Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services

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SAMHSA
Substance Abuse and Mental Health Services Administration

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Acknowledgments

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Foreword

We are pleased to present this publication, *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.*

The *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* document is a result of the dedication and collaboration that was led by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 988 & Behavioral Health Crisis Coordinating Office and Center for Mental Health Services in connection with a diverse array of partners across the field that have been able to infuse best and promising practices into this guidance document. This publication serves as a foundational step to refining the nomenclature for emergency, crisis, and crisis-related services. This document will promote widespread alignment that we see as important in the standardization of services, as well as the ability to expand access to quality care. Per our collaborative discussions with partners and analysis of the rapidly evolving landscape of emergency, crisis, and crisis-related services, we believe that this is a fundamental step that will further the adoption of coverage of these services by a broader set of payors, help move us towards a more financially sustainable landscape for these services, and further expand access and coverage nationwide.

States, territories, tribes, tribal organizations, local communities, and providers across the country work tirelessly to provide emergency, crisis, and crisis-related services to meet the needs of individuals with these potentially life-saving services. These model definitions acknowledge and lift up this work by helping to clarify a rapidly growing, but inconsistently described, landscape of services.

This document, coupled with the newly published *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care,* exemplify the work that goes into upholding SAMHSA's vision that people with, affected by, or at risk of mental health and substance use conditions receive care, achieve well-being, and thrive. This pair of visionary documents will pave the way for future, more detailed implementation guidance documents, such as the Toolkit for Mobile Crisis Teams that is currently under development.

We hope that this guidance will aide communities in their development and enhancement of a widespread, standardized, and quality crisis services continuum for their residents to ensure everyone has access to "someone to contact, someone to respond, and a safe place for help."

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Executive Summary

Crisis services have been undergoing a rapid expansion of growth that has been catalyzed since the release of the *2020 National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* and the transition of the National Suicide Prevention Lifeline to the 988 Suicide & Crisis Lifeline (988 Lifeline). In light of this expansion, communities have been designing crisis systems to meet their specific needs, which has created widespread variability in the landscape of crisis care. In order to coalesce and optimize alignment of this burgeoning field while supporting expansion and sustainability in a manner whereby crisis care will continue to meet the unique needs of communities, this *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* (Model Definitions) document was developed. The content of this document, through the development of more uniform definitions, seeks to promote service quality and consistency, and further payer adoption of emergency, crisis, and crisis-related behavioral health services. Achieving these goals will support increased access to quality, equitable emergency, and crisis care for all individuals.

Approach to Development

A multi-pronged process was conducted to develop this document that included:

- Landscape analysis of selected state crisis services including their service descriptions, regulatory guidance, along with partner listening sessions to gain input on the current state of the crisis system, and existing challenges with crisis services standardization;
- Consultation with subject matter experts regarding services within their specific areas of expertise;
- Gathering and synthesizing behavioral health crisis services research and experiential data;
- Workgroups and in-person convenings to garner feedback on document contents and drafts; and
- Incorporation of public feedback that was provided during a period of public comment.

Core Principles and Essential Service Elements

The Substance Abuse and Mental Health Services Administration (SAMHSA) identified several guiding principles that were deemed to be essential characteristics for both the services themselves and the approach for the development of a crisis continuum.

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

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

C. Crisis Services Should Prioritize Safety

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

E. Crisis Services Should Prioritize Quality and Effectiveness

F. Crisis Services Should Be Developmentally Appropriate

G. Crisis Services Should Be Resiliency- and Recovery-Oriented

H. Crisis Services Should Be Trauma-Informed

I. Crisis Services Should Provide Continuity of Care from Onset of Crisis Until Stability and Include Follow-Up Care and Linkage

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

K. Services Should Be Responsive to Individuals' Wholistic Needs

Furthermore, descriptions and details for service elements, models of specific crisis services, and guidance are organized by and correspond with SAMHSA's three essential elements of crisis response:

1. Someone to Contact: 988 and Other Behavioral Health Lines
2. Someone to Respond: Mobile Crisis and Outreach Services
3. A Safe Place for Help: Emergency and Crisis Stabilization Services

Document Usages and Benefits

This document is intended to identify, categorize, and describe the service array across the country. This document does not dictate specific service element(s) or provide guidance on how to best build on the foundation of these services to create a Behavioral Health Coordinated System of Crisis Care (BHCSCC). Building such robust systems is the focus of the *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.* These two documents are designed to be companion resources to support both service and system design. Additionally, SAMHSA will be working on a series of future technical assistance products and offerings to support service implementation. Prospective end-users may benefit from using this document in numerous ways, such as the following:

State, territory, tribal, and local entities, and/or entities that provide oversight to providers may use this document to:

- Identify services that can address the breadth of the behavioral health needs of those they serve in order to develop a comprehensive BHCSCC that can serve a diverse array of individuals at all levels of acuity;
- Obtain knowledge of expected and preferred service elements for the described crisis services;
- Understand the differences between similar services;
- Classify and categorize existing crisis services within their communities;
- Identify specific opportunities for either initiation of new services and/or expansion of existing services (including both quantitative and qualitative service capacity);
- Based upon the elements of the described service descriptions, the state of their current crisis system, and unique community considerations, identify ways to strategically, systematically, and efficiently expand services;
- Develop standards and/or regulatory guidance for services;
- Provide recommendations for future service enhancements;
- Assess the adherence of implementation of services;
- Identify and incentivize best and promising practices;

- Identify ways to connect and coordinate services in a systematic manner; and
- Identify potential process and outcome measures that can be used as benchmarks for both the individual crisis services and the functionality of the crisis system as a whole to support quality improvement and strategic planning.

Within their scope of financial coverage and care expansion, public and private payers may use this document as described previously, as well as to:

- Develop criteria for service coverage that encourages equitable and increased access to a wide array of emergency and crisis services;
- Develop a reimbursement methodology that sustainably supports the care;
- Develop coverage policies, procedures, and policies that are not overly restrictive and are consistent with the needs of the unique and fast-paced nature of crisis care (such as those related to prior authorizations, etc.); and
- Develop innovative payment methodologies (such as alternative payment models) that support equitable and increased access to a wide array of emergency and crisis services.

Service Providers and the broader community may use this document as described previously, as well as to:

- Have a clear expectation of the services provided in different settings;
- Better understand how to navigate the services within a system's crisis continuum; and
- Advocate for the types of services that they desire in their community.

Strategic Impact and Future Directions

There is a need for a comprehensive framework for defining and standardizing care that is provided to adults, youth, older adults, and families with urgent and emergent mental health and substance use needs. The publication of this document is an integral piece of SAMHSA's visionary efforts to provide national leadership to support the transformation of the BHCSCC.

SAMHSA believes that this document is a critical next step in the development of the nation's behavioral health crisis services system. Although SAMHSA does not have explicit statutory authority to mandate specific standards, we believe that this guidance represents a high standard for crisis care for communities to emulate that will establish a foundation for quality, accessible care that can be systematically interconnected and developed in a manner that supports the health and wellness of all Americans.

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. 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, 12.3 percent (or 3.2 million people) had serious thoughts of suicide.[1] In that same survey, over one-third (37.6%) of adults aged 18 years or older with co-occurring mental illness and a substance use disorder (SUD) in the past year did not receive treatment for either condition.

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics reported a provisional estimate of 49,449 suicides in 2022, which was 2.6 percent higher compared to 2021.[2]

Provisional data from the CDC's National Center for Health Statistics indicate there were an estimated 105,007 drug overdose deaths in the United States during 2023—while this represents a decrease of 2.7% from the 107,941 deaths reported in 2022, these losses continue to underscore the importance of immediately available care and support.[3]

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 Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services

Through SAMHSA's efforts to provide national leadership to support the transformation of crisis systems, SAMHSA, crisis experts, service providers, and payers have identified widespread variability in emergency, crisis, and crisis-related 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 Definitions document is to publish guidance to serve as emergency, crisis, and crisis-related services definitions that will promote clarity, quality, and consistency across services, widespread alignment of services, and further payer adoption of service coverage. This includes the articulation of recommended minimum expectations. Achieving these goals will support increased access to quality, equitable care for the entire lifespan and all individuals.

In this document behavioral health *crisis services* broadly refers to immediately or rapidly responsive, intensive services that are provided to address or prevent behavioral health symptoms, situations, or events that, immediately or in the near term, 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 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 *emergency services* represent an enhanced level of crisis care that provides immediate response and assistance 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. They are unique in the crisis services continuum in that they can offer immediate access for all levels of acuity. *Crisis-related services* typically are less intensive services that can prevent future crisis events and connect people to ongoing treatment and recovery supports.

Methodology

SAMHSA conducted a multi-pronged process to develop the *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services,* 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 United States, 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 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 was comprised of representatives from state, tribal, and local governments; provider associations; crisis service workers; 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 a revised draft version of the *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* 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.

From November 20 to December 4, 2024, the document was available for public comment and review. This was broadcast across through multiple channels in coordination with the SAMHSA Office of Communication. Following the period of public comment, over 175 comments were received. These comments were reviewed, and final revisions were made based on the feedback. Notable edits based on the public comment process include:

- The document title was changed to reflect differences between emergency, crisis, and crisis-related services.
- The overarching principles were strengthened to include additional partners (e.g., intimate partner violence supports and primary care).
- There was an increased emphasis on optimizing voluntary interventions, collecting data on involuntary interventions, and promoting transparency on data sharing and service satisfaction.
- There was an increased emphasis on the importance of follow-up care.
- The third essential pillar, crisis stabilization services, was reorganized to reflect differences between no barrier/emergency level care, low barrier services, and referral-based services.
- Preliminary language around service continuation and discharge criteria was proposed throughout.
- Charts were removed for increased clarity.
- Crisis respite apartments were added as an additional service.

This final document is the result of this process.

How to Use This Document

SAMHSA developed the *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* document for state, territory, tribal, and local entities; crisis services providers; public and private payers; regulators; and help seekers and their supporters, to provide 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 BHCSCC. Crisis services providers also can review recommended 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 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 every element or elements to create a BHCSCC in their community. While SAMHSA

does not have the statutory authority to require specific components for most crisis services, these model definitions are intended to articulate the core elements that should be expected for each service, along with best and preferred practice recommendations. This document offering models of specific crisis services is meant to be used in coordination with the *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care,* which focuses on how to integrate these services into a BHCSCC.

SAMHSA recognizes that the model service definitions alone are just a start in working toward better alignment and coverage of crisis services and that future iterations and refinements of this document will be needed to continue to provide clarifications and support alignment toward the shared vision of crisis system transformation.

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 the potential 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 definitions provided in this document do not provide suggested levels at this time and SAMHSA does not recommend mapping the services in this document to the LOCUS or ASAM for utilization management or gatekeeping purposes. Partners and experts around the country have started to propose a mapping framework for further consideration.[4] 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. 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 Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* 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 Practitioner-Only (BHP-Only) Mobile Crisis Teams (MCTs);
- Co-Responder Mobile Crisis Teams;
- Mobile Response and Stabilization Services; and
- Community Outreach Teams.

A Safe Place for Help: Crisis Stabilization Services

No-Barrier or Low-Barrier Stabilization Settings

- Hospital-Based Emergency Stabilization Units;
- High-Intensity Behavioral Health Emergency Centers;
- High-Intensity Behavioral Health Extended Stabilization Centers;
- Moderate-Intensity Behavioral Health Crisis Centers;
- Moderate-Intensity Behavioral Health Extended Stabilization Centers;
- Behavioral Health Urgent Care;
- Peer Crisis Respite; and
- Sobering Centers.

Referral Based Residential Services

- Moderate-Intensity Crisis Residential Programs;
- Low-Intensity Crisis Residential Programs; and
- Community Crisis Respite Apartments.

Services Specific to Children, Youth, & Families

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

Each service type has sections that provide detail for the following:

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

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. Use of the term crisis services in these principles is intended to apply broadly to all categories of services articulated in the subsequent sections. 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 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, Integrated, Coordinated, and Developed Utilizing a Systems-Based Approach

Key principle: Multi-system collaboration. Behavioral health crisis services should be delivered through a BHCSCC 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 BHCSCC 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, MCTs, crisis services providers, other behavioral health providers, providers addressing social drivers of health (SDOH), state and local governments, tribal nations and organizations, public health agencies, Medicaid agencies and other payers, national mental health and suicide prevention provider and consumer groups, faith-based entities, 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.

Key principle: Clear oversight structures to ensure integration and coordination. Clear oversight structures are needed for the BHCSCC 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). Clinical and medical leadership are a key part of the needed oversight structure to address clinical quality and to ensure services are meeting the needs of all help seekers, including those with medical comorbidities. 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 BHCSCC is a large network of systems that should work together to meet the needs of individuals, including the provision of services that prevent crisis situations.

Systems that should be part of a BHCSCC include, but are not limited to, healthcare settings, including

emergency departments (EDs); schools; social service and child welfare agencies; domestic violence, sexual assault, and human trafficking programs; 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 Certified Community Behavioral Health Clinics (CCBHCs), community mental health centers, behavioral health homes, and Federally Qualified Health Centers (FQHCs). Crisis services providers should engage family, unpaid caregivers, and/or other supporters at all stages of crisis care, as able and appropriate. 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 must also be properly tailored to meet the individualized needs of a community. For example, it is not enough to have a wide array of different crisis services. Services must have the capacity to serve the population size and density of the community in order to provide effective on-demand care and garner community trust as an entity that is truly accessible and effective in a time of crisis. Crisis systems must utilize data to continuously monitor the relevant process and outcome measures of the component crisis services to ensure that the services are not only providing accessible, quality, and equitable care, but that the component services are interconnected into a system that does the same.

SUBSTANCE USE AND SUBSTANCE USE DISORDERS: Services within the crisis system should be able to address all the behavioral health needs of an individual in crisis. Just as crisis workers must know the full range of mental health conditions, they much also know how to assess and intervene with the full range of substance use and know how to provide an appropriately matched integrated response to people with any combination of mental health and substance use crisis, based on the client's level of risk as well as their needs and preferences. 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 supporters in a behavioral health crisis regardless of diagnosis or lack of diagnosis.

Crisis staff should be trained to recognize and assess substance use and SUDs. 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 role, responsibilities, 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 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. 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. In order to prevent unnecessary ED visits, hospitalization, and engagement with the criminal justice system, the availability of care for those with the highest acuity of needs is essential to successfully deflect and divert individuals. Crisis services should develop clear plans for continuity of operations to ensure that care is provided in case of natural and other disasters so that these services are consistently available in the community. Community partners should ensure timely access to services and strive for short wait times and high response rates for services. To further support person-centered care, services across the continuum should recognize peer support practices designed to be delivered by peers. Please see SAMHSA's National Consumer and Consumer Supporter Technical Assistance Centers for more resources.

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 SDOH, 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. While SAMHSA's goal is to be able to link specific crisis services to the ASAM Patient Placement Criteria that consider multiple dimensions of need[5] and the LOCUS and CALOCUS, which attempt to delineate levels of care that are appropriate for an individual at any given time, there remains much work to be done to adapt these levels and map them to the crisis continuum as outlined here. SAMHSA looks forward to continued partnership on this effort.

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.

Services across the crisis continuum should also be transparent about policies impacting data and privacy, as well as policies with respect to initiation of non-consensual interventions, and have established policies for the receipt and response to grievances. Policies should emphasize at all levels the importance and limits of confidentiality and privacy in accordance with the Health Insurance Portability and Accountability Act, Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), and any applicable state requirements. This includes addressing data-sharing practices among family members, caregivers and providers, particularly in the context of follow-up and care coordination. It also considers the role of anosognosia, more commonly known as the lack of insight into one’s own symptoms, on the delivery of services in areas such as informed consent as well as its impact on family, caregivers, and other supporters.

C. Crisis Services Should Prioritize Safety

Although 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. The focus of safety is on making sure help seekers and staff are neither physically or emotionally hurt, through a welcoming, sensitive culture and responsiveness and with a no force first culture and mitigation of risks of iatrogenic harm. Capacity to screen, assess, and respond to the varied needs of people in crisis, including those with suicidal and/or homicidal thoughts and plans, as well as people who are at risk of medical complications and/or substance-related overdose, at risk of harm in a situation of interpersonal violence (IPV), or impacted by natural disasters, 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, services should be operated in a physical setting (when applicable) and in a manner that promotes the safety of the service delivered through strong policies, procedures, protocols, training, respect for individual rights, 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. Most services in the crisis continuum should incorporate evidence-based suicide specialized care, such as Cognitive Behavioral Therapy for Suicide Prevention (CBTSP), Dialectical Behavioral Therapy (DBT), the Collaborative Assessment and Management of Suicidality (CAMS), and other promising practices including suicide attempt survivor support groups. Providers of crisis services should also have adequate training and capacity specifically geared toward responding to those who may be experiencing psychosis as a means for prioritizing safety. Additionally, training should include approaches to screening and service support to people impacted by IPV.

Conducting a suicide and/or violence screening and risk assessment and developing a crisis or suicide safety plan are 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 final rule describes the basic components of safety planning.[6] 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 (PDF)*. 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 facilitated the development 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).[7] 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.[8]

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.

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

The Centers for Medicare and Medicaid Services (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, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[9] 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 American Indian, Alaska Native and Indigenous persons, Asian Americans, Native Hawaiians, and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, and bisexual 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 optimize accessibility and support underserved populations (e.g., LGB youth and adults, people who live in rural areas, people with disabilities, unhoused individuals, older adults, American Indian, Alaska Native, and Indigenous 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.[10]

Crisis services should be designed to facilitate access and utilization, working towards elimination of inequities in care. Crisis services should be culturally relevant and linguistically appropriate, 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, housing status, insurance status, age, 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.

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.

The U.S. Department of Justice has issued *guidance* on the importance or robust crisis services to help achieve compliance with the Americans with Disabilities Act.[11]

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 while respecting the privacy of the help seeker. Both process and outcome measures, such as patient-reported outcome measures should be gathered to measure quality. Data and evaluation plans should have a clear process for disaggregating information by age, race, ethnicity, geography, and sexual orientation variables, among other demographic metrics, including tracking the number of instances that trigger law enforcement and child welfare involvement.

Satisfaction with care should be a prioritized outcome. People having positive experiences of care, where they feel supported, respected, 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. Programs should also document notification of rights and any outcomes from complaints and grievances investigations for periodic review and performance improvement; programs should also collect data, as applicable, on seclusion, restraint, and involuntary interventions.

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*[12] 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*.[13] 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: This category refers to children, youth, and young adults of transition age who are still involved in youth-serving systems. Crisis services for children, youth, and their families, caregivers, and supporters should especially utilize an approach that minimizes screening-out or triage of referrals, while prioritizing a rapid face-to-face, developmentally appropriate assessment as much as possible. Crisis staff should be trained in the unique needs of and best practices for working effectively with children, youth, families, caregivers, and supporters 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, 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, family medicine and pediatric providers, 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 (PDF)*[14] 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 aged 55 years or older. 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, as well as with older adults experiencing abuse, neglect, and exploitation. 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, primary care, 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 and promoting wellness. 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

providers 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 providers 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. These services should be provided in a manner that is guided by *SAMHSA's Working Definition of Recovery (PDF)*, including that peer services are voluntary and chosen by the individual.[15] Peer support also should be aligned with roles and recommendations as outlined in SAMHSA's *Peer Support Services in Crisis Care (PDF)*, which includes a focus on scope of practice and mitigating against a drift away from this scope of practice.

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 effects 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. As noted previously, services should collect data on use of involuntary interventions to inform continuous efforts to minimize such interventions. 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 (PDF) 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 (PDF):

1. Safety;
2. Trustworthiness and transparency;
3. Peer support;
4. Collaboration and mutuality;
5. Empowerment, voice, and choice; and
6. Ensuring that cultural and historical, 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 Provide Continuity of Care from Onset of Crisis Until Stability and Include Follow-Up Care and 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, IPV supports, other behavioral health programs, foster care, school systems) is an important component of a behavioral health crisis system of care.

Crisis services should provide continuity of care, ongoing care coordination, and a continuum of services from onset of crisis until return to stability. While a single crisis service may be sufficient to stabilize a person's situation, it is often the case that someone will need multiple services in the crisis continuum, as well as services like Partial Hospitalization and Intensive Outpatient Programs, before their experience is stabilized enough to return to routine care. Receipt of one crisis service should be a facilitator for access to any of the behavioral health services that can address the help seeker's symptoms and/or distress.

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 and essentially serve as the fourth essential element of the crisis continuum. Although this is more challenging when services do not require disclosure of identity, every effort should be made to engage the individual and family/caregiver to provide follow-up care and appropriate resource linkages as appropriate. All people with current suicidal ideation or otherwise at risk of suicide should be offered follow-up services. 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.[16] Organizations and system leaders should provide the requisite amount of potentially life-saving attention to this component of the care that it deserves. From an operational standpoint, follow-up services should have its own dedicated policies, procedures, and resources that ensure that this follow-up element of care within a crisis episode is a valuable and high-quality addition and not merely an add-on to existing services as resources and time permit. This can include the implementation of dedicated follow-up teams resourced to:

1. Provide brief behavioral health interventions during the high-risk period immediately following a discharge from a crisis service.
2. Engage people proactively to help them connect with community-based behavioral health, health care, and social service resources that meet their needs and preferences, including culturally and linguistically appropriate services and housing services.

J. Crisis Services Should Be Evidence-Based, Evidence-Informed, and/or Reflect Best, 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 should 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 services providers should have awareness of the needs, available community resources, and what constitutes effective care for diverse populations, including Service Members, Veterans and their families, minoritized communities, people impacted by geographic isolation, and LGB populations. Crisis services 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 accommodate 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 have an understanding of reasonable accommodation requests and 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), BRAIN INJURY, AND NEUROCOGNITIVE DISORDERS: Services should be accessible to individuals with I/DD. Crisis staff should be trained to recognize individuals with I/DD, neurodiverse needs, brain injury, and dementia and the best practices for working effectively with impacted individuals, their families, and caregivers. Crisis teams should be equipped with communication tools like Picture, Exchange

Communication Systems (PECS) or other forms of Augmentative and Alternative Communication (AAC), and soothing kits to engage individuals with I/DD.[17] 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 I/DD (e.g., intellectual- and disability-specific service systems, group homes, skilled nursing facilities, assisted living and rehabilitation facilities, child welfare systems, education system), brain injury and dementia, and have protocols for coordinating care and referrals to these agencies and systems.

HOUSING AND OTHER SDOH: Unstable housing is a stressor both contributing to crisis events and complicating resolution of crisis events. Assessment of SDOH is critical at every step of a crisis service encounter. This includes homelessness, unemployment, lack of transportation, poverty, and other SDOH. 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*

1. 988 Suicide & Crisis Lifeline (988 Lifeline)

Service Description

The 988 Lifeline is a behavioral health network of crisis contact centers that provides mental health and substance use crisis counseling, empathetic support and listening, and safety planning and referral 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[18]

- **Certification/Accreditation.** The crisis contact center must provide proof of certification/ accreditation from one of several approved professional organizations that provide certification as per the 988 Lifeline Network Agreement and the *Saving Lives in America: 988 Quality and Services Plan (PDF)*. If a crisis call center does not meet the requirement, they must show demonstrable need for a crisis contact center in that area and sign a provisional status amendment, agreeing to obtain certification within a set timeframe.
- **Network Participation.** Crisis contact 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, crisis contact centers, and state, territory, or tribal authorities. New Federal Communications Commission (FCC) guidelines require network providers to route calls using boundary maps to the nearest Lifeline contact center. These geo-routing features do not provide precise location information and are only utilized to ensure that callers are connected to local centers which are most knowledgeable about the needs of a particular community.

- **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.

Expected 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, videophone service, or chat interface;
- Screening each caller for suicide;
- Crisis counseling/emotional support, safety assessment and safety planning, crisis counseling and prevention planning;
- Follow-up for suicidal and homicidal help seekers;
- Facilitation of self-directed problem-solving;
- Shared decision-making and informed choice; and
- Direct services referrals, warm hand-offs, 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 services intervention in cases of imminent safety concerns (e.g., emergency medical services (EMS), law enforcement).

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

Care Coordination/Follow-Up

Care coordination, recovery support (e.g., Peer Support, Wellness Recovery Action Plans, Psychiatric Advance Directives (PDF)), direct service referrals, warm hand-off to services, and follow-up for those with current suicidal ideation and others who could benefit, such as callers with complex needs and familiar individuals.[19,20]

Eligibility Criteria

None.

Exclusionary Criteria

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

Service Continuation Criteria

None.

Discharge Criteria

Crisis situation is resolved, an adequate continuing care plan has been established, and/or individual is connected to the appropriate level of care.

Modality

Phone, synchronous messaging via text or chat, and American Sign Language (ASL) Videophone.

Setting/Care Environment

988 Lifeline 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 Lifeline crisis contact centers requires a fully executed Lifeline network agreement and adherence to all requirements therein. 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 Lifeline crisis contact centers must maintain 24/7/365 access to supervision and consultation. Supervisors must have significant training and experience in suicide assessment and crisis intervention skills.
- Crisis contact center staff can be volunteers, peer support providers, 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 best practices, risk assessment, and safety planning and intervention in accordance with the Suicide & Crisis Lifeline guidelines. Lifeline workers must complete additional training to provide services through text and chat.

Core Competency Recommendations

- 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 and wellness supports for staff.

Suggested Data Elements, Metrics, and Quality Measures

- Number of calls, chats, and texts received and answered;
- Average length of call, chats, and texts;
- Demographics of help seeker (age range, sex, ethnicity) (if help seeker is willing to provide and it is appropriate to inquire);
- Reason for contact;
- Referral source;
- Location of contact origination;
- Risk assessment and safety planning;
- Number of warm hand-offs;
- Number of linkages to services during initial contact;
- Experience/satisfaction of the help seeker;
- Average speed to answer;
- Answer rates;
- Abandonment rates;
- Disposition of imminent risk, including involuntary interventions;
- Referrals/connections to other community supports and services addressing SDOH;
- State and contact center variation in rate of emergency service referral; and
- Sentinel events.

Preferred Practice Elements

- Follow-up care for non-suicidal help seekers (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; and
- Ability to receive and divert appropriate calls from 911.

2. Other Behavioral Health Crisis Hotlines

Service Description

This section refers to behavioral health crisis hotlines that are not a part of the 988 Lifeline network and which provide support including emergency response and crisis mitigation, empathetic support, and prevention/promotion of wellness 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 county or 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 988 Lifeline.

Distinguishing Features

Other Behavioral Health Crisis Hotlines operate independently of the 988 Lifeline network.

Expected Service Elements

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

- 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;
- Engage in consensual approaches to address risk;
- Emphasize shared decision-making and informed choice;
- Initiate transfer to 988 or 911 if there is an imminent safety concern;
- Provide recovery support; and
- Provide warm hand-off and linkage to care when needed and appropriate.

Care Coordination/Follow-Up

Warm hand-off and linkage to care.

Eligibility Criteria
None.

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

Service Continuation Criteria
None.

Discharge Criteria
Crisis situation is resolved, an adequate continuing care plan has been established, and/or individual is connected to the appropriate level of care.

Modality
Phone or synchronous messaging via text or chat, and ASL Videophone. 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.

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 Recommendations
- 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 and wellness supports for staff.

Suggested Data Elements, Metrics, and Quality Measures
- Number of calls, chats, and texts received and answered;
- Average length of call, chats, and texts;
- Demographics of help seeker (age range, sex, ethnicity) (if help seeker is willing to provide and it is appropriate to inquire);
- Reason for contact;
- Referral source;
- Location of contact origination;
- Risk assessment and safety planning;
- Number of warm hand-offs;
- Number of linkages to services during initial contact;
- Experience/satisfaction of the help seeker;
- Average speed to answer;
- Answer rates;
- Abandonment rates;

- Disposition of imminent risk, including involuntary interventions;
- Referrals/connections to other community supports and services addressing SDOH;
- State and contact center variation in rate of emergency service referral; and
- Sentinel events.

Preferred Practice Elements

- Follow-up care for non-suicidal help seekers (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 crisis contact; and
- 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.

3. Peer-Operated Warmlines

Service 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 support and prevention and the promotion of resilience and wellness in a non-clinical service environment. 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 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.

Expected Service Elements

- Screen each caller for suicide (ideally following 988 Lifeline Guidelines training);
- 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.

Eligibility Criteria

None.

Exclusionary Criteria

None. May provide additional resources as requested by the caller in cases which are beyond the scope of the warmline service.

Service Continuation Criteria

None.

Discharge Criteria

Crisis situation is resolved, an adequate continuing care plan has been established, or individual is connected to the appropriate level of care.

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.

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 providers 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 providers should be provided suicide prevention specific trainings prior to working on the warmline.
- Peer support providers should have access to recovery and wellness supports specific to their peer provider role.
- Youth peer support providers may also staff peer-operated behavioral health warmlines with appropriate adult oversight.
- Peer support providers 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 providers 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:[21,22,23]

- 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 de-escalation techniques;
- Cultural humility and culturally responsive care; and
- Confidentiality.

Suggested Data Elements, Metrics, and Quality Measures

- Number of calls;
- Length of call;
- Demographics (age range, sex, ethnicity) (if help seeker is willing to provide);
- Reason for contact;
- Location where contact originated;
- Average speed to answer;
- Answer rates;
- Disposition (referrals given);
- Abandonment rate;
- Safety planning;
- Warm hand-offs;
- Linkages to services;
- Referrals/connections to other community supports and services addressing SDOH;
- Experience/satisfaction of the help seeker; and
- Sentinel events.

Preferred Practice Elements

- 24/7/365 service availability;
- Peer-based training for warmline staff;
- Training in screening and safety planning;
- Employ Certified Peer Support Specialists (CPSSs) who will offer follow-up to callers who agree to a follow-up;
- Collaborate with the local 988 centers to support bidirectional referrals and coordination;

- Focus on youth and young adult peers and family support or other special populations; and
- Peer support providers should be representative and reflective of the communities served with respect to age (youth, young adults and older adults), race, ethnicity, language and cultural identity, sexual orientation, and other marginalized, disenfranchised, or socially disadvantaged groups and trained in developmentally appropriate care.

4. Other Behavioral Health Emotional Support Lines

Service 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.
- 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.

Expected Service Elements

- Emotional support;
- Brief suicide risk screening;
- 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.

Eligibility Criteria

None.

Exclusionary Criteria

None. May provide additional resources as requested in cases which are beyond the scope of the support line service.

Service Continuation Criteria
None.

Discharge Criteria
Current situation is resolved, an adequate continuing care plan has been established or individual is connected to the appropriate level of care.

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.

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 Recommendations
- Protocols for brief screening of imminent risk including the ability to differentiate between thoughts, feelings, and planned actions;
- Developmentally and cognitively appropriate care;
- Safety planning;
- Active, empathic listening and holding space with compassion;
- Engagement and rapport building;
- De-escalation techniques; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures
- Number of contacts;
- Length of contacts;
- Demographics (age range, sex, 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);
- Abandonment rate;
- Number of safety plannings completed;
- Warm hand-offs;
- Linkages to services;
- Referrals/connections to other community supports and services addressing SDOH;

- Experience/satisfaction of the help seeker; and
- Sentinel events.

Preferred Practice Elements

Staff resources allotted to conduct routine follow-up to anyone willing to receive this service.

Crisis System Component: *Someone to Respond*

Mobile crisis and outreach services address the "someone to respond" component of SAMHSA's comprehensive crisis care definitions and national guidelines framework. This component comprises three service models of MCT programming as well as community outreach teams (the latter represents a separate approach). MCTs provide an on-demand, rapid, mobile, in-person response that includes a licensed or credentialed clinician participating in a clinical assessment of an individual experiencing a behavioral health crisis. Although MCTs can vary in configuration, to meet SAMHSA's definition their services must be:

- **On-demand and rapid:** MCT response begins upon the acceptance of a dispatch request that is initiated by a crisis contact (call, electronic message, or chat). MCTs should seek to engage in a face-to-face encounter as soon as possible, contingent upon a risk assessment to determine whether immediate physical health or safety issues warrant dispatch of a different first responder type (i.e., law enforcement, EMS, or fire department).
- **Mobile:** The MCT goes to the person in crisis at any community-based location (i.e., the response is not limited to specific locations such as EDs or settings that are secure and/or staffed by behavioral health crisis clinicians).
- **In-person:** At least one crisis staff person must meet face-to-face with the individual in crisis (i.e., not a 100% telephonic, online, or telehealth interaction).
- **Inclusive of a licensed or credentialed behavioral health practitioner:** An MCT response must include engagement by a licensed or credentialed behavioral health practitioner who participates in a clinical assessment of the needs of the individual in crisis. If necessary, the clinical assessment can be done by telehealth if at least one other MCT staff member is on scene and interacting with the individual face-to-face.

Additional characteristics include:

- MCT provider organizations may have certification requirements as determined by their state/territory/tribe/county.
- MCTs may be dispatched from a number of settings, such as 988 Lifeline centers, public or private behavioral health service organizations, and/or 911 PSAPs.
- 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).

The goals of MCT services are to collaboratively decrease emotional distress and reduce the risk of danger and harm to people who are experiencing a mental health or substance use crisis. They aim to avoid unnecessary ED care, psychiatric inpatient hospitalizations, and law enforcement involvement through community-based crisis care, referrals, and care coordination. When needed, MCTs can directly or, through referral, initiate involuntary procedures and connect people to facility-based care. Most services in this category should incorporate peer support providers to promote engagement, coaching, and navigation.

The three MCT service models include:

- Behavioral health practitioner-only MCTs
- Co-responder MCTs that include law enforcement, emergency medical personnel, or other first responders
- MCT services provided through mobile response and stabilization service (MRSS) programming.

All three MCT models can operate in the same geographic area and share triage and/or dispatch protocols. These protocols might also be coordinated between 988 or 911 PSAPs to facilitate a clear, efficient process for determining which MCT model is best suited to respond to specific crisis events. In such cases, dispatch should default to BHP-Only MCTs and minimize the use of Co-Responder MCT teams that incorporate law enforcement; however, physical health or safety factors may warrant response by a different MCT model or first responder type. MCT staffing should reflect the needs of the communities served.

These MCT models, as well as the Community Outreach Team approach, are described in more detail following.

5. Behavioral Health Practitioner-Only (BHP-Only) MCT Services

Service Description

BHP-only MCTs is a rapid, on-demand, community-based response provided by a team comprised exclusively of behavioral health practitioners. In addition to at least one licensed or credentialed behavioral health practitioner, the team may include unlicensed or uncredentialed behavioral health practitioners and/or peer support providers. Compared with other MCT models, this configuration offers people in crisis the greatest degree of behavioral health expertise. It includes the provision of both active treatment and prevention efforts.

Distinguishing Features

- **Coverage Capacity:** 24/7/365 service provision is strongly preferred.
- **MCT Staffing:** Should be paired. Pair should include at least one licensed or credentialed behavioral health practitioner and another responder such as an unlicensed or uncredentialed behavioral health practitioner and/or a peer support provider. Although an in-person response by at least one member of the MCT is necessary to meet the service definition, a one-person response should be provided judiciously.
- **Law Enforcement:** Law enforcement is not considered part of response team.

Expected Service Elements

- Provide 24/7/365 on-demand service is preferred when possible.
- Provide de-escalating and/or stabilizing supports to mitigate a crisis.
- Take the lead in a behavioral health crisis response when public safety-first responders are on scene and it is safe to do so.
- Initiate emergency service in cases of imminent safety concerns (e.g., EMS).
- Conduct crisis triage screening and risk assessment.
- Develop or revise/optimize a crisis *safety plan (PDF)*, as appropriate.[24]
- Develop or revise/optimize a crisis plan to mitigate current crisis and help prevent a future crisis.
- Direct service referrals, recovery support, linkages to care, and care coordination with home- and community-based services and supports or higher levels of care if indicated.
- Coordinate or provide transportation for the individual to facilitate crisis stabilization, when needed.
- Provide in-person, telephonic, or virtual follow-up, as appropriate.

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 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.

Service Continuation Criteria

None.

Discharge Criteria

The acute presentation of the crisis is resolved, the appropriate referral(s) and service engagements to stabilize the crisis situation are made, and post-crisis follow-up has been completed.

Modality

Initial response is conducted in person, in some cases with telehealth support; 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.

Considerations

- Service is available 24/7/365 when possible.
- Urban response within one hour and rural response within two hours is recommended.
- For remote regions, especially for services in areas with geography that make a rapid

response extremely challenging (e.g. areas without roads, snow-covered terrain, and/or across bodies of water) efforts should be made to respond as rapidly as possible within the available limitations and resources. In cases of a lack of ability to immediately respond, alternative interim supports should be identified.

- Provide post-crisis follow-up within 72 hours of the initial crisis episode (or sooner if clinically indicated or requested).

Provider Type

- Provider entities are licensed within the state in which services are provided and are encouraged to be accredited by an accreditation body.
- 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

- Potential BHP-only MCT responders include licensed or credentialed clinical behavioral health mobile crisis staff and unlicensed behavioral health practitioners and/or peer support providers.
- At least one BHP-only 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 have the ability to initiate involuntary treatment as appropriate.
- Paired initial response by members of the BHP-only MCT is strongly preferred.
- The number of BHP-only MCT members who should respond to requests for crisis assessments should be predicated upon a triaging of the situation. For example, in locations like EDs, 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.
- All team members should be trained in crisis response.
- In some cases, using telehealth for mobile crisis assessments by the licensed or credentialed behavioral health practitioner will be the timeliest response and 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 also 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 providers, based on the situation.
- Only involve law enforcement when absolutely necessary, and preferably a Crisis Intervention Team (CIT) or Crisis Response Intervention Team (CRIT) trained officer.
- Law enforcement or other traditional public safety personnel are not members of the BHP-only 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;
- Referrals to community-based resources;
- Basic Life Support (BLS) to be provided on scene with activation of 911 as indicated;
- Cardiopulmonary Resuscitation (CPR);
- First aid;
- Harm reduction approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications;
- Cultural humility and culturally responsive care;
- Culturally and Linguistically Appropriate Services (CLAS) and Americans with Disabilities Act (ADA)-related knowledge and capabilities; and
- Self-care and secondary trauma awareness.

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;
- Community stabilization rates;
- Experience/satisfaction of the help seeker;
- Law enforcement involvement;
- Involuntary Treatment Rates;
- Staffing levels and vacancies;
- Availability of mobile crisis response (hours per day);
- Referrals/connections to other community supports and services addressing SDOH; and
- Repeat calls for service within 7 and 30 days.

Preferred Practice Elements

- 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 to identify where mobile teams may be in the community.
- Utilize peers in non-emergent de-escalation and support, follow-up care, and support post-disposition.

6. Co-Responder MCT Services

Service Description

Co-responder MCT 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 behavioral health practitioners to respond to calls/contacts for services involving individuals experiencing mental health and substance use crises. Co-responder teams leverage the skills of both behavioral health practitioners 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. It includes the provision of active treatment and prevention efforts.

Distinguishing Features

- **Coverage Capacity:** Co-response MCTs 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 MCTs are most commonly staffed by both behavioral health professionals and law enforcement officers or EMS staff.

Expected Service Elements

- Crisis triage, crisis screening, and safety assessment.
- Develop or revise/optimize a crisis *safety plan (PDF)*.[25]
- 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.
- Provide access to recovery support.
- Provide direct referrals, care coordination, and linkage to care with community-based stabilization supports.
- Initiate emergency rescue in cases of imminent safety concerns (e.g., overdose response, EMS).
- Coordinate or provide transportation for the individual to facilitate crisis stabilization.
- Provide in-person, telephonic, or virtual follow-up.

Care Coordination/Follow-Up

- Identify and coordinate with 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 peer 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.

Service Continuation Criteria

None.

Discharge Criteria

The acute presentation of the crisis is resolved, the appropriate referral(s) and service engagements to stabilize the crisis situation are made, and post-crisis follow-up has been completed.

Modality

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

Setting/Care Environment

- Co-responder MCTs may be implemented as a stand-alone program for crisis response or integrated into other comprehensive police-behavioral health collaboration models.
- Alternatively, co-responder teams may co-exist within communities with other MCT models, with established triage protocols to determine which type of response will be deployed (i.e., when a safety risk exists, co-responder MCTs may be more appropriate than BHP-only MCTs or MCT services provided by MRSS programs).
- 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 MCT services shall be provided on tribal lands, in collaboration with the tribe, when right of entry has been granted by the tribe.

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 behavioral health professionals.[26]

Staffing Recommendations and Credentialing

- Co-responder MCTs typically consist of one specifically trained law enforcement officer and one licensed and/or credentialed behavioral health professional.
- Some communities may incorporate EMS and fire departments.
- Co-responder MCT 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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; 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;
- Involuntary treatment rates;
- Referrals/connections to other community supports and services addressing SDOH; and
- Law enforcement-specific outcomes, including the reasons for any arrests, use of force, and/or deaths.

Preferred Practice Elements

- Where co-responder teams are present, they should optimally co-exist with BHP-only MCTs so that communities can dispatch the greatest degree of behavioral health crisis expertise whenever possible.
- Require CIT or CRIT 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).
- Use of a validated, standardized tool to develop a crisis and safety plan, as appropriate.
- Access to psychiatric staff for clinical insight and pharmacotherapy services.
- Technology that links 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.
- Use of peers in non-emergent de-escalation and support, follow-up care, and support post-disposition.

7. Mobile Response and Stabilization Services (MRSS)

Service Description

MRSS are timely, time-limited, intensive, home- and community-based crisis services designed to support children, youth, and their families/caregivers through a systems-based approach with the goal of preventing unnecessary out-of-home placements. The core elements of MRSS consist of the provision of both a developmentally appropriate BHP-only MCT response (i.e., mobile response) and time-limited community-based stabilization services (i.e., stabilization services) that are more robust than the typical follow-up service provided by the other two MCT models. MRSS not only de-escalates and mitigates current crises, but intensively supports ongoing stabilization and functioning in order to prevent future crises. The more robust and longitudinal stabilization service is the key distinction between MRSS and the other two MCT models.

MRSS is focused on helping children and youth stabilize in their current living arrangement with a return to routine activities and is grounded in the SAMHSA Systems of Care Principles.[27] 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 who present with less acute needs. Early intervention through MRSS can prevent the utilization of more intensive services in the future by determining needs and supports and proactively addressing them. These services are to be provided in the child/youth's own home or another setting (foster care, kinship care), or a community setting that provides a level of safety for the individual and the MRSS professional. They should include ongoing support as necessary and typically last up to eight weeks. Of note, this model may also be used for adults.

Distinguishing Features[28]

- **Coverage Capacity:** 24/7/365 service provision is preferred.
- **Low Barrier for Physical Response:** Through the use of minimal dispatch criteria, the default is to provide a rapid, face-to-face screening, developmentally-appropriate assessment, and community-based response (ideally within 60–90 minutes), with the capacity for the call center/dispatch entity to remain in contact with the caller while the team is in route.
- **Family Systems Approach:** MRSS recognizes that the distress experienced by an individual is influenced by and 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 eight weeks) of ongoing support through MRSS in addition to follow-up after discharge from services.

Expected Service Elements (Mobile Response)[29]

- Provision of 24/7/365 timely, face-to-face MCT 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.
- Engage in collaborative, systems-based, family- and child/youth-driven treatment planning.
- Provide direct referrals and care coordination with home-, school-, community-, and systems-based stabilization supports.
- Initiate 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 phase of care; may utilize telephonic or virtual follow-up at the child and/or the families/caregiver's request.

Expected Service Elements (Stabilization and Follow-Up)[30]

- Provision of 24/7/365 rapid and scheduled (by need/preference) face-to-face MCT 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;
- Connection of 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 about 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 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-based or evidence-informed care coordination model.
- Identify and coordinate with providers.
- Continue outpatient behavioral health treatment while MRSS is working with the child/youth and family.
- Identify and coordinate with community- and system-based community supports, including those that address the SDOH.
- 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 behavioral health 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; however, it is not limited to this population.

- The symptoms of the behavioral health diagnosis should be the primary clinical issue addressed by services.

Exclusionary Criteria

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

Service Continuation Criteria

- Eligibility criteria continue to apply.
- There is not another more appropriate setting or service in which to address current concerns.
- Discharge criteria have not yet been met.

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[31]

- MRSS mobile response services are available 24/7/365.
- MRSS mobile response allows for multiple in-person responses for up to 72 hours, as often needed during the mobile response phase.
- Crisis, Safety, and Care Planning should occur within 72 hours following the first visit.[32]
- 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 progress up to that point.
- If the 6–8-week period ends, and the child and family still has/have unmet behavioral health needs, the family can re-engage the MRSS program for a new or continued episode of care.

Setting/Care Environment

- Services are provided in the child/youth's current living situation, community (e.g., school), or a setting that provides safety for the child/youth, their family, and the behavioral 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 and inform the safety plan.
- Providers should prioritize in-person service delivery to promote engagement and facilitate informed choice prior to finalization of the treatment plan.

Provider Type

- Mobile response and stabilization services are connected under the same provider organization and workforce.[33]
- 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 Team is strongly preferred.
- At least one member should be a licensed/credentialed behavioral health practitioner 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.
- MRSS should only involve law enforcement when necessary, especially during the initial MCT phase of care.
- Law enforcement personnel do not qualify as members of the MRSS 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 approaches;
- Overdose prevention education;

- Administration of opioid overdose reversal medications (e.g., naloxone and nalmefene); 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;
- Referrals/connections to other community supports and services addressing SDOH;
- Number or percentage of referrals and direct linkages to service;
- Number and type of out of home placements; and
- Sentinel events.

Preferred Practice Elements

Services are flexible, adapt to the specific and changing needs of each child/family, and may include up to daily intervention and very intense supports for not only behavioral health needs, but also those addressing the SDOH.

8. Community Outreach Teams

Service 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 prevention, 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 and connection to supports, rather than responding to crisis situations in an on-demand manner.

Expected Service Elements

- Proactive and responsive outreach;
- In-person engagement;
- Health, safety, and SDOH 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;
- Recovery support;
- Initiation of emergency rescue in cases of imminent safety concerns (e.g., overdose response, EMS);
- Coordination or provision of transportation for the individual to facilitate crisis stabilization;
- Systems navigation supports; and
- Follow-up contacts.

Care Coordination/Follow-Up

- Identify and coordinate with 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.

Service Continuation Criteria

None.

Discharge Criteria

The appropriate referral(s) and service engagements are made and follow-up has been completed.

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.

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 address SDOH 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 screening;
- Crisis support;

- 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 approaches;
- Overdose prevention education;
- Naloxone and other opioid overdose reversal 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;
- Referrals/connections to other community supports and services addressing SDOH;
- Help seeker satisfaction; and
- Sentinel events.

Preferred Practice Elements

- Have access to psychiatric staff for clinical insight and pharmacotherapy services.
- Utilize peers throughout service provision.
- Provide opioid overdose reversal medications (e.g., naloxone or nalmefene) and other harm reduction resources.

Crisis System Component: *A Safe Place for Help*

A Safe Place for Help includes both emergency and crisis stabilization services. This encompasses a range of service models to support individuals' 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. This distinction is best appreciated by how services respond to referrals. For example, there are some facility-based settings that will accept all individuals who present to the facility and provide access to a full range of clinical and non-clinical staffing support (no barrier or emergency settings). Other settings may accept most individuals who come to a facility-based service, but they may have less intensive staffing models, may not be able to accept people who are brought to the facility via an ambulance or law enforcement or who present with a level of acuity that cannot be safely supported (low barrier settings). Finally, some referral-based services may only provide services in accordance with a referral-based system that includes a triage and/or screening process that incorporates the use of pre-determined eligibility criteria. Such distinctions are noted with each service description following. Services in this category also can be distinguished by the setting in which stabilization services are offered.

Across all settings, stabilization services offer a safe environment where individuals can receive support and care to address their acute behavioral health needs and to support the resolution of the crisis, receive connections to appropriate levels of care, and receive follow-up services. 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.

Although youth-specific models are noted in the following, it is recommended that most services in this essential element also have the capacity to serve youth and address the needs

of their families. For all facility-based services, separate, dedicated spaces for youth are important to support the safety of youth as well as support dedicated, developmentally appropriate programming.

No-Barrier or Low-Barrier Crisis Stabilization Services

- Hospital-Based Emergency Stabilization Units;
- High-Intensity Behavioral Health Emergency Centers;
- High-Intensity Behavioral Health Extended Stabilization Centers;
- Moderate-Intensity Behavioral Health Crisis Centers;
- Moderate-Intensity Behavioral Health Extended Stabilization Centers;
- Behavioral Health Urgent Care;
- Peer Crisis Respite; and
- Sobering Centers;

Referral-Based Residential Services

- Moderate-Intensity Crisis Residential Programs;
- Low-Intensity Crisis Residential Programs; and
- Community Crisis Respite Apartments.

Services Specific to Children, Youth, & Families

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

No-Barrier or Low-Barrier Crisis Stabilization Settings

9. Hospital-Based Behavioral Health Emergency Stabilization Units

Service Description

Hospital-Based Behavioral Health Emergency Stabilization 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 facilities 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.

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.

Expected Service Elements

- Screening; triage assessment;
- Diagnostic assessment;
- Bio-psychosocial assessment;
- Medication initiation and administration;
- Laboratory services;
- Medical specialty consultation;
- Ambulatory-level care support for physical health issues;
- Medically managed withdrawal management;
- Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD);
- Safety treatment recovery 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.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of behavioral health emergency and/or individual connected to most appropriate level of care.

Modality

Most services are provided 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

- Operates under a hospital license.
- Accepts voluntary and involuntary admissions.
- 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 and Credentialing

- In-person or telehealth provider with prescribing capabilities coverage, to include assessments and medication orders by a psychiatrist or other individual who is credentialed to prescribe psychiatric medications (accessible 24/7/365);
- Onsite pharmacy or medication dispensing available;
- 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).

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Demographics;
- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- 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 helpseeker.

Preferred Practice Elements

- 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 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 accept all arrivals, including those that are unplanned and unscheduled, without pre-screening or requirement to be "medically cleared" prior to arrival. These centers can provide immediate medical triage and 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.

- **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 all voluntary walk-ins and first responder drop-offs. This includes a rapid drop-off with a "no wrong door" policy. Per this no wrong door policy, if a person arrives who may need services at another program or facility, the person is not turned away but rather is assessed and supported at the crisis facility until such time when a referral or transfer can be completed. Also, as part of this policy, individuals are welcomed back when additional services are needed.
- **Stabilization:** High-Intensity Centers provide emergency care for those in a behavioral health crisis, including triage assessment. Typically, these services occur within 24 hours of entry into the facility. Individuals will then be referred to another care setting based on level of care needed or return to the community if stabilized.

Distinguishing Features

- Receive all individuals for any individual-defined behavioral health emergency.
- Does not require prior authorization.
- Rapid drop-off with a "no wrong door" policy.
- Provide dedicated entrance for law enforcement/EMS drop-offs.
- Receive individuals on voluntary or 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 provider with prescribing capabilities 24/7/365.
- Onsite pharmacy or medication dispensing capabilities.

Expected Service Elements

- Screening; triage assessment;
- Diagnostic assessment
- Bio-psychosocial assessment;

- Medication initiation and administration;
- Crisis counseling;
- Point of care testing;
- Access to laboratory services;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety treatment recovery planning;
- Individual peer support services;
- Psychoeducation;
- 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

- Family engagement.
- Assistance with psychosocial stressors and SDOH.
- 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 providers in follow-up contacts.

Eligibility Criteria

None.

Exclusionary Criteria

Medical conditions that require interventions beyond that of an ambulatory level medical setting.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of behavioral health emergency or individual connected to most appropriate level of care based upon assessed needs and preferences.

Modality

Most services are provided 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

- Accepts voluntary and involuntary admissions.
- Accredited secure units consistent with accreditation body standards for physical settings of behavioral health inpatient units.
- Dedicated law enforcement/EMS drop-off.
- 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

Accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

- Coverage by a psychiatrist or other credentialed non-physician psychiatric provider with prescribing capabilities (accessible immediately onsite or virtually 24/7/365);

- Onsite pharmacy or medication dispensing available;
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists) 24/7/365;
- Certified peer specialists; and
- Social services support 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;
- Crisis counseling;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Referral source;
- Readmissions;
- Average length of stay;
- Activation of involuntary interventions;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers;
- Discharge disposition;
- Involuntary interventions;
- Referrals/connections to other community supports and services addressing SDOH; and
- Experience/satisfaction of the help seeker.

Preferred Practice Elements

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

11. High-Intensity Behavioral Health Extended Stabilization Centers

Service Description

High-Intensity Behavioral Health Extended Stabilization Centers (hereafter referred to as High-Intensity Extensions) are connected to the High-Intensity Centers. These facilities offer extended behavioral health emergency care beyond the initial 24 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 return to the community or

transfer to another setting based on the person's unique needs and preferences. They can provide continued withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.

Distinguishing Features

- Private rooms with beds (as opposed to recliners);
- No length of stay requirement (typical stay 3–5 days); and
- Receive individuals on involuntary basis (based on jurisdiction guidelines).

Expected Service Elements

Same as High-Intensity Centers.

- Screening; triage assessment;
- Bio-psychosocial assessment;
- Diagnostic assessment;
- Psychoeducation;
- Medication initiation and administration;
- Point of care testing;
- Access to laboratory services;
- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Safety treatment recovery planning;
- Individual peer support services;
- Emotional support groups;
- 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; and
- Warm hand-off & community referrals.

Care Coordination/Follow-Up

- Care coordination;
- Family engagement;
- Assistance with psychosocial stressors and SDOH;
- Crisis counseling;
- 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; and
- Engage peers in follow-up.

Eligibility Criteria

Individuals are eligible for this service based on receiving services as an extension of the High-Intensity Centers. Additionally, these programs may accept direct admissions from the community or other providers.

Exclusionary Criteria

Medical conditions that require interventions beyond that of an ambulatory level medical setting.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns

- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of behavioral health emergency or individual connected to other care based upon assessed needs and preferences.

Modality

Most 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

- Accepts voluntary and involuntary admissions;
- Co-located with High-Intensity Centers;
- Length of stay > 24 hours;
- Have the regulatory, physical, and staffing capacity for seclusion and restraints as necessary;
- 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

Accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

Same as High-Intensity Centers.

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (immediately onsite or virtually accessible 24/7/365);
- Onsite pharmacy or medication dispensing available;
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists) 24/7/365;
- Certified peer specialists; and
- Social services support 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;
- Crisis counseling;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;

- Instances of physical management, injury, involuntary activation;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Preferred Practice Elements

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

12. Moderate-Intensity Behavioral Health Crisis Centers

Service Description

Moderate-Intensity Crisis Centers (hereafter referred to as Moderate-Intensity Centers) provide similar services as High-Intensity Centers; however, they are considered low barrier and only accept voluntary individuals and often individuals presenting with a lower level of acuity than High-Intensity Centers. These centers may provide law enforcement and/or EMS drop-offs; however, they are not required to. They are usually unable to provide services for individuals on involuntary holds, or may need to transfer people on involuntary status after a limited period of time. Moderate-Intensity Centers may not have onsite pharmacy or medication dispensing equipment but do have access to local pharmacy services that can enable access to medications for people who need this service while at the Moderate-Intensity Center. These centers offer the management of moderate symptoms of intoxication and withdrawal.

Distinguishing Features

- Exclude involuntary admissions;
- May not have onsite medication dispensing but should have access to local pharmacy services; and
- Should be secure but will not have access to seclusion and/or physical restraints onsite.

Expected Service Elements

Same as High-Intensity Centers.

- Screening; triage assessment;
- Bio-psychosocial assessment;
- Diagnostic assessment;
- Crisis counseling;
- Psychoeducation;
- 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 SDOH;
- 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 onsite medication dispensing but should have a

relationship with a local pharmacy to quickly dispense and possibly administer 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;
- Conditions that require interventions beyond that of an ambulatory level medical setting; and/or
- Acute behavioral health conditions that require a more intensive service environment.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of acute behavioral health crisis and/or transfer to a more appropriate level of care.

Modality

Most 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

- Accepts voluntary admissions.
- 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 and Credentialing

Same as High-Intensity Centers; however, with reduced staffing ratios.

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (immediately onsite or virtually accessible within one hour, 24/7/365);
- Coordination with local pharmacies for rapid access to medications;
- Nursing staff onsite 24/7/365;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Social services support staff; and
- Meal services.

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 support;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- 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.

Preferred Practice Elements

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

13. Moderate-Intensity Behavioral Health Extended Stabilization Centers

Service Description

Moderate-Intensity Behavioral Health Extended Stabilization Centers (hereafter referred to as Moderate-Intensity Extension) are connected to Moderate-Intensity 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 setting or service that offers an appropriate next level of treatment and support. Moderate-Intensity Extension can provide continued moderate withdrawal management services.

Distinguishing Features

- Dedicated rooms with beds;
- Only serve voluntary individuals; and
- No length of stay requirement (typical stay 3–5 days).

Expected Service Elements

Same as Moderate-Intensity Centers.

- Screening;
- Triage assessment;
- Diagnostic assessment;
- Bio-psychosocial assessment;

- Crisis counseling;
- Psychoeducation;
- 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 SDOH;
- Assistance with psychosocial stressors and SDOH;
- Family engagement;
- 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; 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;
- Medical conditions that require interventions beyond that of an ambulatory level medical setting; and
- Acute behavioral health conditions that require a more intensive service environment.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of acute behavioral health crisis and/or transfer to a more appropriate level of care.

Modality

Most 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 Moderate-Intensity Centers.
- Accepts voluntary admissions.
- Length of stay > 24 hours.
- 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 and Credentialing

Similar to Moderate-Intensity Centers; however, with different staffing ratios.

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (immediately onsite or virtually accessible within one hour, 24/7/365);
- Qualified Nursing staff onsite 24/7/365;
- Coordination with local pharmacies for rapid access to medications;
- Licensed behavioral health staff (social workers, counselors, marriage and family therapists);
- Social services support staff; and
- Nutrition services.

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- 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.

Preferred Practice Elements

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

14. Behavioral Health Urgent Care

Service 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 a low-barrier 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 though it may be connected to services that are more longitudinal in nature, such as through a CCBHC.

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 SDOH 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.

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.

Expected Service Elements

- Screening; triage assessment;
- Diagnostic assessment;
- Family engagement;
- Point of care testing;
- Psychoeducation;
- Crisis counseling;
- Assistance with psychosocial stressors and SDOH;
- 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;
- Discharge planning and follow-up; and
- Referrals, including suicide specific care and support groups.

Care Coordination/Follow-Up

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

Eligibility Criteria

None.

Exclusionary Criteria

Individuals with medical needs beyond the capacity of the BHUC or those who are at imminent risk of harm to self, others, or property who cannot engage or do not wish to engage in safety planning may be referred to a more appropriate level of care.

Service Continuation Criteria

None.

Discharge Criteria

Crisis situation is resolved and an adequate continuing care plan has been established and/or individual is connected to the appropriate level of care.

Modality

Most 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;
- Accepts voluntary admissions; 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 and Credentialing

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities either onsite or via telehealth during BHUC operating hours;
- Qualified nursing staff (RN/LPN) onsite during BHUC operating hours;
- Licensed behavioral health staff (e.g., 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.

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Demographics;
- Client experience;
- Nature and duration visit;
- Service referrals;
- Referrals/connections to other community supports and services addressing SDOH;
- Referral follow-through;
- Critical incidents;
- Sentinel events; and
- Experience/satisfaction of the help seeker.

Preferred Practice Elements

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

15. Peer Crisis Respite

Service Description

Peer Crisis Respite services offer voluntary, low barrier, 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 providers who have lived experience with and recovery from behavioral health conditions. Peer Crisis Respite services are provided in a warm, friendly home environment. Most 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.

"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 providers.
- Respite services are voluntary, and individuals may come and go as they wish.
- Peer crisis respite may serve as a safe alternative for people experiencing distress who are seeking a non-clinical environment for support.
- "Home" environment.

Expected Service Elements

- Short-term, approximately 5–7 days temporary lodging;
- Goal identification;
- Therapeutic milieu;
- Individual peer support services;
- Support groups;
- Support self-administration of prescribed medication;
- Educational and recreational activities;
- Resource and wellness education; 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 may be connected to a different level of care. People may request referrals to other resources.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Crisis situation is resolved and an adequate continuing care plan has been established or individual is connected to the appropriate level of care based upon their needs and preferences.

Modality

Most 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

- Accepts voluntary admissions;
- Dedicated bed for individuals remaining for more than 23 hours;
- Accessible private rooms;
- "Home-like" setting; and
- Communal gathering area.

Provider Type

- A site will operate in a residence that meets local building and zoning codes.
- Peer residential services are peer-run and/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 and Credentialing

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

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Demographics;
- Guest recovery measures (e.g., sense of purpose and hope);
- Referrals/connections to other community supports and services addressing SDOH;
- Customer satisfaction; and
- Sentinel events (e.g., death, serious injury).

Preferred Practice Elements

- Employ certified peer support providers that ideally align with the *National Model Standards for Peer Support Certification (PDF)* established by SAMHSA.
- Utilize a best practice model.
- Offer wellness-oriented supports including Wellness Recovery Action Plan (WRAP)34 or similar self-directed recovery planning tool.
- Respites may ask each guest to bring food for the stay at the Respite or may offer meals. Meal service depends on the affordability and personal culture of the respite leadership;
- Provider site may be accredited through a body such as the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or CARF.
- The guest and peer crisis respite management determine who may visit and schedule accordingly at reasonable hours so as not to disrupt the privacy of all guests, preferably in a designated visitation space.

16. Sobering Centers

Service 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.[35]

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.

Expected 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;
- Support self-administration of prescribed medication;
- Management/monitoring of symptoms of intoxication & withdrawal based on ASAM Level;
- Client engagement;
- Safety treatment recovery planning;
- 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 may be connected to a different level of care.
- Individuals requiring medically-managed withdrawal services to safely recover from their state of acute intoxication.

Service Continuation Criteria

- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of symptoms of acute intoxication or transfer to an appropriate level of care based upon a person's needs and preferences.

Modality

Most 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;
- Accepts voluntary admissions;
- 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 and Credentialing

- Minimum of two staff should be available and onsite at any time; it is ideal to have more coverage if feasible.
- Peer support providers.
- 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.

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested 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;
- Referrals/connections to other community supports and services addressing SDOH;
- Time to access referred services;
- Critical incidents;
- Sentinel events; and
- Experience/satisfaction of the help seeker.

Preferred Practice Elements

- 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;
- Memorandums of Understanding (MOUs) or other partnerships with treatment providers providing intensive services (e.g., inpatient SUD rehabilitation services);
- Separate spaces/areas for the different sexes; and
- Private spaces for clients whose acute intoxication is exacerbated by the sobering milieu.

Referral Based Residential Services

17. Moderate-Intensity Crisis Residential Programs

Service Description

Moderate-Intensity Crisis Residential Facilities (hereafter referred to as Moderate-Intensity Residential) are residential crisis programs with daily access (can be virtual), as needed, to psychiatric services; these also provide nursing services. Moderate-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 secured settings 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. Moderate-Intensity Residential facilities can provide withdrawal management for mild to moderate withdrawal symptoms.

Distinguishing Features

- Residential setting, non-hospital based;
- Therapeutic milieu key component of service delivery;
- May accept individuals on involuntary holds or treatment (based on jurisdictional guidelines);
- Typically, stand-alone facilities, not connected to a Behavioral Health Emergency or Crisis Center; and
- Laboratory and pharmacy services are generally not onsite and participants may require transportation for medical specialty appointments.

Expected Service Elements

- Screening;
- Diagnostic assessment;
- Medication initiation and administration (can be self-administration);
- Withdrawal management;
- Safety & recovery planning;

- Management of symptoms of intoxication and withdrawal; MOUD and MAUD;
- Crisis counseling;
- Care coordination;
- Psychoeducation;
- Individual & group therapy;
- Emotional support groups;
- Educational & recreational activities;
- Crisis counseling;
- Family engagement;
- Assistance with psychosocial stressors and SDOH;
- 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 peer support workers and specialists in follow-up contacts.

Eligibility Criteria

- Need for staffed short-term residential support for current behavioral health needs, and
- 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 the capacity of a behavioral health residential setting.

Service Continuation Criteria

- Eligibility criteria continue to apply.
- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of behavioral health crisis and/or individual connected to more appropriate level of care.

Modality

Most 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.
- Accepted voluntary and involuntary admissions.
- Length of stay > 24 hours, typically 5–14 days.
- Individual beds with private space available; capacity limits determined by federal and state laws and regulations.

- Secure, “home-like” setting.
- Meal services tailored to dietary needs.

Provider Type

Should be accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (should offer 24/7/365 access either via phone or telehealth and provide onsite visits at least twice weekly);
- Qualified nursing staff (e.g., RN) onsite at least part-time with 24/7/365 phone coverage;
- Onsite pharmacy or medication dispensing available;
- Licensed practical nurses and emergency medical technicians (LPNs/EMTs) onsite 24/7/365;
- Licensed behavioral health staff (e.g., social workers, counselors, marriage and family therapists); and
- Social services support 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;
- Crisis counseling;
- Crisis intervention and de-escalation techniques;
- Existing community-based resources and referrals;
- BLS;
- CPR;
- First aid;
- Harm reduction approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- Involuntary interventions;
- Injuries;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Preferred Practice Elements

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

18. Low-Intensity Crisis Residential Program

Service Description

Low-Intensity Crisis Residential facilities (hereafter referred to as Low-Intensity Residential) provide similar services as Moderate-Intensity Residential facilities; however, Low-Intensity Residential facilities 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. Low-Intensity Residential only accepts individuals on a voluntary basis. Low-Intensity Residential can provide withdrawal management services for mild symptoms. Services are provided in staff-secured settings.

Distinguishing Features

- Excludes involuntary admissions, and
- Facilities are not locked; provide a secure environment only.

Expected Service Elements

Same as Moderate-Intensity Residential.

- Screening;
- Diagnostic assessment;
- Medication initiation and administration (can be self-administration);
- Withdrawal management;
- Initiation of MOUD and MAUD;
- Safety & recovery planning, as desired;
- Care coordination;
- Psychoeducation;
- Crisis counseling;
- 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

- Need for staffed short-term residential support for current behavioral health needs.
- Ability to participate in safety planning and 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 the capacity of a behavioral health residential setting.

Service Continuation Criteria

- Eligibility criteria continue to apply.
- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of behavioral health crisis and/or individual connected to a more appropriate level of care.

Modality

Most 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.
- Staff-secured setting.
- Meal services tailored to dietary needs.

Provider Type

Should be accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

- Program is staffed with at least one crisis worker 24/7/365;
- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (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.

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- Involuntary interventions;
- Injuries;

- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Experience/satisfaction of the help seeker.

Preferred Practice Elements

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

19. Community Crisis Respite Apartments

Service Description

Community Crisis Respite Apartments (hereafter referred to as Respite Apartments) have been developed in many states as an option of community-based support. These Respite Apartments provide an individual with a supported housing environment. These can be especially supportive of individuals who are in a transitional state from an institutional setting in order to prevent crises that are related to being unhoused, lack a connection to the appropriate community-based re-entry services that may lead to criminal justice recidivism, or need additional stabilizing step-down supports after admission to psychiatric inpatient facility or a facility-based emergency or crisis stabilization service. Programming consists of services that support obtaining or maintaining community-based housing and associated independent living skills. In these settings, people can stay for a limited time to receive crisis prevention and postvention services, such as case management, medication administration, counseling, and skill building.

Distinguishing Features

Respite Apartments that are specifically developed for individuals who are transitioning from acute, subacute, or highly structured behavioral health treatment settings typically have a higher level of clinical support, along with peer staffing, as is reasonably necessary to prevent unnecessary institutionalization.

Expected Service Elements

- Comprehensive needs assessment;
- Referrals & linkages;
- Independent living skills reinforcement and coaching;
- Transition planning/coordination;
- Goal identification;
- Therapeutic milieu;
- Individual peer support services;
- Support groups;
- Administration of prescribed medication;
- Educational and recreational activities;
- Resource and wellness education;
- Crisis prevention and postvention services;
- Case management;
- Counseling; and
- Skill-building.

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

- Individual has a severe and persistent mental illness, or mental illness and a co-occurring SUD, that seriously interferes with their ability to live in the community.
- Individual is transitioning or recently discharged from a psychiatric inpatient setting or jail/prison; or is frequently admitted to a psychiatric inpatient facility or crisis stabilization unit or in emergency rooms for behavioral health needs; or is chronically homeless.
- Individual can live independently.

Exclusionary Criteria

- Individual has medical issues that require daily nursing or physician care.
- Individual would be better served in a different level of care and/or is able to safely remain in an open, community-based placement.

Service Continuation Criteria

Individual continues to meet admission criteria with a documented need for Respite Apartment staff intervention/support and individual is engaged but continues to require assistance.

Discharge Criteria

- An individual requests discharge;
- An individual's needs require a higher level of care due to acuity; or
- An individual has achieved their goals and has appropriate living arrangements that are less restrictive.

Modality

Most services are provided in an independent living setting and in person, face-to-face with individual. Some specialty services may have a telehealth, virtual component.

Setting/Care Environment

- Length of stay > 24 hours, often can be up to 90 days.
- Individual beds with private space available; capacity limits determined by federal and state laws and regulations.
- "Home-like" setting.
- Meal services tailored to dietary needs.

Provider Type

Should be accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

- Each Respite Apartment should have access to peer staff and clinical staff who can respond onsite, up to 24 hours per day, seven days per week, whenever necessary, to meet individualized needs.
- Provider has a 24/7 Staffing Plan that includes on-call coverage with a response time to respond to individuals in crisis;
- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities accessible (although not 24/7/365) and may be provided via telehealth;
- LPNs/EMTs are onsite (although not 24/7/365);
- Licensed behavioral health staff (i.e., social workers, counselors, marriage and family therapists);

- Social services support staff; and
- Peer support providers.

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 approaches;
- Overdose prevention education;
- Administration of opioid overdose reversal medications; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events;
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- Metrics of timeliness of care;
- Medical adverse events;
- Involuntary interventions;
- Injuries;
- ED transfers; and
- Client satisfaction.

Preferred Practice Elements

Family engagement services and visiting hours.

Services Specific to Children, Youth, & Families

20. 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 youth-specific versions of the previously-described services as well.

20A. In-Home Stabilization Services

Service 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, warm hand-offs to other resources and services, psychotherapy, and pharmacotherapy. 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, caregiver, or other 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. While this service has typically been defined for children and young adults, this can be potentially adapted for other populations across the lifespan.

Distinguishing Features

- Services provided to youth and their family;
- Stabilization services occur within the home;
- Alternative to hospitalization; and
- Moderate-intensity community based services.

Expected Service Elements

- Family engagement;
- Screening & triage;
- Diagnostic assessment;
- Goal identification/action planning;
- Skill-building;
- Safety treatment recovery planning;
- Care coordination;
- Assistance with psychosocial stressors and SDOH;
- Educational and recreation activities;
- Discharge planning and follow-up; 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 behavioral 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 home-based setting will be connected to a different level of care.

Service Continuation Criteria

Criteria for service continuation are based upon the individual child/youth and family's specific needs. Generally speaking:

- Eligibility criteria continue to apply.
- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

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

Most 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 and Credentialing

- 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 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 approaches;
- Overdose prevention education;
- Naloxone and other opioid overdose reversal administration; and
- Cultural humility and culturally responsive care.

Suggested 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;
- Referrals/connections to other community supports and services addressing SDOH;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Preferred Practice Elements

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

20B. Youth & Family Crisis Respite Care

Service 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 Care 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 Care 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
- Moderate-intensity community based services.

Expected Service Elements

- Family engagement;
- Goal identification/action planning;
- Skill-building;
- Ambulatory-level care support for physical health issues;
- Therapeutic milieu;
- Safety treatment recovery planning;
- Care coordination;
- Assistance with psychosocial stressors and SDOH;
- Crisis counseling;
- Psychoeducation;
- Educational and recreation activities;
- Discharge planning and follow-up 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 behavioral 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

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.

Service Continuation Criteria

Criteria for Service Continuation are based upon the individual child/youth and family's specific needs. Generally speaking:

- Eligibility criteria continue to apply.
- There is not another more appropriate setting in which to address current concerns.
- Discharge criteria have not yet been met.

Discharge Criteria

Stabilization of acute behavioral health crisis and/or individual connected to a more appropriate level of care.

Modality

Most 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;
- Home-like setting; and
- Meal services tailored to dietary needs.

Provider Type

Should be accredited/licensed by appropriate authority.

Staffing Recommendations and Credentialing

- Coverage by a psychiatrist or other credentialed provider with prescribing capabilities (should offer access 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.

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 approaches;
- Overdose prevention education;
- Naloxone and other opioid overdose reversal administration; and
- Cultural humility and culturally responsive care.

Suggested Data Elements, Metrics, and Quality Measures

- Critical incidents and sentinel events (e.g., serious injury, death);
- Readmissions;
- Referrals/connections to other community supports and services addressing SDOH;
- Involuntary interventions;
- Metrics of timeliness of care;
- Medical adverse events;
- ED transfers; and
- Client satisfaction.

Preferred Practice Elements

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

Conclusion

This *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services* document provides a comprehensive framework for services that are components of a BHCSCC. By defining the essential components for emergency, crisis and crisis-related services, this publication aims to promote consistency, quality, and accessibility of crisis systems. The outlined principles emphasize the importance of a person-centered, trauma-informed, and recovery-oriented approach, ensuring that individuals receive timely and appropriate care tailored to their unique needs. There is a need for collaboration among various stakeholders, including behavioral health providers, emergency responders, and community organizations, to create an integrated and effective crisis response system.

By adopting these model definitions, states, territories, tribes, and local entities can enhance their crisis response capabilities, improve outcomes for individuals experiencing behavioral health crises, and move towards a more equitable and responsive behavioral health system. The goal is to ensure that everyone, regardless of their background or circumstances, has access to the care and support they need during a crisis, fostering resilience and recovery in communities nationwide.

Behavioral Health Crisis Services Glossary

Acuity: The level of severity and complexity of an individual's mental health or substance use condition.

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.[36]

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.[37]

Behavioral Health Crisis: Any 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 wellbeing, safety, and/or the 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 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 that is designed to meet all types of urgent and emerging mental health and substance use needs in a defined population or community, effectively and efficiently within a geographic catchment area. 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, significantly engage peer supports, provide 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 to optimize the shift to behavioral health led crisis response.

Behavioral Health Emergency: A potentially life-threatening behavioral health crisis that may result in significant harm to self, others, or grave disability without appropriate rapid or immediate intervention.[38]

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, sex, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality, accessible mental health and substance use services and support.

Behavioral Health Practitioner: Any individual regardless of a specific license or credential who provides behavioral health services or supports for a behavioral health service provider that is not serving in the capacity of a public safety professional (e.g., law enforcement and/or emergency medical services).

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 substance use disorders; and supports people who are at risk for, experience, and/or are in recovery from, these conditions, along with their families, unpaid caregivers, and communities.

Behavioral Health Urgent Care (BHUC): 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.

Care Coordination: The deliberate organization and facilitation of an individual's care across multiple care providers.[39]

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.[40]

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.[41,42]

Clinical Assessment: The systematic evaluation and measurement of psychological, biological, and social factors (e.g., current symptoms and 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.[43]

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.[44]

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 community members and their community 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: A process of interviewing, observation, and at times also obtaining other information 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 immediate behavioral health treatment plan and services.

Crisis Intervention: Short-term techniques that aim to improve the well-being and prevent harm secondary to an individual's current behavioral health concern. Crisis intervention involves several steps, including defining the issue(s), assessing and promoting safety, providing therapeutic and stabilizing supports, exploring the most appropriate potential resources, and collaboratively making a crisis plan that is focused on coping, well-being and safety, and supporting the implementation of that plan.[45] Crisis Intervention should be followed by follow-up supports.

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.[46]

Crisis Receiving: Walk-in and 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 emergency medical services drop-offs. This includes a rapid drop-off with a "no wrong door" policy.

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 substance use disorder. These services are designed to prevent or improve a behavioral health crisis and/or reduce acute behavioral health symptoms.

Discharge Planning: The collaborative process of developing an individualized plan and providing instructions to an individual (and subsequent behavioral healthcare providers, as applicable) to successfully support an individual's transition from care setting to another.

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.[47]

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, lesbian, gay, bisexual (LGB) individuals, people living in rural settings, service members, Veterans, and people with disabilities. Services are sensitive to the needs of diverse populations. This care also addresses social drivers of health such as housing, education, social supports, transportation, and employment as appropriate for the level of care.

Evidence-Based Practices: Interventions that are guided by the best research evidence with practice-based expertise, cultural humility, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.[48]

Evidence-Informed Practices: Behavioral health interventions and services supported by some data for their effectiveness but may not yet 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.[49]

Family: A group of individuals united by biology or marital, adoptive, foster, kinship, or other intimate ties.[50]

Family/Caregiver Engagement: The process of identifying and incorporating families and unpaid caregivers in 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 the care.[51]

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.[52] Caregivers are broadly defined as family members, friends, or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.[53]

Follow-Up: The timely act of establishing contact with an individual previously served to identify if the state of engagement with services and supports that were a part of the previously developed crisis plan is proximate to the time of the initial service and re-evaluate the crisis plan as necessary.[54] Follow-up also includes reassessment of well-being and risk.

High-Intensity Behavioral Health Emergency Centers: High-Intensity Centers offer stabilization services, providing immediate access for all individuals in emergency crisis and emergency care for those experiencing a behavioral health emergency and/or crisis.

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/Risk: 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.[55]

Imminent Risk Assessment: An assessment which involves identifying risk and protective factors, conducting an inquiry about potentially dangerous thoughts and/or behaviors (including a suicide assessment, assessment of overdose risk, assessment of risk of dangerousness to others, and/or an assessment for other risks to life health, and/or safety). This is followed by an analysis of that information to determine the current risk level and interventions to mitigate that risk, as well as documenting a safety plan.[56]

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 and/or are at risk of medical complications due to their intoxication should be admitted to a medical setting commensurate with the degree of medical need.[57]

Involuntary Legal Status: Emergency evaluation and/or 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 an assessment and/or treatment without their informed consent, where permissible by law. This includes care for individuals whom treatment cannot be safely and effectively delivered with their informed consent in a lesser restrictive environment by less intrusive means. Involuntary care must still preserve the dignity of an individual and promote autonomy to the greatest extent possible.[58]

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 or through a close relationship such as a family member.[59]

Low Barrier: Removing as many preconditions to entry as is possible, safe, and appropriate and responding to the needs and concerns of people seeking services. Expectations placed on incoming clients should be minimal, transparent, and reasonable.[60]

Low-Intensity Crisis Residential Programs: These facilities provide the same types of services as Moderate-Intensity Crisis Residential Facilities but have lower levels of medical/nursing monitoring and lower staffing ratios per patient, generally limiting their ability to accept some individuals presenting with a higher acuity. The primary focus is on providing stabilizing treatment and supports, connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis. Low-Intensity Crisis Residential Programs only accept individuals on a voluntary basis.

Meal Service: The provision of a nutritionally balanced, culturally appropriate, and dietary-specific meal. The service aims to meet the immediate nutritional needs of individuals while supporting their overall well-being and recovery process.[61]

Medical Clearance: A comprehensive assessment process to determine if an individual experiencing a behavioral health crisis is medically stable and appropriate for evaluation or treatment in a mental health treatment facility that has limited medical resources.[62]

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

MOUD refers to treatment with 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.[63]

MAUD refers to treatment with the medications that are 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. These medications include acamprosate, disulfiram, and naltrexone.[64]

Mobile Crisis Team (MCT) Services: An on-demand, rapid, mobile, in-person response that includes a licensed or credentialed clinician participating in a clinical assessment of an individual experiencing a behavioral health crisis.

Mobile Crisis Team (MCT) Services Model – Behavioral Health Practitioner-Only (BHP-Only): a rapid, on-demand community-based response provided by a team comprised exclusively of behavioral health practitioners. In addition to at least one licensed or credentialed behavioral health practitioner, the team may include unlicensed or uncredentialed behavioral health practitioners and/or peer support providers.

Mobile Crisis Team (MCT) Services Model – 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/contacts 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 department utilization and increase the diversion of people with behavioral health concerns from the criminal justice system.

Mobile Crisis Team (MCT) Services Model – 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 that includes two phases of care. The first phase is focused on acute crisis stabilization through BHP-only MCT services and the second is community-based (often in-home) stabilization services that typically last up to 8 weeks.

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

Moderate-Intensity Community Based Services: Services that are more intense than traditional ambulatory care that occur in the home setting involving frequent contact with the individual being served while consistently evaluating and re-evaluating their needs and providing services and supports from a variety of domains that can support wholistic wellness, including, but not limited to a reduction in behavioral health symptoms, and addressing their physical health needs as well as social drivers of health while promoting resilience and recovery.

Moderate-Intensity Crisis Residential Facilities: Residential crisis 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.

Moderate-Intensity Behavioral Health Crisis Centers: These centers provide similar types of services as High-Intensity Behavioral Health Emergency Centers; however, they only accept voluntary individuals and may have less immediate access to medical staffing support and medications, generally limiting their ability to accept some individuals presenting with a higher acuity. They may accept law enforcement and/or emergency medical services drop-offs but are not required to and are unable to provide services for individuals on involuntary holds.

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.

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, neighborhoods, and/or schools, and associations developed through participation in clubs or community organizations.[65,66]

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.[67,68]

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

Peer-Operated 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 Recovery Support Services: Services provided by peer support providers may include emotional (e.g., validation and mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliational (e.g., social events) support.[69]

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

Peer Support Providers (Peer Specialists, Peer Workers): People with lived experience of mental health and/or substance use disorder conditions and/or family members who have been successful in the recovery process who are trained (and often certified) to help others experiencing similar situations navigate their recovery process.

Person-Centered Planning:[70] 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.

Pharmacotherapy: The treatment of mental health, substance use, or other behavioral health condition by the prescribing of medications.[71,72,73]

Point of Care Testing: Clinical laboratory testing conducted at or close to the site where patient care or treatment is provided, enabling rapid turnaround of test results to inform treatment planning and implementation in accordance with any and all applicable laws.[74]

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.[75]

Psychosocial Stressors: A life situation that results in an intense level of stress that may contribute to an individual being at risk for, developing, or exacerbating a behavioral health condition.[76]

Recovery: A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[77]

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.[78,79]

Restraint: Any method that limits a person's ability to move their body, including physical, mechanical, and chemical interventions.

Risk Assessment: A systematic process of identifying, analyzing, and evaluating potential hazards and risks that could negatively impact an individual's safety, well-being, or recovery during a crisis situation. It should understand the individual's unique circumstances and context, identify specific risks and protective factors relevant to the individual, assess likelihood and potential impact of identified risks, and determine appropriate interventions and develop a personalized risk management plan.[80,81,82]

Safety: A state of low risk to the life, well-being, and physical integrity of individuals.

Safety Planning: A brief, collaborative intervention between a worker and person who is at risk of harm that aims to mitigate acute risk through the identification of ways to mitigate that risk such as coping strategies and engagement with other resources such as treatment, and/or engagement with harm reduction services. The basic components of a suicide-specific safety plan include the following: (1) recognizing warning signs of an impending suicidal crisis or actions that increase the risk of suicide; (2) identifying and employing internal coping strategies; (3) utilizing social supports and social settings as a means of improve social connection and provide distraction

from suicidal thoughts; (4) utilizing family members, significant others, caregivers, and/or friends to help mitigate the crisis; (5) contacting mental health professionals, crisis lines or services, or other agencies that can support the individual and mitigate the risk; and (6) making the environment safe, including reducing access to lethal means, as applicable.

Seclusion: The involuntary confinement of a person in a room or area from which they are physically prevented from leaving.

Secure Setting: Treatment facility intended to serve individuals who are in need of continuous, close supervision and support provided by trained behavioral health staff, where entrances, exits, and windows are controlled and/or monitored and/or with locking mechanisms that are inaccessible to individuals who are receiving the service at this facility to prevent individuals from leaving the premises without the authorized support of staff.[83,84]

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.[85]

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 (SDOH): 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.[86]

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.[87]

Telehealth: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.[88]

Therapeutic Milieu: A therapeutic milieu is defined as a structuring of the environment within a treatment setting to support behavioral health and improve the individual's psychological health and functioning.[89]

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.[90]

Urgent Behavioral Health Issues: Behavioral health concerns that do not present as imminently life threatening, are at risk for significantly and/or quickly worsening, and may be at risk of becoming life-threatening if not promptly addressed.[91,92,93]

Voluntary Status: Volitional admission of an individual who has a mental health, substance use, or co-occurring mental health and substance use disorder to a treatment setting 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 through face-to-face, phone, or video interaction in the presence of the person being helped (and family, if present).[94]

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.[95]

Wholistic: An approach that considers and addresses the entirety and interconnectedness of needs as opposed to considering individual parts in isolation.

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 may include the use of medications to address withdrawal symptoms. Services target the physiological and psychological features of withdrawal in addition to habitual, compulsive use in individuals with substance use disorder.[96]

Youth & Family Crisis Respite Care: 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 Care services are distinct from adult respite and crisis residential facilities and are tailored to prioritize family and natural supports.

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