed scarcity creates impediments whether people are being discharged back into the community or to in consumer placements. Peers expressed the need for a real-time bed registry to aid in quickly finding appropriate follow-up care.

## Structural Challenges

**Homelessness**: Consumers experiencing homelessness who are in mental health or substance use crisis may face difficulties after discharge due to structural issues beyond the centers' control. Official identification is a requirement for staying in some shelters and a necessity for various routes to stability such as renting a dwelling, getting a job, or opening a bank account. Some Crisis Centers assist consumers in obtaining identification, but the process can be expensive and take longer than the seven-day maximum stay.

**Rules about who can stay and under what conditions** are also structural barriers. Some locations, particularly those that offer inpatient treatment, require consumers to have insurance. Many faith-based providers will accept consumers without insurance, but some of them ban commonly prescribed psychiatric medications. Peers say that these regulations make consumers choose between housing and psychiatric wellbeing and/or sobriety. They may have family or friends who bring them their medication each day, but doing so is risky because unauthorized possession of a controlled substance like Suboxone comes with risk of criminal charges.

## Other Challenges

Crisis Centers are not designed to meet the needs of every type of crisis a person might experience. Sometimes, this creates misunderstandings. For instance, Crisis Centers are not set up to support women who need shelter after fleeing domestic violence. They are not permitted to admit children. Peers stated they may not be able to provide adequate care for consumer with intellectual and/or physical disabilities that severely limit their mobility or ability to manage basic hygiene. Balancing the desire to provide resources or direction to everyone who walks through their doors with the reality that not every crisis is suited to the Crisis Center model is a challenge that requires ongoing attention and vigilance. However, peers at most centers noted that everyone who comes through their doors is offered some type of resource, even if it is only information about local providers who may better meet their needs.

Crisis Centers may serve fewer consumers from communities outside the immediate metro areas in which they are located. Multiple peers wished out loud that they would see more consumers from outside the immediate area. They were uncertain about what could be done to improve their reach, but they expected word of mouth would be the best way. Unsurprisingly, the older centers have stronger and more refined connections throughout their service areas, with peers noting referrals from law enforcement, hospitals, and direct service providers. One center had to clarify its role with a local emergency shelter that was dropping off unhoused people not otherwise in crisis. That behavior has since stopped.

# Monthly Report Data Analysis

Throughout the analysis stage, ACES raised concerns regarding the accuracy and validity of the report data provided. For example, there were inconsistencies in how admissions and discharges were reported. Though ACES methodology accounts for this particular issue, other inconsistencies with methodology cannot be identified or accounted for without the Limited Data Sets or other more detailed information.

## Presenting Symptoms

Bar chart showing count of consumers with suicidal ideation by crisis center by year for 2022, 2023, and 2024.Presenting symptoms are determined for each consumer at varying points prior to admission into the

**FIGURE |** Count of Consumers with Suicidal Ideation

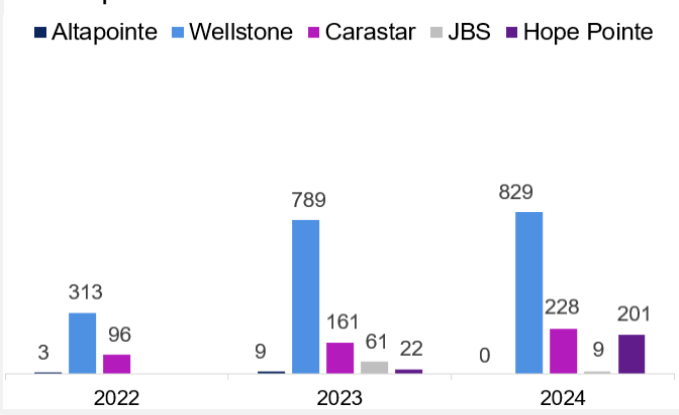



**FIGURE |** Count of Consumers with Psychosis

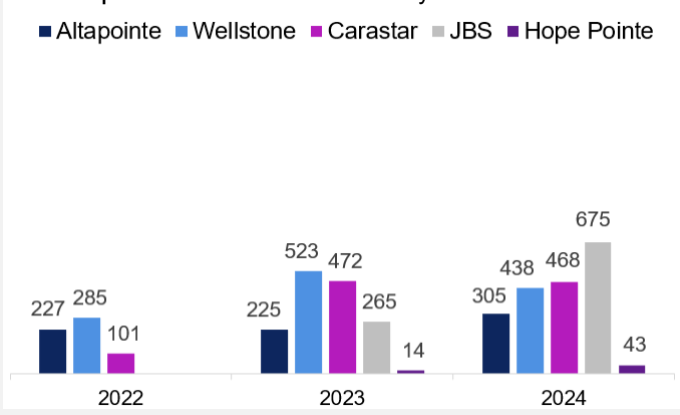



**FIGURE |** Count of Consumers with Anxiety

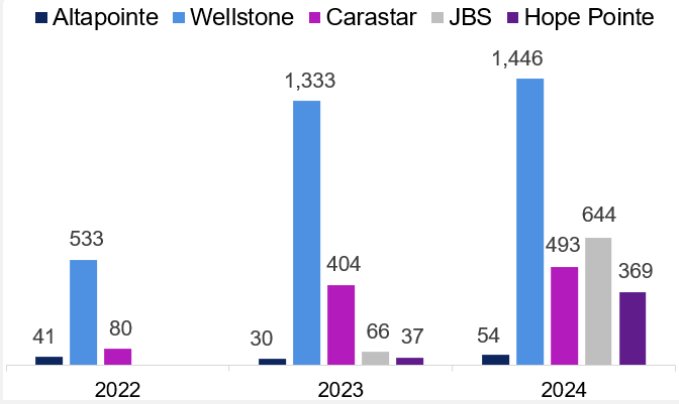



**FIGURE |** Count of Consumers with Depression

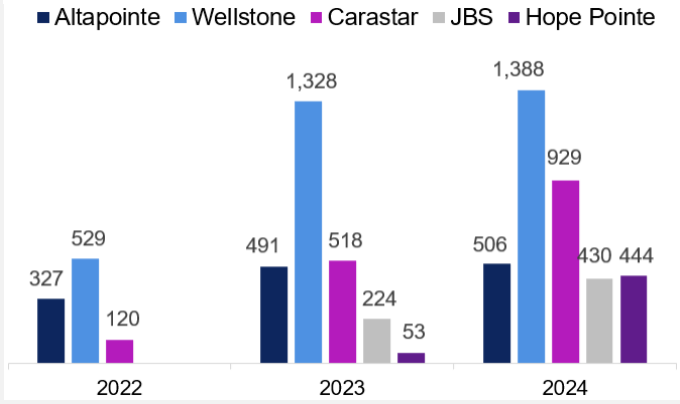



**FIGURE |** Count of Consumers with Mania

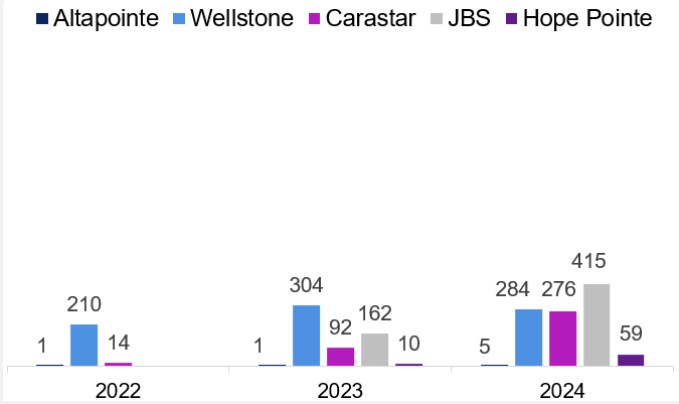
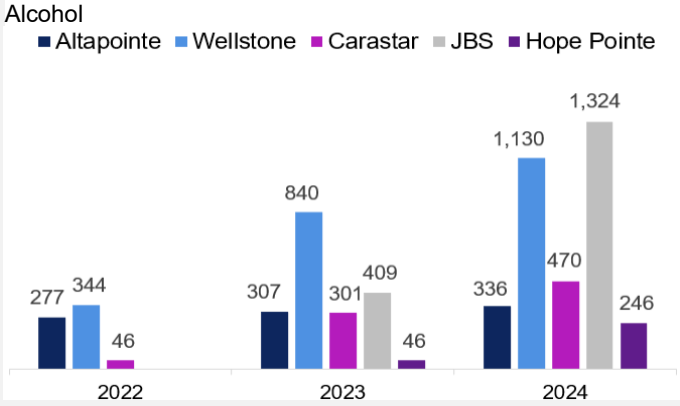



**FIGURE |** Count of Consumers with Substance Use Including Alcohol

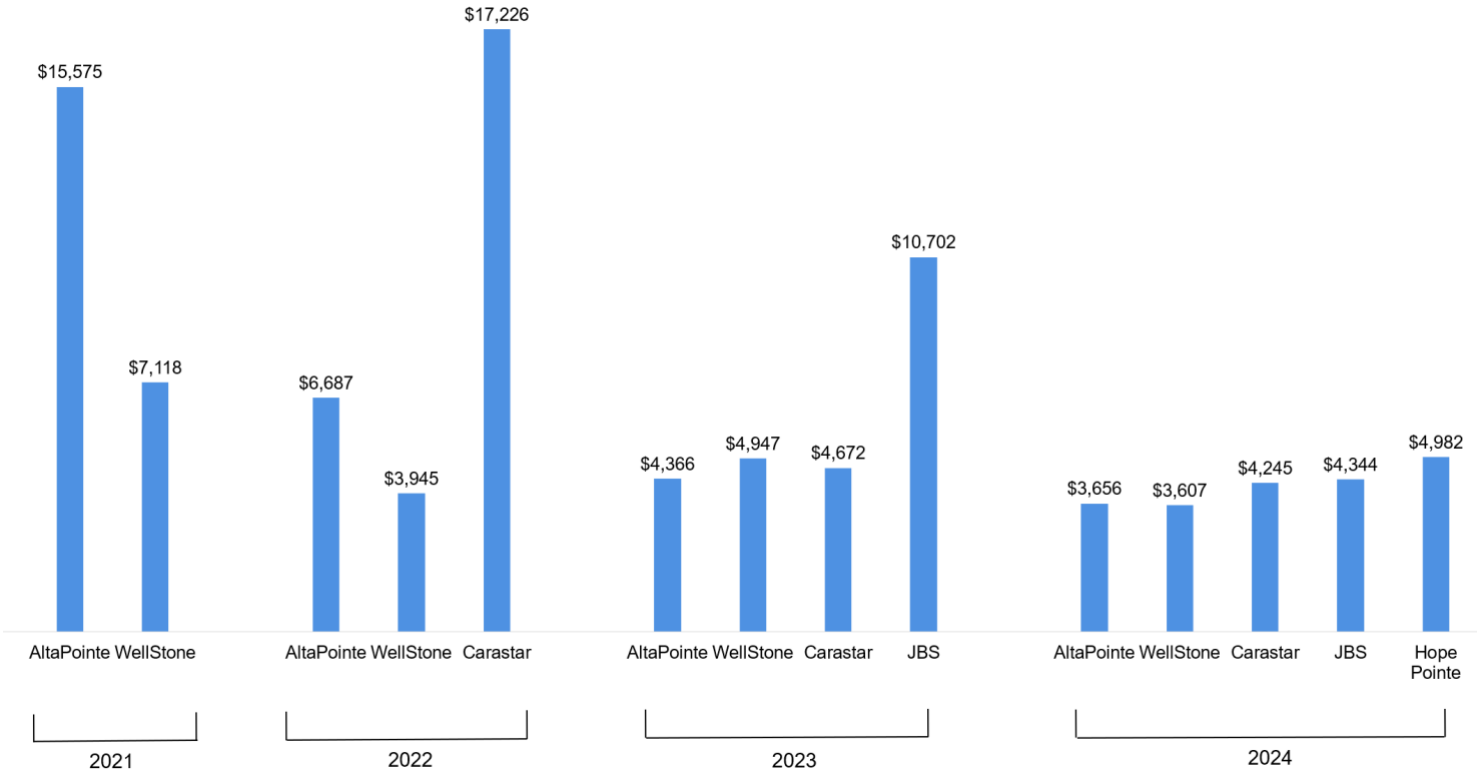


Crisis Center. This may be obtained through an evaluation or through consumer self-report. A consumer may present more than one symptom. This data point was not tracked prior to 2022.

## Cost per Interaction

As an alternative to cost per bed day, ACES also calculated the cost per each interaction. An interaction is any encounter that may or may not have led to an admission into the center. This includes triage encounters which is defined by the Department as "called or walked in requesting information but no evaluation completed" and consumers who left against medical advice prior to or after completing triage.[xxi] Like cost per bed day, the cost reflects operating expenditures which excludes capital and non-cash expenditures. The first year a center appears does not include a full year of operations except for Hope Pointe.

**FIGURE |** Cost per interaction by center and fiscal year



## UTILIZATION

Utilization was also analyzed as a standalone variable. The figures below show the trends in utilization for temporary observation and extended observation every six months since each center opened. Temporary observation utilization may be deflated due to the shorter time limit.

**FIGURE |** Temporary observation utilization rate by length of time since center opened

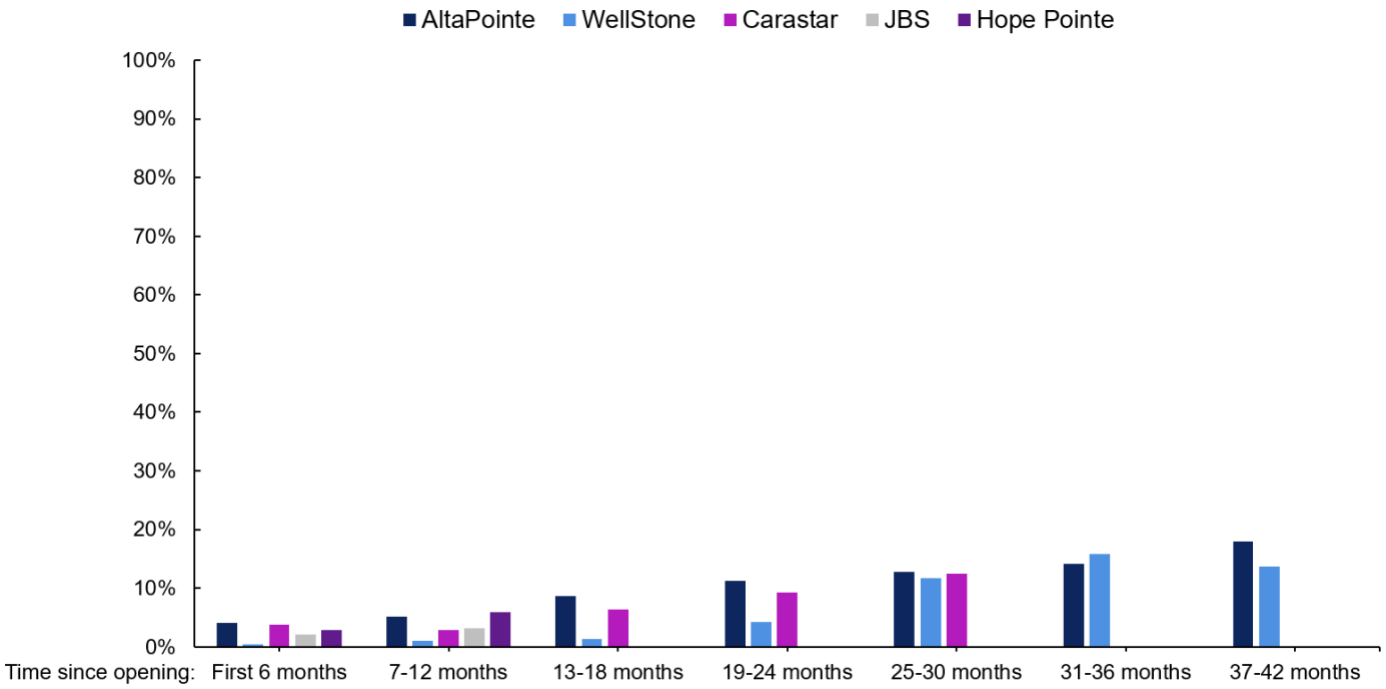
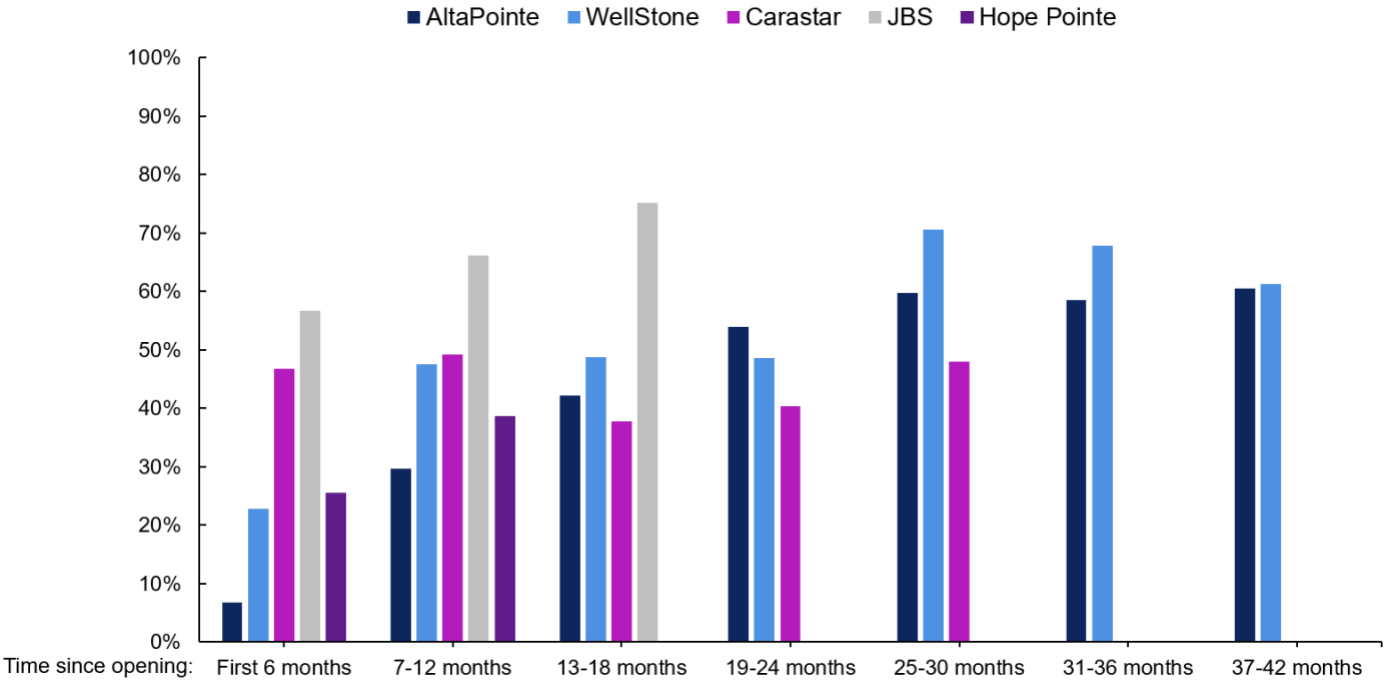



**FIGURE |** Extended observation utilization rate by length of time since center opened



# AGENCY RESPONSE:

# ALABAMA DEPARTMENT OF MENTAL HEALTH

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Kay Ivey
Governor

Kimberly G. Boswell
Commissioner

August 25, 2025

Alabama Commission on the Evaluation of Services
64 North Union Street
Suite 479
Montgomery, AL 36130

Dear Members,

I first want to thank you for your commitment to upholding transparency, efficiency, and accountability in Alabama's state government through your service on the Alabama Commission on the Evaluation of Services (ACES). Through previous education and experience conducting program evaluations, I have a deep appreciation for the work of the ACES Commission Members, leadership, and staff members. While the rest of this document will provide further evidence to the three themes below, I will repeat to you what I said to the ACES staff in our Stakeholder Meeting, August 18, 2025. Reading the report with its negative tone knowing providers worked tirelessly (and in the middle of COVID) to stand up six crisis centers in five years was heartbreaking for everyone involved.

Our evaluation of the Crisis Centers was a simple one. It started with an RFP process that outlined the requirements for the crisis centers. Shortly after the awarding of grants, National Guidelines were published. Our focus was fidelity to the model (Are you delivering the services you said you were going to deliver?) and data collection to address the outcome measures outlined in the National Guidelines.

The purpose of this letter is to respond to the most recent ACES report: *An Evaluation on Crisis Centers*. There are several overarching themes to the report that raise significant concerns about:

1. the lack of evaluation design and agreed upon measures,
2. the lack of time to address data errors and resources to conduct a more rigorous evaluation, and
3. the lack of context provided to give policymakers a full picture of the Crisis Centers' strengths and setbacks.

Regarding the evaluation design, the ACES staff aspired to conduct an impact evaluation. Initially, the ACES staff was interested in linking our client data to hospital and jail data. As they learned, jail data and hospital data are not available. This would have required sharing of protected health information (PHI). As discussed in your last Commission meeting, ACES is not able to accept PHI even if we could have worked through all the legal issues. Time was wasted trying to clarify this

request versus the limited data set that was ultimately submitted. In addition, decreasing ED's admissions and increasing jail diversions are outcome measures not an evaluation of impact. The report was written to the outliers in the information collected, rather than the extensive amount of data provided by ADMH and the Crisis Centers.

Certainly, there were data errors that needed to be corrected. Neither ADMH nor the Crisis Centers were given the chance to review, question, or address the concerns that resulted in ACES throwing out *all* of the monthly programmatic data we have collected since the inception of these programs. Many of the data errors occurred in the first 18 months of opening and data accuracy improved over time as new guidance came out. It raises questions about the effectiveness of evaluating programs that are still in the start-up phase.

Although we agree with many of the recommendations made in the report, they do not necessarily align with the generic statements made before them, nor the description of the evaluation that was stated in our engagement letter: "Evaluation objectives will encompass the effectiveness, efficiency, and capacity of crisis diversion centers."

I join and applaud Alabama's leaders for prioritizing data-informed policymaking. The ACES staff was kind, professional and respectful to all the Crisis Centers. Having participated in three evaluations with ACES, I know the challenges for the ACES staff. Impact assessments and evaluations are some of the most challenging types of evaluations. While a handful exist for health-related impacts, very few exist for behavioral health. When they do, most studies take years to design, plan and complete. If the Commission is in agreement with the types of evaluations the ACES staff aspires to complete, they will need to consider adding staff with different skill sets and adding considerable resources.

Standing up six crisis centers in five years and in the middle of COVID is no small task and I don't believe this evaluation reflects an accurate picture of the strengths and weaknesses. I have attached additional comments for your review.

Sincerely,

Kimberly G. Boswell
*Commissioner*
Alabama Department of Mental Health

ADMH

**ADMH RESPONSE TO ACES REPORT: *An Evaluation on Crisis Centers***

The purpose of this document is to respond to the most recent ACES report: *An Evaluation on Crisis Centers.* There are several overarching themes to the report that raise significant concerns:

I. The lack of evaluation design and agreed upon measures;
II. The lack of time to address data errors and resources to conduct a more rigorous evaluation, and;
III. The lack of context provided to give policymakers a full picture of the Crisis Centers' strengths, as well as setbacks.

The following table outlines further evidence to the issues stated above in page order.

| PAGE | REPORT LANGUAGE OR SECTION | ADMH RESPONSE |
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| 2 | OVERALL SECTION: An Evaluation of the Alabama Department of Mental Health's Crisis Centers | A critical first step in the evaluation process is gaining an understanding of a program's purpose, as well as understanding the context of a program's establishment. Significant context is missing in this section that is fundamental to designing an appropriate evaluation:<br><br>- Before the state's investment in Crisis Centers, there was no place to go on a walk-in basis, 24/7/365 for individuals experiencing a mental health, substance use, or suicidal crisis. Alabamians were left with the option of going to either the ER, waiting days or weeks for an appointment, or not receiving care.<br><br>- The state's investment in Crisis Centers established an entirely new system of care consisting of new, start-up programs. Evaluators must take this into consideration when developing an evaluation design.<br><br>- At the time ADMH received funding for Crisis Care, there were no standards or guidelines from SAMHSA. Since, |

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| | | ADMH and the six Crisis Centers operate within the SAMHSA best practices, which is often referenced in this report (see footnote 2).<br><br>- Due to the significant demand for 24/7/365 behavioral healthcare, compounded by the pandemic, four out of the six Crisis Centers opened temporary locations before opening their current, permanent buildings. These include Altapointe, Carastar, Wellstone, and Hope Point (new building opened in March 20225 with an increase in beds).<br><br>- Spectracare's grand opening of the Dothan-based Crisis Center was significantly delayed due to several unforeseen issues, including supply-chain issues as well as the heart attack and death of an employee in the Crisis Center during its final stages of construction. At the same time, staff were hired and trained prior to the opening, so that the Crisis Center would be able to fully operate on day one. |
| 3 | "This evaluation seeks to analyze the following:<br><br>1. What impacts do Crisis Centers have on the communities they serve?<br>2. How have Crisis Centers improved the quality and access to care?<br>3. Is the program delivered to fidelity across all Crisis Centers?<br>4. What costs are associated with Crisis Centers?" | When ADMH received the draft report, this was the first time we were presented with the purpose statement of the evaluation. This is evidence of the lack of evaluation design needed on the front end to review ACES staff's intended evaluation purpose, develop a logic model to meet this purpose, and implement an evaluation plan with agreed upon measures that would provide them with the information they need.<br><br>Developing a logic model, or another similar concept, is a critical component to evaluation design. It provides a road map to your evaluation that is based in reality, and it also helps outline what measures are needed to conduct your evaluation. This – nor any process like it – was completed on the front end of the evaluation |

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| | | process. Rather, ADMH blindly gathered the information and data requested by ACES with the resources, staff, and IT infrastructure available at the time. |
| 4 | "Although Crisis Centers collect and report data, the current data does not measure impact on these outcomes and is not uniformly collected across all the Centers." | If ACES staff intend on completing impact evaluations, rather than outcome evaluations, this should be discussed and outlined on the front-end of the evaluation design process. Unfortunately, this did not happen, and ADMH found out ACES' expectations of conducting an impact evaluation in its 8/18/25 Stakeholder Meeting.<br><br>If the Commission agrees with ACES staff that the Crisis Centers should undergo an Impact Evaluation, rather than an Outcome Evaluation, this requires a significantly higher level of evaluation design, sophistication, and data collection that involves Protected Health Information (PHI). Further, it involves data collection from outside, private entities that ADMH does not have oversight of, such as hospitals and jails. Finally, it requires several years of evaluation when a system or program is well established, rather than the start-up phase.<br><br>The Commission should carefully evaluate its capacity and willingness for ACES staff to collect PHI, as there could be significant legal and programmatic consequences. Without the correct infrastructure, BAAs, or data sharing agreements in place, ACES staff requested sensitive PHI data (social security numbers, names, zip codes, presenting symptoms) from the Crisis Centers over regular email. In response, ADMH asked the Crisis Centers to not respond in order to prevent them from breaking several federal laws, and to wait until an agreement was made with ACES. This ultimately led to unidentifiable data being shared after a considerable amount of time and resources were spent on several CMHC attorneys. |

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| 5 | **"There are deficiencies in the Department's strategic control of Crisis Centers.** Strategic control is a process for determining the extent to which the organization or agency's strategies are successful in meeting its goals and objectives. It should address the gaps between intent and realized goals.[vi] | This is an opinion that is not backed by facts. As stated in the cover letter, we fully implemented the evaluation design planned by ADMH.<br><br>ACES cannot make the determination on whether the Department has "strategic control" over the Crisis Centers, by their definition, because ACES has a different understanding and expectation of the Crisis Center's goals and objectives. As stated in the report, each Crisis Center operates in fidelity, and the Department oversees their ability to keep patients safe and cared for while meeting state and federal outcome measures. |
| 5 | "After the Department awarded funding for CMHCs to establish a Crisis Center, the Department allowed the CMHCs to take on much of the operational management. Although Crisis Center operations are primarily the CMHCs' responsibility, the Department continues to play a key role in approvals, investigating complaints, and oversight. Despite the Department's role in oversight, there is a lack of clarity surrounding the processes and procedures that are taken to ensure data is collected to uniform standards. Without clear oversight and strengthened strategic control, there is limited information to reliably evaluate performance." | These false opinions are backed by false assumptions and a lack of context. Each of the Crisis Centers can speak for themselves on how involved the Department was in the development, launch, and implementation of the programs. While the program started without set national guidelines, the Department set expectations on service delivery, use of funds, and data collection. As national guidelines were published, the Department made sure Crisis Centers were following them to the fidelity of the model.<br><br>The data the Department collects is aligned with the national guidelines for the evaluation of services. It was not until the 8/18/25 meeting that the Department learned that ACES does not consider the extensive data the Department collects as measures it would accept.<br><br>ACES cannot make claims like this when it does not hold its own evaluations to the same standards. There was no work on the front end to develop and agree upon the best ways to measure outcomes and/or impact. |

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| 5 | **"The Department has not prioritized collecting consumer-based data from Crisis Centers.** Crisis Centers are viewed as one piece of a transitional infrastructure with a broader focus of gaining access to more federal funding through becoming a CCBHC. According to the Department, developing a data system specifically for Crisis Center outcomes was thought to be inefficient as the centers shift into the CCBHC model which may require different data reporting metrics. It should be noted that while future data reporting may require different elements, SAMHSA emphasizes the importance of data collection and outlines which performance metrics should be tracked for crisis centers through ***Monitoring System and Provider Performance."*** | The Department has prioritized data since the inception of the Crisis Centers, insisting on the collection of data with the resources and tools available to us. As with any start-up system or program, the way data was collected as well as the measures tracked evolved with time and experience.<br><br>In the same guidelines ACES references, guidance on evaluation design and metrics for Crisis Centers are addressed. The Department tracks the overwhelming majority of metrics advised.<br><br>ACES makes the statement that the Department does not prioritize consumer-based data from Crisis Centers, when at the same time, ACES critiques the Department for using data that was self reported by the people served regarding avoidance of jail and the ED. |
| 5 | **Crisis Centers' monthly data reports contain inconsistencies, suggesting a lack of quality control and accountability in reporting**. The Department requires each center to submit monthly reports that align with metrics found in the SAMHSA Guidelines. While the Department does provide a data dictionary for these metrics, Crisis Centers' reports, at times, deviate from the definitions. Additionally, some of the provided definitions are broad, leaving room for interpretation, creating inconsistencies in how a metric may be reported. For example, there were inconsistencies in the reporting of temporary observation discharges, where reporting differed among centers and differed within the same center from month-to-month. Variations in data and differences in reporting methodologies among centers suggest other data points such as presenting | This is an example of how the report was written to data outliers. It is also an example of how ACES is heavily critiquing a start-up system and its programs. Since the inception of the Crisis Centers, ADMH has worked with the program directors to define, track, and report data. This has been an evolving process, because this is an entirely new system with complex programming. For example, the data issues regarding temporary observation discharges used AltaPointe data from 2021 and JBS data from 2023 – the first year they opened. This was used as a basis the throw out all other data points for all years.<br><br>We are committed to explaining or resolving any issues raised with the data, which were given to ADMH in the 8/18/25 Stakeholder Meeting after this report was drafted.<br><br>We agree there needs to be more quality control of the data. |

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| | symptoms, emergency department or jail avoidance, and ambulatory follow-up rates are also affected. Currently, there are not any quality control measures in place to ensure monthly reports are reliable. | |
| 5-6 | **Consistent methodology is needed to determine Crisis Center effectiveness and impact.** One of the Department's key performance indicators of effectiveness is the number of individuals who avoided emergency department and/or jail admission. Even though these are designated outcomes, there is no consensus among centers in the way individuals who avoided jail admission is collected. One center has never tracked or reported avoidance of jail admission, always submitting zeros for this metric. Despite the consistent reporting of zero jail avoidances, this issue has not been addressed by the Department. While these examples largely influence the credibility of monthly reporting data, they also call into question the objectivity of these metrics. **When objective metrics are collected subjectively, they are unable to serve as key performance indicators of a program's success.** | It is important to note that an admission into the crisis center *is* the intervention. The individual is not in a hospital or jail. Rather, the individual is in the appropriate place to receive services and help.<br><br>Ideally, we would have like to collect jail and hospital data to validate our outcomes. This is impossible.<br><br>One option for ACES would have been to work with the EMS providers. Crisis Centers could have been asked "which EMS providers drop off and which do not?" Numbers from EMS providers could have been used to verify drop offs. For those that do not drop off, a short survey could have been developed to identify barriers.<br><br>One center did not collect jail data because they did not have a methodology. This does not call into question the objectivity of the metric. In fact, quite the opposite. This is not an indicator of inaccurate data – this is missing data. Technical assistance should have been provided to this provider. |
| 6 | Because of the subjective and inconsistent nature of current data collection, the Department cannot determine the extent to which the program's strategies are successful in meeting its goals and objectives. Additionally, ACES cannot verify the accuracy of key performance indicators or determine whether Crisis Centers are reducing the strain on emergency rooms and jails. Since the methodologies used to track these | The report's assertion that they cannot determine the success of its strategies due to subjective and inconsistent data collection reflects a narrow and incomplete analysis. The report focuses exclusively on two metrics—emergency room and jail diversion—while disregarding the broader scope of data that speaks directly to program effectiveness and patient care. |

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| | performance metrics and outcomes are unreliable, they do not support a robust evaluation of effectiveness. | This critique fails to recognize key indicators such as the number of individuals served, those discharged safely and in stable condition, and those receiving follow-up care. These metrics are central to evaluating the impact of Crisis Centers and the overall health outcomes of the populations served. They are also metrics that are in the SAMHSA guidance for Crisis Center evaluations.<br><br>Moreover, the inability of ACES to verify the accuracy of performance indicators appears to stem not from flaws in the data itself, but from a fundamental lack of understanding of how to evaluate a healthcare system and its complex, multi-dimensional outcomes. Their limited methodology does not account for the nuances of behavioral health care delivery, nor does it reflect best practices in program evaluation.<br><br>To dismiss the program's effectiveness based on two isolated metrics—while ignoring the broader clinical and operational data—is not only misleading, it undermines the integrity of the evaluation process. A robust assessment must consider the full spectrum of outcomes, not just those that are easiest to quantify. |
| 7 | **There are reimbursement barriers for EMS providers.** Crisis Centers are equipped as a prime spot for individuals in a mental health crisis, without need of medical intervention, to receive care. In 2022, EMS protocols were updated and the Alabama Department of Mental Health confirmed with the Alabama Department of Public Health that EMS drop-offs could be made, due to the Crisis Center's designation as a definitive care facility. While this designation allows paramedical services to drop-off consumers at a Crisis Center, Medicaid and private insurance are not required to reimburse those drop-offs. They only reimburse emergent EMS drop-offs at a hospital or for | EMS <u>can</u> drop off at a crisis center. Some do drop off and others don't. The issues are complex and would need more investigation to determine the real barriers. From the acknowledgments on the front page of the report, it appears ACES only spoke with one EMS provider. Medicaid does provide reimbursement for non-emergency transportation which is significantly less reimbursement than an emergency drop off to the ED. This is a policy issue ACES could explore in more detail and propose a more detailed solution. We had a good conversation with ACES about this problem. |

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| | a hospital-to-hospital transfer. Without a process to ensure adequate reimbursement for EMS drop-offs, Crisis Centers may be missing opportunities to provide services to consumers and alleviate burdens on hospitals. It is important to note that although financial reimbursement can be a barrier statewide, some Crisis Centers have worked to create partnerships with their local EMS providers. | |
| 7 | **Access to Care Findings from Peer Interviews**<br>Due to the sensitive nature of consumers' protected health information and multiple barriers, ACES did not directly interview consumers who have used Crisis Center services. As an alternate approach, ACES interviewed peers at the operating Crisis Centers. Certified Peer Specialists and Certified Recovery Support Specialists4 have a unique viewpoint into Crisis Center operations as they play a significant role in a consumer's time at the center. | It is important to note that the barriers that they are referencing is that ACES staff were informed that they could not interview patients while being treated at the Crisis Center, because that would be a violation of HIPAA as well as an interruption in treatment. HIPAA does not prohibit consumer engagement when its voluntary, consensual, and not during a patient's treatment. |
| 7 | **Overall, peers expressed pride in the quality and access to care Crisis Centers offer to consumers.**<br>Many peers said that if a Crisis Center had been available when they were in crisis, they would have benefitted from it. In addition to positive feedback regarding the centers, peers shared concerns about Crisis Center operations and the recovery process. | Evaluating the effectiveness, efficiency, and capacity of these centers requires a focus on clinical operations, service delivery, and system-level outcomes—not peripheral workforce components. Including unrelated findings dilutes the integrity of the evaluation and suggests a lack of clarity around what constitutes core operational metrics in a healthcare setting. |
| 7 | **Transportation barriers exist for consumers after leaving the Crisis Center.** | The evaluation was supposed to assess the effectiveness, efficiency, and capacity of Crisis Diversion Centers. Findings should reflect how well the program meets its intended operational goals—such as timely service delivery and successful linkage to follow-up care. |

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| | | While transportation barriers for consumers post-discharge may be a relevant concern in the broader behavioral health landscape, they are not a reflection of the Crisis Centers' effectiveness, efficiency, and capacity.<br><br>This is also an example of how the report is written to data outliers. Crisis Centers demonstrated strong fidelity in achieving a high percentage of follow-up appointments, which directly aligns with the evaluation's core metrics. However, those data points were not used or considered valuable, even though they were provided. Having an epidemiologist or a clinician on the evaluation team to interpret the data would have been a valuable investment for this evaluation.<br><br>Including unrelated findings risks misrepresenting the program's performance and diluting the focus on its operational strengths and needed improvements. |
| 8 | **Consumers need the proper assessments that facilitate timely access to care.** All peers at one center noted consumers who are seeking SUD treatment face barriers to receive care after leaving the Crisis Center. Part of the Crisis Center process for those with SUD is to complete a criteria assessment developed by the Department. This assessment aligns with the criteria developed by the American Society of Addiction Medicine (ASAM). This is a mandatory requirement for consumers to be admitted into a treatment facility that receives state funding after leaving the Crisis Center. The peers stated that their center's criteria assessment would not transfer to the treatment facilities. Consumers have to call or visit | This is one Crisis Center whose CMHC did not previously provide substance use treatment. The reason this Center's ASAM Assessments did not transfer to other facilities is because the Center was using the standard ASAM, not the complete ADMH version of the ASAM. This issue has since been corrected with collaboration from the other crisis centers.<br><br>ADMH is grateful to ACES for identifying this issue. |

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| | outside resources to have the correct criteria assessment completed for admission into treatment. Many consumers feel discouraged when they are required to take an additional assessment, especially when they believe they have already taken that specific assessment. At times, this could be a big enough hurdle for them to stop the recovery process completely. | |
| 9-10 | **"Crisis Centers consistently operate with fidelity to the guidelines.** All six centers have been operational 24 hours a day, seven days a week since opening. They are staffed with the appropriate professionals, receive walk-ins and first responder drop-offs, and provide care coordination which includes referrals to other community services. Finally, all centers maintain low barriers to admission. Consumers are not excluded for inability to pay for services nor denied admission based on Medicaid or private insurance criteria.**"** | As stated in the cover letter, this was an important part of our evaluation design. Sustaining 24/7 operations with appropriate staffing is far from a passive accomplishment—it requires ongoing recruitment, retention, and training of specialized professionals within an already strained workforce. The ability to accept walk-ins and first responder drop-offs demands robust triage protocols, real-time coordination, and the capacity to manage unpredictable volumes and acuity levels.<br><br>The fact that these centers have consistently delivered on these commitments since opening reflects not only operational success, but a deep and enduring dedication to community needs, clinical integrity, and system-wide collaboration.<br><br>This level of fidelity is neither easily reached nor effortlessly sustained. It depends on strategic oversight, leadership, resilient infrastructure, and a workforce that is both highly skilled and deeply compassionate. Without proper context, this narrative risks minimizing the extraordinary work being done on the ground every day. |
| 10 | **"Consumers occasionally exceed the maximum duration for length of stay."** | Discharging a consumer prematurely places their treatment, progress, and safety at risk. This clinical reality is entirely absent from the evaluation. Evaluating without this context is not only misleading—it undermines the integrity of the entire assessment. |

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| | | Once again, the focus is placed on an outlier in the data without any attempt to investigate the underlying reasons. No follow-up was conducted to clarify why these numbers appeared, which further calls into question the validity of the conclusions drawn. |
| 10 | **Involuntary holds have occurred at some Crisis Centers.** In addition to the SAMHSA Guidelines, the Department described voluntary admissions as a key element of a Crisis Center. While the 2020 SAMHSA guidelines do not refer to voluntary admissions as a minimum expectation or best practice, the 2025 SAMHSA Guidelines state that Moderate-Intensity Behavioral Health Crisis Centers and Extended Stabilization Centers "accept only individuals who are voluntarily seeking services and are unable to provide services for individuals on involuntary holds." | Crisis centers were always designed to be a place for voluntary treatment. The purpose did not change from the inception to the 2025 guidelines as this report portrays.<br><br>Additionally, another example of how the report was written to the outliers, as only one center allows for that due to local law. |
| 11-13 | OVERALL SECTION: Costs – What are the Costs Associated with Crisis Centers | The $7 million figure for Crisis Centers came from Georgia's Crisis System of Care. In an entirely new start-up system, the state invested in Crisis Care to have enough resources available to them to construct and implement 24/7/365 services in facilities that meet anti-ligature requirements.<br><br>ADMH nor the Crisis Centers know who ACES states has accumulated over $4.4 million across four years of state funding. For the Center it refers to regarding the $6 million, there is no acknowledgment that after the Center had significant delays, they were ready to serve on day one. This is also the only Center with a full call center as well as Mobile Crisis Team offices within it. Staff were also hired and trained well before the opening. Also, what is missing from this analysis is that many of our Crisis Centers are still paying off building loans and continued capital costs. |

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| | | There are significant flaws in the financial analysis, and ADMH questions the methodology of how utilization and average daily bed costs were calculated in Figure 2. ACES combined both temporary observation beds with the extended observation beds, which skews the numbers significantly. ACES also does not clarify that each of these centers are in a different year of service in this analysis. |
| VII | Data Methodologies: Utilization | The charts attached to the document were provided on August 22, 2025. Of most concern is the utilization table. Since we know most centers function at capacity most days, the table is not accurate. There could be several reasons including not taking into account the four centers that opened temporary units with a smaller number of beds. To say that is guessing because we have no idea how ACES calculated the numbers. |

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