MODEL BEHAVIORAL HEALTH CRISIS SERVICES DEFINITIONS

WORKING DRAFT

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Substance Abuse and Mental Health Services Administration

Model Behavioral Health Crisis Services Definitions

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Introduction

The United States is currently experiencing a national behavioral health crisis that is impacting individuals, families, and caregivers in virtually every community across the country. Recent data demonstrate the need for a behavioral health coordinated crisis system of care that can provide timely and comprehensive crisis services to adults, youth, older adults, and families living with mental health and substance use challenges. Data continues to demonstrate the urgent need for behavioral health crisis services in the U.S. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), in 2023, 5 percent of adults aged 18 years or older (12.8 million people) had serious thoughts of suicide. Of youth aged 12 to 17 years, 13.4 percent (or 3.4 million people) had serious thoughts of suicide.[1] The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics reported a provisional estimate of 49,513 suicides in 2022, which was 2.6 percent higher compared to 2021.[2]

Provisional data from CDC's National Center for Health Statistics indicate there were an estimated 107,543 drug overdose deaths in the United States during 2023—while this represents a decrease of 3% from the 111,029 deaths estimated in 2022, these losses continue to underscore the importance of immediately available care and support.[3]

In that same NSDUH survey, about 2 in 5 adults aged 18 or older with co-occurring mental illness and a substance use disorder (SUD) in the past year did not receive treatment for either condition.

In March 2022, Congress passed, and the President signed, the Consolidated Appropriations Act, 2022 (P.L. 117–103), which provided $5 million to establish the 988 Suicide & Crisis Lifeline (988 Lifeline) and Behavioral Health Crisis Coordinating Office under SAMHSA's Office of the Assistant Secretary for Mental Health and Substance Use. This legislation also established SAMHSA as the lead federal behavioral health crisis services entity. SAMHSA is dedicated to two key goals: (1) strengthening and expanding the 988 Lifeline and (2) transforming America's behavioral health crisis system. SAMHSA is actively working to achieve these goals and its vision of a comprehensive, integrated, equitable, and trauma-informed behavioral health crisis system, including "someone to contact, someone to respond, and a safe place for help" that is equipped to address crisis care needs.

Purpose of the Model Behavioral Health Crisis Services Definitions

Through SAMHSA's efforts to provide national leadership to support the transformation of crisis services and systems, SAMHSA, crisis experts, service providers, and payers have identified widespread variability in crisis services definitions. This has led to some confusion regarding what specific services entail and variability in service delivery. Further, state, territory, tribal, and local partners as well as public and private payers lack clarity on services definitions and minimum standards that would be needed to clarify services and payer coverage. The goal of the Model Behavioral Health Crisis Service Definition document is to publish guidance to serve as crisis services definitions that will promote quality of and consistency across services, widespread alignment of services, and further payer adoption of crisis service coverage. Achieving these goals will support increased access to quality, equitable care for the entire lifespan and all individuals.

Methodology

SAMHSA conducted a multi-pronged process to develop the Model Behavioral Health Crisis Services Definitions, which are based upon input and guidance from behavioral health crisis subject matter experts as well as existing and recommended practices in states, territories, tribes, and local entities. SAMHSA convened behavioral health crisis experts to discuss the need for definitions, standards, and essential components of this publication. SAMHSA included a range of external partners that conducted an environmental scan to identify the various crisis services available across the U.S., as well as how states and communities were defining and setting standards for services. With support from the Crisis Systems Response Training and Technical Assistance Center, SAMHSA gathered and synthesized behavioral health crisis services research, results from the environmental scan, and experiential data from states and local entities throughout the country. SAMHSA also hosted a number of listening sessions to gain input on current challenges with crisis services terminology. After multiple draft versions were processed, SAMHSA developed several draft definitions and standards documents and convened an expert workgroup of over 35 members to provide feedback on the draft in two virtual meetings in June of 2024 and one in-person convening July 9–10, 2024. The expert workgroup comprised representatives from state, tribal, and local governments; provider associations; public and private payers; behavioral health crisis researchers; and individuals with lived experience with mental health and substance use challenges. SAMHSA continued to revise the draft model crisis definitions document and sought feedback at a convening of 50 behavioral health crisis experts, including the original workgroup at a hybrid in-person and virtual convening on August 20–22, 2024 in Washington, D.C. SAMHSA sought additional feedback specifically from youth and families with lived experience with both behavioral health needs and child welfare involvement. SAMHSA developed the final version of the Model Behavioral Health Crisis Services Definitions document following the August 2024 convening.

The workgroup provided feedback on crisis services definitions according to SAMHSA's three essential elements of behavioral health crisis response: Someone to Contact, Someone to Respond, and A Safe Place for Help. Notetakers and writers documented all feedback through meeting minutes and recordings and worked with SAMHSA after the in-person meeting to reach consensus on revisions to the draft document.

How to Use This Document

SAMHSA developed the Model Behavioral Health Crisis Services Definitions document for state, territory, tribal, and local entities; crisis services providers; public and private payers; regulators; and help seekers and their supporters about the definitions for behavioral health crisis services as well as recommended elements and optional enhancements for specific services. State, territory, tribal, and local entities can use this document to assess their implementation of services along the crisis continuum and add or enhance services to their Behavioral Health Coordinated System of Crisis Care (CSCC). Crisis services providers also can review required and optional services for program enhancement, and they can examine service aspects such as optimal staffing, service setting requirements, and other factors to ensure they are aligned to the extent possible with the definitions and standards in this document. The various models under each category are intended to capture, categorize, and standardize the current services array across the country, not dictate that a state must have each element or elements to create a CSCC in their community. This document offering models of specific crisis services is meant to be used in coordination with the [upcoming National Guidelines 2.0] which focuses on how to integrate these services into a Behavioral Health CSCC.

Public and private payers as well as regulators may choose to use these model definitions and guidance to distinguish among various services and set their own requirements for specific services. Additionally, public and private payers can use this document to inform reimbursement for services using the model definitions and standards and the connection in this document of crisis services to American Society of Addiction Medicine (ASAM) criteria and the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) recommendations and standards.

The current versions of both the LOCUS Family of Tools (LOCUS, CALOCUS-CASII, and ECSII) and the ASAM Criteria (4th Edition, 2023) offer some potential opportunities for assigning "levels of care" to the emerging array of crisis programs in these guidelines. However, this must be done with caution, in that neither LOCUS nor ASAM is currently designed with this comprehensive and detailed list of crisis components in mind. Therefore, the suggested levels included in this document should be viewed as approximations only. We are hopeful that the emerging crisis continuum will inform future editions of both LOCUS Family of Tools and ASAM, so that these criteria all evolve together in providing consistent information for the field.

Finally, the broader community can use this document to better understand the array of crisis services that are provided in different settings to empower them to advocate for services and settings that best meet their needs and/or the needs of others in their community. While this document intentionally focuses on crisis services that have been a source of considerable confusion and variability, it is not intended to minimize the importance of other components of the behavioral health crisis and services continuum, including inpatient care, partial hospitalization, intensive in-home services, intensive outpatient treatment, and traditional outpatient care. Additionally, this document does not cover services that have been well defined in other publications or have standards or definitions already provided elsewhere at the state, federal, or local level (such as Certified Community Behavioral Health Clinics (CCBHCs)). In a fully functioning coordinated system of crisis care, all of these components need to work together to address the vision of meeting all needs, anywhere and anytime.

Organization of the Document

This Model Behavioral Health Crisis Services Definitions document is presented in accordance with the underlying principles of crisis care and SAMHSA's three essential elements of crisis response and the service types included in each element:

- **Someone to Contact: 988 and Other Behavioral Health Lines**
  - 988 Suicide & Crisis Lifeline;
  - Other Behavioral Health Crisis Hotlines;
  - Peer Operated Warmlines; and
  - Emotional Support Lines.
- **Someone to Respond: Mobile Crisis and Outreach Services**
  - Behavioral Health Provider-Only Mobile Crisis Teams;
  - Co-Responder Mobile Crisis Teams;
  - Mobile Response and Stabilization Services; and
  - Community Outreach Teams.

- **A Safe Place for Help: Crisis Stabilization Services**
  - Hospital-Based Behavioral Health Emergency 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;
  - High-Intensity Crisis Residential Programs;
  - Medium-Intensity Crisis Residential Programs;
  - Behavioral Health Urgent Care;
  - Peer Crisis Respite;
  - Sobering Centers; and
  - Children, Youth, & Families:
    a. In-Home Stabilization, and
    b. Youth & Family Crisis Respite.

Each of the services listed above has a section in this document that provides detail for the following elements:

- Service Type/Description;
- Distinguishing Features;
- Recommended Service Elements;
- Care Coordination/Follow-Up;
- Eligibility Criteria;
- Exclusionary Criteria;
- Discharge Criteria;
- Modality;
- Setting/Care Environment;
- Provider Type;
- Staffing Recommendations and Credentialing;
- Core Competency Recommendations;
- Suggested Data Elements, Metrics, and Quality Measures; and
- Optional Service Enhancements.

Overarching Principles

In pursuit of the strategic goals to strengthen and expand the 988 Lifeline and help transform the nation's behavioral health system of crisis care, SAMHSA has identified the following overarching principles that should guide the long-term development of behavioral health crisis services and systems. These principles provide a solid foundation for an integrated and effective behavioral health crisis system. This foundation ensures that individuals and communities have appropriate access and support to engage in the behavioral health continuum of care. These principles also offer aspirational guidance on the model definition of the services and standards that are prioritized in this document with the understanding that the activities to operationalize these principles will vary based on a myriad of factors.

A. Crisis Services Should Be Comprehensive, Coordinated, and Developed Utilizing a Systems-Based Approach

Behavioral health crisis services should be delivered through a Behavioral Health Coordinated System of Crisis Care (CSCC) that acknowledges the need for multiple systems (i.e., a system of systems) to collaborate and support the individual seeking services and their family and significant others. The Behavioral Health CSCC should include strong cross-sector partnerships between the public sector, private sector, and key non-profit entities. Critical partners include the network of 988 Lifeline crisis contact centers, mobile crisis teams (MCTs), crisis services providers, other behavioral health providers, providers addressing social drivers of health, state and local governments, tribal nations, payers, national mental health and suicide prevention provider and consumer groups, and multiple sectors with an interest in seeing a transformed behavioral health crisis care system, including first responders, law enforcement, emergency medical professionals, and 911 Public Safety Answering Points (PSAPs), among others.

Clear oversight structures are needed for the CSCC to drive system implementation and ensure that individuals can move throughout the system and participate in different services without experiencing gaps in care—(i.e., to ensure seamless support and flow for the help seeker across various system components). Meaningfully improving an individual's prospects for success requires not only high-quality triage, crisis services, and discharge planning but also an understanding that a CSCC is a large network of systems that should work together to meet the needs of individuals. Systems that should be part of a CSCC include, but are not limited to, healthcare settings, including emergency departments (Eds); schools; social service agencies; housing providers; public safety-first responders; and adult and juvenile justice systems, among others. A community's crisis system is embedded within a behavioral health continuum; it is not meant to replace a robust behavioral health system that includes services for people with a wide array of needs. Crisis services should be linked to the broader continuum of health and behavioral health services and social supports, including, but not limited to CCBHCs and Federally Qualified Health Centers (FQHCs). Crisis service providers should consider engaging family, unpaid caregivers, and/or other supporters at all stages of crisis care. This engagement can provide valuable support during the acute stabilization phase of the crisis and facilitate engagement with follow-up care to prevent future crises through fostering a connection with the community.

Services within the crisis system should be able to address all the behavioral health needs of an individual in crisis. Throughout the crisis system, services should be co-occurring capable and designed to meet the needs of individuals who present with SUDs as well as mental health

conditions. This means that services should serve all individuals, families, and other supports in a behavioral health crisis regardless of diagnosis or lack of diagnosis.

Crisis staff should be trained to recognize and assess substance use conditions. Providers should not exclude individuals regardless of substance-related or co-occurring needs at time of service if it is safe to engage them (e.g., not actively experiencing a life-threatening overdose or intoxication leading to high-risk behaviors that are unable to be safely de-escalated). Providers should have established policies and protocols for serving individuals experiencing substance use intoxication and/or withdrawal and protocols for screening, brief interventions, harm reduction, and referrals to higher levels of care in circumstances where the need of the individual exceeds provider capabilities.

All crisis services providers and staff are likely to encounter individuals with co-occurring needs and therefore should be trained and supervised based on their job and level of training. This includes competency in how to engage, screen, and manage the needs of individuals who may be experiencing co-occurring mental health and substance use needs.

B. Crisis Services Should Be Person-Centered, Family-Focused, and Provide the Right Level of Care at the Right Time

Crisis services should be strength-based, person-centered, resilience and recovery oriented and responsive to those in need. When able, family members, caregivers, and other supporters may act as partners, in resolving the acute crisis, stabilizing, and safely supporting the individual within any crisis service setting. The coordinated crisis services that SAMHSA envisions allow people and their families, caregivers, and other supporters (when appropriate) to determine what is a crisis and when emergency services are needed to the greatest extent possible. As with the use of 911 and Eds, the help seekers themselves can define the crisis. This is fundamental when designing, building, and/or enhancing the crisis continuum in a community. Individuals, families, and caregivers and other supporters can define what is a crisis and therefore a system should have services to address all levels of crisis need. Communities should have an array of crisis services at different levels of care, including emergency access for people who have the highest acuity of need and services in less restrictive and more inclusive environments for those with less acute needs. Communities should ensure timely access to services and strive for short wait times and high response rates for services. Services across the continuum should recognize Psychiatric Advance Directives (PAD) and Wellness Recovery Action Plans (WRAP), as locally authorized, to further support person-centered care.

It is imperative for a community's behavioral health crisis services continuum to have the capacity to assess individuals in crisis and to ensure that they receive the appropriate level of care at the appropriate time to serve their needs, improve their mental health and substance use-related symptoms, address social drivers of health, and help mitigate current and future crises. Collaboration among all partners in the service continuum is critical, including 988 contact centers; MCTs; crisis stabilization settings; hospitals/Eds; residential programs; peer services; 911 PSAPs and public safety first responders; and others. Delineation of which types of services are available for whom, and what level of care corresponds to these services is described in SAMHSA's publication, Model Behavioral Health Crisis Services Definitions. This publication defines behavioral health crisis services and links them to the ASAM Patient Placement Criteria that consider multiple dimensions of need[4] and the LOCUS and CALOCUS, which attempt to delineate levels of care that are appropriate for an individual at any given time.[5] Of note, these crosswalks are approximations and not definitive matches.

Collaboration should exist at both the system level and the individual person and family/caregiver level. Many people experiencing a mental health, substance use, or co-occurring crisis will have contact with multiple systems and providers. Crisis systems should be embedded within larger behavioral health continuums and include strong collaboration and coordination across crisis system partners. Equally, the crisis service continuum should be coordinated across its own service array, allowing for seamless connection between the three essential elements of the crisis care system: Someone to Contact, Someone to Respond, and A Safe Place for Help. People in crisis and their supports require “no wrong door” entry into the crisis system with quick connections to the right service, at the right time, in the right location.

C. Crisis Services Should Prioritize Safety

While many crisis events do not involve life-threatening situations, crisis settings often provide care for people who are experiencing them and should be able to assess and mitigate those risks accordingly. Safety, for individuals experiencing a crisis, those providing the services, and the community as a whole is a foundational element for all crisis service settings. Capacity to screen, assess, and respond to the varied needs of people in crisis, including those with suicidal or homicidal thoughts and plans, as well as people who are at risk of substance-related overdose, is a key to crisis system design. Services and systems should be designed in a way that people have a sense of both physical and emotional safety. Furthermore, the services should be operated in a physical setting (when applicable) and manner that promotes the safety of the service delivered through strong policies, procedures, protocols, training, and quality improvement activities that promote safer care and positive outcomes, while minimizing adverse outcomes, for both those receiving and providing care as well as visitors. Individuals with disorders such as psychotic disorders may also be at risk of not being able to care for themselves; risks to safety and well-being for this population should also be a consideration.

Developing a crisis or suicide safety plan is vital for promoting both the immediate safety and long-term stability of people seeking behavioral health crisis care. The Centers for Medicare & Medicaid Services (CMS) in its proposed rule describes the basic components of safety planning. The safety plan development process should be collaborative with the care-seeking person and the provider, and should focus on their strengths and goals. SAMHSA describes safety planning in detail in Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth, an evidence-based resource guide. This resource details the need for a safety plan that is brief, clear, and person-centered. Safety planning can be done with any qualified crisis or health professional and should be made universally available to all individuals at high risk of or experiencing a behavioral health crisis.

Overdose prevention is also critical. SAMHSA has released the *Overdose Prevention and Response Toolkit* which provides guidance about how to prevent and respond to overdoses. Crisis systems should be developed with the evolving understanding and responsivity to the culture of substance use in their service catchment area including overdose trends. They should also be aware of harm reduction principles and activities, and consider any relevant laws governing harm reduction activities, such as naloxone distribution.

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that healthcare organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC). The following seven key elements of Zero Suicide or Suicide Safer Care are applicable to crisis care:

- Creating a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
- Training providers in evidence-based and culturally informed clinical practices;
- Systematically identifying and assessing suicide risk among people receiving care;
- Ensuring every individual has a pathway to care that is both timely and adequate to meet their needs and includes collaborative safety planning and a reduction in access to lethal means;
- Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
- Providing continuous contact and support, especially after acute care; and
- Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.[6]

It should be noted that the elements of Zero Suicide closely mirror the standards and guidelines of the 988 Suicide & Crisis Lifeline, which has established suicide risk screening and assessment standards, guidelines for help seekers at imminent risk, and protocols for follow-up contact after the crisis encounter. Zero Suicide also promotes collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors into the service provided. This framework can also be used for overdose prevention as well.

Finally, although individuals with behavioral health conditions are more likely to be a victim of crime than a perpetrator, crisis services need to be aware of how to assess for the risk of both aggression or violence and risk of victimization of an individual who has a behavioral health condition(s).

D. Crisis Services Should Be Equitably Accessible and Responsive to the Diverse Needs of Populations

CMS defines health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.” SAMHSA defines behavioral health equity as the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

In pursuit of equity, it is necessary to acknowledge that access to behavioral health crisis care services can vary significantly for different populations. All crisis services should be universally accessible and support underserved populations (e.g., LGBTQI+ youth and adults, people who live in rural areas, people with disabilities, older adults, American Indian/Alaska Native (AI/AN) communities and other racial and ethnic minority groups). The U.S. Department of Health and Human Services (HHS) recently published its *Agency Equity Action Plan* to address the behavioral health issues that disproportionately impact underserved populations.

Crisis services should be designed to facilitate access and utilization, working towards elimination of inequities in care. Crisis services should be culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve. Services should be welcoming and accessible to all people experiencing behavioral health crises, maximizing simplified assessment, recommendations, and open access.

Services should be equitably available to all populations and not discriminate based on race, color, religion, national origin, language spoken, ancestry, immigration status, insurance status, age, gender identity or expression, sexual orientation, height, weight, marital status, or physical, mental, or intellectual or developmental disability. Programs should not refuse to serve an individual based on forensic engagement, citizenship status, or other factors. Behavioral health crisis services and system performance data should be disaggregated to identify and address impact disparities.

Services should be delivered in a skilled manner that recognizes and respects the culture and practices of individuals and groups within the community with shared cultural identities and/or experiences. This includes an understanding of individual, interpersonal, systemic, and structural racism and historical trauma including the disproportionate impact of reliance on law enforcement for crisis response. Staffing patterns for crisis services should reflect the diversity of the community that is served, with individuals from minority or marginalized groups ideally holding positions throughout all levels of the organization.

E. Crisis Services Should Prioritize Quality and Effectiveness

Comprehensive crisis intervention systems design should be data-driven to determine effectiveness. Regular data collection and well-implemented evaluation plans help ensure the continuing quality improvement process and enhances the effectiveness of quality crisis care. All crisis services should use data to measure and optimize performance. Both process and outcome measures, such as patient-reported outcome measures should be gathered to measure quality. Satisfaction with care should be a prioritized outcome. People having positive experiences of care where they feel supported, engaged, and prepared for next steps help build trust and likelihood of using the services again when needed. Satisfaction with services, improvements in level of distress, and linkages to follow-up care are examples of care that can positively impact the quality, effectiveness, and safety of care. Sentinel events such as a death by suicide should also be reviewed in a systematic manner to identify how to prevent further adverse outcomes.

Ongoing evaluation and cycles of planning, executing, studying, and adjusting are crucial for quality crisis work. Crisis services need to identify key performance indicators to track and make necessary adjustments to improve crisis care. Frameworks such as the *Plan-Do-Study-Act Worksheet, Directions, and Examples* can help to ensure that the goals and objectives of a crisis program and broader system are being met. Specific to crisis care, the National Council for Mental Wellbeing has also published a helpful framework in *Quality Measurement in Crisis Services*. Quality care is equitable care and data should be stratified to ensure that everyone in the program is receiving equitable care.

F. Crisis Services Should Be Developmentally Appropriate

CHILDREN AND YOUTH: Crisis services for children, youth, and their families/caregivers should, when able, utilize a "Just Go" approach with little to no screening-out or triage, offering the help seeker an immediate face-to-face, developmentally appropriate assessment. Crisis staff should be trained in the unique needs of and best practices for working effectively with children, youth, and their families and caregivers in crisis. Crisis staff should recognize that the parent, caregiver, or sibling(s) who are present are experiencing a traumatic event and should be trained in best practices for working effectively with other people who are significant to the child or youth. Finally, crisis staff need to recognize that any removal from the home is often traumatic for children and their families. Eds and inpatient and other crisis bedded facilities are typically a last resort, with an emphasis on maintaining the child safely at home by engaging the family, caregivers, and others' supports in a strong crisis safety plan.

Crisis staff should have knowledge of community and home-based resources for children, youth, and families. Crisis services should have relationships with agencies and systems serving children and youth (e.g., schools, juvenile justice, child welfare, youth and family peer services). Protocols should be in place that guide care coordination and service referrals to these agencies and systems. When forming protocols, systems should make every effort to prevent the unnecessary and inappropriate involvement of the child welfare system. A whole family approach is needed when working with children, youth, and their families. *Mobile Response & Stabilization Services National Best Practices* is an example of a best practice crisis system model for serving children, youth, and their families and caregivers.

OLDER ADULTS: Crisis services should be accessible for older adults. Crisis staff should be trained in the unique needs of and best practices for working effectively with older adults and conditions such as dementia, even if a specialized service that serves older adults exists in their organization. Crisis staff should be trained in engaging and working effectively with family members and caregivers and have knowledge of community and home-based resources specific to older adults. Loneliness, social isolation, and lack of access to treatment providers are contributing factors for older adults experiencing a behavioral health crisis. Crisis services should have relationships with agencies and systems serving older adults (e.g., agencies on aging, community-based home care services, skilled nursing facilities, assisted living facilities, senior centers, nutrition service providers, adult day care facilities, protective services, Veterans service organizations and U.S. Department of Veterans Affairs facilities) and have protocols that guide care coordination and service referrals to these agencies and systems.

G. Crisis Services Should Be Resiliency and Recovery-Oriented

Providers and crisis staff should recognize that a crisis is self-defined by the help seeker and all interventions should include a strengths-based discovery to identify important skills, strengths, resources, and positive behaviors that are helpful in adapting and overcoming adverse experiences. The crisis intervention should be guided by the specific, individualized recovery goals in SAMHSA's recovery domains of "health, home, purpose, and community" in a respectful and strengths-based manner. Individual and parent/guardian/caregiver autonomy (for minors or others who are unable to consent to medical care) should be prioritized and maintained as much as possible. This includes ensuring access to the most appropriate level of care needed based on the crisis.

Peer support and recovery support services can be an integral way to help ensure services are resiliency and recovery oriented. Peer support workers bring their own lived experiences and can apply their own personal knowledge to the behavioral health challenges of living a life of recovery and resilience. Peer support workers can provide support for help seekers, being an example of hope and providing real examples of the power of recovery and resilience. Peer support services should be embedded in the crisis continuum and provided in a manner that is guided by *SAMHSA's Working Definition of Recovery,* including that peer services are voluntary and chosen by the individual.[7] Peer support also should be aligned with roles and recommendations as outlined in SAMHSA's *Peer Support Services in Crisis Care,* which includes a focus on scope of practice and mitigating against drift.

For children and youth, there should be a focus on resilience and returning the child/youth and their families and caregivers to routine activities including at home, school, and recreation. Crisis staff should assist the child/youth and family members to identify their strengths and goals, encourage communication with family/caregivers and other trusted adults, and build hope for a positive resolution.

H. Crisis Services Should Be Trauma-Informed

The impact of traumatic events on behavioral health crisis is significant: from the ongoing effects of adverse childhood experiences and recent victimization to the added impact of community or historical traumatization. For all those experiencing a crisis, but especially children, youth, and young adults, difficult or challenging behaviors should be seen through the lens of "what has happened or is happening to" rather than "what is wrong with" the individual. People may experience trauma associated with behavioral health systems, including the use of restraint or seclusion, or witnessing its use and effect on others. These experiences may induce resistance to seek help for future behavioral health crisis situations. Trauma-informed services recognize these potential traumas and prioritize providing the most integrated care with dignity to the individual. Trauma-informed care assumes that everyone may have been traumatized, yet people have hope for recovery and resilience. Trauma-informed care includes both a trauma-informed approach and the use of evidence-based or evidence-informed approaches that are appropriate for the crisis care context and the person. Crisis care should be provided in the context of SAMHSA's six trauma-informed principles:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support;
4. Collaboration and mutuality;
5. Empowerment, voice, and choice; and
6. Ensuring that cultural, historical, and gender considerations inform the care provided.

Please see SAMHSA's *Practical Guide for Implementing a Trauma-Informed Approach* for additional information and guidance.

I. Crisis Services Should Have a Component of Follow-Up Care and Services for Linkage

Emergency and crisis interventions should focus on both alleviating the current crisis and lowering the risk of future episodes. Behavioral health crisis systems should implement a "no wrong door" approach where individuals are able to access crisis services regardless of how or where they initially seek help. If an individual seeks crisis care from a facility or program that does not provide crisis services, collecting and providing information about their needs to entities that have the responsibility and authority to do so (e.g., crisis stabilization, MCTs, other behavioral health programs, foster care, school systems) is an important component of a behavioral health crisis system. Crisis providers also should conduct follow-up contacts to check in with help seekers, ask if they have received services to which they were referred, and assess any needs for additional services. This follow-up is critical to ensure the help seeker receives care beyond initial services and to address any gaps in the system of care.[8]

People who are experiencing a crisis need to have continued support and resources after the initial acute crisis event. These follow-up services should be planned for and occur at every point on the crisis continuum. While this is more challenging when services are anonymous, every effort should be made to engage the individual and family/caregiver to provide follow-up care and appropriate resource linkages as appropriate. Following up with someone after receiving crisis services has shown to aid in reductions in suicidal behaviors and reduces the likelihood that they will need crisis services again.[9]

J. Crisis Services Should Be Evidence-Based, Evidence-Informed, and/or Reflect Promising and Emerging Practices

Services should be informed by the best available research and practice-based evidence. Services should be considered in the context of the populations served, organizational context, and the broader community in which they are provided. Provider organizations should ensure adequate resources to employ paid staff trained in evidence-based practices and to provide staff with supervision to ensure services are delivered as intended. As appropriate, providers may need to adapt services to increase their fit given the available evidence and community context in which they are delivered. Providers should engage in programmatic evaluation and quality improvement activities to assess and improve effectiveness. Evaluations of specific services and interventions could include a clear description of the service and key components, a logic model, process and outcomes measures, a description of data collection and analysis methods, results, and recommendations.

K. Services Should Be Responsive to Individuals' Wholistic Needs

Crisis service providers should have awareness of the needs, available community resources, and what constitutes effective care for diverse populations, including Veterans, minoritized communities, and LGBTQI+ populations. Crisis service providers should be able to respond to people with complex mental health, substance use, or co-occurring challenges across the lifespan. Providers should be able to be responsive to those who may have past treatment histories with multiple helping systems.

CO-OCCURRING MEDICAL CONDITIONS: Providers should ensure services are accessible to individuals with co-occurring medical conditions. Providers should include individuals with common infectious diseases (e.g., COVID-19) and have established criteria for maintaining safety and preventing disease transmission. Providers should not exclude individuals with

physical disabilities (e.g., ambulatory, vision, hearing), but should offer supportive adaptations, translation, and supports. Providers should have established protocols for guiding coordination and referrals to medical providers. Crisis staff should be trained to work in collaboration with medical providers and have knowledge of community and home-based resources for individuals with co-occurring medical conditions.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD) AND NEUROCOGNITIVE DISORDERS: Services should be accessible to individuals with I/DD. Crisis staff should be trained to recognize individuals with I/DD and dementia and the unique needs of and best practices for working effectively with individuals with IDD, their families, and caregivers. Crisis teams should be equipped with communication tools like Picture, Exchange Communication Systems (PECS), and soothing kits to engage individuals with IDDs.[10] Considerations should include potential communication challenges, cognitive limitations, physical health comorbidities, varying verbal skills, and/or differing social skills levels. Providers should have relationships with agencies and systems serving individuals with IDD (e.g., intellectual- and disability-specific service systems, group homes, skilled nursing facilities, assisted living and rehabilitation facilities, child welfare systems, education system) and dementia, and have protocols for coordinating care and referrals to these agencies and systems.

HOUSING AND OTHER SOCIAL DRIVERS OF HEALTH: Unstable housing is a stressor both contributing to crisis events and complicating resolution of crisis events. Assessment of social drivers of health is critical at every step of a crisis service encounter. This includes homelessness, unemployment, lack of transportation, poverty, and other social drivers of health. Linkages to resources that address basic needs like hunger, homelessness, and poverty are essential. Crisis providers who interact with children, youth, and families should work closely with their state child welfare agency and other relevant state entities to ensure protocols around mandated reporting are followed and appropriately train crisis providers on the distinction between observed conditions of poverty and neglect. This is important to prevent cases of unnecessary child welfare involvement.

Crisis System Component: Someone to Contact

Someone to Contact Service Element Summary Tables

Key: ● = Recommended, ❍ = May Have Available, - (Dash) = Not an Element of Service

Service Orientation

Service Elements	988 Suicide & Crisis Lifeline	Other Behavioral Health Crisis Hotlines	Peer Operated Warmlines	Other Behavioral Health Emotional Support Lines
Emergency Response and Crisis Mitigation	●	●	-	-
Empathic Support and Listening	●	●	●	●
Prevention and Promotion of Wellness	-	-	-	•

Service Modality

Service Elements	988 Suicide & Crisis Lifeline	Other Behavioral Health Crisis Hotlines	Peer Operated Warmlines	Other Behavioral Health Emotional Support Lines
Phone	●	●	●	●
Synchronous Messaging via Text or Chat	●	❍	●	●

Coverage and Staffing

Service Elements	988 Suicide & Crisis Lifeline	Other Behavioral Health Crisis Hotlines	Peer Operated Warmlines	Other Behavioral Health Emotional Support Lines
24/7/365 Coverage Capacity Required	●	-	-	-
Master's Level Clinician (Supervision and Consultation) Required	●	-	-	-
Certification of Peer Call Center Staff Required	-	-	●	-

Services

Service Elements	988 Suicide & Crisis Lifeline	Other Behavioral Health Crisis Hotlines	Peer Operated Warmlines	Other Behavioral Health Emotional Support Lines
Triage, Screening	●	●	●	●
Safety Assessment	●	❍	❍	❍
Initiation of Transfer to 911 (imminent safety concerns)	●	●	-	-
Crisis and Safety Planning	●	❍	●	●
Crisis Counseling	●	❍	-	-
Crisis Support and Prevention Planning	❍	❍	●	●
Emotional Support	●	❍	❍	❍

Service Elements	988 Suicide & Crisis Lifeline	Other Behavioral Health Crisis Hotlines	Peer Operated Warmlines	Other Behavioral Health Emotional Support Lines
Facilitation of Self-Directed Problem-Solving	❍	❍	●	●
Shared Decision-Making and Informed Choice	❍	❍	●	●
Recovery Support (e.g., Peer Support, WRAP, Integrated Psychotherapeutics(IPS) PADs)	●	●	●	❍
Formal Peer Support	-	-	●	-
Direct Service Referrals	●	❍	❍	❍
Warm Hand-Off and Linkage to Care	●	●	●	●
Care Coordination	❍	❍	❍	❍
Follow-Up	❍	❍	❍	❍

1. 988 Suicide & Crisis Lifeline (988 Lifeline)

Service Type/Description:

The 988 Lifeline is a behavioral health network of crisis contact centers that provides crisis and emergency mental health and substance use services 24 hours a day, 7 days a week, 365 days a year (24/7/365) to people experiencing any form of emotional distress or to a third party who is concerned about another person (e.g., caregivers, parents, friends, partners, schools).

Distinguishing Features:[11]

- **Certification/Accreditation.** Crisis contact centers must have independent verification of their qualifications to provide 988 Lifeline services. The crisis contact center must provide proof of certification/accreditation from one of several professional organizations that provide certification, including, but not limited to, the American Association of Suicidology (AAS), the International Council for Helplines (formerly CONTACT USA), and the Commission on Accreditation of Rehabilitation Facilities (CARF). If a crisis call center does not meet the requirement, they must show demonstrable need for a crisis call center in that area and sign a provisional status amendment, agreeing to obtain certification within a set timeframe.
- **Network Participation.** Crisis call centers must be willing to engage in a formal agreement with the SAMHSA Lifeline Administrator by signing a Network Agreement. Crisis contact centers must also demonstrate compliance with all technical, operational, training, and clinical requirements to be participating members of the 988 Lifeline network.
- **Coverage Capacity.** Coverage over a specific geographic region for specified times must be accomplished. Coverage boundary determinations for local response are made by county, area code, zip code, or state in collaboration with the Lifeline Administrator, centers, and state, territory, or tribal authorities.
- **988 Staff Time & Guidelines.** Organizations or entities providing 988 Lifeline services must identify 988 crisis contact center operations, procedures, fiscal management, and training protocols, and hire staff and administrators responsible for the operation's oversight.
- **Crisis Center Liaison**. All crisis contact centers must designate at least one contact to serve as a liaison to the 988 Lifeline Administrator that regularly acts in a managerial or training capacity and who has knowledge of the center's and the 988 Lifeline's most current policies and procedures.

Recommended Service Elements:

The crisis contact centers participating in the Lifeline network must be aligned through network standards set by SAMHSA and the Lifeline Administrator and must demonstrate administrative, staffing, and programmatic resources deemed sufficient by SAMHSA and the Lifeline Administrator to support 988 response as a distinct service. These include, but are not limited to, the following:

- A 24/7/365 on-demand, two-way enabled, secure communication system including phone, text, or chat interface;
- Crisis screening, safety assessments and safety planning, crisis counseling, and emotional support;
- Follow-up for suicidal help seekers;

- Direct services referrals and linkages to care as well as resources for accessing emergency and crisis responses (e.g., mobile crisis and response teams) and initiation of emergency rescue in cases of imminent safety concerns (e.g., emergency medical services (EMS), law enforcement); and
- All crisis call centers provide call services; select centers also may provide text, chat, or other specialized services (e.g., videophone).

Additional details regarding required services for the 988 Lifeline are available in SAMHSA's *Saving Lives in America: 988 Quality and Services Plan* published in 2024.

Care Coordination/Follow-Up:

Care coordination, warm hand-off to services, and follow-up for those with current suicidal ideation.

Eligibility Criteria:

None.

Exclusionary Criteria:

None. In cases of imminent risk that cannot be addressed through collaborative safety planning, connect with 911.

Discharge Criteria:

None.

Modality:

Phone or synchronous messaging via text or chat.

Setting/Care Environment:

988 crisis contact center staff may work from a centralized office or remote location but are connected to the contact's physical location by real time synchronous technology.

Provider Type:

Certification of 988 crisis contact centers requires a fully executed Lifeline network agreement and adherence to all requirements therein. 988 crisis contact centers should be accredited by an approved accreditation entity. Centers also may have additional certification requirements as determined by their state/territory/tribe/county.

Staffing Recommendations and Credentialing:

- 988 crisis contact centers must maintain 24/7/365 access to a master's level clinician for supervision and consultation.
- Crisis contact center staff can be volunteers, peer support workers, community health workers, clinicians, behavioral health aides, or certified crisis workers.
- All Lifeline workers must complete core required trainings and experiential training components as required by the Lifeline Administrator; these include engagement and triage best practices, risk assessment, and intervention in accordance with the Suicide & Crisis Lifeline guidelines.

Core Competency Suggested Requirements:

- Active empathic listening;
- Engagement and rapport building techniques;
- Developmentally appropriate care;
- Assessment for suicide risk and risk of harm to others;
- Determining need for emergency service intervention;
- Crisis counseling;
- Safety planning;
- Crisis intervention and de-escalation techniques ;
- Cultural humility and culturally responsive care; and
- Self-care.

Suggested Data Elements, Metrics, and Quality Measures:

- Number of calls, chats, texts received and answered;
- Average length of call, chats, and texts;
- Demographics of help seeker (age range, gender, ethnicity) (if help seeker is willing to provide and it is appropriate to inquire);
- Reason for contact;
- Location of contact origination;
- Safety planning;
- Number of warm hand-offs;
- Number of linkages to services;
- Experience/satisfaction of the help seeker;
- Average speed to answer
- Answer rates;
- Abandonment rates;
- Disposition of imminent risk;
- State and contact center variation in rate of emergency service referral; and
- Sentinel events.

Optional Service Enhancements:

- Follow-up care (e.g., post-encounter stabilizing engagement and linkages to community resources) including facilitation of engagement with follow-up plan and/or refinement of follow-up versus crisis plan;
- Follow-up assessment of safety;
- Direct technological connection to local MCTs in order to directly dispatch from the 988 contact;
- Use of technology to facilitate coordination of care through data sharing across entities (e.g., mobile crisis agencies, EMS, law enforcement, EDs, and crisis stabilization) for purposes such as care coordination and/or quality improvement purposes;
- Ability to receive and divert appropriate calls from 911; and
- Wellness supports for staff.

2. Other Behavioral Health Crisis Hotlines

Service Type/Description:

This section refers to behavioral health crisis hotlines that are not a part of the 988 Lifeline network and which provide support to people experiencing emotional distress and/or third-party callers who are concerned about another person who is experiencing emotional distress. The hotlines in this service category refer to behavioral health crisis hotlines that may be more topically focused on a specific type of need or stressor, sometimes focused on a specific population of focus (e.g., a geographic catchment area), as well as those that may target the needs of individuals experiencing the types of emotional distress that are similar in scope to the 988 Lifeline but are not connected to the Lifeline.

Recommended Service Elements:

Available services are determined by the individual hotline. Any hotline marketed as a "crisis line" should, at a minimum:

- Triage/screen each caller for suicide (ideally following 988 Lifeline Guidelines training).
- Have established protocols in place for positive suicide screens and access to clinical staff trained to provide a more in-depth suicide risk assessment.
- Initiate transfer to 988 or 911 if there is an imminent safety concern.
- Provide recovery support.
- Provide warm hand-off and linkage to care when needed and appropriate.

Care Coordination/Follow-Up:

Warm hand-off and linkage to care; care coordination and follow-up (optional).

Eligibility Criteria:

None.

Exclusionary Criteria:

None. In cases of imminent risk that cannot be addressed through collaborative safety planning, connect with 911.

Discharge Criteria:

None.

Modality:

Phone or synchronous messaging via text or chat. Not all hotlines may be able to provide all modalities of communication.

Setting/Care Environment:

Hotline staff may work from a centralized office or remote location but are connected to the help seeker's physical location by real-time synchronous technology.

Temporal Considerations:
Hours of service availability determined by individual provider.

Provider Type:

Hotlines may have certification recommendations as determined by their state/territory/tribe/county or the centralized administration of the respective hotline.

Staffing Recommendations and Credentialing:

Hotlines independently establish their staffing standard and required trainings or it is part of contractual requirements, as well as their core competency requirements.

Core Competency Suggested Requirements:

- Active empathic listening and holding space with compassion;
- Engagement and rapport building techniques;
- Developmentally appropriate care;
- Shared decision-making and informed choice;
- Crisis-safety planning;
- Crisis support and prevention planning;
- Trauma-informed care;
- Harm reduction;
- Crisis intervention and de-escalation techniques; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures:

Hotlines determine their own required data elements, metrics, and quality measures or it is part of contractual requirements.

- Number of calls;
- Length of call;
- Demographics (age range, gender, ethnicity) (if help seeker is willing to provide);
- Reason for contact;
- Location where contact originated;
- Average speed to answer;
- Answer rates;
- Disposition (referrals given; transferred to 988, 911, or other crisis service);
- Abandonment rate;
- Crisis-safety planning;
- Warm hand-offs;
- Linkages to services;
- Experience/satisfaction of the help seeker; and
- Sentinel events.

Optional Service Enhancements:

- Utilize technology to enhance access;
- Wellness supports for hotline workers;
- Suicide risk assessment; and
- Determining need for emergency service intervention.

3. Peer-Operated Warmlines

Service Type/Description:

Peer-operated behavioral health warmlines are phone, chat, or text lines that provide empathetic listening and peer support to individuals who may be experiencing distress or loneliness, or those seeking validation from a peer with lived experience who identifies with their concerns and can offer a confidential and non-judgmental space for connection and self-directed exploration of possible solutions and alternatives. Peers work collaboratively and transparently with callers or service recipients, within a recovery- and resilience-oriented care framework to facilitate safety planning, crisis support planning and prevention, and informed choice as appropriate.

Distinguishing Features:

- Provide connection and formal peer support, focused on crisis prevention and the promotion of resilience and wellness in a manner that is complementary to the more specific emergency response and crisis mitigation function of the 988 Suicide and Crisis Lifeline and other behavioral health crisis hotline services.
- Operated and staffed, unlike other behavioral health support lines, by peers with self-identified personal experience living with mental health and SUDs who leverage their lived experience, applying the peer values and principles of choice, self-determination, respect, hope, recovery, and resilience to empower help seekers to be proactively involved in their own decision-making related to safety planning, crisis planning and prevention, and informed choice of services, resources, and supports.
- Predicated on the shared, lived experience and the inherent sense of connection forged by the peer-to-peer relationship as the primary active ingredients of the service.
- Operate from a consensual rescue approach, recognizing the iatrogenic trauma of coercive treatment on individuals with mental health and SUDs and the historical and cultural trauma of marginalized communities who have been exposed to the disproportionate use of force. Certain individuals may not seek help for fear that they might be arrested or institutionalized. For these individuals, peer-operated warmlines offer a safe space to discuss and explore distressing thoughts, feelings, or experiences.

Recommended Service Elements:

- Protocols for helping to ensure the safety of the individual with limited screening and referral based on caller preference;
- Safety planning;
- Active, empathic listening and holding space with compassion;
- Engagement and rapport building;
- Crisis support and prevention planning;
- Facilitation of self-directed problem-solving;
- Shared decision-making and informed choice;
- Modeling of hope, recovery, and resilience;
- Formal peer support and strategic self-disclosure of specific lived experiences, when appropriate;
- Provision of information and referral to community resources, services, and supports based on individual's self-identified needs; and
- Warm hand-off and linkage to community resources, services, and supports at the expressed request of the individual.

Care Coordination/Follow-Up:

Warm hand-off and linkage to care; care coordination and follow-up (optional).

Eligibility Criteria:

None.

Exclusionary Criteria:

None. In cases of imminent risk that cannot be addressed through collaborative safety planning, refer to 988.

Discharge Criteria:

None.

Modality:

Phone or synchronous messaging via text or chat.

Setting/Care Environment:

Peer behavioral health warmline staff may work from a centralized office or remote location and are connected to the caller's or service recipient's physical location by real time synchronous technology.

Temporal Considerations:
Service may be available 24/7/365 or only during certain hours/days.

Provider Type:

- From an administrative standpoint, peer-operated behavioral health warmlines may be delivered by a recognized peer-run organization, as a stand-alone service or as part of an array of peer-operated services, or by a provider organization that employs peers to deliver the service.
- Licensing, certification, or registration of the service delivery organization may be required by the state or jurisdictional behavioral health oversight authority in which the services are provided or by the entity that financially supports the service.

Staffing Recommendations and Credentialing:

- Peer support specialists delivering the service should be certified as such by the state or jurisdictional peer support certification entity, as applicable, or be in the process of pursuing peer support certification with a designated timeframe for completion.
- Peer support specialists should have access to recovery and wellness supports specific to their peer provider role.
- Youth peer support specialists may also staff peer-operated behavioral health warmlines with appropriate adult oversight.
- Peer support specialists should receive recovery-oriented peer supervision in accordance with the recommendations of the state or jurisdictional peer support certification entity.

Core Competency Recommendations:

Peer support specialists should be knowledgeable about trauma-informed practices, mutual support groups, and recovery principles and should have knowledge of relevant peer-led interventions that are appropriate for use in this setting which could include: [12, 13, 14]

- Active empathic listening and holding space with compassion;
- Engagement and rapport building techniques;
- Developmentally appropriate care;
- Shared decision-making and informed choice;
- Safety planning;
- Crisis support and prevention planning;
- Trauma-informed care;
- Harm reduction;
- Crisis intervention and de-escalation techniques;
- Cultural humility and culturally responsive care;
- Diversity and equity; and
- Confidentiality.

Suggested Data Elements, Metrics, and Quality Measures:

- Number of calls;
- Length of call;
- Demographics (age range, gender, ethnicity) (if help seeker is willing to provide);
- Reason for contact;
- Location where contact originated;
- Average speed to answer;
- Answer rates;
- Disposition (referrals given; transferred to 988, 911, or other crisis service);
- Abandonment rate;
- Safety planning;
- Warm hand-offs;
- Linkages to services;
- Experience/satisfaction of the help seeker; and
- Sentinel events.

Optional Service Enhancements:

- 24/7/365 service availability;
- Intentional Peer Support (IPS) training for warmline staff;
- Employ Certified Peer Support Specialists (CPSSs) who will offer follow-up to callers who agree to a follow-up. CPSSs will recommend to a higher level of intervention, including, but not limited to, 988, MCTs, or other community-based crisis services, when appropriate or necessary for the safety of the caller;
- Collaborate with the local 988 centers to support bidirectional referrals and coordination;
- Warmlines that include and/or focus on youth and young adult peers and family support or other special populations; and

- Peer support specialists should be representative and reflective of the communities served with respect to race, ethnicity, language and cultural identity, sexual orientation and gender identity and expression, and other marginalized, disenfranchised, or socially disadvantaged groups and trained in developmentally appropriate care.

4. Emotional Support Lines

Service Type/Description:

Emotional support lines are phone, chat, or text lines that provide empathetic listening, information and referral, and support to individuals who may be experiencing emotional distress or loneliness. They offer a confidential and non-judgmental space for connection and self-directed exploration of possible solutions and alternatives. Support line staff work collaboratively and transparently with individuals to facilitate safety planning, as well as crisis support planning and prevention when indicated.

Distinguishing Features:

- Provide connection, focused on crisis prevention and the promotion of wellness as opposed to the more specific emergency response and crisis mitigation function of the 988 Crisis Lifeline.
- Typically embedded within a multi-service organization with capacity for coordination and linkages to other more intensive interventions, as needed.
- Focused on information and referral to community-based behavioral health providers and social services organizations.

Recommended Service Elements:

- Emotional support;
- Brief suicide risk screening protocols to determine if referral to a crisis hotline or other more intensive intervention is indicated. Ability to transfer calls to 988;
- Safety planning;
- Active, empathic listening and holding space with compassion;
- Engagement and rapport building;
- Crisis support and prevention planning;
- Facilitation of self-directed problem-solving;
- Shared decision-making and informed choice;
- Provision of information about community resources, services, and supports based on the individual's self-identified needs; and
- Warm hand-off and linkage to community resources, services, and supports, when desired.

Care Coordination/Follow-Up:

Warm hand-off and linkage to care; care coordination and follow-up (optional).

Eligibility Criteria:

None.

Exclusionary Criteria:

None. In cases of imminent risk that cannot be addressed through collaborative safety planning, refer to 988.

Discharge Criteria:

None.

Modality:

Phone or synchronous messaging via text or chat.

Setting/Care Environment:

Behavioral health emotional support line staff or volunteers generally work from a centralized office or virtually.

Temporal Considerations:
Service may be available 24/7/365 or only during certain hours/days.

Provider Type:

- Behavioral health emotional support lines may be operated by a recognized or licensed provider organization, as a stand-alone service, or as part of an array of behavioral health services.
- Licensing, certification, or registration of the service delivery organization may be required by the state or jurisdictional behavioral health oversight authority in which the services are provided or by the entity that financially supports the service.

Staffing Recommendations and Credentialing:

- Behavioral health emotional support line staff or volunteers should meet qualifications established by the jurisdictional behavioral health oversight authority in which the services are provided or by the funding entity.
- Provider staff and volunteers should have real time 24/7/365 access to a supervisor with expertise in crisis intervention and/or suicide prevention. Provider staff should receive supervision in accordance with the recommendations of the state or jurisdictional entity.

Core Competency Suggested Requirements:

- Protocols for brief screening of imminent risk including the ability to differentiate between thoughts, feelings, and planned actions, to recognize an emergency, and to discern when to transfer to 988 or other services or resources for more intensive intervention;
- Developmentally and cognitively appropriate care;
- Safety planning;
- Active, empathic listening and holding space with compassion;
- Engagement and rapport building;
- De-escalation techniques;
- Cultural humility and culturally responsive care; and
- Diversity and equity.

Suggested Data Elements, Metrics, and Quality Measures:

- Number of contacts;
- Length of contacts;
- Demographics (age range, gender, ethnicity) (if help seeker is willing to provide);
- Reason for contact;

- County where contact originated (if center covers multiple counties);
- Average speed to answer;
- Answer rates;
- Disposition (referrals given; transferred to 988, 911, or other crisis service);
- Abandonment rate;
- Number of safety planning completed;
- Warm hand-offs;
- Linkages to services;
- Experience/satisfaction of the help seeker; and
- Sentinel events.

Optional Service Enhancements:

- Collaborate with the local 988 centers to support bidirectional referrals and coordination;
- Established protocols for identifying callers who require service acuity/intensity beyond what the emotional support line offers and connection to appropriate services for these individuals; and
- Staff resources allotted to conduct routine follow-up to anyone willing to receive this service.

Crisis System Component: Someone to Respond

Someone to Respond Service Element Summary Tables

Key: ● = Recommended, ❍ = May Have Available, - (Dash) = Not an Element of Service

Service Orientation

Service Elements	Mobile Crisis Teams	Co-Responder Teams	MRSS	Community Outreach Teams
Active Treatment	●	●	●	-
Prevention	●	●	●	●
Ongoing Support	-	-	●	-

Service Modality

Service Elements	Mobile Crisis Teams (I|F*)	Co-Responder Teams (I|F*)	MRSS (I|F*)	Community Outreach Teams (I|F*)
In-Person	●|❍	●|❍	●|❍	●|❍

Coverage and Staffing

Service Elements	Mobile Crisis Teams	Co-Responder Teams	MRSS	Community Outreach Teams
24/7/365 Coverage Capacity Required	●	-	●	-
Paired Response by Team Preferred	●	●	●	-
Law Enforcement Considered Part of Response Team	-	●	-	-

*I|F represents Initial Contact (I) vs Follow-Up Contact (F); where in-person response is not required, service may be provided through telephonic or virtual means.

Services

Service Elements	Mobile Crisis Teams	Co-Responder Teams	MRSS	Community Outreach Teams
Proactive Outreach	-	-	-	●
Triage, Screening, Assessment	●	●	●	●
Crisis and Safety Planning	●	●	●	-
De-Escalation	●	●	●	-
Stabilization	●	●	●	-
Recovery Support (e.g., Peer Support, WRAP, IPS, PADs)	●	●	●	●

Service Elements	Mobile Crisis Teams	Co-Responder Teams	MRSS	Community Outreach Teams
Service Referrals, Linkage, Care Coordination	●	●	●	●
Initiation of Emergency Rescue (imminent safety concerns)	●	●	●	●
Coordinate Transportation to Facilitate Stabilization	●	●	●	●
Provision of Voluntary Transport	❍	❍	❍	❍
Follow-Up	●	●	●	●

5. Behavioral Health Provider-Only Mobile Crisis Team (MCT) Services

Service Type/Description:

MCT services should provide a rapid, on-demand community-based response that includes a clinical assessment and community-based stabilization supports to decrease emotional distress and reduce the immediate risk of danger and subsequent harm to individuals who are experiencing a mental health or substance use crisis. Through community-based crisis care, referrals, and care coordination, MCTs aim to avoid unnecessary ED care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Distinguishing Features:

- **Coverage Capacity:** 24/7/365 service provision is strongly preferred.
- **MCT Staffing:** Paired, when indicated, in-person response by MCT strongly preferred.
- **Law Enforcement:** Law enforcement is not considered part of response team.

Suggested Service Elements:

- Provision of 24/7/365 on-demand service is preferred when possible.
- Initiation of emergency (911 PSAP) service in cases of imminent safety concerns (e.g., EMS).
- Coordinate transportation for the individual to facilitate crisis stabilization.
- Conduct crisis triage screening and assessment using standardized assessment tools.
- Develop or revise/optimize a crisis safety plan, as appropriate.
- Provide de-escalating and/or stabilizing supports to mitigate a crisis.
- Develop or revise/optimize a crisis plan to mitigate current crisis and help prevent a future crisis.
- Direct service referrals, linkages to care, and care coordination with home- and community-based services and supports or higher levels of care if indicated.
- Provide in-person, telephonic, or virtual follow-up, as appropriate.

Suggested Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to:
  - Outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating significant others, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

None.

Exclusionary Criteria:

People who cannot be safely supported with this intervention will be connected to a different level of care

Discharge Criteria:

None.

Modality:

Initial response is conducted in person or in some cases via telehealth; follow-up may occur in person, telephonically, or virtually.

Setting/Care Environment:

Initial response occurs at the location where an individual is experiencing a crisis, including, but not limited to, at home, school, work, or on the street. MCT services shall be provided on tribal lands when right of entry has been granted by the tribe and in collaboration with the tribe. Follow-up occurs in person, telephonically, or virtually.

Temporal Considerations:

- Service is available 24/7/365 when possible.
- Urban response within one hour and rural response within two hours is recommended.
- Provide post-crisis follow-up within 72 hours of the initial crisis episode (or sooner if clinically indicated) or requested.

Provider Type:

- MCT provider organizations may have certification requirements as determined by their state/territory/tribe/county.
- Vehicles used by MCT staff during service provision should be compatible with the location and geography where services are provided (e.g., vehicles that are suitable for snowy or rocky and unpaved terrain).

Staffing Recommendations and Credentialing:

- Potential MCT responders include credentialed mobile crisis staff and other credentialed crisis staff, including certified peer recovery staff.
- At least one MCT member should be a licensed and/or a credentialed crisis trained responder with the ability to conduct a clinical crisis assessment within their scope of practice according to the governing state of local laws and/or regulations. At least one team member should also have the ability to initiate involuntary treatment as appropriate.
- Paired initial response by members of the MCT is strongly preferred.
- The number of MCT members who should respond to requests for crisis assessments should be predicated upon a triaging of the situation. For example, in locations like emergency departments, jails, nursing homes, schools, medical offices, etc., deploying one credentialed mobile crisis member might be warranted and follow-up may be provided by peer staff or other unlicensed staff.
- When there is a second team member responding, that person should be trained in crisis response. This includes certified peer support workers or specialists.

- In some cases, using telehealth for mobile crisis assessments by the clinician will be the timeliest response and is the best modality if agreed upon by all parties (individual in crisis, entity where they are located, and the mobile crisis program); in this scenario at least one member of the team should still respond in person and telehealth might be used while the responder is in route.
- Follow-up visits can be performed by any one member of the team if deemed to be appropriate, but preferably by peer support specialists, based on the situation.
- Only involve law enforcement when absolutely necessary, and preferably a Crisis Intervention Training (CIT) unit where available.
- Law enforcement or other traditional public safety personnel are not members of the MCT.

Core Competency Recommendations:

- Active and empathic listening;
- Engagement and rapport building techniques;
- Developmentally and cognitively appropriate care;
- Situational safety and risk assessment;
- Safety planning;
- Suicide risk assessment;
- Crisis assessment;
- Crisis counseling;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- Basic Life Support (BLS) to be provided on scene with activation of 911 as indicated;
- Cardiopulmonary Resuscitation (CPR);
- First aid;
- Harm reduction;
- Overdose prevention;
- Naloxone administration;
- Cultural humility and culturally responsive care; and
- Culturally and Linguistically Appropriate Services (CLAS) and Americans with Disabilities Act (ADA) related knowledge and capabilities.

Suggested Data Elements, Metrics, and Quality Measures:

- Sentinel events;
- Demographics;
- Date and time of service;
- Method of response;
- Response time;
- Types of response delays;
- Service location;
- Reason for service;
- Duration of service;
- Completion of assessments;
- Acuity;
- Patient disposition;
- Type of service(s) requested/provided/denied;

- Connections to crisis services as needed;
- Diversion rates;
- Experience/satisfaction of the help seeker;
- Law enforcement involvement;
- Staffing levels and vacancies; and
- Availability of mobile crisis response (hours per day).

Optional Service Enhancements:

- Develop "Just Go" approach or an on-demand approach with minimal criteria for dispatch.
- Utilize a validated, standardized tool to develop crisis and safety plan.
- Have means for direct dispatch of MCT services from 988 or other hotlines.
- Have direct connection to law enforcement to facilitate rapid bidirectional connection.
- Have access to psychiatric staff for clinical insight and pharmacotherapy services.
- Utilize GPS enhanced devices, linked to local 988 Lifeline and other local hotlines.
- Utilize peers in non-emergent de-escalation and support, follow-up care, and support post-disposition.

6. Mobile Crisis Team Services – Co-Responder Teams

Service Type/Description:

Co-responder team models vary significantly across communities, but generally pair specially trained (e.g., crisis intervention trained) law enforcement officers or other public health first responders with mental health professionals to respond to calls for services involving individuals experiencing mental health and substance use crises. Co-responder teams leverage the skills of both mental health professionals and law enforcement officers or other public safety-first responders to reduce the need for hospitalization or EMS and increase the diversion of people with behavioral health concerns away from the criminal justice system.

Distinguishing Features:

- **Coverage Capacity:** Co-response teams tend not to provide 24/7/365 coverage and may be focused on shifts or times of day with greater utilization.
- **Co-Responder Team Staffing:** Co-response teams are most commonly staffed by both mental health professionals and law enforcement officers.

Suggested Service Elements:

- Conduct crisis screening and safety assessment using standardized, validated assessment tools.
- Develop or revise/optimize a crisis safety plan.
- Provide de-escalating and/or stabilizing supports to mitigate the crisis.
- Develop or revise/optimize a crisis plan to mitigate current crisis and help prevent a future crisis.
- Direct referrals and care coordination with community-based stabilization supports.
- Initiate emergency rescue in cases of imminent safety concerns (e.g., EMS).
- Coordinate transportation for the individual to facilitate crisis stabilization.
- Provide in-person, telephonic, or virtual follow-up.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up such as: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers support workers/specialists in follow-up contact.

Eligibility Criteria:

None.

Exclusionary Criteria:

People who cannot be safely supported with this intervention will be connected to a different level of care.

Discharge Criteria:

None.

Modality:

Initial response is conducted in person by the co-response team; follow-up occurs in person, telephonically, or virtually.

Setting/Care Environment:

- Co-responder teams may be implemented as a stand-alone program for crisis response or integrated into other comprehensive police-mental health collaboration models.
- Alternatively, co-responder teams may co-exist within communities with traditional MCTs, with established triage protocols to determine which type of response will be deployed.
- Co-responder teams may serve as the primary response to calls for service that involve a behavioral health crisis and/or serve as a secondary response with teams dispatched later to assist first-responding officers.
- Initial response occurs at the location where an individual is experiencing a crisis, including home, school, work, or on the street.
- Follow-up may occur in person, telephonically, or virtually.
- Co-responder team services shall be provided on tribal lands, in collaboration with the tribe, when right of entry has been granted by the tribe.

Temporal Considerations:
Specific days/times of availability may vary by community.

Provider Type:

- Provider entities are licensed within the state in which services are provided and are encouraged to be accredited by an accreditation body.
- The Bureau of Justice Assistance (BJA) has developed a *Police-Mental Health Collaboration (PMHC) Toolkit* on best practices for collaborative ventures between law enforcement and mental health professionals.

Staffing Recommendations and Credentialing:

- Co-responder teams typically consist of one specifically trained law enforcement officer and one licensed and/or credentialed mental health professional.
- Some communities may incorporate EMS and Fire Departments.
- Co-responder team members may be co-located or located separately within the law enforcement/first responder or behavioral health agency.

Core Competency Recommendations:

- Active and empathic listening;
- Engagement and rapport building techniques;
- Developmentally appropriate care;
- Situational safety and risk assessment;
- Safety planning;
- Suicide risk assessment;
- Crisis assessment;
- Crisis counseling;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction;
- Overdose prevention;
- Naloxone administration; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures:

- Sentinel events;
- Demographics;
- Date and time of service;
- Method of response;
- Response time;
- Types of response delays;
- Service location;
- Reason for service;
- Duration of service;
- Completion of assessments;
- Acuity;
- Disposition;
- Type of service(s) requested/provided/denied;

- Connections to crisis services as needed;
- Diversion rates;
- Number of repeat calls for service;
- Hand-offs;
- Number of direct service referrals;
- Number of linkages to services;
- Experience/satisfaction of the help seeker;
- Staffing levels and vacancies;
- Availability of co-response teams (days and hours per day);
- Number of individuals taken into custody;
- Reason for arrest; and
- Use of force.

Optional Service Enhancements:

- Where co-responder teams are present, they should optimally co-exist with traditional MCTs so that communities can lead with a behavioral health provider-only response whenever possible.
- Require CIT for co-response staff who are not behavioral health professionals.
- Behavioral health personnel should be invited to participate in specialized training provided to law enforcement officers/first responders to learn more about the roles, responsibilities, and policies of public safety personnel.
- Cross-sector data use agreements that can facilitate information exchange and support service provision, quality of care, and outcomes.
- Key programmatic leadership and oversight of the operation should be performed by the behavioral health professional to encourage a public health driven approach to service delivery.
- Law enforcement should present in the community in a manner that distinguishes them from their traditional public safety role such as being dressed in more civilian-like uniforms and/or driving unmarked vehicles.
- Use of protocols that limit public safety use of restrictive means (e.g., officer discretion as to when to use handcuffs).
- Utilize a validated, standardized tool to develop a crisis and safety plan, as appropriate.
- Have access to psychiatric staff for clinical insight and pharmacotherapy services.
- Be technologically linked to local crisis hotlines in a manner that encourages an efficient and well-coordinated response such as the use of GPS-enabled devices that are linked to local 988 Lifeline and other local hotlines.
- Utilize peers in non-emergent de-escalation and support, follow-up care, and support post-disposition.

7. Community Outreach Teams

Service Type/Description:

Community Outreach Teams (COTs) engage in outreach to communities and community members to support a variety of needs for individuals including behavioral health, physical care, housing, benefits, education, and employment. Through outreach and engagement, COTs aim to promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Though not crisis responders, COTs can work effectively

alongside or in a complimentary manner to MCTs to prevent crises and provide wraparound supports to those in need.

Distinguishing Features:

- **Prevention Oriented:** COTs primarily engage in outreach efforts aimed at prevention.

Suggested Service Elements:

- Proactive and responsive outreach;
- In-person engagement;
- Health, safety, and social drivers of health screenings;
- Support and coaching;
- Strategies to promote recovery and improvement;
- Assistance to meet basic emergency needs (e.g., food, shelter, clothing);
- Direct referral and linkages with services;
- Systems navigation supports; and
- Follow-up contacts.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person (preferable), telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

Dependent upon the scope of the COT.

Exclusionary Criteria:

Dependent on the scope of the COT.

People who cannot be safely supported with this intervention will be connected to a different level of care.

Discharge Criteria:

None.

Modality:

Initial service is provided in-person; follow-up service may occur in-person, telephonically, or virtually, as appropriate.

Setting/Care Environment:

Services are provided on the streets, in shelters, or in any location where a population may be found.

Temporal Considerations:
Specific days/times of service provision and availability may vary. Teams often have designated hours and may have routine sites for outreach. Some outreach and engagement services should be provided during evenings and weekends. Services should be structured to overcome social drivers of health such as homelessness.

Provider Type:

Standards vary based on the scope, function, and composition of the team. At minimum, COTs should have protocols in place to connect individuals requiring acute/urgent/emergency behavioral or physical health care with the appropriate services.

Staffing Recommendations and Credentialing:

Staffing of COTs varies by organizational administration and team function. At minimum, COTs should be staffed by individuals qualified to perform the functions of the team. Depending on the function of the team, COTs may be staffed by the following: Licensed Practitioner of the Healing Arts (LPHA), Mental Health Professional (MHP), Qualified Mental Health Professional (QMHP), Rehabilitative Services Associate (RSA), Certified Peer Support Specialist, Community Health Worker, paraprofessional, or a Crisis Worker. Depending on the model, COTs may include medical and psychiatric staff.

Core Competency Recommendations:

- Active and empathic listening;
- Engagement and rapport building techniques;
- Developmentally appropriate care;
- Situational safety and risk assessment;
- Safety planning;
- Suicide risk assessment;
- Crisis assessment;
- Protocols for referring to required acute/urgent/emergency behavioral health or physical healthcare services;
- Knowledge of existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction;
- Overdose prevention;
- Naloxone administration; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures:

- Demographics;
- Duration of encounter;
- Location visited;
- Presenting issues;
- Staff activity during encounter;
- Referrals and linkages to service;
- Outcome of interaction;

- Improvement or resolution of presenting issues;
- Well-being metrics;
- Development of or connection to natural supports;
- Help seeker satisfaction; and
- Sentinel events.

Optional Service Enhancements:

- Have access to psychiatric staff for clinical insight and pharmacotherapy services.
- Utilize peers throughout service provision.
- Provide naloxone and other harm reduction resources.

8. Mobile Response and Stabilization Services (MRSS)

Service Type/Description:

MRSS is timely, time-limited, intensive home- and community-based crisis service designed to support children and youth through a systems-based approach with the goal of preventing unnecessary out-of-home placements. High-fidelity MRSS is comprised of three distinct service components: single access point, mobile response, and stabilization. Mobile response and stabilization services (defined in this section) offer intervention to de-escalate and mitigate current crises and support ongoing stabilization and functioning to prevent future crises.

MRSS is designed to support children, youth, their families/caregivers, and other supports through a systems-based approach with the goal of stabilizing the acute crisis and providing follow-up and stabilization services, thereby preventing unnecessary hospitalizations, out-of-home placements, and future crises. It is focused on helping children and youth stabilize in their current living arrangement with a return to routine activities. Services should be flexible and robust enough to meet a broad spectrum of needs and presentations, including supporting young people at immediate risk of psychiatric hospitalization and providing early intervention for young people and families/caregivers newly concerned about worsening behavioral health. Early intervention through MRSS can offset the need for future more intensive services by determining needs and supports and connecting to care before issues become more complex. These services are to be provided in the child/youth's own home or another setting (foster care, kinship care), or a community setting which provides a level of safety for the individual and the MRSS professional.

Distinguishing Features:[15]

- **Coverage Capacity:** 24/7/365 service provision is preferred.
- **A "Just Go" approach:** The default is to provide a rapid, face-to-face screening, assessment, and response to the help seeker (within 60–90 minutes), with the capacity for the call center/dispatch entity to remain in contact with the caller within minimal dispatch criteria.
- **Family Systems Approach:** MRSS recognizes that the distress experienced by an individual impacts all members of the family system and that children and youth live within the context of their families and caregivers. MRSS leverages a family systems approach and family- and youth-driven services and supports.
- **Home- and Community-Based Services:** MRSS is aimed at maintaining the child/youth in their current living arrangement and prioritizes community-based services to support stabilization and improve functioning.

- **Ongoing Stabilization and Follow-Up:** Children/youth and their families/caregivers (as appropriate) may receive several weeks (typically up to 8 weeks) of ongoing support through MRSS in addition to follow-up after discharge from services.

Recommended Service Elements (Mobile Response):[16]

- Provision of 24/7/365 timely, face-to-face response in homes, schools, and any other community location where the crisis is occurring.
- Conduct initial crisis screening and safety assessment including universal screening for suicide using developmentally appropriate, standardized assessment tools.
- Provide de-escalating and/or stabilizing supports to mitigate the crisis and maintain the child/youth in their current living arrangement.
- Assist in establishing improved safety within the home environment including lethal means counseling.
- Develop, revise, and/or optimize a crisis-safety plan to mitigate the current crisis and prevent a future crisis.
- Collaborative, systems-based, family- and child/youth- driven treatment planning.
- Direct referrals and care coordination with home-, school-, community- and systems-based stabilization supports.
- Initiation of emergency rescue in cases of imminent safety concerns (e.g., EMS).
- Coordinate transportation for the individual that will facilitate crisis stabilization.
- Prioritize in-person stabilization and follow-up but may utilize telephonic or virtual follow-up at the child and/or the families/caregiver's request.

Recommended Service Elements (Stabilization and Follow up):[17]

- Provision of 24/7/365 rapid and scheduled (by need/preference) face-to-face response including continued support around crisis de-escalation and help assuring immediate safety;
- Collaborative review and update of child/family specific assessments;
- Collaborative review and update of crisis-safety plans;
- Collaborative development and implementation of written plans of care;
- Connect child/youth and their family to informal/natural and formal supports and services;
- Skills development includes parent training, building coping skills for children and caregivers, psychoeducation, and behavioral support;
- Peer support including youth (same or near-age) and family support peers;
- Brief clinical interventions including use of evidence-based or promising practices;
- Reduction of access to lethal means such as counseling, providing education on or access to equipment such as lock boxes, gun locks, and contact alarms for doors and windows, and helping families/caregivers to develop plans for increased supervision during times of higher risk. This could include MRSS staff providing some one-on-one supervision for a specific and limited duration of time in addition to leveraging the other natural and formal supports available to the young person and their family/caregivers;
- Coordination across systems and needs; MRSS staff should collaborate with educational, child welfare, juvenile justice, primary care, early education, and other systems with whom the young person and their family/caregiver may be engaged. Collaboration may include a team-based approach and coordinated plan of care;
- Care coordination including referrals to services and supports identified through the comprehensive strengths and needs assessments. Referrals should be based on the

needs, strengths, preferences, ideas, and cultural contexts of the young person and their family unit and include a mix of natural, community-based, and formal supports. When available, services offered as appropriate should include evidence-based and promising practices. If longer-term care coordination services are required (e.g., wraparound) that connection should be made including a warm hand-off and continuity of crisis and care planning;
- Initiation of emergency PSAP services in cases of imminent safety concerns (e.g., EMS);
- Coordination of transportation for the individual that will facilitate crisis stabilization; and
- Provision of in-person, telephonic, and virtual follow-up based on needs of preferences of the young person and their family/caregivers.

Care Coordination/Follow-Up:

- Utilize an evidence-informed care coordination model.
- Identify and coordinate with already established providers.
- It is expected that existing outpatient mental health treatment will continue while MRSS is working with the child/youth and family.
- Identify and coordinate with community- and system-based community supports.
- Identify and coordinate with informal/natural supports.
- Provide home- and community-based resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers (youth and family peers) in follow-up.

Eligibility Criteria:

- Service eligibility may vary based on a community's criteria.
- The target population for the MRSS service is children and youth ages 5 to 24 years who are experiencing a psychiatric crisis so severe that unless immediate effective intervention is provided, the child/youth will likely be admitted to a psychiatric hospital or placed in a treatment residence.
- The symptoms of the behavioral heath diagnosis should be the primary clinical issue addressed by services and meet eligibility criteria that may vary by jurisdiction.

Exclusionary Criteria:

People who cannot be safely supported with this intervention will be connected to a different level of care

Discharge Criteria:

A child's enrollment in MRSS is complete when the crisis has consistently stabilized to the point that the risk for out-of-home placement or psychiatric hospitalization has abated, if further services are no longer needed, or if less intensive services will safely maintain the child/youth in the community.

Modality:

Initial response is conducted in person; follow-up may occur in person (preferable), telephonically, or virtually.

Service Duration: [18]

- MRSS Mobile Response services are available 24/7/365.
- MRSS Mobile Response allows for multiple in-person responses for up to 72 hours, as needed.
- Crisis, Safety, and Care Planning should occur within 72 hours following the first visit. [19]
- MRSS Stabilization Services are typically provided for a duration of approximately 6–8 weeks.
- MRSS Stabilization Services may continue for the full 6–8-week period if the family is in need or requests continued support, if there are no other community services or resources available to help reach specified goals, or if it is agreed that termination will cause a deterioration of accomplishment up to that point.
- If the 6–8-week period ends, and the child and family still has/have unmet mental health needs, the family can re-engage the MRSS program for a new episode of care.

Setting/Care Environment:

- Services are provided in the child/youth's current living situation, community (e.g., school), or a setting which provides safety for the child/youth, their family, and the mental health professional.
- Providers should prioritize in-person service delivery. At least one intake and evaluation session should be completed in person to promote engagement and facilitate informed choice prior to finalization of the treatment plan.
- Although telehealth can be adjunctively used to facilitate access and engagement, it should not replace in-person program recommendations by restricting or denying in-person access.
- An Environmental Risk Assessment of Service Location should be conducted to ensure safety.
- Providers should prioritize in-person service delivery to promote engagement and facilitate informed choice prior to finalization of the treatment plan.

Provider Type:

- MRSS Mobile Response and Stabilization services are connected under the same provider organization and workforce. [20]
- Programs are often licensed by a state or local authority and are encouraged to be accredited by a designated agency.
- Vehicles used by MRSS staff during service provision should be compatible with the location and geography where services are provided.

Staffing Recommendations and Credentialing:

- MRSS teams should consist of a master's level licensed supervisor and clinical staff.
- MRSS teams may include a peer/family advocate, a consulting psychiatrist, or consulting psychiatric nurse practitioner, and clerical support if the program feels that these

additional positions are beneficial to the development of the team and service to their clients.
- Each MRSS staff should have a master's degree or a bachelor's degree with relevant experience.
- Programs may determine the most appropriate staffing model for their catchment area.
- Paired initial response by members of the MRSS Mobile Response Team is strongly preferred.
- At least one member should be a licensed/credentialed clinician with the ability to conduct an assessment to support the initiation of involuntary treatment within their scope of practice within the governing state of local laws and/or regulations.
- The second team member can be a person who has been trained in crisis response, or a peer recovery specialist.
- If paired in-person response is not possible, one individual should provide the initial response onsite and the other team member may participate using telehealth; the person responding onsite should be licensed/credentialed.
- Whether participating in person or remotely, MRSS Mobile Response staff should participate throughout the duration of the mobile crisis response.
- MRSS Mobile Response should only involve law enforcement when appropriate.
- Law enforcement personnel do not qualify as members of the MRSS Mobile Response Team.
- A master's or bachelor's level human service worker should be assigned to the child/youth and is supported by a broader clinical team for ongoing MRSS Stabilization.

Core Competency Recommendations:

- Active and empathic listening;
- Youth and family engagement and rapport building techniques;
- Situational safety and risk assessment;
- Safety planning;
- Suicide risk assessment;
- Crisis assessment;
- Crisis counseling;
- Family psychoeducation;
- Crisis intervention and de-escalation techniques ;
- Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction;
- Overdose prevention;
- Naloxone administration; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures:

- Demographics;
- Average face-to-face response time;
- Child strengths and needs;

- Family strengths and needs;
- Discharge plan and status;
- Number or percentage of hand-offs;
- Number or percentage of referrals and direct linkages to service;
- Number and type of out of home placements; and
- Sentinel events.

Optional Service Enhancements:

- Services are flexible, adapt to the specific and changing needs of each child/family, and may include up to daily intervention.
- Interventionists provide a wide range of services, such as helping families meet the basic needs of food, clothing, shelter, transportation, and budgeting.

Crisis System Component:
A Safe Place for Help

A Safe Place for Help Service Recommended Elements Summary Tables

Key: ● = Recommended, ❍ = May Have Available, - (Dash) = Not an Element of Service

Service Orientation

Service Elements	Hospital-Based Behavioral Health Emergency 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	High-Intensity Crisis Residential	Medium-Intensity Crisis Residential	Behavioral Health Urgent Care	Peer Respite	Sobering Centers	Youth Services In-Home Stabilization	Youth/Family Respite
Active Treatment	●	●	●	●	●	●	●	●	●	●	●	●
ASAM Level 4 Psychiatric	●	-	-	-	-	-	-	-	-	-	-	-
ASAM Level 3.7	-	●	●	●	●	●	-	-	-	-	-	-
ASAM Level 3.5	-	-	-	-	-	-	●	-	-	-	-	-
ASAM Recovery Residence	-	-	-	-	-	-	-	-	●	-	-	-
LOCUS Level 6	●	●	●	-	-	-	-	-	-	-	-	-
LOCUS Level 5	-	-	-	●	●	●	❍	-	-	-	-	-
CALOCUS Level 3	-	-	-	-	-	-	-	-	-	-	●	●

Service Modality

Service Elements	Hospital-Based Behavioral Health Emergency 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	High-Intensity Crisis Residential	Medium-Intensity Crisis Residential	Behavioral Health Urgent Care	Peer Respite	Sobering Centers	Youth Services In-Home Stabilization	Youth/Family Respite
In-Person	●	●	●	●	●	●	●	●	●	●	●	●
Accepts Involuntary Admissions	●	●	●			●						
Accepts Voluntary Admissions	●	●	●	●	●	●	●	●	●	●	●	●
Dedicated Law Enforcement/EMS Drop-Off	❍	●	-	❍	-	-	-	-	-	❍	-	-
Length of Stay > 24 Hours	-	-	●	-	●	●	●	-	❍	-	-	❍
Private Rooms with Beds	-	-	●	-	●	❍	❍	-	❍	❍	-	●

Service Elements	Hospital-Based Behavioral Health Emergency 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	High-Intensity Crisis Residential	Medium-Intensity Crisis Residential	Behavioral Health Urgent Care	Peer Respite	Sobering Centers	Youth Services In-Home Stabilization	Youth/Family Respite
Capacity for Seclusion and Restraints	●	●	●	-	-	●	-	-	-	-	-	-
“Home-Like” Setting	-	-	❍	-	❍	●	●	-	●	❍	●	●

Coverage and Staffing

Service Elements	Hospital-Based Behavioral Health Emergency 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	High-Intensity Crisis Residential	Medium-Intensity Crisis Residential	Behavioral Health Urgent Care	Peer Respite	Sobering Centers	Youth Services In-Home Stabilization	Youth/Family Respite
24/7/365 Coverage	●	●	●	●	●	●	●	❍	❍	❍	●	●
Onsite Pharmacy or Medication Dispensing Available	●	●	●	❍	❍	●	❍	❍	-	-	-	-
Access to Prescriber 24/7/365	●	●	●	❍	❍	❍	-	❍	-	-	-	-
Licensed Behavioral Health Staff	●	●	●	●	●	●	●	●	-	-	●	●
Certified Peer Support Specialists	❍	●	●	❍	❍	❍	❍	❍	●	❍	❍	❍
Nursing/Other Medical Staff	●	●	●	●	●	●	❍	●	-	●	-	●

Services

Service Elements	Hospital-Based Behavioral Health Emergency 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	High-Intensity Crisis Residential	Medium-Intensity Crisis Residential	Behavioral Health Urgent Care	Peer Respite	Sobering Centers	Youth Services In-Home Stabilization	Youth/Family Respite
Screening & Triage	●	●	●	●	●	●	●	●	-	●	●	-
Diagnostic Assessment	●	-	-	-	-	●	●	-	-	-	-	-
Medication Initiation & Administration	●	●	●	●	●	●	●	●	-	-	-	-
Laboratory Services	●	-	-	-	-	-	-	-	-	-	-	-
Point of Care Testing		●	●	●	●	-	-	●	-	-	-	-
Ambulatory-Level Care Support for Physical Health Issues	●	●	●	●	●	●	●	-	-	-	-	●
Management/Monitoring of Symptoms of Intoxication & Withdrawal Based on ASAM Level	●	●	●	●	●	●	●	-	-	●	-	-
Medications for Opioid Use Disorder & Alcohol Use Disorder (MOUD/MAUD)	●	●	●	●	●	❍	❍	●	-	-	-	-
Safety Treatment Recovery Planning	●	●	●	●	●	●	●	-	-	●	●	●
Care Coordination	●	●	●	●	●	●	●	-	-	●	●	●
Assistance with Psychosocial Stressors and Social Drivers of Health	❍	●	●	●	●	●	●	-	❍	❍	●	●
Therapeutic Milieu			❍		❍	●	●	-	●	-	-	●
Crisis Counseling	●		❍		❍	●	●	-	-	-	●	●
Family Engagement	❍	●	●	●	●	●	●	-	-	-	●	●
Psychoeducation			●		●	●	●	-	❍	-	-	●
Individual Peer Support Services	❍	●	●	❍	❍	❍	❍	❍	●	❍	❍	❍
Educational & Recreational Activities	-	-	-	-	-	●	●	-	●	-	●	●
Emotional Support Groups	-	-	●	-	●	●	●	-	●	-	-	●
Discharge Planning and Follow-Up	●	●	●	●	●	●	●	●	❍	❍	●	●

Crisis Stabilization Settings

A Safe Place for Help reflects a range of service models to support individuals through emergent and urgent behavioral health needs. It involves facility and community-based services that address three key needs for people in crisis: access, stabilization, and follow-up. A Safe Place for Help encompasses stabilization services across a continuum of care from no barrier, low barrier, to referral-based services.

Community-Based Crisis Stabilization

Community-based stabilization provides onsite, face-to-face intervention at the location of the crisis, (e.g., home, or another community setting), offers a comprehensive assessment and includes immediate de-escalation and stabilization support. Community-based stabilization provides an assessment to determine the safety and level of risk for harm to self or others and determines the services and supports necessary for resolving the current crisis and maintaining the individual in the most integrated environment.

Community-based stabilization uses a strengths-based discovery process to develop an individualized crisis safety plan that offers immediate concrete steps in response to the current acute phase and includes proactive concrete steps for avoiding future crisis. Community-based stabilization should offer immediate access to psychiatric consultation for clinical support and medication review and reconciliation, and coordination with existing providers. Community-based stabilization also provides linkages and referrals to new services and supports and may serve as facilitators for admission to higher levels of care, such as inpatient care and/or other higher level crisis stabilization services.

Facility-Based Crisis Stabilization

Facility-based crisis stabilization centers offer low barrier, direct immediate intervention for individuals experiencing behavioral health emergencies. Facilities supporting this function provide an open access approach for individuals seeking emergency care while in a behavioral health crisis. Such service centers ideally would accept all behavioral health emergencies at all levels of acuity, allowing the individual to define the crisis, while also providing rapid drop-off options for law enforcement and EMS. Not all facilities, however, may be able to provide services for everyone at all levels of acuity and the description of the settings found below provide distinctions between the various settings. Low barrier and referral-based services strengthen the continuum of care and expand options for people in crisis.

Across all settings, stabilization services offer a safe environment where individuals can receive support and care to address their behavioral health crisis needs and to support crisis resolution and connections to appropriate levels of care. Stabilization services offer specialized services designed to help address the behavioral health crisis and reduce acute symptoms. These services are recovery and resilience-focused and trauma-informed, offering therapeutic support and observation.

Crisis stabilization services provide access to mental health and substance use services while working with individuals of varying ages (as allowed by licensure) and clinical conditions across various levels of service intensity. Services within a Safe Place for Help are identified by the inclusion of multidisciplinary treatment teams, lengths of stays, function of services, and distinguishing features. Services outlined in a Safe Place for Help have been categorized into three sections based on their functions. Where possible, services also are mapped to align with ASAM Levels of Care (4th Edition) and LOCUS.

CRISIS AND EMERGENCY STABILIZATION SERVICES INCLUDE:

- Hospital-Based Emergency Stabilization Units;
- High-Intensity Behavioral Health Emergency Centers;
- High-Intensity Behavioral Health Extended Stabilization Centers;
- Medium-Intensity Behavioral Health Crisis Centers; and
- Medium-Intensity Behavioral Health Extended Stabilization Centers.

CRISIS RESIDENTIAL SERVICES INCLUDE:

- High-Intensity Crisis Residential Programs, and
- Medium-Intensity Crisis Residential Programs.

SERVICES INCLUDED AS ADDITIONAL SETTINGS INCLUDE:

- Behavioral Health Urgent Care;
- Youth/Family Crisis Respite Care;
- Peer Crisis Respite; and
- Sobering Centers.

SERVICE SPECIFIC TO CHILDREN, YOUTH, & FAMILIES INCLUDE:

- In-Home Stabilization, and
- Youth & Family Crisis Respite Care.

Crisis Emergency Services

9. Hospital-Based Behavioral Health Emergency Units

Service Type/Description:

Hospital-Based Behavioral Health Emergency Units (also known as Emergency Psychiatric Assessment, Treatment, and Healing (EMPATH) or are sometimes referred to as Psychiatric Emergency Services (PES) units) are co-located on hospital grounds and linked to the ED for triage and referral of individuals in need of behavioral health emergent crisis care. These units accept individuals of all level of acuity outside of an inpatient setting and can accept both voluntary and involuntary admissions from the hospital ED. These units can help mitigate the problem of individuals “boarding”, untreated, in traditional EDs as they await hospital inpatient admission, or other care coordination. The primary focus is assessment and *treatment*, with a goal of acute stabilization of emergency behavioral health symptoms, leading to discharge to community as appropriate. Length of stay is typically less than 23 hours but can be extended based on individual needs and physician recommendation. Additionally, these units can offer more intensive medication management and access to medical services due to medical comorbidities, and need for more complex monitoring and testing, etc., including complex withdrawal management (ASAM Level 4 Inpatient Hospitalization).

Distinguishing Features:

- Located on hospital grounds and linked to ED.
- Offers intensive medication monitoring, continuous observation and treatment in a safe setting, and behavioral health crisis care with access to medical specialty services for medical comorbidities.
- Complex withdrawal management services – ASAM Level 4 Inpatient Hospitalization.
- LOCUS Level 6A – High-Intensity, Acute Medically Managed Residential Program.

Recommended Service Elements:

- Screening; triage assessment;
- Bio-psychosocial assessment;
- Medication initiation and administration;
- Laboratory services;
- Medical specialty consultation;
- Medically managed withdrawal management;
- Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD);
- Treatment planning;
- Care coordination;
- Active treatment and observation;
- Crisis counseling;
- Motivational interviewing; and
- Discharge planning and follow-up with community based services where indicated.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up contacts.

Eligibility Criteria:

None.

Exclusionary Criteria:

None.

Discharge Criteria:

Stabilization of behavioral health emergency – individual connected to most appropriate level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

- People enter this level of care via hospital ED, which accepts all who are brought to the facility by the police and ambulance as well as walk-ins 24/7/365.
- Facility is located on hospital grounds with staffing area and dedicated space for clients in a setting that meets hospital and accreditation body safety standards for a behavioral health setting.
- This setting has the ability to perform seclusion and restraint as a last resort measure for those with safety concerns that cannot be safely supported otherwise.
- Meal services tailored to dietary needs.

Provider Type:

Should be accredited/licensed by appropriate authority. Unit is based within hospital facility.

Staffing Recommendations:

- In-person or telehealth prescriber coverage, to include assessments and medication orders by a psychiatrist or other individual who is credentialed to prescribe psychiatric medications (accessible 24/7/365);
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (e.g., social workers, counselors, marriage and family therapists);
- Social services support staff;
- Connection to general hospital support staff (e.g., chaplains, advocates); and
- Access to hospital medical specialty services (e.g., cardiology).

Sample Data Elements, Metrics, and Quality Measures:

- Demographics;
- Critical incidents and sentinel events;
- Readmissions;
- Instances of seclusion or restraint and any activity resulting in injury;
- Metrics of timeliness of care (e.g., door to provider time);
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Peer/family support specialists onsite (exempt from seclusion/restraint);
- Provide a dedicated drop-off area for law enforcement and EMS; and
- Family waiting area, family engagement/services/and visiting hours, preferably 24/7/365.

10. High-Intensity Behavioral Health Emergency Centers

Service Type/Description:

High-Intensity Behavioral Health Emergency Centers (hereafter referred to as High-Intensity Centers) operate with two functions: no barrier access and stabilization. High-Intensity Centers have no restrictions or exclusionary criteria. These centers can provide ambulatory-level care for non-urgent medical issues and may transfer an individual requiring further medical work-up and/or management to an ED with expectation of re-acceptance upon medical stabilization. These centers can provide withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting (ASAM Level 3.7 Psychiatric).

No Barrier Access: High-Intensity Centers offer immediate access for individuals in emergency crises. These facilities receive individuals on a 24/7/365 basis, including walk-ins, drop-offs, and law enforcement and/or EMS drop-offs. This includes a rapid drop-off with a “no wrong door” policy.

Stabilization: High-Intensity Centers provide emergency care for those in a behavioral health crisis, including triage assessment. Typically, these services occur within 23 hours of entry into the facility. Individuals will then be referred to another care setting based on level of care needed.

Distinguishing Features:

- Receive all individuals for any individual defined behavioral health emergency.
- Rapid drop-off with a “no wrong door” policy.
- Provide dedicated entrance for law enforcement/EMS drop-offs.
- Receive individuals on involuntary basis (based on jurisdiction guidelines).
- Have the regulatory, staffing, and environmental capacity for seclusion and restraints if necessary and are locked units.
- Have access to a psychiatric prescriber 24/7/365.
- Onsite pharmacy or medication dispensing capabilities.
- ASAM Level 3.7 Psychiatric.
- LOCUS Level 6A – High-Intensity, Acute Medically Managed Residential Program.

Recommended Services Elements:

- Screening; triage assessment;
- Medication initiation and administration;
- Point of care testing;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety treatment recovery planning;
- Care coordination;
- Family engagement;
- Assistance with psychosocial stressors and social drivers of health;
- Ambulatory-level care support for any physical health issue; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate and accessible levels of care.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peer support workers and specialists in follow-up contacts.

Eligibility Criteria:

None.

Exclusionary Criteria:

None.

Discharge Criteria:

Stabilization of behavioral health emergency – individual connected to more integrated level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component, as permitted by federal and state regulations.

Setting/Care Environment:

- Settings are consistent with accreditation body standards for physical settings of behavioral health inpatient units.
- Have the regulatory, physical, and staffing capacity for seclusion and restraints as necessary.
- Stays can be served through a configuration of chairs/recliners in an open milieu.
- Meal services tailored to dietary needs.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:

- Prescriber coverage by a psychiatrist or other credentialed psychiatric prescriber (accessible immediately onsite or virtually 24/7/365);
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Certified peer specialists;
- Social services support staff; and
- Security support staff.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Waiting area, engagement services, and visiting hours, preferably 24/7/365.

11. High-Intensity Behavioral Health Extended Stabilization Centers

Service Type/Description:

High-Intensity Behavioral Health Extended Stabilization Centers (hereafter referred to as High-Intensity Extensions) are connected to the High-Intensity Behavioral Health Emergency Centers. These facilities offer extended behavioral health emergency care beyond the initial 23 hours and provide access to individual bed space. They typically offer services for an average of 3–5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can be transferred to a less intensive and more inclusive treatment and support setting. They can provide continued withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting (ASAM Level 3.7 Psychiatric).

Distinguishing Features:

- Rooms with beds (as opposed to recliners);
- No length of stay requirement (typical stay 3–5 days);
- Receive individuals on involuntary basis (based on jurisdiction guidelines);
- ASAM Level 3.7 Psychiatric; and
- LOCUS Level 6A – High-Intensity, Acute Medically Managed Residential Program.

Recommended Service Elements:

Same as High-Intensity Centers

- Screening; triage assessment;
- Medication initiation and administration;
- Point of care testing;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety treatment recovery planning;
- Care coordination;
- Family engagement;
- Assistance with psychosocial stressors and social drivers of health;
- Ambulatory-level care support for any physical health issue; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate levels of care.

With the addition of:

- Skill-building;
- Support groups;
- Warm hand-off & community referrals; and
- Psychoeducation services.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

Individuals are eligible for this service based on receiving services as an extension of the High-Intensity Behavioral Health Emergency Centers.

Exclusionary Criteria:

None.

Discharge Criteria:

Stabilization of behavioral health emergency – individual connected to less restrictive and more inclusive level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component as appropriate and permissible.

Setting/Care Environment:

- Co-located with High-Intensity Centers;
- Settings are consistent with accreditation body standards for physical settings of behavioral health inpatient units, including meal services; and
- Individuals are provided dedicated rooms with beds.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:
Same as High-Intensity Centers

- Prescriber coverage by a psychiatrist or other credentialed prescriber (immediately onsite or virtually accessible 24/7/365);
- Nursing staff onsite 24/7/365;

- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Social services support staff;
- Certified peer specialists; and
- Security support staff (e.g., ideally non-specialized security staff trained in de-escalation techniques on units and potentially hired security off-unit).

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Waiting area, engagement services, and visiting hours, preferably 24/7/365.

12. Medium-Intensity Behavioral Health Crisis Centers

Service Type/Description:

Medium-Intensity Crisis Centers (hereafter referred to as Medium-Intensity Centers) provide similar services as High-Intensity Centers; however, they only accept voluntary individuals and hence often a lower level of acuity. These centers may provide law enforcement and/or EMS drop-offs; however, they are not required to and are unable to provide services for individuals on involuntary holds. Medium-Intensity Centers may not have onsite pharmacy or medication dispensing capabilities but do have access to local pharmacy services. These centers offer the management of moderate symptoms of intoxication and withdrawal (ASAM Level 3.7 COE, Medically Managed Residential with Co-Occurring Enhanced Support).

Distinguishing Features:

- Exclude involuntary admissions;
- May not have onsite medication dispensing but should have access to local pharmacy services;
- Should be secure but will not have access to seclusion of physical restraints onsite; ASAM Level 3.7 COE; and
- LOCUS Level 5A – Intensive, Short-Term Medically Monitored Residential Services.

Recommended Service Elements:

Same as High-Intensity Centers

- Screening; triage assessment;
- Medication initiation and administration;
- Point of care testing;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety planning
- Recovery planning;

- Care coordination;
- Family engagement;
- Assistance with psychosocial stressors and social drivers of health;
- Ambulatory-level care support for any physical health issue; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate and accessible levels of care.

Except for:

- May not have an onsite pharmacy or capacity or onsite medication dispensing but *should* have a relationship with a local pharmacy to dispense medications.

Care Coordination/Follow-Up:

- Identify and coordinate with established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

None.

Exclusionary Criteria:

- Involuntary admissions, and
- Medical needs requiring a significant medical treatment & services beyond behavioral health needs.

Discharge Criteria:

Stabilization of acute behavioral health crisis – individual connected to more inclusive level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

- Settings are consistent with accreditation body standards for physical settings of behavioral health inpatient units.
- Short stays can include chairs/recliners in an open milieu.
- Meal services tailored to dietary needs..

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:
Same as High-Intensity Centers; however, with reduced staffing ratios

- Prescriber coverage by a psychiatrist or other credentialed prescriber (immediately onsite or virtually accessible within one hour, 24/7/365);
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Social services support staff;
- Security support staff (e.g., facility security); and
- Meal services.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Peer/family specialists, and
- Waiting area, engagement services, and visiting hours.

13. Medium-Intensity Behavioral Health Extended Stabilization Centers

Service Type/Description:

Medium-Intensity Behavioral Health Extended Stabilization Centers (hereafter referred to as Medium-Intensity Extension) are connected to Medium-Intensity Behavioral Health Crisis Centers. These facilities offer extended behavioral health crisis care beyond 23 hours and provide access to individual bed space. These units typically offer services for an average of 3–5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can be transferred to a less intensive treatment and support setting. Medium-Intensity Extension can provide continued moderate withdrawal management services (ASAM Level 3.7 COE, Medically Managed Residential with Co-Occurring Enhanced Support).

Distinguishing Features:

- Private rooms with beds;
- Only serve voluntary individuals;
- No length of stay requirement (typical stay 3–5 days);
- ASAM Level 3.7 COE; and
- LOCUS Level 5A – Intensive, Short-Term Medically Monitored Residential Services.

Recommended Service Elements:

Same as Medium-Intensity Behavioral Health Crisis Centers

- Screening;
- Triage assessment;
- Medication initiation and administration;
- Point of care testing;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety planning
- Recovery planning;
- Care coordination;
- Family/caregiver engagement;
- Help with psychosocial stressors and social drivers of health;
- Ambulatory-level care support for any physical health issue; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate and accessible levels of care.

With the addition of:

- Skill-building;
- Support groups;
- Warm hand-off & community referrals;
- Psychoeducation services; and
- Waiting area, engagement services, and visiting hours.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with other individuals, as appropriate.
- Engage peers support workers and specialists in follow-up contacts.

Eligibility Criteria:

None.

Exclusionary Criteria:

- Involuntary admissions, and
- Medical needs requiring significant medical treatment & services beyond behavioral health needs.

Discharge Criteria:

Stabilization of acute behavioral health crisis – individual connected to more inclusive level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component, as appropriate/permitted.

Setting/Care Environment:

- Co-located with Medium-Intensity Centers.
- Settings are consistent with accreditation body standards for physical settings of behavioral health inpatient units.
- Each individual is provided with a dedicated bed.
- Meal services tailored to dietary needs.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:
Same as Medium-Intensity Behavioral Health Crisis Centers ; however, with different staffing ratios

- Prescriber coverage by a psychiatrist or other credentialed prescriber (immediately onsite or virtually accessible within one hour, 24/7/365);
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Social services support staff;
- Nutrition services; and
- Security support staff.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Optional Service Enhancements:

- Certified peer/family specialists onsite, and
- Family waiting area & family engagement services and visiting hours, preferably 24/7/365.

Crisis Residential Services

14. High-Intensity Crisis Residential Programs

Service Type/Description:

High-Intensity Crisis Residential Facilities (hereafter referred to as High-Intensity Residential) are residential crisis programs with high levels of medical and nursing involvement. High-Intensity Residential programs are non-hospital-based programs with lengths of stay that typically range from a few days to two weeks and allow for relatively intensive 24/7 monitoring and support as well as provision of medical, nursing, and crisis intervention. These facilities are often in controlled settings (i.e., entry and departure from the facility is closely monitored), permitting admission of individuals who may need more intensive services. Admissions are typically voluntary; though depending on local regulations and laws, individuals may be legally mandated to this level of care. High-Intensity Residential facilities can provide withdrawal management for mild to moderate symptoms (ASAM Level 3.7 COE Medically Managed Residential with Co-Occurring Enhanced Support).

Distinguishing Features:

- Residential setting, non-hospital based;
- Therapeutic milieu key component of service delivery;
- May accept individuals on involuntary holds (based on jurisdictional guidelines);
- Typically, stand-alone facilities, not connected to an Emergency Crisis Care Center;
- Laboratory and pharmacy services are generally not onsite and participants may require transportation for medical specialty appointments;
- ASAM Level 3.7 COE; and
- LOCUS Level 5 – Medically Monitored Residential Services.

Recommended Service Elements:

- Screening;
- Diagnostic assessment;
- Medication initiation and administration (can be self-administration);
- Withdrawal management;
- Safety & recovery planning;
- Care coordination;
- Psychoeducation;
- Individual & group therapy;
- Family engagement;
- Therapeutic Milieu ;
- Ambulatory-level care support for minor physical health issues; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate levels of care.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.

- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with the person's support system, as appropriate.
- Engage peers support workers and specialists in follow-up contacts

Eligibility Criteria:

Ability to participate in safety planning and residential services.

Exclusionary Criteria:

- Individuals who are at imminent risk of harm to self, others, or property who cannot engage or do not wish to engage in safety planning, and
- Medical needs requiring significant medical treatment & services beyond behavioral health needs.

Discharge Criteria:

Stabilization of behavioral health crisis – individual connected to more inclusive level of care and/or safety plan in place, as desired.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component, as appropriate and permissible.

Setting/Care Environment:

- Settings are consistent with accreditation body standards for physical settings of behavioral health residential units.
- Individual beds with private space available; capacity limits determined by federal and state laws and regulations.
- Meal services tailored to dietary needs.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:

- Psychiatric services (should offer 24/7/365 access to psychiatric care providers (MD/DO/NP/PA) either via phone or telehealth and provide onsite visits at least twice weekly);
- Skilled nursing staff (RN) onsite with 24/7/365 phone coverage;
- Licensed practical nurses and emergency medical technicians (LPNs/EMTs) onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists); and
- Social services support staff.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Optional Service Enhancements:

- Peer/family support specialists, and
- Family waiting area, family engagement services, and visiting hours, preferably 24/7/365.

15. Medium-Intensity Crisis Residential Program

Service Type/Description:

Medium-Intensity Crisis Residential facilities (hereafter referred to as Medium-Intensity Residential) provide the same services as High-Intensity Crisis Residential facilities; however, Medium-Intensity Residential have lower levels of medical/nurse monitoring and less staffing per client. The primary focus is on connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis**.** Medium-Intensity Residential only accepts individuals on a voluntary basis. Medium-Intensity Residential can provide withdrawal management services for mild symptoms (ASAM 3.5 COE – Co-Occurring Enhanced, Clinically Managed Residential Services).

Distinguishing Features:

- Excludes involuntary admissions;
- Facilities are not locked; provide a secure environment only;
- ASAM Level 3.5 COE; and
- LOCUS 5 – Medically Monitored Residential Services.

Recommended Service Elements:

Same as High-Intensity Residential

- Screening;
- Diagnostic assessment;
- Medication initiation and administration (can be self-administration);
- Withdrawal management;
- Safety & recovery planning, as desired;
- Care coordination;
- Psychoeducation;
- Individual & group therapy;
- Family engagement;
- Therapeutic Milieu;
- Ambulatory-level care support for minor physical health issues; and
- Discharge planning including referrals and warm hand-offs to clinically appropriate and accessible levels of care.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

Ability to participate in residential services.

Exclusionary Criteria:

- Involuntary admissions.
- People who cannot safely be supported in a residential setting will be connected to a different level of care.
- Medical needs requiring significant medical treatment & services beyond behavioral health needs.

Discharge Criteria:

Stabilization of behavioral health crisis – individual connected to less restrictive and more inclusive level of care and/or safety plan in place.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component, as appropriate/permissible.

Setting/Care Environment:

- Settings are consistent with accreditation body standards for physical settings of behavioral health residential units.
- Individual beds with private space available; capacity limits determined by federal and state laws and regulations.
- Dietary services.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:

- Program is staffed with at least one crisis worker 24/7/365;
- Psychiatric services are accessible (although not 24/7/365) and typically provide onsite services once weekly;
- Skilled nursing staff (RN) availability variable;
- LPNs/EMTs onsite 24/7/365;

- Licensed behavioral health staff (social workers, counselors, marriage and family therapists); and
- Social services support staff.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Peer/family support specialists, and
- Family waiting area, family engagement services, and visiting hours, preferably 24/7/365.

Services Included as Other Settings

16. Behavioral Health Urgent Care

Service Type/Description:

Behavioral Health Urgent Care (BHUC) offers a safe, voluntary, and timely alternative and diversion from the use of hospital EDs or more intensive crisis services as an entry point of care to address the needs of individuals experiencing behavioral health crises. BHUC occurs in an ambulatory setting and typically does not include longitudinal behavioral health treatment. Rather, it provides time-limited, targeted services and supports and is not meant to be a routine or ongoing source of care unless it is connected to services that are more longitudinal in nature, such as through a Certified Community Behavioral Health Clinic. BHUCs operate in community-based locations with extended operating hours (i.e., nights and weekends), up to 24/7/365. BHUCs offer the availability of immediate, unscheduled, in-person assessments to individuals requesting care. BHUCs operate as an outpatient service that can accept voluntary walk-in crisis referrals for individuals. BHUC services provide rapid access to care and should have strong relationships with recovery communities and more intensive SUD services. They should be able to assess and stabilize mental health and SUD related crises and initiate MOUD and MAUD if appropriate and in accordance with medication prescribing and dispensing laws and regulations. BHUCs should have the ability to identify individuals' needs related to social drivers of health and connect them to social services or supports to address those needs. They should provide a clinical assessment that includes an evidence-based safety assessment for danger to self or others and create a crisis plan that includes a safety plan as appropriate and desired to mitigate the acute crisis and safety risk. Individuals utilizing BHUC are not an imminent safety risk.

Distinguishing Features:

- Time-limited, targeted services;
- Offer immediate, unscheduled services – rapid access to care;
- Outpatient services with extended operating hours;
- Offer an alternative to ED for behavioral health needs; and
- Provide walk-in voluntary services.

Recommended Service Elements:

- Screening; triage assessment;
- Point of care testing;
- Physical health screening;
- Clinical evaluation;
- Observation;
- Immediate, short-term intervention;
- Medication initiation and administration, including MOUD & MAUD as appropriate and in accordance with medication prescribing and dispensing laws and regulations;
- Care coordination; and
- Referrals.

Care Coordination/Follow-Up:

Warm hand-off and linkage to care; care coordination and follow-up (optional).

Eligibility Criteria:

None.

Exclusionary Criteria:

Individuals who are at imminent risk of harm to self, others, or property who cannot engage or do not wish to engage in safety planning.

Discharge Criteria:

None.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component, as permitted by federal and state laws and regulation.

Setting/Care Environment:

- Outpatient, clinic setting, and
- Can be stand-alone centers; however, may be an adjunct service to a hospital, a more intensive crisis service, or a longitudinal ambulatory clinic.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations

- Psychiatric prescribing providers either onsite or via telehealth during BHUC operating hours;
- Qualified nursing staff (RN/LPN) onsite during BHUC operating hours;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists) onsite during BHUC operating hours;
- Social services support staff onsite during BHUC operating hours; and
- Access to nearby local pharmacy services.

Sample Data Elements, Metrics, and Quality Measures:

- Demographics;
- Client experience;
- Nature and duration visit;
- Service referrals;
- Referral follow-through;
- Critical incidents;
- Sentinel events; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Peer/family support specialists, and
- May provide on-going follow-up care.

17. Peer Crisis Respite

Service Type/Description:

Peer Crisis Respite Services offer voluntary, short-term residential services and peer support to individuals experiencing a behavioral health crisis that is operated by peer-recovery specialists. Services focus on recovery, resiliency, and wellness and are provided and operated by trained peer support professionals who have lived experience with and recovery from behavioral health conditions. Peer Crisis Respite Services are provided in a warm, friendly home environment. All services are voluntary and guests may come and go as they wish. Services offer assistance that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and skills building. Some Peer Respite Services models, such as the Peer Living Room Model, may have more restricted hours and/or limit guests' stay to <23 hours, and thus would be considered ambulatory rather than residential and are peer operated, usually under a broader array of peer services.

Peer operated means staff, leadership, and governance are peers with lived experience. All staff, all leadership, and their job descriptions require lived experience and the governance of the program is either operated by a peer-run organization, or has an advisory group with 51 percent or more members having lived experience.

Distinguishing Features:

- Services are provided by peer support specialists.
- Respite services are voluntary, and individuals may come and go as they wish.
- "Home" environment.

Recommended Service Elements:

- Short-term, temporary lodging;
- Goal identification;
- Individual peer support services;
- Support groups;
- Educational and recreational activities; and
- Skill-building.

Care Coordination/Follow-Up:

- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.

Eligibility Criteria:

None.

Exclusionary Criteria:

People who cannot safely be supported in this service environment will be connected to a different level of care.

Discharge Criteria:

None.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

- May offer recliners in open milieu for short-term stays (e.g., Peer Living room model, less than 23 hours);
- Dedicated bed for individuals remaining for more than 23 hours;
- Meal services tailored to dietary needs;
- Accessible private rooms; and
- Communal gathering area.

Provider Type:

- A site will operate in a residence that meets local building and zoning codes.
- Peer residential services may be peer-run or peer-operated.
- If the site is offered by a non-peer-run parent organization, it is operated by a director and staff members who are peers.

Staffing Recommendations:

- Peer support professionals as defined by state standards and requirements.
- At least one peer support professional should be onsite at all times when there is a guest.
- Peer support professionals should be trained in CPR and first aid.
- Staffing patterns should be diverse and culturally sensitive to reflect the cultural and linguistic needs of the community served.

Sample Data Elements, Metrics, and Quality Measures:

- Demographics;
- Guest recovery measures (e.g., sense of purpose and hope);
- Customer satisfaction;
- IPS Core Competencies; and
- Sentinel events (e.g., death, serious injury).

Optional Service Enhancements:

- Employ CPSSs that ideally align with the *National Model Standards for Peer Support Certification* established by SAMHSA.
- Utilize a best practice model, such as the Intentional Peer Support Model.
- Offer wellness-oriented supports including WRAP or similar self-directed recovery planning tool.
- Provider site is accredited through a body such as the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or CARF.
- Family waiting area, family engagement services, and visiting hours, preferably 24/7/365.

18. Sobering Centers

Service Type/Description:

Sobering centers are low-barrier, short-term (typically <24 hours), voluntary, community-based facilities typically operating 24/7/365 that provide monitoring and oversight of adults with acute alcohol and/or other drug intoxication in a supervised and supportive environment in order for an individual to safely recover from the effects of acute intoxication. They accept intoxicated persons referred by paramedics, law enforcement, EDs, clinics, other community programs, or via self-referral and walk-in. They serve as an alternative to jail or the ED. Sobering centers are not intended as treatment, nor aimed at achieving abstinence nor the full removal of alcohol and/or drugs from the body. Acutely intoxicated individuals may decrease the amount of the intoxicating substance in a safe setting within a harm reduction and recovery-oriented framework. Sobering centers provide this opportunity while connecting clients to any appropriate and desired treatment, recovery, medical care, and/or social services. Access is provided with minimal eligibility criteria, typically without regard for their ability to pay. Providers should deliver a service that is consistent with the most recent edition of the standards developed by the National Sobering Collaborative.[21]

Distinguishing Features:

- Harm reduction and recovery framework;
- Not a treatment service;

- Focus of services is on recovery from intoxicating effects of alcohol and/or drugs, without active medical withdrawal management; and
- Low barrier access that provides a viable alternative to jail or ED.

Recommended Service Elements:

- Screening; triage assessment;
- Physical stabilization;
- Oral rehydration and food service; assigned, individual mat, bed, chair, cot, or other furnishing (not necessarily, in a closed or private room);
- Physical monitoring and support;
- Client engagement;
- Referral to community resources and/or treatment and recovery support services, as appropriate;
- 24/7 visiting hours;
- Care coordination; and
- Warm hand-off to community resources.

Care Coordination/Follow-Up:

- Identify and coordinate with already established providers.
- Provide community resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers in follow-up.

Eligibility Criteria:

None.

Exclusionary Criteria:

- People who cannot safely be supported in this setting will be connected to a different level of care.
- Individuals requiring medically-managed withdrawal services to safely recover from their state of acute intoxication.

Discharge Criteria:

Stabilization of symptoms of acute intoxication.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

- Community-based setting which is separate from medical or criminal justice settings;
- Dedicated spaces for individuals, typically recliners or beds; and
- Safe, trauma-informed environment.

Provider Type:

- Sobering center facilities shall meet applicable state and local building codes, fire codes, and ordinances to help ensure the health, safety, and security of all individuals.

Staffing Recommendations:

- Minimum of two staff should be available and onsite at any time; it is ideal to have more coverage if feasible.
- Qualified staff, with minimum certification equivalent to an emergency medical technician (EMT-basic).
- Staffing is determined based on population and community needs.
- Staff will not be uniformed security or law enforcement.
- Staff are trained in de-escalation techniques.

Sample Data Elements, Metrics, and Quality Measures:

- Number of encounters;
- Number of encounters resulting in clinical sobriety;
- Number of repeat visitors;
- Intake time;
- Demographics;
- Referrals and linkages;
- Time to access referred services;
- Critical incidents;
- Sentinel event; and
- Experience/satisfaction of the help seeker.

Optional Service Enhancements:

- Progressive engagement and motivational interviewing to support reduced drug use;
- Community outreach and education;
- Co-location with treatment services such as those that offer ambulatory or inpatient withdrawal management services, mental health services, or social services such as homeless shelters;
- MOUs or other partnerships with treatment providers providing intensive services (e.g., inpatient SUD rehabilitation services);
- Separate spaces/areas for genders; and
- Private spaces for clients whose acute intoxication is exacerbated by the sobering milieu.

Service Specific to Children, Youth, & Families

19. Children, Youth, and Families

As described in SAMHSA's *National Guidelines for Child and Youth Behavioral Health Crisis Care*, published in 2022, youth crisis services are centered on de-escalation and stabilization within the home and community. This is an important priority for all crisis services, but it is especially important for youth. Every effort should be made to maintain the young person in their current living environment as safe and appropriate, ideally with the active participation of family members and other supports. However, there are times when the safest and best management

of a situation involves inpatient care or out-of-home crisis stabilization. When young people receive out-of-home services, the priority should be to transition them back to the home and to appropriate services in the community (as needed) as soon as it is safe to do so. Although these services are specific to children, youth, and families, these populations can receive services in the other described services as well.

19A. IN-HOME STABILIZATION SERVICES

Service Type/Description:

In-home stabilization services may serve as a bridge that helps youth transition from immediate crisis services (e.g., mobile response, crisis facilities) to ongoing care in the community. In-home stabilization services are provided as soon as practicable and may continue for several weeks. For example, in the MRSS model, in-home stabilization services are provided for up to 8 weeks, while other models range from 6–16 weeks. Services may be provided by a therapist or clinician in partnership with a paraprofessional who can help youth and families/natural supporters implement the plan that they identify with their therapist. Sample in-home services include assessment, parent education programs, peer support, coping and conflict management skills-building, behavior management training, and warm hand-offs to other resources and services. Stabilization can also involve evidence-based therapies for the young person and their family/natural support providers, such as Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multidimensional Family Therapy, or Multisystemic Therapy. Stabilization providers collaborate with the youth and family/supports as active partners to develop goals that are integrated into a crisis plan of care. This involves identifying unmet needs, communication challenges, underlying concerns, individual strengths, and coping strategies. Importantly, services are provided to both the youth and their family/natural support providers. Too often, families have felt sidelined by service providers who focus exclusively on the young person, without sufficiently considering important family dynamics or the supports that family members/natural support providers need.

Distinguishing Features:

- Services provided to youth and their family;
- Stabilization services occur within the home;
- Alternative to hospitalization; and
- CALOCUS Level 3: High Intensity Community Based Services.

Recommended Service Elements:

- Family engagement;
- Goal identification/action planning;
- Skill-building;
- Educational and recreation activities; and
- Warm hand-off & community referrals.

Care Coordination/Follow-Up:

- Utilize an evidence-informed care coordination model.
- Identify and coordinate with already established providers.
- It is expected that existing outpatient mental health treatment will continue while MRSS is working with the child/youth and family.
- Identify and coordinate with community- and system-based community supports.

- Identify and coordinate with informal/natural supports.
- Provide home- and community-based resource linkages and referrals.
- Provide warm hand-off to care linkages.
- Provide in-person, telephonic, or virtual follow-up, including, but not limited to: outreach, engagement, and support; risk reassessment; reviewing, updating, and facilitating the individual's implementation of the crisis and safety plan; care coordination; and collaborating with natural supports, as appropriate.
- Engage peers (youth and family peers) in follow-up.

Eligibility Criteria:

- Service eligibility may vary based on a community's medical necessity criteria.
- The target population for service is children and youth ages 5 to 24 years who are experiencing a psychiatric crisis so severe that unless immediate effective intervention is provided, the child/youth will likely be admitted to a psychiatric hospital or placed in a treatment residence.
- Individuals qualifying for in-home services shall demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness which results in significant functional impairments in major life activities.
- The diagnosis should be the primary clinical issue addressed by services and meet medical necessity criteria that may vary by jurisdiction.

Exclusionary Criteria:

People who cannot safely be supported in a residential setting will be connected to a different level of care.

Discharge Criteria:

A family's enrollment is complete when the crisis has consistently stabilized to the point that the risk for out-of-home placement or psychiatric hospitalization has abated, if further services are no longer needed, or if less intensive services will safely maintain the child/youth in the community.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

Services are provided in the individual's natural environment. Services are provided onsite and in-home.

Provider Type:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations:

- In-home stabilization teams should consist of a master's level licensed supervisor and clinical staff.
- Teams may include a peer/family advocate, a consulting psychiatrist, or consulting psychiatric nurse practitioner, and clerical support if the program feels that these additional positions are beneficial to the team and their clients.
- Each in-home stabilization staff should have a master's degree or a bachelor's degree with relevant experience.
- Programs may otherwise determine the most appropriate staffing model for their catchment area.
- Paired initial response by members of the in-home stabilization team is strongly preferred.
- At least one member should be a licensed/credentialed clinician with the ability to conduct an involuntary assessment and/or treatment within their scope of practice within the governing state of local laws and/or regulations.
- The second team member can be an unlicensed professional, behavioral health technician who has been trained in crisis response, or a peer recovery support specialist.
- If paired in-person response is not possible, one individual should provide the initial response onsite and the other team member may participate using telehealth; the person responding onsite should be licensed/credentialed.
- A master's or bachelor's level human service worker is assigned to the family and is supported by a broader clinical team for ongoing in-home stabilization.

Core Competencies:

- Active and empathic listening;
- Youth and family engagement and rapport building techniques;
- Situational safety and risk assessment;
- Safety planning;
- Suicide risk assessment;
- Crisis assessment;
- Crisis counseling;
- Family psychoeducation;
- Crisis intervention and de-escalation techniques ;
- Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction;
- Overdose prevention;
- Naloxone administration; and
- Cultural humility and culturally responsive care.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Optional Service Enhancements:

- Peer support specialists, and
- Follow-up services.

19B. YOUTH AND FAMILY CRISIS RESPITE

Service Type/Description:

Every effort should be made to maintain the young person in their current living environment, ideally with active participation of family and natural supports. However, Youth/Family Crisis Respite Services provide an alternative to hospitalization for people, family, and youth experiencing emotional crises. They are safe, warm, and supportive home-like places to rest and recover when more support is needed than can be provided at home. Youth/Family Crisis Respite Services are distinct from adult respite and crisis residential facilities and are tailored to prioritize family and natural supports. Services are provided to both the youth and their family and are aligned with the system of care values and principles: they are family driven, youth guided, trauma informed, and culturally and linguistically responsive.

Distinguishing Features:

- Services provided to youth and their family;
- “Home-like” setting;
- Alternative to hospitalization; and
- CALOCUS Level 3: High Intensity Community Based Services.

Recommended Service Elements:

- Family engagement;
- Goal identification/action planning;
- Skill-building;
- Therapeutic milieu
- Educational and recreation activities; and
- Warm hand-off & community referrals.

Eligibility Criteria:

Youth under the age of 24 years; specific range determined by provider and accreditation entity.

Exclusionary Criteria:

No present imminent risk of harm to self or others.

Discharge Criteria:

Stabilization of acute behavioral health crisis – individual connected more inclusive level of care.

Modality:

All services are provided in a facility setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment:

- Individual beds with private space available;
- Homesetting; and
- Meal services tailored to dietary needs.

Provider/Entity Standards:

Should be accredited/licensed by appropriate authority.

Staffing Recommendations & Credentialing:

- Psychiatric services (should offer access to psychiatric care providers (MD/DO/NP/PA) either via phone or telehealth and provide onsite visits at least twice weekly);
- Skilled nursing staff (RN) with 24/7/365 phone coverage;
- LPNs/EMTs;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists); and
- Social services support staff.

Sample Data Elements, Metrics, and Quality Measures:

- Critical incidents and sentinel events (e.g., serious injury, death);
- Readmissions;
- Instances of physical management not resulting in injury and all instances of restraint;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Optional Service Enhancements:

- Peer support specialists;
- Follow-up services; and
- Family waiting area, family engagement services, and visiting hours, preferably 24/7/365.

Behavioral Health Crisis Services Glossary

Acuity: The level of severity and complexity of an individual's mental health or substance use condition as determined by recognized assessment tools.

Adult: An individual who has reached the age of majority as defined by law. The age of majority for most but not all states, territories, jurisdictions, and tribal entities is 18 years.[22]

Ambulatory-Level Care Support: All types of health services that do not require an overnight hospital stay, including diagnosis, observation, treatment, and rehabilitation that is provided on an outpatient or professional basis.[23]

Behavioral Health Crisis: The experience of stress, emotional or behavioral symptoms, difficulties with substance use, or a traumatic event that compromises or has the ability to negatively impact an individual's ability to function within their current family or caregiver environment, living situation, school, workplace, or community, as defined by the individual experiencing the crisis or by a parent, caregiver, guardian, or designee of the individual as appropriate.

Behavioral Health Crisis Services: Intensive services that are provided to address or prevent behavioral health symptoms, situations, or events that may negatively impact an individual's ability to function within their current family/caregiver and living situation, school, workplace, or community. Behavioral health crisis services are for anyone, anywhere, and at any time and can be provided in a variety of settings, including via text or telephone, face-to-face at an individual's home, or in the community.

Behavioral Health Crisis System: An organized set of structures, processes, and services in place to meet all types of urgent and emerging mental health and substance use needs in a defined population or community, effectively and efficiently. Essential elements of a behavioral health crisis system include 988 crisis lines that accept all calls and texts and provide support and referrals based on the needs of the individual or family member/caregiver; mobile crisis teams that respond to the location of need in the community; and crisis stabilization facilities that serve everyone who enters their doors from all referral sources. Comprehensive behavioral health crisis systems address recovery needs, significant use of peers, and trauma-informed care; provide "suicide safer" care; ensure safety and security for staff and those in crisis; and involve collaboration with law enforcement and emergency medical services.

Behavioral Health Emergency: Life threatening behavioral health issues that will likely result in significant harm to self, others, or grave disability without rapid or immediate crisis intervention.[24]

Behavioral Health Emergency Centers: High-Intensity Centers have no restrictions or exclusionary criteria; they offer stabilization services, providing immediate access for individuals in emergency crisis and emergency care for those in a behavioral health crisis, including triage assessment.

Behavioral Health Emergency Services: Immediate response and assistance available 24 hours a day, 7 days a week, 365 days a year for individuals having a behavioral health emergency that includes, but is not limited to, individuals at imminent risk of harming themselves or others.

Behavioral Health Equity: The right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality, accessible mental health and substance use services and support.

Behavioral Health System: A system of care that promotes primary prevention, mental health, resilience, and well-being across the lifespan; includes harm reduction and the treatment of mental health and SUDs; and supports people who experience and/or are in recovery from these conditions, along with their families, unpaid caregivers, and communities.

Behavioral Health Urgent Care: An ambulatory setting that offers safe, voluntary, and time-limited services and supports to individuals experiencing behavioral health crises. This setting is an alternative to the use of hospital emergency departments or more intensive crisis services.

Peer Operated Behavioral Health Warmline: A phone and/or text line that provides connection and is focused on crisis prevention and the promotion of wellness as opposed to the more specific emergency or crisis mitigation function of crisis hotline services. Although many of these lines are provided by peer supporters, these lines are not limited to peers.

Care Coordination: The deliberate organization of an individual's care across multiple care providers.[25]

Case Management: Services furnished to assist individuals who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.[26]

Child or Minor: Any person who is below the age of majority as defined by law and who has not otherwise been emancipated by law. Most, but not all, states, territories, jurisdictions, and tribal entities define a minor as any person under 18 years of age.[27, 28]

Clinical Assessment: The systematic evaluation and measurement of psychological, biological, and social factors (e.g., current experiences, psychosocial and cultural history, and assets and resources) to determine and define an individual's presenting issues, develop an appropriate treatment plan, and make an informed and collaborative decision about treatment.[29]

Clinical Services: Care provided to a client to diagnose, describe, predict, and/or explain that client's status relative to a disabling condition or problem, and where necessary, to treat the client to reduce impairment due to that condition.[30]

Clinician: An individual who is appropriately licensed, certified, or credentialed in the state or locale in which they practice, is practicing within the scope of that licensure, certification, or credential, and is deemed qualified to deliver certain behavioral health services.

Community Outreach Teams: A group of professionals that engages communities and community members to support a variety of needs of individuals, including behavioral health, physical care, housing, benefits, education, and employment. Though not crisis responders, they can work effectively alongside mobile crisis teams to prevent crises and provide wraparound supports to those in need.

Crisis Assessment: An interview to evaluate an individual's current and previous level of functioning, potential for harm to self and/or others, physical health, substance use, and psychiatric and medical conditions to inform the individual's behavioral health treatment plan and services.

Crisis Intervention: Short-term techniques that aim to prevent harm to individuals experiencing behavioral health distress. Crisis intervention involves several steps, including defining the issue(s), ensuring a level of safety, providing support, exploring alternatives, making plans focused on coping, well-being and safety, and obtaining commitment to these plans. [31]

Crisis Planning: The process of empowering an individual in crisis and coordinating with immediate supports to evaluate and consider factors that contributed to the current crisis episode, mitigate and/or resolve the current crisis, and develop or update a range of planning tools (e.g., a safety plan) featuring strategies to prevent or manage future crises. [32]

Crisis Receiving: Walk-in or drop-off access to services for individuals experiencing mental health and substance use distress that accept all individuals and offer immediate access for individuals in emergency crisis. This is a function of some crisis stabilization facilities. These facilities receive individuals on a 24/7/365 basis, including walk-ins, drop-offs, and law enforcement and/or EMS drop-offs. This includes a rapid drop-off with a “no wrong door” policy.

Crisis Residential Facilities: Residential crisis programs with high levels of medical and nursing involvement. High-Intensity Residential programs are non-hospital-based programs with lengths of stay that typically range from a few days to two weeks and allow for relatively intensive 24/7 monitoring and support as well as provision of medical, nursing, and crisis intervention.

Crisis Stabilization Service: A direct service that assists with de-escalating the severity of a person’s level of distress and/or need for urgent care associated with a mental health or SUDs. These services are designed to prevent or improve a behavioral health crisis and/or reduce acute behavioral health symptoms.

Discharge Planning: The process of developing individualized instructions provided to an individual (and subsequent behavioral healthcare providers, as applicable) as the individual transitions from one level of care to the next.

Emancipated Minor: An individual who has not yet reached the age of majority as defined by law, but who is self-supporting, exercises general control over their life, and may claim certain legal rights of an adult, as defined by law. [33]

Emotional Support Lines: Phone, chat, or text lines that provide empathetic listening, information and referral, and support to individuals who may be experiencing distress or loneliness. They offer a confidential and non-judgmental space for connection and self-directed exploration of possible solutions and options.

Equitable Services: Care that increases opportunities for access to treatment and recovery support services for underserved and under-resourced populations and communities including people of color, youth, older adults, women and girls, LGBTQI+ individuals, people living in rural settings, Veterans, and people with disabilities. This care addresses social drivers of health such as housing, education, social supports, transportation, and employment.

Evidence-based Practices: Interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes. [34]

Evidence-informed Practices: Behavioral health interventions and services supported by some data for their effectiveness but may not have a strong research base that supports effectiveness. Data and support for these services can include research, lived experience and client voice, and behavioral health professional expertise.[35]

Family: A group of individuals united by biology or marital, adoptive, foster, kinship, or other intimate ties.[36]

Family/Caregiver Engagement: The process of identifying, enrolling, and retaining families and unpaid caregivers in treatment services. Family engagement is characterized by the acts of motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing.[37]

Family/Caregiver Support Partners: Individuals who provide services to parents and caregivers of children and youth receiving services from mental health, substance use, and related service systems. Family support providers deliver services through face-to-face support groups, phone calls, or individual meetings. They bring expertise based on their own experience as family members of individuals, children, and youth with social, emotional, behavioral, or substance use challenges.[38] Caregivers are broadly defined as family members, friends, or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.[39]

Follow-Up: The act of establishing contact with an individual previously served to determine if services to which they were referred were provided in a timely manner and are meeting the individual's needs.[40] Follow-up also includes reassessment of risk.

Hospital-Based Emergency Stabilization Units: Also known as Emergency Psychiatric Assessment, Treatment, and Healing (EMPATH) or Psychiatric Emergency Services (PES) units, Hospital-Based Emergency Stabilization Units are co-located on hospital grounds and linked to the emergency department for triage and referral of individuals in need of behavioral health emergent crisis care. These units accept high acuity individuals outside of an inpatient setting and can accept both voluntary and involuntary admissions from the hospital emergency department.

Imminent Danger: A situation in which a current risk assessment of the individual indicates the immediate likelihood of actions leading to the harm of self or others.[41]

Imminent Risk Assessment: An assessment which involves identifying risk and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan.[42]

Person-Centered Planning:[43] A facilitated, individual-directed, positive approach to the planning and coordination of a person's services and supports based on individual aspirations, needs, preferences, and values. The goal of person-centered planning is to create a plan that would optimize the person's self-defined quality of life, choice, and control, and self-determination through meaningful exploration and discovery of unique preferences and needs and wants in areas including, but not limited to, health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to the development, implementation, and maintenance of a flexible service plan for paid and unpaid services and supports.[44]

Intoxication Management: Procedures undertaken to assess for and treat symptoms of intoxication from alcohol and/or other drugs. Treatment for mild to moderate intoxication is largely supportive and focuses on maintenance of an individual's airway, breathing, and circulation, in addition to monitoring for cardiovascular conditions and other relevant vitals impacted by intoxication of the substance consumed. Individuals who are severely intoxicated should be admitted and further managed in a setting where high-dependency or intensive care can be provided.[45]

Involuntary Legal Status: Admission of an individual who has a mental health, substance use, or co-occurring mental health and substance use disorder and who meets clinical and legal criteria for admission to treatment without their informed consent, where permissible by law, and for whom treatment cannot be safely and effectively delivered with their informed consent in a lesser restrictive environment by less intrusive means, while preserving the dignity and autonomy of the individual.[46]

Lived Experience: Personal knowledge about mental health, substance use, or co-occurring mental health and substance use disorders, treatment, and recovery gained through direct involvement as an individual with past or current mental health and/or substance use challenges.[47]

Locked Setting: Residential treatment facility intended to serve individuals who need continuous, close supervision and support provided by trained behavioral health staff, where entrances, exits, and windows are controlled with locking mechanisms that are inaccessible to residents to prevent residents from leaving the premises of their own volition.[48,49]

Low Barrier: Removing as many preconditions to entry as possible and responding to the needs and concerns of people seeking services. Expectations placed on incoming clients should be minimal, transparent, and reasonable.[50]

Medication for Opioid Use Disorder (MOUD)/Medication for Alcohol Use Disorder (MAUD) Initiation:

MOUD refers to the class of medications that are approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid use disorder (OUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of OUD. This class of medications includes buprenorphine, methadone, and naltrexone in different formulations.[51]

MAUD refers to the class of medications that is FDA-approved for the treatment of alcohol use disorder (AUD). They are often used in combination with counseling and other behavioral therapies to provide a whole-patient approach to the treatment of AUD. This class of medications includes acamprosate, disulfiram, and naltrexone.[52]

Medium-Intensity Behavioral Health Extended Stabilization Centers: These centers are connected to Medium-Intensity Behavioral Health Emergency Centers. They offer extended behavioral health emergency care beyond the initial 23 hours and provide access to personal bed space.

Medium-Intensity Crisis Residential Facilities: These facilities provide the same services as High-Intensity Crisis Residential Facilities but have lower levels of medical/nursing monitoring and lower staffing ratios per patient. The primary focus is on connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis**.** Medium-Intensity Residential only accepts individuals on a voluntary basis.

Medium-Intensity Crisis Centers: These centers provide the same services as High-Intensity Centers; however, they only accept voluntary individuals. They may provide law enforcement and/or emergency medical services drop-offs but are not required to/are unable to provide services for individuals on involuntary holds.

Mobile Crisis Team Services – Co-Responder Teams: A collaborative approach to behavioral health crises that typically pairs crisis intervention-trained law enforcement officers or other public safety-first responders with behavioral health professionals to respond to calls involving individuals experiencing behavioral health crises. Co-responder teams leverage the skills of behavioral health professionals and public safety-first responders to reduce the need for hospitalization or emergency medical services and increase the diversion of people with behavioral health concerns from the criminal justice system.

Mobile Crisis Team Services – Behavioral Health Provider Only: A rapid, on-demand community-based response that includes a clinical assessment and community-based stabilization supports to alleviate emotional distress and reduce the immediate risk of danger and subsequent harm to individuals experiencing a mental health or substance use crisis. This care is delivered by a multidisciplinary mobile crisis team at the location where an individual is experiencing a crisis, including, but not limited to, at home, school, work, or on the street.

Mobile Response and Stabilization Services (MRSS): Time-limited, intensive community-based services designed to support high acuity children and youth in a systems-based approach with the goal of preventing unnecessary out-of-home placements including but not limited to psychiatric hospitalizations and engagement with the juvenile justice system.

Other Supporters: Personal associations and relationships typically developed in the community that enhance the quality and security of life for people. These include family relationships, friendships, relationships developed through work or school, and associations developed through participation in clubs or community organizations.[53, 54]

Other Behavioral Health Crisis Hotlines: Hotlines that are not a part of the 988 Lifeline network that provide support to people experiencing emotional distress and/or third-party callers who are concerned about another person who is experiencing emotional distress.

Parent or Legal Representative: The primary caregiver(s), which may include a biological or adoptive parent, foster parent, legal guardian, or designee who has legal authority to make medical decisions on behalf of the person being served.

Peer Crisis Respite: Voluntary short-term programs offering rest and peer support in a home environment for individuals experiencing or recovering from a crisis.[55, 56]

Peer-Operated Behavioral Health Warmlines: Phone, chat, or text lines that provide empathetic listening and peer support to individuals who may be experiencing distress or loneliness, or those seeking validation from a peer with lived experience who identifies with their

struggles and can offer a confidential and non-judgmental space for connection and self-directed exploration of possible solutions and options

Peer Operated Crisis Respite Centers: Respite centers where staff, leadership, and governance are peers with lived experience. All staff, all leadership, and their job descriptions require lived experience and the governance of the program is either operated by a peer-run organization, or has an advisory group with 51 percent or more members having lived experience.

Peer Support Workers (Peer Specialists): People who have been successful in the recovery process who help others experiencing similar situations.

Peer Recovery Support Services: Services provided by peer support workers may include emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support.[57]

Peer Residential Services: Voluntary, short-term residential services and support from individuals with lived experience to individuals experiencing a behavioral health crisis.

Pharmacotherapy: The treatment of mental health, substance use, or other behavioral health condition by administration of pharmaceutical drugs.[58, 59, 60]

Point of Care Testing: Clinical laboratory testing conducted close to the site where patient care or treatment is provided, enabling rapid turnaround of test results to inform treatment planning and implementation.[61]

Psychiatric Advance Directive (PAD): A form of advance directive that addresses preferences for treatment in advance of a mental health crisis. PAD can include an advance instruction specific to mental health treatment, including consent for treatment and admission to a hospital. It can also include a health care power of attorney to appoint a health care agent to make decisions if the person is unable to make those decisions secondary to incapacity.[62]

Psychosocial Stressors: A life situation that results in an intense level of stress that may contribute to the development or aggravation of a mental health or behavioral challenge.[63]

Recovery: A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[64]

Recovery-Oriented System of Care: A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to improve health, wellness, and quality of life for people at risk and mental health conditions.

Recovery Planning: The process of developing and implementing an action plan to assist an individual in achieving their unique recovery goals. Recovery planning involves collaboration between an individual and their behavioral healthcare provider(s) and natural supports. The plan should be oriented to and apply the principles of recovery, incorporate and be consistent with best practices, include the individual's individualized goals and expected outcomes, and describe interventions that are trauma-informed, person-centered, strengths-based, and recovery oriented.[65, 66]

Safety Planning: A brief, collaborative intervention between a worker and person who is suicidal that aims to mitigate acute risk through a specific set of coping strategies and

resources. The basic components of a safety plan include the following: (1) recognizing warning signs of an impending suicidal crisis or actions that increase the risk of suicide; (2) employing internal coping strategies; (3) utilizing social contacts and social settings as a means of distraction from suicidal thoughts and/or taking steps to reduce the risk of suicide; (4) utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; (5) contacting mental health professionals, crisis services, or agencies; and (6) making the environment safe, including restricting access to lethal means, as applicable.

Sentinel Event: An unexpected occurrence that results in death or serious physical or psychological injury to an individual, or the risk of such.

Shared Decision Making: A collaborative interaction between a provider and an individual that aims to encourage the individuals' self-efficacy and voice in treatment and care decision-making.[67]

Significant Impairment in Functioning: A condition, including suicidal ideation or thoughts of harming self or others, which harmfully impacts an individual's activities of daily living, including, but not limited to, employment, housing, family and social relationships, or education.

Sobering Centers: Low-barrier, short-term (<24 hours), community-based facilities typically operating 24/7/365 that provide monitoring and oversight of adults with acute alcohol and/or other drug intoxication in a supervised and supportive environment.

Social Drivers of Health: The conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[68]

Staff-Secured Setting: Residential treatment facility intended to serve individuals who need continuous, close supervision and support provided by trained behavioral health staff, where building entrances and exits are unlocked, but continuously monitored and controlled by staff. Residents are not permitted to leave the premises of their own volition.[69]

Telehealth: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.[70]

Therapeutic Milieu: A therapeutic milieu is defined as a scientific structuring of the environment to affect behavioral changes and improve the individual's psychological health and functioning.[71]

Trauma-Informed Care: Program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[72]

Urgent Behavioral Health Issues: Serious, behavioral health issues that do not present as life threatening if not dealt with immediately but require prompt medical attention.[73,74,75]

Voluntary Status: Admission of an individual who has a mental health, substance use, or co-occurring mental health and substance use disorder who meets clinical criteria for admission to treatment and who has capacity to provide informed consent for services.

Warm Hand-off: A transfer of care between two members of the behavioral healthcare team that occurs in person and in front of the individual (and family, if present).[76]

Wellness Recovery Action Plan (WRAP): WRAP gives easy-to-follow instructions for developing a personal wellness toolbox, a daily wellness maintenance plan, a list of triggers and a triggers action plan, a list of early warning signs and an action plan, a list of signs that things are breaking down and an action plan, a crisis plan, and a postcrisis plan.[77]

Withdrawal Management: Medical and psychological care services (formerly referred to as detoxification) provided to individuals experiencing withdrawal symptoms after ceasing or reducing substance use. Services target the physiological and psychological features of withdrawal in addition to habitual, compulsive use in individuals with substance use disorder.[78]

Youth/Family Crisis Respite Services: These facilities provide an alternative to hospitalization for people, family, and youth experiencing emotional crises. They are safe, warm, and supportive home-like places to rest and recover when more support is needed than can be provided at home. Youth/Family Crisis Respite Services are distinct from adult respite and crisis residential facilities and are tailored to prioritize family and natural supports.

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