2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care

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SAMHSA
Substance Abuse and Mental Health Services Administration

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Acknowledgments

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Contents

Foreword

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this publication, the *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* (2025 National Crisis Guidelines).

The transition in July of 2022 from the National Suicide Prevention Lifeline to the 988 Suicide & Crisis Lifeline (988 Lifeline) was a monumental achievement created through bipartisan support of the National Suicide Hotline Designation Act of 2020. The 988 Lifeline provides an easy to remember three-digit number to access trained support for those in mental health, suicidal, or substance use crisis or experiencing any form of emotional distress. Since its launch in July 2022, the 988 Lifeline has received more than 12 million calls, texts, and chats. This large volume of calls, texts, and chats continues to emphasize the need for and support for crisis services.

With rapid expansion of crisis services around the country as catalyzed by the 988 Lifeline, SAMHSA identified the need for ongoing guidance for states, tribes, territories, and other local partners to create and maintain an effective crisis continuum of services, particularly focused on using a systems-based approach that can provide the needed oversight, integration, and sustainability to care for people throughout and after a crisis episode. As a result, SAMHSA pulled together a team of experts to support the revision of and enhancement to the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (PDF)* (2020). The original publication in 2020 has been heavily reviewed and used as guide for the development of crisis care nationwide as the first document of its kind that provided a national vision for crisis services. In 2025, in light of the rapidly expanding field and landscape of crisis care after the launch of 988, SAMHSA with the assistance of a vast array of partners, has produced a new publication to provide revised guidance.

The 2025 National Crisis Guidelines builds from the work of the original guidelines, as well as from research, new and innovative approaches, and emerging best practices. Along with its companion document, the *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services,* these new publications are a result of the dedication, collaboration, and work that this team has done to provide guidance and highlight effective practices for crisis care services across the country. SAMHSA has identified the essential elements for an effective crisis continuum such that everyone in the nation has a robust system that meets their needs, one that includes “someone to contact, someone to respond, and a safe place for help.” This evolution highlights the various models and strategies that communities have been using to effectively implement services and programs to support the specific needs of their populations.

The 2025 National Crisis Guidelines exemplifies 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.* We hope that this guidance will aid communities in their development and enhancement of the crisis services continuum for their citizens to ensure everyone has access to care that meets their needs.

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Executive Summary

The *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care (2025 National Crisis Guidelines)* establishes a framework to transform behavioral health crisis care systems and reduce the impact of substance use and mental illness on communities throughout the United States. Spearheaded by the Substance Abuse and Mental Health Services Administration (SAMHSA), these guidelines aim to provide equitable, accessible, and effective responses to behavioral health crises, and support program design, development, implementation, and continuous quality improvement for behavioral health crisis care throughout the nation.

This update is spurred by the country's transition to the 988 Suicide & Crisis Lifeline (988 Lifeline), as well as recent progress and emerging needs in the field related to behavioral health crisis system transformation. The 2025 National Crisis Guidelines will accomplish three goals:

1. Establish overarching principles for behavioral health crisis system transformation;
2. Clarify the various elements that comprise the continuum; and
3. Offer guidance to support the systematic coordination of these elements to create and sustain behavioral health crisis systems.

Overarching Principles

The 2025 National Crisis Guidelines emphasize the following principles:

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. Crisis Services Should Be Responsive to Individuals' Wholistic Needs

Essential Elements

The 2025 National Crisis Guidelines are built upon three foundational elements that are essential within an integrated crisis care system:

1. Someone to Contact: Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support.
2. Someone to Respond: Services like mobile crisis teams deliver rapid, on-site interventions to de-escalate crises and connect individuals to

care and other community-based supports that provide crisis prevention and postvention care.

3. A Safe Place for Help: Emergency and crisis stabilization services that support on-demand crisis care and crisis-related supports in a variety of community settings.

SAMHSA envisions that these collective elements integrate to establish a seamless *system of systems* that can serve "anyone, anywhere, at anytime"[1] in order to provide a local Behavioral Health Coordinated System of Crisis Care (BHCSCC) that offers high quality behavioral health care for individuals at all levels of acuity that can support wellness, promote safety, and avoid unnecessary care in both healthcare and law-enforcement institutional settings.

Strategic Impact and Future Directions

A BHCSCC strives to improve outcomes for individuals and families while reducing reliance on emergency departments and law enforcement for the care of those with urgent or emergent behavioral health needs. By providing person-centered care that emphasizes not only treating the crisis, the goal of the BHCSCC is to foster resilience and long-term recovery, reduce suicide and overdose rates, and strengthen communities.

This 2025 update reflects the landscape in the context of the transition to the 988 Lifeline and introduces expanded recommendations for service delivery, system equity, and technological integration. These guidelines lay the foundation for a system that ensures no individual faces a behavioral health crisis without access to appropriate support and resources. It is a call to action for federal, state, tribal, and local partners to collaborate in building sustainable crisis care systems.

Introduction

The Consolidated Appropriations Act of 2022 (P.L. 117-103) provided $5 million to establish a 988 Suicide & Crisis Lifeline (988 Lifeline) and Behavioral Health Crisis Coordinating Office (BHCCO) within the Substance Abuse and Mental Health Services Administration's (SAMHSA) 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.

The establishment of 988 represents a once-in-a-lifetime opportunity to strengthen the 988 Lifeline and transform the behavioral health crisis care system in the United States. The overarching goal of the transformation is to save lives by serving "anyone, anywhere, at any time"[2] and in a manner that minimizes law enforcement involvement and promotes linkages to ongoing local supports. This goal is aligned with a comprehensive national strategy and related investments to address the country's mental health crisis, as well as SAMHSA's *Strategic Plan: 2023–2026 (PDF),* the *Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities (2023) (PDF)* issued by the U.S. Departments of Justice (DOJ) and Health and Human Services (HHS),[3] as well as the Centers for Medicare & Medicaid Services' (CMS) work on expanding coverage for crisis care such as through their specific work on mobile crisis services.

These initiatives are focused on protecting and strengthening equitable access to high-quality and affordable care, as well as improving social well-being, equity, and economic resilience. SAMHSA actively continues its work to advance this agenda by strengthening system capacity, connecting more people to care, and creating a continuum of wholistic and equitable behavioral health supports designed to transform our health and social services infrastructure. Similarly, states, local governments, tribes and tribal organizations, jurisdictions, and territories also have done a significant degree of work to develop their crisis systems over the past several decades. The transition of the National Suicide Prevention Lifeline to the 988 Lifeline has accelerated further advancement to these efforts.

Recent data regarding suicide and drug overdose deaths, and gaps in receiving behavioral health services[4] underscore the need for a coordinated system of crisis care that is integrated within the larger behavioral health system of care.[5] Children and adults who do not receive needed behavioral health crisis services are at risk for experiencing unnecessary and/or multiple hospital readmissions, incarceration, homelessness, overdose, early death, and suicide.[6] Families and youth may become unnecessarily involved in the child welfare system and/or juvenile justice system, which separates youth from their family and caregiver supports.

Communities that already face disparities in access to services and resources may be further marginalized through primary law enforcement response to behavioral health crisis and extended stays in emergency departments (EDs). Crisis responders may refer individuals in crisis to psychiatric inpatient services when they may have better outcomes in less restrictive and more inclusive community-based services. Finally, the current approach to crisis care in many communities involves delivering a range of disparate services that are not coordinated within a larger system of care. This results in fragmented

services that are not matched to individual needs, long wait times for high-demand services, and minimal or no follow-up provided to individuals after their initial treatment.

Fortunately, there are significant ongoing efforts to mitigate these concerns. A Behavioral Health Coordinated System of Crisis Care (BHCSCC) helps prevent and address mental health and substance use-related crises, saves lives, enables families to remain together, provides person-centered and recovery-oriented care at the optimal level for the individual, addresses structural inequities, and uses high-intensity, expensive resources only when necessary. A BHCSCC is aligned with the compass of the quintuple aim to optimize health systems, including enhancing the experience of the help seeker and family, using resources effectively and efficiently, improving overall community and population health, advancing health equity, and improving the well-being, morale, and job satisfaction of behavioral health crisis workers.[7]

In its pursuit of an effective, coordinated, and integrated behavioral health crisis system, SAMHSA is dedicated to two key goals:

1. Strengthen and expand the 988 Lifeline and
2. Transform the behavioral health crisis response system in the United States.

SAMHSA is actively working to achieve these goals and is guided by a vision of a comprehensive, integrated, equitable, and trauma-informed BHCSCC that includes "someone to contact, someone to respond, and a safe place for help" for "anyone, anywhere, at anytime."[8] This vision of coordinated crisis services, a system of systems, is inclusive and longitudinal—it meets the needs of all and recognizes that people need support over time, not only in discrete crisis events.

Movement toward the vision of a comprehensive, integrated, equitable, and trauma-informed system should start with the experience of the person seeking care. It must also address the capabilities of the system in responding to individual needs as defined by the help seeker. The establishment of an emergency-capable system for public safety and acute medical concerns is an important reference point. When people need assistance for a public safety or emergency physical health condition, the triad of 911 Public Safety Answering Points (PSAPs), emergency service dispatches, and ED transfers to a location that is equipped to care for the condition is widely available regardless of the ability to pay, admissions criteria, or clearance protocols. As with public safety and emergency physical health situations, behavioral health emergency response capability should be present to help ensure access to services for all and parity within the BHCSCC.

In 2020 and 2022, SAMHSA published the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (PDF)* (2020) and the *National Guidelines for Child and Youth Behavioral Health Crisis Care (PDF)* (2022), respectively, to articulate the need for more comprehensive and integrated crisis system design practices. In these documents, SAMHSA identified three essential elements of a behavioral health crisis system: crisis call lines, mobile crisis response, and emergency and crisis stabilization services.

This 2025 update, the *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* (2025 National Crisis Guidelines), is spurred by the country's transition to the 988 Lifeline, as well as recent progress and emerging needs in the field related to behavioral health crisis system transformation. The 2025 National Crisis Guidelines will accomplish three goals:

1. Establish overarching principles for behavioral health crisis system transformation;
2. Clarify the various elements that comprise the continuum; and
3. Offer guidance for communities so they can better understand the resources needed to implement and sustain behavioral health crisis systems and services.

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, seven 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.

SAMHSA conducted a multi-pronged process to develop the 2025 National Crisis Guidelines based upon input from behavioral health crisis care experts, updated evidence and practices, and public comments. SAMHA completed research and engaged partners to understand the state of and needs for the field of crisis care and developed a draft document based on that information.

SAMHSA convened a work group in August 2024 to review an early draft of the updated 2025 National Crisis Guidelines and provide feedback at a hybrid in-person and virtual convening of 50 behavioral health experts on August 20–22, 2024 in Washington, D.C. Additional revisions and feedback were also provided by specific child and youth services experts, crisis contact center experts, mobile crisis experts, crisis residential services experts, and crisis stabilization services experts. Upon completion of revisions and edits, SAMHSA made the draft 2025 National Crisis Guidelines available for public comment and review from December 5 through December 15, 2024. This was broadcast across multiple channels in coordination with the SAMHSA Office of Communication. Following the period of public comment, over 145 comments were received. These comments were reviewed and final revisions were made based on feedback.

Within this document, SAMHSA has spotlighted organizations, programs, and services that highlight and model a particular service or initiative that supports the guidance indicated throughout this document. These spotlights were selected based on a number of characteristics, including how well they exemplified a particular crisis service or system concept, as well as evidence or expert opinion regarding the featured practice. These spotlights are not inclusive of all the organizations, programs, and services that exemplify the vision and goals of the BHCSCC and do not provide a formal endorsement by SAMHSA regarding any specific program.

SAMHSA supports crisis system development by asserting a national vision for crisis services, refining crisis services definitions, linking available federal resources to address upstream and downstream intersections with crisis situations, and developing structures and processes to continue to

learn from and support knowledge dissemination across non-federal partners. Similarly, states, local governments, tribes and tribal organizations, jurisdictions, and territories play a key role in system development, including:

- Assessing, designing, implementing, and evaluating local service development and impact, with a particular emphasis on cultural responsiveness;
- Supporting local capacity to ensure availability of crisis services and access to care;
- Securing funding, legislation, or appropriations for crisis services continuum development and sustainability;
- Leading coordination efforts between crisis contact centers, the provider network, local partners, advocacy, and federal government;
- Leading innovation efforts to advance equitable access to crisis services; and
- Providing oversight and accountability of funding, services, outcomes, performance, and health of the crisis network.

SAMHSA acknowledges that states, local governments, tribes and tribal organizations, jurisdictions, and territories are in different phases of BHCSCC development. Some are currently focusing on the creation and sustainability of services, others on the accountability structure and intersections that piece the services together, still others on coordinating and integrating services and partners, and many on multiple aspects. These guidelines are designed to support those building a BHCSCC at every stage of development. This includes opportunities for phased approaches as partners scale up to the desired crisis care vision. As partners consider themselves and their BHCSCC while reviewing this document, they are encouraged to reflect upon the following:

- At what stage is my system towards achieving the vision of a fully capable, equitable, resilience and recovery-oriented, and trauma-informed behavioral health crisis response for help seekers?
- What resources are missing?
- Where are the assets and strengths in my community that could be better leveraged to achieve this vision?
- What are the barriers to developing a comprehensive BHCSCC and how can we develop solutions for them?
- Where are the learning opportunities and examples in the field that could inform local success?

2025 National Crisis Guidelines Update: Key Differences

The *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (PDF)* (2020) has guided partners around the country in building out systems of care. Partners continue to use and reference those guidelines to identify the key components of crisis care systems design and to learn from practice spotlights around the country. The 2025 National Crisis Guidelines builds upon the strong foundation that was created with the original document; readers will note that many concepts and components have been preserved or updated to reflect the dynamic field as of the present day. These updated guidelines also slightly update the three essential elements of a comprehensive behavioral health crisis system that are necessary to support those in need:

1. 988 and Other Behavioral Health Lines;
2. Mobile Crisis and Outreach Services; and
3. Emergency and Crisis Stabilization Services.

SAMHSA has leveraged the 2020 document to expand upon or clarify specific areas; companion documents intended to provide greater implementation support are forthcoming. The following summarizes key ways in which the 2025 National Crisis Guidelines differ from the 2020 guidelines. The 2025 National Crisis Guidelines does the following:

- Focuses on the dissemination of general guidelines and is no longer labelled a “toolkit”. Separate companion documents that offer more detailed implementation support (e.g., toolkits) will be published at future dates to complement the guidelines.
- Reflects the national crisis landscape post transition to the 988 Lifeline.
- Incorporates more recent research related to evidence-based and promising practices and reflects the input of a broad array of partners and field experts.
- Incorporates guidance related to the nuanced distinctions in services and behavioral health crisis services definitions, particularly for the third element, “A Safe Place for Help.”
- Expands on the importance of supporting the whole person and family system, incorporating youth and developmental considerations that were separately described in the *National Guidelines for Child and Youth Behavioral Health Crisis Care (PDF)* (2022).
- Places emphasis on follow-up services, care coordination, critical service intersections, and crisis systems development. Provides proposed sample metrics to support data-driven, effective, efficient, and equitable services.

The Role of Crisis Services within the Broader Behavioral Health Ecosystem

As a crucial component of the broader behavioral health ecosystem, a comprehensive behavioral health crisis system is responsive at any time and any place for anyone. A crisis response system should have the capacity to prevent, recognize, respond to, de-escalate, and follow up on crises across a continuum, from crisis planning to early stages of support and from crisis stabilization and intervention to post-crisis follow-up and support for the individual and their family and other supporters. Given the multi-system involvement of many individuals with behavioral health issues, the crisis care system approach provides the infrastructure to improve care coordination and outcomes and better invest resources across the systems that serve individuals experiencing behavioral health crisis.

A behavioral health crisis system represents a key set of services that includes "someone to contact, someone to respond, and a safe place for help." This includes crisis contact centers, mobile crisis teams (MCTs) and outreach services, and crisis stabilization services that work together to coordinate care. These services address the acute behavioral health needs of people in crisis; are consistent with goals to improve well-being; decrease psychological distress/substance use and prevent suicide and overdose; and are linked to sub-acute and outpatient services that support ongoing engagement harm reduction, treatment, and supports that foster recovery and resilience.

Individuals with lived experience with mental health and/or substance use crisis have reported difficulty accessing responsive and timely care. People can become lost in a system that is not coordinated and does not follow up consistently with help seekers. Under-resourced and marginalized populations, such as those from racial, ethnic, sexual orientation, and other minority groups, as well as individuals with co-occurring intellectual and developmental disabilities and/or from rural communities, often face additional burdens with respect to access and outcomes.

Required services cut across these care elements. It is essential to ensure that systems are coordinated and integrated to meet the needs of people with mental health and substance use concerns. Services should be trauma-informed, culturally and linguistically relevant across the developmental lifespan, and include linkages to services that address social drivers of health (SDOH) and health-related social needs. SDOH refer to conditions in the environments 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.[9] It also is important to remember that many people continue to receive behavioral health services and supports outside of the behavioral health system as strictly defined—this includes primary care providers, faith-based supports, and traditional healers, among others. Such partners should be engaged in coordination efforts to ensure that they are informed, and trusting, of available crisis services.

The continuum of care encompasses a full range of services. It can support the needs of an individual with a mental health and/or substance use disorder (SUD) with preventive and early intervention care, recovery and resilience support services, crisis care, and more intensive outpatient or inpatient treatment, recovery, and resilience, if needed.

Overarching Principles for a BHCSCC

In pursuit of the strategic goals to strengthen and expand the 988 Lifeline and transform the nation's behavioral health crisis care system, SAMHSA has identified the following overarching principles that should guide the long-term development of a BHCSCC. Use of the term crisis services in these principles is intended to apply broadly to all categories of services articulated in the subsequent sections. This foundation ensures that individuals and communities have appropriate access and support to engage in the behavioral health crisis services. The principles of the BHCSCC have been developed using important concepts from two existing frameworks, Recovery-Oriented Systems of Care[10] and Children's Systems of Care,[11] which are individual- and family-centered and focus on community coordination to improve outcomes for individuals, families, and communities. These principles are also found in the *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.* These principles here focus not only on how the services should be implemented, but on how they should be integrated into a systems-based approach to develop a BHCSCC.

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 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 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 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. Individuals, families, and caregivers and other supporters can define what is a crisis. 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 American Society of Addiction Medicine (ASAM) Patient Placement Criteria that consider multiple dimensions of need[12] and the Level of Care Utilization System (LOCUS) and

Child and Adolescent Level of Care Utilization System (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 nor 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. CMS in its Calendar Year (CY) 2025 Medicare Physician Fee Schedule final rule describes the basic components of safety planning interventions.[13] Safety planning interventions involve the development of a personalized list of coping and response strategies and sources of support that the person can use in the event of experiencing thoughts of harm to themselves or others.

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).[14] 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.[15]

The elements of Zero Suicide closely mirror the standards and guidelines of the 988 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

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."[16] 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, 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). HHS recently published an Agency Equity Action Plan to address the behavioral health issues that disproportionately impact underserved populations.[17]

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, or other factors. Behavioral health crisis services and system performance data should be disaggregated to identify and address impact disparities.

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

DOJ has issued *guidance* on the importance or robust crisis services to help achieve compliance with the Americans with Disabilities Act.[18]

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*[19] 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*.[20] 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)[21] 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.[22] 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, 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, historical, and sexual 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.[23] 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. Crisis 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.[24] 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 SOCIAL DRIVERS OF HEALTH (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.

Behavioral Health Crisis Services: *Three Essential Elements*

The following represent the 2025 National Crisis Guidelines essential elements within an integrated crisis care system as described in the companion document *Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services:*

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

There are a range of service types within these three essential elements that together make up a robust BHCSCC. These services, while complementary, are not interchangeable, as they have different staffing models, and address varying levels of complexity. SAMHSA is highlighting the distinction between emergency-capable services, crisis services, and crisis-related services. Each of these is important and, when working together effectively, they can address both the immediate and long-term needs of individuals in crisis. Emergency capable services are on par with the existing medical emergency system—that is, 24/7 services which are not referral-based, where the person, family, or partner seeking care can request the service, where there is no pre-approval requirement for receiving the service, and where the service will not screen a person out but will connect someone to a different service (including more restrictive care) if they are unable to safely care for the help seeker. Among the services described in this section, the following are designated as emergency capable:

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

SAMHSA envisions that all community members have access to the full array of services noted in the following, many of which can be less intensive and more inclusive alternatives to emergency care, provide stepdown linkages from emergency care, and/or prevent the need for more intensive emergency care.

For each service across the three crisis system elements, this document provides a brief description and summary of literature supporting its role in the crisis continuum. For more specific details on the service definitions and staffing, please refer to the model crisis service definitions document, which serves as a companion to these updated guidelines. Finally, though this section discusses specific types of services and settings, a BHCSCC should not operate in isolation and

should strive to coordinate fully within broader systems to ensure seamless service delivery and transitions of care for adults and youth in crisis.[25] This means processes to ensure continuity of service care as people move across different levels, care coordination at a higher level to make sure that individuals and populations truly engage with the care that supports their needs, and transportation from one place to another, both to higher levels and lower levels.

1. Someone to Contact: 988 Lifeline and Other Behavioral Health Lines

Crisis and other behavioral health lines are the first of three foundational programmatic elements essential to a BHCSCC. They fulfill a crucial role by offering free and easily accessible support to individuals experiencing an acute crisis, those facing barriers to accessing behavioral health care, and/or people who support help seekers. In addition, these lines are a critical component of an evidence-based, public health approach to suicide prevention.[26]

This section details the following 988 and other behavioral health line categories:

- **988 Suicide & Crisis Lifeline:** previously known as the National Suicide Prevention Lifeline, the 988 Lifeline offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing suicidal ideation, substance use, and/or mental health crisis, or any other kind of emotional distress.
- **Other Behavioral Health Crisis Hotlines:** includes hotlines that are not part of the 988 Lifeline network that provide crisis counseling to people experiencing emotional distress and/or third-party callers who are concerned about another person in distress.
- **Peer-Operated Warmlines:** a phone and/or text service run by peers (individuals with behavioral health lived experience) that provides connection focused on support and wellness. These lines share hope, provide coaching, and help people navigate the recovery process.
- **Other Behavioral Health Emotional Support Lines:** a phone and/or text service operated by individuals who are not peers that provides connection focused on support and wellness.

Across all contact lines, workers should receive training on supporting people with a range of behavioral health issues. It is essential to consider the specific needs and preferences of children, youth, and families to establish effective points of contact within the crisis care continuum, including services detailed in this section. Crisis contact centers can be responsive to the needs of young people in several ways. First, they should be staffed with an interdisciplinary team, including those trained to address child and adolescent-specific behavioral health needs. Crisis contact centers should ensure that responders receive crisis training such as de-escalation strategies that are specific to young people and any family members who may be present, an understanding of mandatory reporting requirements in cases of adult and child abuse and neglect, typical developmental milestones and how they may present during a crisis, assessment of family system strengths and challenges, and specific stressors and concerns that are important for children and adolescents. They should also be familiar with related services available in their communities. Crisis line responders also should

be trained in how to provide support to third-party youth callers who may seek help on behalf of a family member or peer.[27] Lastly, for services such peer-operated warmlines, it is essential to include youth and young adults in the staffing (with the appropriate supervision), as they play an instrumental role in providing age-appropriate and relatable support and resources.

988 Suicide & Crisis Lifeline

Overview

"988" is the three-digit, nationwide phone number to connect directly to a live person at any time via the following four options:

1. Connection to the Veterans Crisis Line;
2. Connection to the national Spanish language subnetwork;
3. Connection to the national LGB subnetwork for youth and young adults; or
4. Option to remain on the line or press 0 to be connected to a local trained counselor who can listen and provide local support resources.

Individuals seeking to access 988 can make contact by call, chat, text, or videophone. If an individual requests access to one of the national subnetworks, they are connected to that service. Local routing is available for individual contacts that do not request connection to a national subnetwork.

Lifeline operators engage with callers to promote collaboration and explore care options and safety plans together.

In September of 2024, SAMHSA led collaboration with the Lifeline Administrator, federal partners, and telecommunications providers to begin activation of geo-routing for calls. The geo-routing process directs individuals to the nearest crisis contact center without providing precise location information. For carriers which have not yet activated geo-routing and for all text communications, contacts are currently routed based upon the individual's area code. With the recent Federal Communications Commission (FCC) rule, it is expected that all carriers will activate geo-routing for both calls and texts in the coming months and years.[28]

Native and Strong Lifeline: The Nation's First 988 Crisis Line for Indigenous People

Developed in Washington State, the Native and Strong Lifeline (NSLL) is the first state-wide 988 subnetwork that is designed by and for Indigenous people. A pilot for the NSLL was launched in November 2022 and is operated by the Volunteers of America Western Washington (VOAWW). According to former VOAWW Director of Tribal Services Rochelle Hamilton, it was developed to "break down barriers to really get to the heart of trauma-informed care." The NSLL is available 24/7/365 and offers support for any Indigenous individual in crisis. In its first year, NSLL received over 4,150 calls, with 90.25 percent of calls answered in under 30 seconds.

More Information

- Suicide Prevention Resource Center, Native and Strong Lifeline

Background

Congress first appropriated funding for a suicide prevention hotline in 2001. After SAMHSA awarded a competitive grant to a single grantee to establish a network of crisis contact centers, the National Suicide Prevention Lifeline launched in 2005 with the number 1-800-273-8255 (TALK).[29]

The National Suicide Hotline Designation Act of 2020 required the FCC to designate 988 as the universal number for a national suicide prevention and mental health crisis hotline. After several

subsequent policy initiatives, the country transitioned to the 988 Lifeline in July 2022.

Staffing, Structure, and Oversight

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 Lifeline and BHCCO 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. In conjunction with a 988 Lifeline Administrator (funded via a cooperative agreement with SAMHSA), they oversee administration of the 988 Lifeline system with formal expectations of clinical, technical, and operational network performance.

The Lifeline Administrator is responsible for leadership and coordination of 200+ individual state and locally funded crisis contact centers across the country. Each individual center is responsible for abiding by a series of requirements that include, but are not limited to, an accreditation process, practice insurance, a formal agreement with the Lifeline Administrator, and a center liaison.

Centers should provide training for all crisis contact center staff consistent with the 988 Lifeline Suicide Safety Policy and the 988 Lifeline Safety Assessment Model. The minimum training includes completion of all 988 Lifeline Core Clinical Training Courses and the completion of a designated number and type of live role plays reflecting the type of information and care that staff will be expected to provide. For additional information about the 988 Lifeline, please see SAMHSA's *Saving Lives in America: 988 Quality and Services Plan (PDF)*.

Service Description

The 988 Lifeline is a behavioral health network of crisis contact centers that provides crisis and emergency mental health and substance use services 24 hours a day, seven 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.

State of Service-Related Evidence

Existing evidence for the effectiveness of crisis lines has primarily focused on short-term improvements in user distress and on user satisfaction. A study conducted from October 2017 to June 2018 using data from 39,911 pre-chat surveys and 13,130 pre- and post-chats found that those who chatted with the 988 Lifeline were significantly less distressed at the end of the chat intervention than at the beginning of the chat.[30,31] A follow-up study found that two-thirds of suicidal callers reported thatf the conversation had been helpful and nearly half of suicidal callers reported they were feeling less suicidal after the chat intervention.

A study that analyzed third-party calls to the Lifeline regarding individuals at imminent risk found that crisis counselors were able to successfully assess risk and implement interventions, applying non-emergency interventions in 68.6 percent of calls. These findings emphasize the importance of third-party calls, which represent about 25 percent of all Lifeline calls, in reaching individuals who may not seek help on their own.[32]

A recently completed evaluation of 988 Lifeline effectiveness from 2019 to 2023 similarly showed that a high percentage of callers interviewed following a Lifeline interaction or participating in a post-call survey reported that the call stopped them from attempting suicide. Interviewed callers reported that their counselors engaged to a high degree in behaviors fostering connection and

engagement, in collaborative problem-solving behaviors, and in safety assessment and management behaviors during their crisis calls.[33]

Research findings also show that individuals remain at elevated risk of suicide in the period following crisis encounters.[34] This includes time after crisis calls, ED discharges, and inpatient psychiatric hospitalizations. One SAMHSA-funded study found that 43 percent of suicidal Lifeline callers who completed evaluation follow-up assessments experienced some recurrence of suicidality (ideation, plan, or attempt) in the weeks after their crisis call, and only 22.5 percent of suicidal callers had been seen by the mental healthcare system to which they had been referred.[35]

Based in part on the SAMHSA-funded studies noted previously, SAMHSA funded an initiative in 2008 to offer and provide follow-up to all 988 Lifeline callers who reported suicidal desire during or within 48 hours before making a call to the Lifeline. An evaluation of this initiative, which included interviews with 550 callers followed by 41 crisis counselors from six crisis contact centers, revealed that 79.6 percent of callers interviewed 6–12 weeks after their crisis call reported that the follow-up calls stopped them from attempting suicide.[36] Callers said the follow-up call gave them hope, made them feel cared about, and helped them connect to further mental health resources.

A number of additional studies have documented the benefit of follow-up care. Outcomes from an approach that included initial safety planning interventions (in various settings) and a follow-up phone contact included improved treatment engagement, decreased risk of hospitalization, and reduced suicidal behaviors.[37,38,39,40] Given the potentially life-saving impact of follow-up interventions, along with explicit requirements for follow-up care in the National Suicide Hotline Designation Act of 2020, 988 Lifeline and all hotlines and warmlines should be sufficiently staffed by trained responders to provide follow-up services.

Other Behavioral Health Crisis Hotlines

Overview

Other behavioral health crisis hotlines include phone, text, and chat services that are not part of the 988 Lifeline network but that also provide support to people experiencing emotional distress and/or to third-party callers who are concerned about another person. These hotlines typically fall into one or more of the following categories:

1. Topically focused to a specific type of need or stressor;
2. Focused on providing services to a specific population (e.g., a county or other geographic catchment area); and
3. Targets 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.

Other behavioral health crisis hotlines play an important part in the crisis response system, as some individuals prefer hotlines that are local or specifically tailored to their demographic background or type of distress.

Background

Crisis hotlines first appeared in the mid-twentieth century, starting in 1958 with the Los Angeles Suicide Prevention Center hotline (now the Didi Hirsch Suicide Prevention Hotline). The total number of crisis hotlines in the United States is constantly evolving as different jurisdictions, entities, and support groups offer a variety of services to individuals in need. In addition,

some local crisis lines are being phased out as 988 Lifeline centers address more local contacts.

Staffing, Structure, and Oversight

Other than the creation of guidelines, standards, and definitions, SAMHSA does not provide formal oversight to other behavioral health crisis hotlines. Although individual hotline administrators are able to determine their own service provision and staffing details, SAMHSA advises that all hotlines advertised as "crisis" should have the capacity to screen each caller for suicide and have protocols in place for positive suicide screenings as well as offer 24/7/365 availability.

Service Description

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 other 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.

State of Service-Related Evidence

Behavioral health crisis hotline research typically focuses on process measures (e.g., how many calls were placed and the typical demographic of callers), varying hotline modalities, and suicide risk assessment best practices. For example, a meta-analysis of 64 studies found that there was no difference in effectiveness when comparing face-to-face and internet intervention, supporting the development of hotlines with multiple entry points for users.[41]

Structured and consistent suicide risk assessments are noted as a best practice during crisis care calls. Across the collective research, results indicate that other behavioral health crisis hotline counselors are not likely to ask callers about current and past suicide ideations,[42] which, the research suggests, is a missed opportunity to provide critical support. The 988 Lifeline guidelines recommend asking questions such as "are you currently thinking of suicide?" (current ideation), "have you thought about suicide in the last two months?" (recent ideation), and "have you ever attempted to kill yourself?" (attempt).[43] A streamlined risk assessment process may be an effective way to decrease the likelihood of repeat contacts for the same behavioral health crisis episode.

The Applied Suicide Intervention Skills Training (ASIST) is an example of a best practice for crisis hotlines. ASIST can be administered by anyone 16 years of age and over and is suitable for adults and older teens. For younger teens and children, the ASIST approach can be effective if adapted to meet their developmental needs and potentially with parent and/or family engagement.[44] A study that examined the impact of the implementation of ASIST found that this training yielded significantly longer calls and an increased number of "invitations" (i.e., signs of suicide risk) revealed by callers. Counselors that received the training were more likely to try to link the callers' invitations to suicidal thoughts, explore reasons for living and ambivalence about dying, and explore informal support contacts as part of the callers' safety plans compared to those who did not receive the training. For each additional minute spent on the call, there was a decrease in suicidal ideation. When comparing callers who spoke with an ASIST-trained counselor to those who did not, the odds that the caller would be less depressed increased by 31 percent and that they would be less suicidal by 74 percent.[45]

Peer-Operated Warmlines

Overview

Peer-operated warmlines provide ongoing phone, text, or chat support by an individual with lived experience. Calls are answered by trained peers who have lived experience with the type of mental health support the line is intended to provide. Peer-operated warmlines are typically local to the caller's jurisdiction or state, though there also are national peer warmlines geared toward specific groups such as teens, older adults, and LGB individuals. Consumer, youth, and family-run organizations usually offer warmlines as well as support and connection for those in crisis. As of 2023, nearly all states had one or more peer-operated warmlines. The National Alliance on Mental Illness (NAMI) provides a NAMI National Warmline Directory.[46]

Peer-operated warmlines serve a critical role in supporting people experiencing emotional distress. They provide timely and responsive access to support, peer coaching, and support for systems navigation to individuals experiencing behavioral health crisis.[47]

Background

Peer-operated warmlines first emerged in the 1990s when the concept of support provided by peers began gaining traction. Peer warmlines highlight key principles that promote healthy peer relationships such as trauma-informed ways of relating, starting with no assumptions about the experience or problem of the help-seeking individual, and the importance of mutually accountable relationships and communities.[48]

Staffing, Structure, and Oversight

There are multiple expectations for operating and staffing a peer warmline. Support specialists should be certified by the state or jurisdiction and should have access to additional recovery and resilience resources specific to their role. They also should receive peer supervision when they first begin responding to warmline contacts.

Warmline.org

Warmline.org is the largest national directory of warmlines provides information on warmlines for anyone in the U.S. Interested individuals can input their preferred time for a call, their state, and their preferred language and be connected to warmline information catered to their location and preferences. Individuals are provided information about hours of operation, areas of focus (if relevant), and whether they accept out-of-state calls. As of October 2024, the warmline.org site has had over 130,000 visitors.

More Information

- warmline.org

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, loneliness, or who are seeking validation from a peer with lived experience who identifies with their struggles and offers 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.

State of Service-Related Evidence

Research on peer-operated warmlines focuses on their effectiveness in making callers feel heard and supported and the extent to which warmlines successfully link callers to other resources.

Findings from a phone survey completed by 480 warmline callers found that peer-operated warmlines provided an important mechanism of support. These findings were consistent regardless of the time of day the calls were placed. Lines that were open past 5:00 p.m. local time, however, presented an opportunity to provide support not typically available in the evenings or at night, which can be helpful to alleviate feelings of loneliness or isolation. Warmlines are an important resource to supplement other mental health services in both rural and urban areas.[49]

A study on the findings from a Recovery Assessment Scale (a validated tool that asks respondents to provide their level of agreement on statements pertaining to their perception of self and feelings of self-worth), community integration measures, and crisis services usage found that warmlines were linked to increased visits to primary care doctors, increased leisure/recreation activities, and increased socialization with others after warmline interaction.[50,51]

According to the American Psychological Association, young people often feel more comfortable talking to their peers about their problems versus to adults.[52] Hand-offs to peer-operated warmlines, when clinically indicated, are therefore particularly necessary to address the needs of children and youth effectively.

Other Behavioral Health Emotional Support Lines

Overview

Other behavioral health emotional support lines focus on providing connection and wellness promotion. They are not hotlines; however, they are still expected to have the capacity to determine if referral to a crisis hotline or more intensive intervention is warranted. They are sometimes referred to as helplines. Prominent examples include SAMHSA's National Helpline, the Alcohol and Drug Helpline, and the Alzheimer's Association 24/7 Helpline.

Other behavioral health emotional support lines are recognized for providing services such as active, empathetic listening, safety planning, rapport building, and crisis support and prevention planning.

Staffing, Structure, and Oversight

Unlike peer-operated warmlines, other behavioral health emotional support lines may not be staffed by peers. They are often embedded within a multi-service organization.

Service Description

Other behavioral health emotional support lines are 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 alternatives. Support line staff work collaboratively and transparently with individuals to facilitate safety planning, as well as crisis support planning and prevention.

State of Service-Related Evidence

A small qualitative study that explored the experiences of young people using the Kids Help Line online chat function in Australia found that youth were significantly less stressed at the end of their call than they were at the beginning.[53]

A comparative study examining telephone and one-on-one online chat service of a Dutch lifeline geared towards children found that both modalities of services contributed to increased well-being and a decrease in the severity of the problem. Children

using the chat service reported a somewhat more favorable experience.

An overall literature review conducted to understand the effectiveness of helplines for the treatment of alcohol and illicit substance use found that, in aggregate, there is insufficient evidence to determine that the helpline services provided a measurable degree of effectiveness, as the available research used treatment satisfaction and service utilization as the primary outcomes of interest.[54] However, consensus among experts interviewed for the development of the 2025 National Crisis Guidelines indicates that support offered by other behavioral health emotional support lines can effectively address a gap in the crisis care continuum.

Coordination with Other Service Components

Effective coordination with other community resources related to each service component helps to establish a robust continuum of crisis care. An interconnected approach ensures that individuals receive comprehensive support tailored to their needs.

Entities have different considerations for coordination of best practices. This section will identify the need for coordination and provide a high-level overview of approach and specific considerations by service component. It contains the following sections:

- 988-911 Coordination;
- Other Behavioral Health Hotlines, Topic-Specific Hotlines, Emotional Support Lines, and Warmlines and 988 Intersection;
- 988/Other Call Line Coordination with MobileCrisis;
- 988/Other Call Line Coordination with Service Referrals; and
- Integrated Crisis Response for Mental Health and Substance Use.

Louisville Kentucky's Crisis Call Diversion Program

Louisville, KY's Crisis Call Diversion Program (CCDP) facilitates the redirection of specific 911 calls to a trained Crisis Triage Worker (CTW) from Seven Counties Services, Louisville's 988 Crisis and Information Center. The goal of CCDP is to minimize Louisville Metropolitan Police Department (LMPD) intervention in crises related to behavioral health, directing these calls to a more suitable resource equipped to deliver immediate and professional responses to behavioral health crises, including Mobile Crisis Response Teams. This strategic shift enhances the overall efficiency and effectiveness of LMPD resources, and most notably, aims to reduce the detention or hospitalization of individuals grappling with behavioral health problems, promoting a more compassionate and effective approach to crisis response. Launched in 2022, CCDP has grown from serving a single LMPD division to serving all eight LMPD divisions. In 2023 alone, more than 1,800 calls to 911 were diverted to a non-police response. In 2024, service hours expanded, and the program currently operates 24 hours per day, seven days a week.

More Information

- Louisville, Kentucky Crisis Call Diversion Program

988-911 Coordination

911 remains the default option for many individuals experiencing a crisis.[55,56] Unfortunately, 911 call centers do not have a comparable level of access to behavioral health resources as 988 Lifeline crisis contact centers. 988-911 coordination is an

ongoing challenge and opportunity that states, tribes, and territories are tackling in different ways.

First, coordination requires protocols, procedures, and agreements that allow for and dictate the need for transfer of calls between the two entities. In a series of three state case studies conducted by the RAND Corporation, researchers identified several key components common to states navigating interoperability:[57]

1. Clearly articulated decision points regarding the transfer of calls between entities was a key factor in successful coordination.
2. Effective planning and implementation across entities should include a collaborative approach, engaging a variety of partners, and the development of shared language and mutual respect.
3. A local champion for interoperability serves as a critical facilitator for successful planning and implementation.
4. 988-911 interoperability requires more than just protocols for transferring between the two entities; these vary by state and should be decided upon via the partner collaboration process.

Where possible, formal agreements are recommended to strengthen collaboration. An additional critical feature of the collaboration is a structure to regularly review challenging cases and adverse outcomes for system improvement.

Lastly, an important aspect of effective coordination is the role of law enforcement who, with their partners, frequently play a role in crisis response as they are often the first responders in a crisis situation in which the caller accessed 911. For effective 988-911 coordination, it is necessary for law enforcement partners to receive the necessary tools and training to improve practices with an eye toward less restrictive responses.[58] SAMHSA's BHCCO currently is developing a toolkit to help address 911 and other first responder concerns about risk and liability when encountering and providing assistance to individuals experiencing a behavioral health crisis.

Other Behavioral Health Hotlines, Topic-Specific Hotlines, Emotional Support Lines, and Warmlines and 988 Intersection

There are opportunities for hand-offs among the 988 Lifeline, other behavioral health hotlines, topic-specific hotlines, peer-operated warmlines, and emotional support lines. These warm hand-offs where staff from both lines share information will help ensure that individuals and communities can have access to care tailored to their specific needs. The warm hand-off approach may be particularly impactful for children and youth in crisis as they may be more likely to seek support from a peer-operated warmline.

The National Association of State Mental Health Program Directors' (NASMHPD) *988 Convening Playbook: Public Safety Answering Points (PSAPs)* recommends that the process for hand-offs and referrals should be supported by a regularly updated database of available resources.[59] All 988 Lifeline crisis contact centers should maintain a regularly updated database of other behavioral health hotlines and warmlines to which they can provide warm hand-offs to individuals in need of care beyond the scope of the 988 Lifeline capabilities. 988 Lifeline crisis staff also should be trained to facilitate warm hand-offs to minimize caller disengagement.

Similarly, behavioral health hotlines can transfer callers to a 988 Lifeline crisis contact center in cases when they do not have the capacity to respond effectively to the callers' needs. This should be supported by a warm hand-off approach.

988/Other Call Line Coordination with Mobile Crisis

All crisis lines should have established protocols with local MCTs that enable dispatch, referrals, and/or exchange of information between services, while adhering to privacy laws. Where possible, formal agreements are recommended to strengthen collaboration. Crisis Line/MCT collaborations can and will look different in various communities.

The 988 Lifeline has begun activation of geo-routing, which identifies the Lifeline center closest to the help seeker. This facilitates transfer and dispatch to mobile crisis services when necessary.

988/Other Call Line Coordination with Service Referrals

988 Lifeline crisis contact centers should have a regularly updated database from which to provide call service referrals. All crisis contact line operators should be trained in how to make referrals that will best suit the needs of the caller. The quick connection of help seekers to referral services recently has been enhanced by the expansion of same-day and next-day access models that provide prompt walk-in options following a 988 contact.

CCBHCs provide access to coordinated comprehensive behavioral health care.[60] They are required to serve anyone who requests care for mental health or substance use issues regardless of their ability to pay, place of residence, or age. The CCBHC model requires that crisis services are available 24 hours a day, seven days a week, including but not limited to MCTs, and that they offer walk-in crisis support during regular business hours and extended evening hours.[61] The model also requires care coordination partnerships with the 988 Lifeline center serving the area in which the CCBHC is located.

211 Life Line in Finger Lakes, NY

In Finger Lakes, New York, 211 and 988 resources go hand-in-hand. Both callers and 211lifeline.org visitors are directed immediately to 988 when seeking access to behavioral health crisis services. Similarly, 211 at-large services are featured prominently for those seeking 988 services online. This promotes the connection of SDOH needs with those seeking crisis services and ensures immediate access for those in crisis.

More Information

- 211lifeline.org

There are currently more than 500 CCBHCs in 48 states, the District of Columbia, and Puerto Rico. As of January 2021, every CCBHC either operates their own local crisis line or refers individuals to another crisis hotline such as the 988 Lifeline. Crisis lines are an important mechanism to ensure CCBHCs can deliver round-the-clock, continuous care.

The “211” line is a referral service that connects individuals with community resources. It was designed to address SDOH, which are defined by CMS as, “[t]he conditions in the environments 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.”[62] 211 provides access to services that address housing, nutrition, and employment, among other SDOH. The 211 line operates in all 50 states and the District of Columbia.

211 and the 988 Lifeline work in coordination with one another. According to 211.org, approximately one in four 211 lines have reported answering calls for the 988 Lifeline or their state or local suicide prevention hotlines. Similarly, when individuals call the 988 Lifeline and are not in a behavioral health

crisis but need resources other than behavioral health services, 988 may refer callers to 211.

The 211 system has a long-standing history of using the Inform USA (formerly the Alliance of Information & Referral Systems (AIRS)) standards for classification and taxonomy as a framework for organizing referrals databases including standards related to inclusion criteria, data structure and elements, classification and taxonomy, content management, and database data collection analysis and reporting. 988 centers should be familiar with these standards when creating a referral database and consider using them to ensure efficient referral provision and sharing of community referral information.

Integrated Crisis Response for Mental Health and Substance Use

To fully realize the potential of a BHCSCC, interventions should be capable of responding to the needs of individuals with substance use, mental health, and/or both with an integrated approach based upon a help seeker's needs and preferences. This includes having staff trained in conducting targeted screening and assessment, level of care assessment, medical monitoring and triage, brief counseling interventions, as well as ensuring referral services have the capacity to provide withdrawal management, stabilization, and medication initiation. Operators of behavioral health lines should be aware of resources that support the full array of needs of a caller, including SUD needs. This also is a crucial area where coordination and protocol development with 911 is critical, as substance-related situations, including intoxication, withdrawal, and/or overdose, require the 988 Lifeline to collaborate closely with the 911 system.

Data, Evaluation, and Quality Improvement

Regular data collection and well-implemented evaluation plans help ensure the continuing effectiveness of 988 and other behavioral health lines. Measures such as call volume, response times, user demographics, and rates of successful follow-up provide crisis contact centers with important information on the extent to which they are meeting the needs of their community and provide opportunities for continuous quality improvement.

Insights from data also provide centers the opportunity to identify trends and patterns in the types of crises being reported. This information can inform targeted interventions, resource allocation, and other support services to improve the care provided to a community.

Communities currently collect data for several performance and outcome measures related to 988 and other behavioral health crisis lines. A sample list of metrics to help demonstrate outcomes and impact of these services (provided by call, chat, and text) includes but is not limited to:

- Number of unique individuals served;
- Number of contacts;
- Number of inbound call transfers (e.g., 988, 911, other behavioral health hotlines, warmlines, other behavioral health emotional support lines);
- ZIP code (if voluntarily provided) of individual served;
- Number of help seekers with thoughts of suicide, determined to be at imminent risk;
- Number of suicide attempts in progress;
- Referral source;
- Presenting problems;

- Response time;
- Duration of contact;
- Abandonment rate;
- Interventions offered;
- Involuntary interventions;
- Demographic information (when not anonymous);
- Language;
- Event disposition (including but not limited to imminent risk);
- Diversion (e.g., from 911, law enforcement);
- Help seeker experience and satisfaction; and
- Number of unique individuals referred to services by service type (e.g., mobile crisis, residential, peer support).

Embedding Equity

To offer equitable, comprehensive behavioral health care to all communities and better meet the needs of individuals in crisis, SAMHSA, working with the 988 Lifeline Administrator and other key partners, has made the 988 Lifeline more accessible by offering chat and text services in Spanish; launching a new video-phone option for individuals who are deaf or hard of hearing; and introducing specialized access for LGB youth and young adults through call, chat, and text. The 988 Lifeline also provides interpreter services via a language line for 200+ additional languages.

SAMHSA requires that crisis contact centers create a plan of action to engage with emergency response units and other support entities regarding the intersectional needs and barriers for groups who experience disproportionate harm when engaging with law enforcement and other emergency response entities.

SAMHSA also has worked toward better coordination of the 988 Lifeline and 911 services, partnered with federal agencies to elevate its messaging and better reach communities across the nation, and has provided support and education to develop a common understanding of the 988 Lifeline and communicate a shared vision for its execution and practice. SAMHSA remains committed to continuous improvement to build upon these performance gains.

2. Someone to Respond: Mobile Crisis and Outreach Services

Mobile crisis and outreach services are an essential component of the crisis continuum of care, providing community-based support to individuals experiencing a crisis wherever they are. Mobile crisis services were first developed in the United States as part of a de-institutionalization movement in the 1960s, as a response to meet the increased needs of the population living independently with behavioral health needs.[63]

NRI's 2023 state profiles reported that of the 50 states who responded to their survey, 98 percent of states have active MCT services, operating 1,820 MCTs. Mobile crisis services continue to expand their reach in the United States: 40 states saw an increase of 21 percent in the number of individuals served by MCTs in 2023 compared with 2022.[64]

Communities across the country have designed their mobile crisis services to rapidly meet the needs of individuals, provide support, ensure safety, and coordinate follow-up care. This has resulted in variations in service delivery and team composition. SAMHSA recommends

that communities have mobile crisis services available that do not involve law enforcement, recognizing the potential harm and stigma associated with police involvement in behavioral health crises. In 2023, 96 individuals were killed after law enforcement responded to reports of someone behaving erratically or having a mental health crisis.[65] A recent study has shown that individuals with behavioral health diagnosis and a history of utilizing crisis services prefer receiving crisis services from MCTs due to their specialized training and minimization of law enforcement presence.[66]

Peers play a crucial role in outreach services, contributing to enhanced outcomes such as reduced rates of re-hospitalization, lower overall service costs, improved quality of life, fewer overdoses, and diminished behavioral health symptoms. The peer support model fosters a non-hierarchical relationship that is distinct from the dynamic between individuals and clinicians. By integrating into the care team, peers bolster the support system for individuals and their families, aiding them in navigating the recovery process.[67]

The *National Guidelines for Child and Youth Behavioral Health Crisis Care (PDF)* (2022) provides a comprehensive framework for addressing the unique needs of children and youth experiencing a behavioral health crisis. These guidelines emphasize the importance of early intervention, family involvement, and trauma-informed care. They strongly recommend that youth crisis care systems keep youth in their home, provide developmentally appropriate services and supports, integrate family and youth peer support, and meet the needs of all families by providing culturally and linguistically appropriate services. Therefore, the stabilization element of MCTs may occur over a long time period for youth to achieve these goals.

Mobile crisis and outreach services comprise 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).
- **Mobile.** The MCT goes to the individual 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).
- I**nclusive of a licensed or credentialed provider.** An MCT response must include engagement by a licensed or credentialed behavioral health clinician 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.

The three MCT service models include behavioral health practitioner–only (BHP-only) MCTs, co-responder MCTs that involve law enforcement, and the MCT services provided through mobile response and stabilization service programming. These models, as well as the Community Outreach Team approach, are described in more detail.

Behavioral Health Practitioner-Only MCT Services

Service Description

BHP-only MCTs provide a rapid, on-demand, community-based response through 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 workers. Compared with other MCT models, this configuration offers individuals in crisis the greatest degree of behavioral health expertise.

BHP-only MCTs provide behavioral health practitioner-led responses and are considered the best practice for provision of mobile crisis services. BHP-only MCTs provide a response that includes a clinical assessment and community-based stabilization supports to decrease emotional distress and reduce the immediate risk of danger and subsequent harm to individuals experiencing a mental health or substance use crisis. Care is delivered by a multidisciplinary BHP-only MCT at the location where an individual is experiencing a crisis, including, but not limited to, at home, school, work, or on the streets. Through community-based crisis care, referrals, and care coordination, BHP-only MCTs can avoid unnecessary ED care, psychiatric inpatient hospitalizations, and law enforcement involvement. SAMHSA recognizes that individual community needs and resources will inform which models are most suitable. However, some general principles are noted here:

- Activation of BHP-only MCTs should be supported by an intentional triage/screening process in which BHP-only MCT staff assess the risk of the individual/families in crisis and determine the most appropriate response (e.g., phone consultation, face-to-face BHP-only MCT intervention).[68]
- Law enforcement presence should be minimized to the degree possible. In cases where law enforcement is needed or required to respond, they should receive extensive training in working with adults and youth experiencing a behavioral health crisis.
- Peer support specialists should be incorporated in all models of BHP-only MCT delivery.
- Teams should be configured in a way that is attentive to the safety and well-being of the individual in crisis as well as team members.
- Teams should be community-based and not restricted to supervised settings (e.g., schools, hospitals).

State of Georgia

Georgia offers 24/7 mobile crisis response for assessment, de-escalation, consultation, and referral. One may call the toll-free Georgia Crisis & Access Line to request an on-site team of mental health professionals to support an individual and their families and loved ones through a crisis. Provided by the Georgia Department of Behavioral Health and Developmental Disabilities through regional service providers, mobile crisis services are offered state-wide. Georgia strives to provide a mobile crisis response without the engagement of law enforcement whenever possible. Calls are stratified by the level of acuity and even those that are deemed to be emergent and urgent are responded to with mobile crisis teams staffed by mental health practitioners alone and without law enforcement unless requested by the MCT due to specific safety-related concerns.

More Information

- Georgia Department of Behavioral Health and Developmental Disabilities, *Mobile Crisis Services*

- For children and youth, consider ways to encourage the inclusion of family and youth peers in multidisciplinary teams, centering family needs and experiences in BHP-only MCT design. Optimally, communities will develop these services and tailor BHP-only MCT services to the circumstances, preferences, and needs of adults and youth experiencing crisis, their families, and other supporters.

Mobile Crisis Team Services Models and Staffing

BHP-only MCTs should be comprised of a multidisciplinary team, including a minimum of two people with at least one team member licensed and/or credentialed to conduct a crisis assessment within their scope of practice Though there may be specific situations in which a response by one member of a team alone is sufficient or the only option, it is preferred to maintain a team of at least two individuals. The pre-dispatch triage function (whether by the MCT itself or a separate dispatch entity) is critical to inform the most appropriate response. Considerations include location, the concern of the caller, degree to which there are immediate life and/or health concerns, whether the person seeking help is known to the responders, and whether telehealth is available and/or appropriate to support the on-site response. The MCT response should occur without law enforcement unless special circumstances warrant their presence. In cases when law enforcement is present, the MCT response should be led by the behavioral health team member unless a clear public safety risk exists. MCTs should be well-trained including completing standardized training and meeting competencies established by their state or contract. With training requirements and access to 24/7/365 supervision, consultation, and onsite or virtual support by master's level clinical staff, a variety of backgrounds and degrees can support the services provided by a MCT including master's and bachelor's level social workers, peer support workers, certified youth and family peers, and non-degreed trained crisis workers. Follow-up visits to continue stabilization efforts, coordinate care, and make referrals can generally be performed by any team member, but may vary based on the specific follow-up needs of that individual (i.e., ongoing stabilization or assessment may need a licensed or credentialed staff person to provide follow-up care). MCT services should be provided under the supervision of a behavioral health professional licensed and/or credentialed in accordance with state law to be able to provide oversight of the individuals providing care. Examples of individuals who might provide supervision include licensed physicians, social workers, or counselors.

Children and youth mobile crisis services can be integrated into a MCT that serves the lifespan or a dedicated team that is specific to this age group. Services should be centered on de-escalation and stabilization within the home and community. This is an important priority for all crisis services and is especially important for youth. If it is safe for the young person and their family, every effort should be made to help them stay in their current living environment with family and/or other supporters actively participating in the young person's care and stabilization. Staffing for youth mobile crisis services therefore may look different from staffing for adult mobile crisis services based on the specific needs of children and youth, their families, and other supporters.

State of Service-Related Evidence

Multiple studies have provided empirical evidence on the effectiveness of mobile crisis services, including three that incorporated quasi-experimental design.[69,70,71,72,73] These studies suggested that mobile crisis services are effective

at diverting people in crisis from psychiatric hospitalization, linking individuals with suicidal ideation discharged from the ED to services, and more effective than hospitalization at linking people in crisis to outpatient services. One study assessed the cost-effectiveness of mobile crisis services by analyzing the effectiveness and efficiency of a mobile crisis program compared to regular law enforcement intervention and found that mobile crisis services resulted in a 23 percent lower average cost per case.[74] Another study analyzing the cost impact of mobile crisis intervention found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.[75] Finally, a study comparing youth who utilized mobile crisis services to those who did not found that those receiving mobile crisis services had a significantly lower likelihood of a subsequent behavioral health ED visit compared to those who did not use mobile crisis services.[76]

MCT Services – Co-Responder Teams

Service Description

Co-response is a collaborative approach to behavioral health crisis developed in response to the need for local adaptation. Co-response models vary significantly across communities but generally pair specially trained law enforcement officers or other public health first responders (e.g., fire, emergency medical services (EMS)) with behavioral health professionals to respond to calls involving individuals experiencing a behavioral health crisis. Some co-responder teams have leveraged existing crisis intervention team (CIT) programs to deploy CIT-trained law enforcement officers to work alongside behavioral health staff, including behavioral health providers, adults and youth living with mental health or substance use

MCT Services in Anne Arundel County, Maryland

Anne Arundel County, Maryland has established a multifaceted MCT. It incorporates both BHP-only and co-responder MCT services within its service line. The BHP-only team follows the best practices for inclusion of a clinician and additional team member. The default response is such of this type of team. However, they also have the option to provide services with the assistance of law enforcement as well. This can occur in situations where the rapidity of the response is paramount and/or there are concerns for dangerousness that might include weapons. In order to ensure that the co-responder services are not stigmatizing and supportive of the behavioral health specific needs of the community, the co-responder element of the MCTs is managed by the entity that oversees the BHP-only team as a branch of the of that work in a collaboration with the local police department. The unit has a dedicated captain and a team of trained law enforcement officers. Participating officers and behavioral health team members wear polo shirt uniforms in colors that compliment that of the MCT clinicians as opposed to a traditional uniform. They develop strong relationships with the MCT staff and engage not only in the primary response, but also in the follow-up care. This helps to reinforce that law enforcement can be a positive community resource as opposed to only be reactive to acute scenarios. This also helps both the people who are served, BH providers on the MCT team, and law enforcement officers to remain optimistically focused on the long-term needs of individuals and a shared goal of encouraging resilience and recovery.

More Information

- Anne Arundel Mental Health, Crisis Response System

concerns, their families, and other community partners to improve behavioral health crisis response and outcomes.[77] Law enforcement members of CITs typically receive training such as CIT or Crisis Response Intervention Training (CRIT), which is a 40-hour training program developed to educate law enforcement officers on how to respond to adults and youth experiencing a behavioral health crisis.[78] Co-response teams are especially common in rural areas where crisis workforce limitations are significant. Co-response teams can leverage the partnership of behavioral health providers and law enforcement officers or other public safety-first responders to reduce the need for hospitalization or emergency medical services and increase the diversion of people with behavioral health concerns from the criminal justice system.

SAMHSA recommends implementation of co-responder teams as an additional service option and not a replacement for BHP-only MCTs. Each community needs to weigh the risks and benefits of co-response teams with their specific needs and access to care challenges. Communities that choose to use co-response teams should develop their own optimal team composition and processes based on their community needs and the community response to the service. For example, co-response teams that include law enforcement can be stigmatizing and reinforce the criminalization of mental illness. Further, the American with Disabilities Act (ADA), which prohibits discrimination towards and offers equal opportunity for people with disabilities, outlines that people with disabilities have the same opportunities to participate in state and local government programs in addition to other guarantees.[79] DOJ has noted that this includes access to emergency response services and there is current legal precedent that indicates that an over-reliance on law enforcement for those with mental health emergencies is a violation of the ADA.[80] The U.S. Supreme Court further determined in Olmstead v. L.C. that unjustified segregation of people with disabilities violates the ADA as a form of unlawful discrimination.[81]

Benefits of the co-responder model include the fact that law enforcement may have the ability to travel distances or difficult terrain more quickly or respond to scenarios where civilian BHP-only safety may be of a concern. Fire and EMS often are associated with less stigma, and this work could complement other programs such as a community paramedicine program.[82] Programmatic details such as who operates or manages the program (law enforcement or a behavioral health provider), the types of uniforms worn, the degree to which the team is embedded in the community, and the acculturation of first responders to behavioral health culture, are all important considerations in co-responder models. It is important to note that the choice for the type of MCT team (BHP-only or co-responder) is not one of mutual exclusivity. With the proper degree of coordination and collaboration, these teams can co-exist within a community to provide complementary services.

State of Service-Related Evidence

There is evidence that co-response teams may lead to improved outcomes in comparison to law enforcement-only responses to behavioral health calls.[83] One recent study found that specialized behavioral health training of law enforcement officers was key to reducing arrest rates and injury during crisis co-response.[84] Regarding the personal preference of individuals that have previously received mobile crisis services and their families, one study showed that they preferred co-response teams led by a clinician over a law enforcement-only response, highlighting that the training, expertise, and empathy of the clinician is perceived

as critical to achieving de-escalation and voluntary connection to treatment.[85]

Children and Youth Mobile Crisis Services

In *National Guidelines for Child and Youth Behavioral Health Crisis Care (PDF)* (2022), a comprehensive framework is provided for addressing the unique needs of children and youth experiencing a behavioral health crisis. The guidelines emphasize the importance of early intervention, family involvement, and trauma-informed care. They strongly recommend that youth crisis care systems keep youth in their home, provide developmentally appropriate services and supports, integrate family and youth peer support, and meet the needs of all families by providing culturally and linguistically appropriate services.

The guidelines provide a framework in which crisis services for children and youth should be aligned with SAMHSA's Systems of Care values and principles.[86] One way that mobile response services achieve this alignment is with the inclusion of family and youth peers in multidisciplinary teams, which centers the family needs and experiences in systems design. Children and youth mobile crisis services are focused on de-escalation and stabilization within the home and community. This is an important priority for all crisis services and especially important for youth. If it is safe for the young person and their family, every effort should be made to help them stay in their current living environment with family and other supporters actively participating in the young person's stabilizing care.

Mobile Response and Stabilization Services, described in the following section, is a type of a BHP-only MCT that provides evidence-based mobile response services in both an acute and stabilizing phase that is customized for children, youth, and families.[87]

SAMHSA System of Care Core Values

1. Family and Youth-Driven;
2. Community Based; and
3. Culturally and Linguistically Competent.

SAMHSA System of Care Guiding Principles

- Comprehensive Array of Services and Supports;
- Individualized, Strengths-Based Services and Supports;
- Evidence-Based Practices and Practice-Based Evidence;
- Trauma Informed;
- Least Restrictive Natural Environment;
- Partnerships with Families and Youth;
- Interagency Collaboration;
- Care Coordination;
- Health & Mental Health Integration;
- Developmentally Appropriate Services and Supports;
- Public Health Approach; and
- Mental Health Equity.

MCT members who serve children and youth should have specialized training in addition to general MCT training to better serve children and youth.

Examples of specialized training topics that several states use to train MCTs who work with children and youth include:

1. Child Development;
2. Family Systems/Relationships;
3. Crisis Intervention with LGB Youth;

4. Child Abuse and Reporting;
5. Family De-Escalation;
6. Developmentally Informed Crisis and Safety Planning;
7. Trauma Responsive Care;
8. Assessing and Supporting Youth with Co-Occurring Needs; and
9. Systems of Care Framework.

Mobile Response and Stabilization Services (MRSS)

Service Description

MRSS is a youth- and family-specific crisis intervention model rooted in Systems of Care principles that recognize the developmental needs of children, the role of families or caregivers, and the importance of avoiding out-of-home placements or the removal of youth from their school and community. MRSS models have been implemented in numerous states and localities, and some communities are beginning to apply the MRSS model to adult services as well.[88]

MRSS allows for young people and families to define the crisis and offers face-to-face responses regardless of acuity and/or presenting need. This universal access approach prevents delays in care that can lead to worsening outcomes and the need for higher intensity services both in the immediate time period and throughout the lifespan.

MRSS supports families wherever the crisis is taking place in the community. Youth and families may request MRSS themselves, although youth-serving systems (e.g., schools) also frequently make these requests. MRSS supports de-escalation, assessment, education and coping skills, safety planning, identification of next steps, referrals to additional care (as needed), transitions to crisis stabilization or hospital settings (as needed), and follow-up services. MRSS offers stabilization services that focus on community-based care coordination to engage, plan, monitor, adjust, and offer support and care. Further details on this component of the MRSS model are discussed in the crisis stabilization section of this document.

State of Service-Related Evidence

Multiple studies have found evidence for the effectiveness of MRSS. One study of MRSS implementation in Connecticut found a reduction of 20–25 percent in youth ED utilization over an 18-month timeframe.[89] In New Jersey, 98 percent of the young people who received MRSS services remained in their home.[90] In Oklahoma, 83 percent of children, youth, and young adults receiving MRSS were successfully diverted from any change in their living environment.[91]

Mobile Response and Stabilization Service Project, New Jersey

The State of New Jersey has built an integrated and comprehensive MRSS program that serves the entire state. Families can call for help to address a crisis, as defined by the family. MRSS responds to the home within one hour or finds a convenient time for the family within 24 hours of the initial call. MRSS works alongside the family to address the presenting crisis and is prepared to provide intervention services during the 72 hours following the dispatch request. A plan is developed that focuses on strategies to obtain the desired outcomes and avoid a future crisis. MRSS also links and refers families to other services to support further stabilization.

More Information

- State of New Jersey, Department of Children and Families, Mobile Response and Stabilization Service Project

In addition, states have found MRSS services to be cost-effective. In Connecticut, between 2016 and 2019, 2,212 young persons were diverted from inpatient care. Of these youth, 61 percent were enrolled in Medicaid. The averted costs for Medicaid totaled $15,720,154.[92]

Community Outreach Teams

Community Outreach Teams (COTs) are not crisis providers but instead offer important crisis-related services and engage in outreach to communities and community members to support a variety of needs including behavioral health, physical care, housing, benefits, education, and employment. COTs do not provide on-demand crisis services, but provide crisis prevention and postvention services through their work. Through outreach and engagement, COTs aim to promote wellness, resilience, recovery, self-advocacy, development of supports, and maintenance of community living skills while connecting often marginalized individuals to community resources. COTs can work effectively alongside MCTs to prevent crisis and provide wraparound support to those in need. Some rural and under-resourced communities have created teams with dual roles of mobile crisis services and COTs. COTs can be especially helpful for follow-up care. COTs can serve a complementary function but are not meant to replace MCT services and it is SAMHSA's vision for the entire nation that MCT services should be available to anyone, anytime, and anywhere and connected to the 988 Lifeline so that anyone across the country can get an in-person response if they need additional support after a contact with 988.

Geographic Considerations

Expectations related to response time and composition of the MCT should consider geography, culture, travel conditions, weather, and crisis workforce limitations in urban, suburban, rural and remote areas, and tribal communities. For example, while MCT best practice is a team of two responders in person to the location of the crisis, a two-person team may not be available due to crisis workforce shortages and travel distances. A response model of one person to the location with a remote clinician providing telehealth services may be considered as a possible adaptation upon considering particular situations.[93]

Another MCT best practice is limiting law enforcement involvement to situations with imminent safety concerns. MCTs should recognize that historically underserved or oppressed populations (e.g., racial/ethnic minority and tribal populations) lack trust and confidence in law enforcement. However, in urban, rural, tribal and remote areas, law enforcement often is part of a

Projects for Assistance in Transition for Homelessness (PATH)

SAMHSA's Center for Mental Health Services funds PATH to help people with serious mental illness who are unhoused or at risk of becoming unhoused. PATH's goal is to connect people to voluntary mental health services and stable housing. PATH grantees have supported community outreach teams that offer screening and diagnostic treatment services, case management, habilitation and rehabilitation services, referrals for primary health care, job training, and educational services, assistance with obtaining financial and healthcare benefits, and more. PATH grants are distributed annually to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands.

More Information

- SAMHSA PATH

co-responder team due to behavioral health crisis workforce limitations and law enforcement's ability to reach the crisis location quickly. In addition, law enforcement is often familiar with the crisis location and/or the individual and family to whom they are responding.[94] Therefore, while it is best practice to avoid including law enforcement on MCTs, SAMHSA recognizes that involving law enforcement or other first responders does occur when their involvement is the only feasible way for communities to maintain access to 24/7/365 mobile crisis services with quick response.

Coordination with Other Service Components

MCTs are part of the crisis continuum of care, behavioral health system, and community resource network. These teams reside at a unique intersection of many services, providing a specialized opportunity for coordination beyond treatment referrals. MCTs may coordinate a transition to community-based behavioral health services, crisis receiving and stabilization services, or a hospital setting.

MCTs can also provide longer-term stabilization support, for children, youth and adults, in a range of community settings. Such services can support care continuity for a period of 30–90 days in a manner which is more intensive than traditional outpatient care and more flexible than partial hospital and intensive outpatient programs.

MCTs should have knowledge of all the crisis and medical facilities that serve their community, as well as other support services for children and adolescents. These include community behavioral health providers, school-based supports, housing supports, and other community resources, including resources that are culturally appropriate for diverse populations such as drop-in centers for

Durham North Carolina's Community Safety Department

In 2022, Durham's Community Safety Department (DCSD) launched three new crisis response units called "HEART" (Holistic Empathetic Assistance Response Teams), which aim to connect people experiencing non-violent mental health crises with the right care and supports by providing responses that best match residents' needs. HEART has several components that support the integration of elements of the behavioral health crisis system into the public safety first responder system.

These activities include crisis call diversion whereby mental health professionals in the 911 Public Safety Access Point call center and allows mental health responders to de-escalate crises that might have otherwise led to a police response over the phone. HEART Care Navigators follow up with these callers and complete follow-ups as well. The program also has community response teams, which are three-person unarmed units consisting of a licensed mental health professional, an EMT, and a peer support provider. These teams are dispatched through the 911 PSAP and respond to calls for issues including trespassing, public intoxication,, welfare checks, and suicidality without the presence of a weapon. These teams often transport people to relevant services and resources as well as carry supplies like snacks, clothing, tents, and sleeping bags. Additionally, HEART also has an additional co-responder component that sends clinicians and police officers to calls that are carry a risk of violence or have been already deemed to be violent.

Durham has had success with the program, in part, by securing buy-in from key partners including community activists, city leaders and rank and file police officers within the Durham Police Department.

More Information

- Durham, North Carolina, HEART

Fairbanks Emergency Communications Center

The Fairbanks, Alaska Emergency Communication Center is responsible for managing emergency calls (911) and dispatching appropriate services, including MCTs. Mobile crisis services and the police department developed a plan to coordinate each response based on severity and other factors, operationalizing the philosophy of ensuring the "right care, in the right setting, when they need it." In January 2024, 84 percent of the crisis calls in Fairbanks were resolved with MCTs, just nine percent were referred to an inpatient setting, and seven percent were resolved with law enforcement on-scene.

More Information

- *Anchorage Daily News,* For Alaskans in Behavioral Health Emergencies, Mobile Crisis Teams Are an Effective New Approach
- Implementing a Behavioral Health Crisis System of Care [PowerPoint file]
- City of Fairbanks, Alaska, Mobile Crisis Team
- City of Fairbanks, Alaska, Fairbanks Emergency Communication Center

LGB youth. MCTs also should have resource lists of peer, youth, and family-run organizations.

Warm hand-offs to other services, such as crisis stabilization services, outpatient behavioral health providers, or community support services offer smooth transitions with a person-centered approach. This practice ensures alignment among providers and other community services. Warm hand-offs also are needed for safety and stability in some circumstances, such as when transporting a young person in medical distress and in need of stabilization services.

Mobile Crisis Coordination with 911 and Law Enforcement

To ensure a collaborative community approach to crises, it is important for MCTs to build a partnership with 911 and local law enforcement entities. Education, relationship building, and on-scene collaboration are key elements of these partnerships. The CIT model promotes building relationships within the BHCSCC to ensure alignment, identify collective community goals, and find ways innovate to improve access and collaboration.[95]

Mobile Crisis Coordination with Behavioral Health Service Continuum

MCTs should be familiar with the available behavioral health treatment options in their community (including SUD treatment facilities and CCBHCs) and should work with other entities to establish formal and informal collaborations to ensure quick access to care for help seekers. MCTs can help achieve and sustain stabilization by facilitating help seeker connection to specialized behavioral health supports and services when needed—"the right care at the right time."

Mobile Crisis Coordination with Other Community Resources

MCTs should nurture relationships with culturally appropriate resources, such as religious communities, immigrant or refugee resources, and support groups. In addition, they should have access to on-demand language service providers to ensure access to services for youth, adults, and families with limited English proficiency.

Data, Evaluation, and Quality Improvement

States, local governments, tribes and tribal organizations territories, jurisdictions, and service providers have several quality metrics

available to evaluate mobile crisis services for effectiveness and quality improvement. During the process of selecting metrics, these entities should ensure that metrics are informed by their quality assurance framework and BHCSCC vision in their communities. Select examples of mobile crisis services quality metrics in use in some communities include:

- Number of unique individuals served;
- Number of service requests;
- Number of mobile crisis activations;
- ZIP Code (if voluntarily provided) of individual served;
- Referral source;
- Presenting problems;
- Response time;
- Demographic information (when not anonymous);
- Language;
- Event disposition (this can include resolutions in community, transfer to ED, etc.);
- Diversion (e.g., from 911, law enforcement);
- Collaboration with PSAP;
- Collaboration with MCT;
- Law enforcement involvement;
- Involuntary intervention; and
- Restraint use.

In addition to the quality metrics, developing a mechanism to gather participant satisfaction feedback with surveys and/or interviews is a crucial step toward building a BHCSCC response that is centered on and reflective of participant experiences. Partners are also encouraged to look at existing measures in SAMHSA's Performance Accountability and Reporting System (SPARS).

It is important to recognize that MCTs often encounter difficulty obtaining important data, particularly demographic information, during a crisis event. The acuity of some crises, the quick response nature, and the necessity to build a trusting relationship with the person in crisis poses a challenge to requesting individual demographic data during the intervention. However, demographic information is important to assess and help progress towards a more equitable BHCSCC that is improving care for underserved communities. At times, data collection may be more appropriate post intervention.

3. A Safe Place for Help: Emergency and Crisis Stabilization Services

Emergency and crisis stabilization services reflect a range of models and care to support individuals through emergent and urgent behavioral health needs. Emergency and crisis stabilization services include facility-, home-, and community-based services that provide access to care and stabilization for adults and youth in crisis. Emergency and crisis stabilization services are delivered across a continuum of care that includes no-barrier, low-barrier, and referral-based services.

The range of services in this section are categorized by the breadth of the on-demand receiving capacity. For example, no-barrier emergency services are available for anyone and at anytime, regardless of acuity, including people who voluntarily walk in and/or are brought by law enforcement and/or EMS, both voluntarily and/or involuntarily. Low-barrier services typically receive walk-ins and people who present voluntarily though may screen out those who are involuntarily

coming for care or whose needs cannot safely be supported in the care environment. This may lead to a difference in acuity of the individuals who are presenting for care with the no-barrier setting having a potentially higher acuity of service needs and therefore offering a higher intensity of services. Referral-based services do not permit walk-ins and have established admission protocols to ensure that the environment is suitable for a help seeker's needs.

Across all settings, emergency and crisis stabilization services should offer a safe environment where individuals can receive support and care to address their behavioral health crisis needs and to support crisis resolution and connection to appropriate levels of care and follow-up. Ideally every community should have a wide range of these settings. Emergency and crisis stabilization services are designed to ameliorate the behavioral health crisis and reduce acute symptoms while identifying and connecting individuals to supports that foster sustaining these gains as well as longer-term goals. These services are resiliency- and recovery-focused, trauma-informed, and offer both observation and therapeutic support.

Emergency and crisis stabilization services provide access to mental health and substance use care and are delivered to individuals of varying ages, clinical conditions, and levels of acuity. In this section, emergency and crisis stabilization services are described based on their functions: crisis stabilization services (no- or low-barrier) and crisis residential services (referral-based). SAMHSA is hopeful that the emerging crisis continuum will inform future editions of both the LOCUS Family of Tools and ASAM, so that these criteria all evolve together in providing consistent information for the behavioral health field.

While specific child, youth, and family models are noted in the following, all systems should have the ability to serve people across the lifespan.

No-Barrier or Low-Barrier Crisis Stabilization Services

Crisis stabilization services provide no-barrier or low-barrier access points for adults and youth experiencing a range of behavioral health emergencies and crises. Short-term crisis stabilization services (typically providing care for under 24 hours with extension capabilities) offer opportunities for diversion from law enforcement and other first responder interventions, especially when there is no barrier to entry for individuals who have behavioral health emergencies. Crisis stabilization services focus on initial response, triage, screening, assessment, and intervention to rapidly address the needs of the person in crisis and promote de-escalation and stabilization. Without no-barrier services that support individuals who are experiencing highly acute behavioral health emergencies without admissions criteria, SAMHSA's vision to divert as many individuals as possible away from EDs and jails for their urgent and emergent behavioral health needs cannot truly be achieved. No-barrier services also serve an important function in supporting behavioral health equity in crisis care as this can mitigate bias in screening and referrals. Finally, these no- and low-barrier services are well-suited to be paired with other crisis stabilization services so that individuals and providers have options about the setting whereby they receive their care. This can also minimize any associated stigma surrounding more secure settings and support obtaining care in the least restrictive environment.

Hospital-Based Behavioral Health Emergency Stabilization Units

Hospital-based emergency stabilization units (also sometimes known as Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) or Psychiatric Emergency Services (PES) units) are co-located on hospital grounds and linked to the ED for triage and referral of individuals in need of behavioral health emergent crisis care. These units accept high acuity individuals outside of an inpatient setting and can accept both voluntary and involuntary admissions from the hospital ED. Length of stay is typically less than 24 hours but can be extended based on individual needs and physician recommendation. These units offer more intensive medication monitoring and access to medical specialty services due to medical comorbidities and the need for more complex monitoring and testing, including complex withdrawal management.

High-Intensity Behavioral Health Emergency Centers

High-intensity behavioral health emergency centers provide care for adults and youth experiencing a behavioral health crisis and/or emergency, including triage assessment, rapid treatment to stabilize a crisis, and emergency stabilization. These centers accept individuals 24/7/365, including walk-ins, drop-offs, and law enforcement and/or ED drop-off. They operate as the lowest barrier access to behavioral health crisis care because they have no restrictions or exclusionary criteria. Typically, emergency behavioral health services are provided within 24 hours of center entry, after which time adults and youth are referred to another level of care based on their needs. High-intensity behavioral health emergency centers also provide ambulatory-level care for non-urgent medical issues and may transfer individuals requiring further medical work-up and/or management to an ED with the expectation of re-acceptance upon medical stabilization. High-intensity centers can provide medication initiation for SUDs and withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.

M Health Fairview Southdale Hospital EmPATH

Minnesota introduced its first EmPATH center in 2021 at M Health Fairview Southdale Hospital in Edina, Minnesota. Upon its first year of opening, this service reduced inpatient admission for mental health crises by 60 percent. Staffed by multidisciplinary mental health specialist, including psychiatrists, licensed therapists, and psychiatric nurses, the EmPATH provides a calming living-room style environment that is designed to center around individual's preferences and needs on their path to stabilization. Each individual receives screening and triage assessment by a mental health counselor and psychiatric provider, and with the individual and their supporters as appropriate, collaboratively develop safety treatment recovery planning for their care. When individuals leave, they are given next steps and follow-up resources and programs to empower and equip them with ongoing mental health support, in accordance with discharge planning and follow-up with community based services.

- M Health Fairview, Minnesota's first EmPATH opens March 29 at M Health Fairview Southdale Hospital [blog]

High-Intensity Behavioral Health Extended Stabilization Centers

High-intensity behavioral health extended stabilization centers are connected to or located on the same grounds as high-intensity behavioral health emergency centers and individuals often access these through an extension of their care at high-intensity behavioral health emergency centers. These facilities offer extended behavioral

health crisis care beyond the initial 24 hours, provide access to personal bed space, and offer the same services as the high-intensity behavioral health emergency centers with the addition of support groups, skill-building activities, and psychoeducation services. High-intensity behavioral health extended stabilization facilities typically offer services for 3–5 days, but the timeframe may be longer to ensure a safe and appropriate disposition, especially for adults and youth with complex needs where resources may be limited (e.g., persons with I/DD). They provide an additional period of stabilization, when necessary, before the help seeker can be transferred to the most appropriate next level of care. These centers provide medication initiation for SUDs and continued withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.

Moderate-Intensity Behavioral Health Crisis Centers

Moderate-intensity behavioral health crisis centers provide the same range of services as the high-intensity centers. However, they accept only individuals who are voluntarily seeking services, are unable to provide services for individuals on involuntary holds, and their staffing and infrastructure may limit the timeliness or scope of crisis response. These centers may provide law enforcement and/or EMS drop-off, but they are not required to do so. Although on-site pharmacy services are ideal, moderate-intensity centers may not have on-site pharmacy or medication dispensing capabilities. They do have access to local pharmacy services and also may have a limited stock of medications. These centers also offer medication initiation for SUDs and the management of moderate symptoms of intoxication and withdrawal.

The Bridge Center for Hope, Baton Rouge Louisiana

The Bridge Center for Hope, provides comprehensive crisis care to East Baton Rouge residents experiencing a mental health or substance use crisis. The Bridge Center for Hope provides pathways to treatment for people experiencing behavioral health issues and links providers to create an integrated continuum of care from prevention to rehabilitation. Their “no wrong door” approach denotes that there are no barriers to accessing the Bridge Center’s services. The Bridge Center provides “the care you need, no matter how you arrive.” The facility opened in 2021 and has had more than 9,000 crisis presentations to the facility.

More Information

- The Bridge Center for Hope

Moderate-Intensity Behavioral Health Extended Stabilization Centers

Moderate-intensity behavioral health extended stabilization centers are connected to or located on the same grounds as moderate-intensity centers behavioral health crisis centers. These facilities offer extended behavioral health crisis care beyond the initial 24 hours and provide access to personal bed space. These units typically offer services for an average of 3–5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can be transferred to a less intensive treatment and support setting. Medium-intensity extension units provide medication initiation for SUDs and continued moderate withdrawal management services.

Behavioral Health Urgent Care

Behavioral health urgent care (BHUC) offers a safe, low-barrier, voluntary, and timely alternative and diversion from the use of hospital EDs or more

intensive crisis services as an entry point of care to address the needs of individuals experiencing behavioral health crises. BHUC occurs in an ambulatory setting and typically does not include long term behavioral health treatment. A BHUC center can be free-standing or embedded with other services components. It provides time-limited, targeted services and supports and is not meant to be a routine or ongoing source of care. 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 assessment to individuals requesting care. They 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 SUD services. They can assess and stabilize mental health and SUD-related crises and initiate medications for opioid use disorder (MOUD) and alcohol use disorder (MAUD). BHUCs should have the ability to identify individuals' needs related to SDOH and connect them to social services or supports to address identified needs. BHUCs should provide a clinical assessment that includes an evidence-based safety assessment for dangerousness to self or others and create a crisis plan that includes a safety plan to mitigate the acute crisis and safety risk. The walk-in crisis capacity required at CCBHCs would typically be consistent with a BHUC setting unless that CCBHC meets their crisis stabilization requirements by operating a more intensive level of crisis stabilization.

Peer Respite

Peer respite services, offer voluntary, low-barrier, short-term residential services and peer support to individuals experiencing a behavioral health crisis. Services focus on recovery, resiliency, and wellness, and are operated and provided by trained peer support professionals who have lived experience with and recovery from behavioral health conditions. Peer respite services are provided in a warm, friendly home-like environment. All services are voluntary and provide the least restrictive level of individual freedom. Services offer assistance that promotes engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and skill building.

People USA

People USA is a peer-run mental health non-profit that creates innovative peer-driven crisis response and wellness services throughout the New York Hudson Valley. They operate four peer crisis respites, called Rose Houses, where individuals can receive 24/7/365 short-term crisis respite services for up to seven days. They are 100% operated by peer support providers with lived experiences. During the crisis respite stay, peer providers support individuals through goal identification, support groups, educational and recreational activities, resources and wellness education and skill building. Peer support providers also provide community resources linkages and referrals.

- People USA Rose Houses

Sobering Centers

Sobering centers are low-barrier, short-term (<24 hours), community-based facilities typically operating 24/7/365 that provide monitoring and oversight of adults in a substance-related crisis with acute alcohol and/or other drug intoxication in a supervised and supportive environment. The primary goal is to provide clinical sobriety. Sobering centers accept intoxicated persons referred by paramedics, law enforcement, EDs, specialty

SUD and other ambulatory healthcare clinics, other community programs, or via self-referral and walk-in. They serve as an alternative to jail or the ED. Sobering center services are not aimed at achieving abstinence nor the full removal of alcohol and/or other drugs from the system. Rather, acutely intoxicated individuals may biologically decrease the amount of the intoxicating substance in a safe setting within a harm reduction and recovery-oriented framework. Sobering centers provide this care while connecting clients to any appropriate and desired treatment, recovery, medical care, and/or social services. Access is provided with minimal pre-conditions to entry including accessibility to clients regardless of ability to pay, insurance status, or documentation. Sobering centers are not treatment centers, but they can still be part of the broader continuum of substance use care, which may include various substance use services.

Sobering care can be delivered in an independent center or integrated into existing delivery systems like those addressing homelessness, substance use recovery providers, mental health stabilization, or CCBHCs so the multifaceted needs of individuals can be addressed.

Referral-Based Crisis Residential Services

Crisis residential settings are referral-based and typically voluntary with lengths of stay lasting from several days to a couple of weeks. As distinguished from shorter-term emergency stabilization units, their focus is on program structure and establishment of a milieu to support rehabilitation, resilience, and recovery goals, to further stabilize persons in crisis, and to provide connections for wraparound care.

Crisis Residential- Birch Tree Center

Birch Tree Center provides residential crisis stabilization to adults experiencing a mental health crisis. Staffed with behavioral health practitioners, it offers short-term, recovery focused services including screening, care coordination, safety and recovery planning, support and intervention, psychiatric medication services, discharge planning with referrals and support to families. Individuals work with a behavioral health practitioner daily, engage in individual and group therapy, participate in educational and recreations activities, and engage in the therapeutic milieu. Birch Tree Center provides coordinated care with existing providers, agencies, and organizations involved in the individual's treatment, as well as discharge planning including referrals and warm hand-offs to clinically appropriate levels of care.

More Information

- Birch Tree Center

Moderate-Intensity Crisis Residential Programs

Moderate-intensity crisis residential programs (hereafter referred to as moderate-intensity residential) are residential crisis programs with high levels of medical and nursing involvement. Moderate-intensity residential programs are non-hospital-based programs with lengths of stay that typically range from a few days to two weeks. They allow for relatively intensive monitoring and support 24 hours a day, seven days a week, as well as provision of medical, nursing, and crisis intervention. Medical staff often have limited on-site hours but are on call for consultation. The primary focus is on milieu and programmatic support and connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis. Moderate-intensity residential programs are often located in secured settings, permitting admission of individuals who may need

more intensive services. Admissions are typically voluntary, though depending on local regulations, laws, and programs, individuals may be legally mandated to this level of care. These programs can offer medication initiation and continuation for SUDs and provide withdrawal management for mild to moderate symptoms.

Low-Intensity Crisis Residential Programs

Low-intensity crisis residential programs (hereafter referred to as low-intensity residential) provide a similar range of services as moderate-intensity residential programs; however, they have lower levels of medical/nursing monitoring and lower staffing ratios per patient. These staffing levels will impact facility capacity with respect to the timeliness of response and acuity of presentation which can be supported safely. As with moderate-intensity residential, the primary focus is on milieu and programmatic support and connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis. Low-intensity residential programs only accept individuals on a voluntary basis and can provide withdrawal management services for mild symptoms. They may offer medication initiation and continuation for SUDs.

Community Crisis Respite Apartments

Community crisis respite apartments have been developed in many states as an option for community-based support. 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. These apartments typically have a higher level of clinical support, along with peer staffing, as is reasonably necessary to prevent unnecessary institutionalization. Each crisis apartment should have access to peer staff and clinical staff available to be onsite, up to 24 hours per day, seven days per week, whenever necessary, to meet individualized needs.

Crisis Respite Apartments — NFI North Apartments New Hampshire

NFI North provides a supportive housing environment to adults in Manchester, Ashland, Concord, Bradford, and Bethlehem, New Hampshire. Each of the programs offers a complement of clinical, medical, vocational and residential options for adult men and women with behavioral health conditions. Their goal is to help these individuals achieve independence by successfully obtaining meaningful employment or supporting the pursuit of other purposeful activities and transitioning into permanent housing. Services offered include independent living skills reinforcement and coaching, transition planning/coordination, psychiatric services, medication administration, support groups, case management, counseling, crisis prevention and postvention services, and resource and wellness education. Referrals come from the New Hampshire state hospital and community behavioral health centers.

More Infomration

- NFI North, Transitional Housing Services

State of Service-Related Evidence

The evidence for emergency and crisis stabilization services demonstrates effectiveness for outcomes such as timely access to care and shorter wait times, diversion from the ED and inpatient services, participant satisfaction, and lower costs for services compared to inpatient care. Some evidence also exists for improved mental health symptoms and functioning. Though several studies contributed to the literature on emergency and crisis stabilization services, the evidence is far from robust, and more research is needed to identify outcomes and impacts as well as improvements to services and processes. The brief review of select

evidence in this section is presented according to the following categories: crisis stabilization services, crisis residential programs, BHUC, peer crisis respite, and sobering centers.

Crisis Stabilization Services

Research on emergency stabilization centers, also known as crisis stabilization facilities, indicates that many individuals assessed for hospitalization can instead receive safe and effective care in these crisis settings. The outcomes for individuals receiving these services are as strong as or better than hospital care and the cost of these services is substantially less than the costs of inpatient care.[96,97] Emergency stabilization models such as EmPATH have been shown to reduce wait times, psychiatric hospital admissions, and return of individuals to the ED within 30 days.[98,99,100] EmPATH units also have demonstrated that they are beneficial in establishing post-ED follow-up care and are effective in rural communities.[101]

In addition, research has found that individuals who receive crisis services prefer going to a safe place, receiving services from peers and trained behavioral health professionals, and interacting with people who offer respect and dignity to them as individuals – experiences that they report not having in the hospital setting.[102] Emergency and crisis stabilization services can help fulfill these needs and provide timely services to address and resolve behavioral health crises.

Crisis Residential Programs

The findings from the research on crisis residential programs are similar to those of crisis stabilization services for the specific populations that were served by these programs: the outcomes for individuals receiving these services are as strong as those for hospital-based care, and the costs of residential programs are significantly less than hospital-based services.[103,104,105] A study by Hawthorne et al. compared participant outcomes for acute short-term residential programs to those of acute psychiatric hospital settings and found that individuals with similar levels of psychiatric distress at admission had similar improvements in symptoms and functioning at discharge.[106] In addition, participant satisfaction was similar between the two settings. The cost of treatment for the short-term residential programs was much lower than the cost for the acute psychiatric hospital settings.[107] In one study, Veterans favored acute short-term residential treatment environments over hospital-based settings, providing evidence of the important role of these services as alternatives to acute psychiatric hospital settings.[108,109]

BHUC

The evidence related to BHUC demonstrates that this service increases access to care, decreases wait times for services, reduces ED visits, and costs less than ED visits.[110,111,112] One challenge related to BHUC centers is that more than half of them are located in higher-income communities, which could limit access for lower-income help seekers.[113] A benefit of BHUC is help seekers can obtain access to a psychiatric care in person or through telehealth and avoid lengthy wait times that exist in many behavioral health systems.[114] Additional research is needed on outcomes after individuals receive services from BHUC centers.

Peer Respite

The available research on peer crisis respite outcomes shows that peer crisis respite services are associated with improved self-esteem, mental health symptoms, and social functioning.[115,116] Peer respite services also are associated with decreased use of inpatient or ED services and increases in guest satisfaction.[117] In a study by Croft and Isvan, individuals using peer crisis respite services were 70 percent less likely to

require inpatient care or visit EDs compared to those who did not use respite services.[118] For those peer crisis respite service guests who did seek inpatient or emergency care, spending more days in respite was linked to fewer hours spent in those services – however, this connection was minimal for respite stays that lasted longer than 14 days.[119] The evidence also demonstrates that peer crisis respite services are far less costly than inpatient or ED crisis services.[120] One study of peer crisis respite programs in New York City found that these programs resulted in decreased rates of hospitalization for Medicaid recipients and fewer Medicaid health expenditures for peer crisis respite participants versus a comparison group.[121]

Sobering Centers

Research related to sobering centers demonstrates that they are effective for stabilizing adults with acute alcohol and/or other drug intoxication and that they are less costly alternatives to EDs and jails.[122,123,124,125] One study of the utility of sobering centers in five U.S. jurisdictions found that sobering centers are beneficial alternatives to arrest, particularly for unhoused persons to divert them from the criminal justice system.[126] A 2019 study of the cost impact of sobering centers revealed that the use of sobering centers instead of the ED for individuals with uncomplicated acute intoxication could result in significant savings for the nation's healthcare system.[127] A 2021 literature review on sobering centers, EDs, and EMS recommended additional research to identify protocols for EMS to assess and transfer individuals to the most appropriate service location.[128]

Emergency and Crisis Stabilization for Children and Youth

For children, youth, and families, a strong crisis response system will require policies and practices that are aligned with SAMHSA's System of Care values, including family-driven, youth-driven, trauma-informed, and culturally and linguistically responsive care.[129] The crisis response system is one of many systems that serve youth with behavioral health needs. Operating within a system of care framework is key to understanding how youth and families access services, identifying system gaps, and ensuring coordination among all the systems that serve youth (e.g., schools, primary care, children's behavioral health, child welfare, juvenile justice).[130]

As described in SAMHSA's *National Guidelines for Child and Youth Behavioral Health Crisis Care (PDF)* (2022), and also in these 2025 National Crisis Guidelines, youth crisis services are focused on de-escalation and stabilization within the home and community.[131] Behavioral health crisis responders should strive to maintain the young

Connecticut 23-Hour Urgent Crisis Center for Children

The Connecticut Department of Children and Families established community-based Urgent Crisis Centers (UCC) for youth in 2023 as an alternative to EDs for families facing behavioral health crises. These licensed outpatient walk-in clinics provide immediate resources for youth experiencing issues like suicidal thoughts, anxiety, or substance misuse, allowing stays of up to 23 hours. Core services include nursing evaluations, clinical crisis stabilization, and additional ongoing support. In the fourth quarter of Fiscal Year 2024, 322 youth were treated at the UCCs, with 99 percent meeting treatment goals and 96 percent discharged to their homes, with an average length of stay was 3.5 hours.

More Information

- Connecticut State Department of Children and Families, Urgent Crisis Centers for Children

person in their current living environment, ideally with the active participation of family members and other supporters. 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. In the sections that follow, services are described from least to most restrictive.

Home and community-based crisis stabilization offers short-term, intensive services focused on helping children and youth, individuals with I\DD, and other people in crisis stabilize in their current living arrangement and return to routine activities. This may include utilization of crisis apartments and other community-based settings where people can receive supports to help them transition from hospitals and other more restrictive settings. Through collaborative crisis safety and care planning, individuals and their families are diverted from more restrictive services (e.g., facility-based and residential) and supported to remain in their homes and communities. Services typically begin with an initial crisis response by an MCT but also could be initiated following a crisis facility contact or as a transition from a higher level of care such as inpatient psychiatric hospitalization. Services often are provided for up to eight weeks and may include direct support such as ongoing access, timely mobile response services, assistance with making environments safe, peer and family support, psychoeducation, brief clinical interventions, skill building, and safety monitoring, as well as linkages to longer-term support and care. Services should align with the unique strengths, needs, preferences, and cultural contexts of the youth or adult in crisis and their families and other supporters.

In-Home Stabilization Services

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 eight weeks, while other models range from 6–16 weeks.[132] 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 develop with their therapist.[133,134] Examples of in-home services include assessment, parent education programs, peer support, coping and conflict management skills-building, behavior management training, and warm hand-offs to other resources and services. Stabilization can also involve evidence-based therapies for the young person and their family/natural support providers, such as Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multidimensional Family Therapy, or Multisystemic Therapy.[135] Stabilization providers collaborate with the youth and family/supports as active partners to develop goals that are integrated into a crisis plan of care. This involves identifying unmet needs, communication challenges, underlying concerns, individual strengths, and coping strategies. Importantly, services are provided to both the youth and their family/natural support providers. Too often, families have felt sidelined by service providers who focus exclusively on the young person, without sufficiently considering important family dynamics or the supports that family members/natural support providers need.[136]

Youth and Family Crisis Respite

Youth and family crisis respite services provide an alternative to hospitalization for youth experiencing emotional crises that are warm, safe, and supportive home-like places to rest and recover when more support is needed than can be provided at home. Youth and family crisis respite services are distinct from adult respite and crisis residential facilities and are tailored to prioritize family and natural supports. Services are provided to both the youth and their family and are aligned with the System of Care values and principles. These services are family-driven, youth-driven, trauma-informed, resiliency- and recovery-oriented, and culturally and linguistically responsive.

Crisis Stabilization Facilities

There are various types of crisis facilities designed to support youth with more intensive care and safety needs than can be provided through home and community-based services. Examples include crisis emergency and stabilization centers, 23-hour beds/observation units, respite care, walk-in services, and BHUC.[137] Benefits include a safe environment and short-term care that avoids hospitalization or that provides transition services post-hospitalization. These services aim to facilitate a swift return home and, when needed, a transition to outpatient care.[138]

Residential settings such as respite care facilities aim to prevent longer term out-of-home placements and alleviate family stress.[139] Crisis stabilization facilities often have a small number of chairs (e.g., 6–16), and they may operate in a residential, home-like setting.[140] They generally impose a maximum period of stay, ranging from less than a day (23-hour units) up to two or three weeks. Services provided in these facilities include assessment, medication management, care coordination and service linkages, discharge planning, and others. Facilities are often staffed by peer support providers and other crisis response paraprofessionals or professionals. If needed, supervision and medical consultation may be provided by trained professionals such as physicians or psychiatrists.[141]

Short-Term Crisis Residential for Children and Youth

Short-term crisis residential centers offer short-term out-of-home placement for the child, allowing the family to avert the need for psychiatric inpatient treatment or lengthy out-of-home placement. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time, concomitant with high-quality, home- and community-based services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.[142]

Coordination with Other Service Components for Crisis Stabilization

Providers of emergency and crisis stabilization services should coordinate with other sectors and service components to ensure safety, continuity of care, and optimal outcomes for adults and youth receiving these services. Coordination of services is an integral part of a robust BHCSCC.

Coordination with 988 Lifeline, Other Behavioral Health Crisis Lines, and MCTs

Prior to using emergency and crisis stabilization, many individuals have interacted with other BHCSCC services. As such, referrals or requests for emergency and crisis stabilization commonly originate from the 988 Lifeline, other behavioral health crisis lines, or MCTs. Clear communication methods and coordination with these services ensures appropriate access to treatment and

proper follow-up support for adults and youth experiencing a behavioral health crisis.

Coordination with Law Enforcement and EMS

Emergency and crisis stabilization provide an alternative option for law enforcement and EMS to avoid sending individuals in behavioral health crisis to jail or hospital EDs. Coordination with law enforcement and EMS provides a safe and effective way for adults and youth to get the care they need in a more supportive setting and avoid adding to their distress. Direct access and communication channels with local law enforcement and EMS is a critical part of the success of emergency and crisis stabilization. This is particularly important for services that permit law enforcement drop-off to ensure that transfers are rapid and person-centered and that there are clear protocols to optimize collaboration. Regular team meetings are recommended to build relationships and trust, improve connections, and problem-solve when negative experiences and/or outcomes occur.

Coordination for Follow-Up Care

Coordination for follow-up care is important across the full crisis services continuum, and it is particularly crucial for emergency and crisis stabilization. Since these services are typically time-limited and facility-based, participants' continued progress is dependent on coordinated follow-up care. Coordination of emergency and crisis stabilization ensures that the proper referrals and warm hand-offs occur for adults and youth discharging from services and that they are connected to appropriate levels of care post-discharge. It is critical that emergency and crisis stabilization coordinate directly with community-based behavioral health services, recovery housing services, community health services, and others, including same day or rapid access connections to care.

Data, Evaluation, and Quality Improvement

Evaluation and data for emergency and crisis stabilization serves an important role in documenting processes related to implementing services, assessing the impact of services through performance measurement, identifying gaps and areas for improvement, and disseminating results to local communities and the broader behavioral health crisis field to inform future development of services.

Sample metrics that can be used in performance measurement and evaluation of emergency and crisis stabilization, in addition to existing measures in SAMHSA's *Performance Accountability and Reporting System*, include:

- Number of unique individuals served;
- Number of service requests;
- Number of admissions;
- ZIP Code (if voluntarily provided) of individual served;
- Referral source;
- Presenting problems;
- Duration of service/length of stay;
- Demographic information;
- Language;
- Event disposition (this can include transfer to another level of care, etc.);
- Diversion (e.g., from 911, law enforcement);
- Patient experience and satisfaction;
- Restraint use;
- Seclusion use; and
- Legal status (involuntary/voluntary).

Developing a Behavioral Health Coordinated System of Crisis Care

To realize the vision of a robust, high-quality BHCSCC, communities should ensure that individuals have access to each of the three essential elements of behavioral health crisis care. In addition, providers, system partners, and payers should collaborate to ensure coordination of services and that system components are accountable for effective crisis response in communities.[143] Currently, this vision of crisis system collaboration and coordination is not fully realized in all communities, which leaves some adults and youth without the support they need. BHCSCCs should serve all members of the community, address the diverse needs of various populations, and promote equitable access to care. They also should have clear administrative functions and oversight; policies and procedures designed to support goals and objectives; detailed plans for communication and public engagement; the ability to use data and technology to assess and improve systems and services; a strategy for long-term financing and sustainability of services; and supports in place for the behavioral health crisis workforce. A well-developed BHCSCC will be able to respond to crises effectively as well as foster resilience and well-being across the communities it serves.

BHCSCC design, implementation, and sustainability are dependent upon the following essential infrastructure components:

- Administrative Structure, Oversight, and Policy;
- Communications and Community Engagement;
- Equitable Behavioral Health Crisis Care;
- Evaluation and Data Collection;
- Optimizing Crisis Systems Through Technology;
- Financing and Fiscal Sustainability; and
- Behavioral Health Crisis Workforce Recruitment, Retention, and Support.

Administrative Structure, Oversight, and Policy

BHCSCCs require administrative structure, oversight, and policy entities responsible for a myriad of functions, including, but not limited to, decision making, financing, developing and/or implementing regulations, and accountability. Together, these structures help ensure that:

1. The crisis system can function effectively and meet the needs of individuals and communities, and
2. Individuals can seamlessly participate in different services without experiencing gaps in care.

Administrative Structure and Oversight

Administrative entities have the responsibility for planning, coordinating, and overseeing all components of the BHCSCC. They help ensure that the collective system meets the needs of individuals and communities. One way for communities to incorporate administrative structure and oversight for BHCSCCs is through the designation of an accountable entity.

Accountable Entity

In its 2021 publication, *Roadmap to the Ideal Crisis System,* the National Council for Mental Wellbeing described and recommended establishing the role of an "accountable entity" to provide high-level oversight in a crisis care system that ensures the coordination of interconnected services.[144] In addition, an accountable entity's primary functions can include community assessment and planning, managing multiple funding sources to support the continuum, establishing performance benchmarks, and striving to fulfill the quintuple aim for health care: improving care experience, enhancing population health, reducing costs, addressing worker well-being, and advancing equity.[145]

Accountable entities for communities or local areas can be a variety of agencies or organizations, including state or county government, a tribe or tribal government, a nonprofit organization, a behavioral health collaborative designed for crisis system administration and oversight, or other entity. Multiple entities may share elements of system accountability, such as states sharing some of these responsibilities with counties or local governments.[146]

SAMHSA recognizes that states, local governments, tribes and tribal organizations, territories, and jurisdictions are ultimately responsible for designing and implementing

Accountable Entities

State: Georgia

The Georgia Behavioral Health Reform and Innovation Commission (BHRIC) conducts comprehensive reviews of and initiates necessary reforms in Georgia's behavioral health system of care. Through oversight and funding resources for crisis services, the BHRIC creates policies and guidance for programs across the state to best serve the needs of Georgia residents.

County: King County, Washington

The King County Behavioral Health Advisory Board, comprised of volunteer citizens, reviews mental health and substance use disorder services and provides counsel on priorities, policies, budgets and programs to behavioral health service providers for King County residents.

Regional: Central Maryland Regional Crisis System

The Central Maryland Regional Crisis System, formerly known as the Greater Baltimore Regional Integrated Crisis System (GBRICS) Council, works to develop strategy, implementation, and sustainability of behavioral health crisis systems in the region, as well as support accountability for the regionally integrated initiative.

Tribal: OK Consortium of Tribes

The Oklahoma Intertribal Consortium is a collaborative effort to ensure behavioral health and substance use prevention resources are available across Oklahoma tribal nations. The Oklahoma Area Tribal Epidemiology Center serves as the public health authority under the Indian Health Care Improvement Act.

More Information

- Georgia Department of Behavioral Health and Developmental Disabilities, Behavioral Health Reform and Innovation Commission
- King County, WA Behavioral Health Advisory Board
- Central Maryland Regional Crisis System
- Oklahoma Area Tribal Epidemiology Center

their BHCSCCs and ensuring that the system is accessible, equitable, and integrated. SAMHSA also recognizes that successful BHCSCCs require organization, collaboration, and accountability at regional or local levels, including relationships among state Medicaid agencies and Medicaid managed care plans, law enforcement, EMS, hospitals, local agencies, behavioral health crisis providers, and individuals with lived experience. Therefore, states, local governments, tribes and tribal organizations, territories, and jurisdictions may choose to designate their existing behavioral health system structures (e.g., local/regional behavioral health authorities, community service boards, county behavioral health departments) to act as, or partner in the performance of the functions of, the accountable entity.

Essential Functions of Accountable Entities

Accountable entities are responsible for the following essential functions necessary for the operation and continuous quality improvement of comprehensive and equitable BHCSCCs:

- **Authority and Accountability:** The accountable entity should establish and communicate lines of authority and accountability throughout the BHCSCC. Entities should delineate the organizations and partners responsible for providing effective services through each of SAMHSA's three essential service elements, who has authority or serves as lead organization at different points in the continuum, and to define and lead the system towards the achievement of benchmarked outcomes. This includes medical leadership to ensure that systems are capable of supporting people with a range of medical and psychiatric concerns.
- **Community Assessment and Planning:** Accountable entities should involve diverse partners in the process of determining community needs and plans to address them. These partners include the broader behavioral health system, crisis partners outside the behavioral health system, peer and family-led organizations, organizations that serve children and youth, public and private payers, individuals who have used the system and their families, tribes and tribal organizations, and members of communities that have been historically disenfranchised and underserved by the crisis system. Accountable entities should identify the current need and forecast growth and a trajectory for the BHCSCC through community assessment and planning. They also should coordinate the multi-sector input for the assessment and planning process, map their BHCSCC, identify goals for the BHCSCC, develop specific action steps, and facilitate the ability for individuals and organizations to be held accountable for completing steps in the process.
- **Coordination and Integration:** Effective coordination among crisis system partners (e.g., EMS, law enforcement, hospitals/EDs, social services, schools, child welfare) across the state or local area is crucial to improve integration of services and systems, including improved data sharing, resource connectivity, and avoiding duplication of effort. Accountable entities should collaborate with systems that serve children and youth, adults, and older adults as well as individuals with I/DD to increase access to and quality of crisis services and improved outcomes for all.
- **System Flow, Continuity and Throughput:** Accountable entities are responsible for understanding how an individual is able to flow through the system, including entry and exit points. This can be accomplished through comprehensive system mapping. They should

have a process and mechanism for identifying where individuals are in the BHCSCC and the involvement of partner systems (e.g., law enforcement, EMS, social services, crisis-related services, other behavioral health services, and social services) in their care. Accountable entities can then use mapping to inform system gaps, service needs, and areas for improvement. System mapping can be similar to a systems-based approach of the "air traffic control" analogy noted in the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (PDF)* (2020) at a population instead of individual level. Additionally, accountable entities should develop and maintain a well-structured emergency plan to ensure that there is no disruption of services during large scale emergencies, such as a natural disaster or mass casualty event. These emergencies may also indicate the need for additional crisis support due to the unique behavioral health needs that may arise due to the nature of the event. These emergency plans should include specific protocols and procedures for collaborating with Incident Command Systems (ICS) and working alongside federal agencies that might be involved such as the Federal Emergency Management Agency (FEMA) and/or SAMHSA, as well as state emergency management organizations and local disaster response teams.

- **Financing:** The accountable entity should play an active role in coordinating funding streams for crisis services across funding sources and payer types, as well as provide input in coordination with states, tribes, territories, and payers into decisions related to the funding and contracting of services and providers. The entity also should be able to identify and support the best payment mechanisms and models to support income generation in the challenges of the crisis setting. Medicaid is generally the payer of last resort. Per federal regulations in 42 CFR 433.51(c), federal funds generally may not be used as non-federal share to draw down additional federal matching funds for Medicaid and the Children's Health Insurance Program (CHIP) expenditures. More details are provided in the subsequent section on Financing and Fiscal Sustainability.
- **Regulations:** Accountable entities should have the authority to create, interpret, and apply regulations to support effective behavioral health crisis management. Entities should balance the need for regulations to help ensure comprehensive and equitable services with the need for flexibility to ensure that regulations do not pose unintentional barriers for individuals to receive services. One example of this is being prescriptive with how many or what type of providers can deliver specific types of services. Regulations should aim to ensure adherence to evidence-informed practices and the entity's established standards across multiple situations or settings.
- **Data, Evaluation, and Quality Improvement:** Accountable entities are responsible for data collection, tracking, and sharing as well as evaluation of BHCSCCs and their services. In this role, accountable entities can:
  - Develop process and outcome metrics for services and system components.
  - Develop and implement processes for data collection systems, tracking data over time, data sharing, data use, and linking administrative data.
  - Develop and implement a standard about how to use data for continuous quality improvement for services and the system.

- Disseminate data and results to the public through dashboards and/or other visual tools to improve system transparency, celebrate successes, and raise awareness regarding system barriers.

Policy

Accountable entities typically have some authority to develop, interpret, and/or implement policies (e.g., legislation, regulation, or procedures) that are necessary to ensure BHCSCCs are accessible, equitable, and integrated. Accountable entities may not be able to impact all types of policies that impact the crisis system, such as federal and tribal laws and regulations and state and local policies for which partner agencies, such as law enforcement, have authority. Policy making should be done in a collaborative manner with authentic engagement and consideration of the partners in the BHCSCC. In these circumstances, identifying ways to support policy change and/or processes to improve the BHCSCC in the absence of specific authority is within the scope of the accountable entity. Specific roles and responsibilities for accountable entities may include but are not limited to:

- Analyzing, interpretating, and providing guidance to crisis system partners regarding legislation and policies that impact the implementation of components of the BHCSCC;
- Ensuring continuity of operations for essential services in cases of emergencies;
- Setting policies and providing guidance for essential behavioral health crisis services and requirements regarding their implementation;
- Developing policies to encourage system partners to work collaboratively and on how to clarify roles and responsibilities of crisis partners in specific situations; and
- Establishing and enforcing requirements for public and private payers to provide behavioral health crisis services coverage for individuals living within specific geographic areas.

Accountable entities should be empowered to create policies and rules designed to support a BHCSCC. Specific types of policies that accountable entities may consider developing, supporting, and implementing include but are not limited to:

- Establishing an oversight body and multi-sector advisory board for behavioral health crisis system;
- Advocating for and/or participating in legislative and/or regulatory changes to support diversion of individuals from EDs or jail;
- Establishing trauma-informed, decriminalized, and dignified mental health transport options;
- Setting roles, responsibilities, and accountability for referral processes, engaging or monitoring individuals, and providing follow-up services;
- Developing rules/oversight to implement help seeker satisfaction surveys and a process for implementation of complaint/appeals policies and procedures, including incorporation of oversight for independent third parties;
- Establishing competencies, roles, and responsibilities for different types of behavioral health crisis workers, including peer workers, to avoid role drift, establish clear scopes of practice, and describe how the multidisciplinary team can work together to ensure that the BHCSCC is served by an effective team;
- Developing rules related to data sharing among system partners and with the accountable entity

and/or other funders or oversight bodies (e.g., state, federal, tribal);

- Identifying and securing funding sources for the crisis continuum such as tribal, state, and/or local fees or funds for the BHCSCC;
- Expanding access to naloxone through the passage, implementation, and/or dissemination of information about Good Samaritan and Naloxone administration laws;
- Developing and enforcing critical incident management policies and procedures that are designed to improve the BHCSCC;
- Developing and ensuring the implementation of policies related to safety assessment and triage; and
- Understanding and interpreting compliance with federal laws while facilitating a stronger system such as compliance with Emergency Medical Treatment and Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2.

Communications and Community Engagement

Communications

Development of community-driven crisis communication plans should involve a broad set of partners, including the BHCSCC and the broader behavioral health system, crisis partners outside the behavioral health system, peer- and family-led organizations, organizations that serve children and youth, public and private payers, individuals who have used the system and their families, tribes and tribal organizations, and members of communities that have been historically disenfranchised and underserved by the crisis system. The goal should be to create publicly accessible materials and educational campaigns that highlight regional and statewide crisis care system resources with specific details on how the three essential elements offer immediate access to care for anyone in the community. Successful communications plans shape public discourse, influence the adoption of social policies, connect people to services, and provide education and motivation to influence behavior.[147]

Communication plans should include equitable and accessible content for the different audiences represented in the crisis system and be co-created with the target community.[148] Successful communications plans require content written in a manner that will broadly resonate; it also requires making the plans available in multiple languages and modalities to meet the community's needs.

In addition to messaging with broad appeal, tailored communications plans may be needed for specific populations or for roles within the crisis care continuum, including providers and policymakers. Research shows that messaging tailored to youth is particularly important for increasing public health awareness and behavior changes.[149] Youth are well-suited to support the development of communications that are specific to their needs.

Community Engagement

Community engagement is a process of developing relationships that enable partners to work together to address crisis-related issues and promote mental well-being to achieve positive health impact and outcomes. Community engagement enables changes in behavior, policies,

programs, and practices within communities.[150] Community engagement can assist with creating communication plans that appeal to different cultural and demographic communities, shape needs assessments, and inform quality improvement efforts to continue to enhance efficient and effective crisis practices.

Communities should develop and implement a plan to engage diverse partners in the design and operation of their BHCSCC. This ensures an effective response and facilitates ongoing trust building with care providers and community members.

The engagement plan should be embedded in the larger crisis care plan but also be able to serve as a standalone process. Communities should solicit and incorporate input from representatives of all entities involved in the BHCSCC (e.g., 988 Lifeline and other behavioral health lines, 911, MCTs, crisis stabilization, peer crisis respite, law enforcement, housing authorities, child welfare, adult and juvenile justice, tribes, Indian Health Service providers, domestic violence hotlines, re-entry providers, peer and family-run organizations). They also should incorporate the perspectives of individuals who have received or may in the future use crisis services and their families or other supporters. Multiple, diverse perspectives regarding BHCSCC design and identification of areas for improvement are critical to ensure that the system works for everyone.

Strategies for community engagement to embed in the plan could include surveys, listening sessions, information sessions, and lectures. Strategies can be organized in partnership with other local entities and may include attending pre-established community events to gather information in locations such as schools, places of worship, or community centers.

Establishing the Albuquerque Community Safety Department

In June 2020, the City of Albuquerque, New Mexico approved the creation of the Albuquerque Community Safety (ACS) department started with the singular probing, yet provocative question: "What if every call for behavioral health support brought care, not criminalization?" Albuquerque city officials subsequently formed the ACS Planning Committee, composed of key community leaders and experts, and engaged with local communities to develop the ACS. They gathered feedback through the ACS Community Input Survey, which received 2,858 responses and over 1,000 public comments. City leaders also hosted 7 virtual events with more than 25 community partner groups and summarized the results in a January 2021 Community Engagement Report (PDF). This feedback and report informed the strategic direction of the ACS which can be found in its December 2021 Organizational Plan (PDF).

Through this collaborative process, they have since clarified their vision to be a city where a person can call for help and get a purposeful, humane, and appropriate response in order to "to provide Albuquerque with a holistic, empathetic, and informed response to behavioral and mental health-related 911 calls." Responses are personalized to the needs of the individual, family, and community so that ACS can bring the right response at the right time. Among other milestones in their first year, they diverted their first 911 call and responded to over 16,000 calls in September 2021. Through ongoing implementation, they strive to create a collaborative environment that promotes the engagement of public safety and behavioral health first responders to fulfill the program's mission and continue to remain accountable to partners that provided strategic guidance by the transparent display of data on their website as well as a clear way to provide ACS feedback to inform ongoing operations.

More Information

- CSG Justice Center, ACS Department

The Center for Rural Pennsylvania provides the following steps to guide the development of a community engagement plan:[151]

Step 1: Define the issue;

Step 2: Identify the purpose and degree of citizen engagement;

Step 3: Identify tools for engaging citizens;

Step 4: Identify individuals and groups that need to be involved;

Step 5: Develop a plan for recruiting and retaining participants;

Step 6: Create a positive environment for citizen engagement;

Step 7: Develop evaluation criteria and decide next steps; and

Step 8: Maintain open lines of communication.

A routine evaluation of the community engagement plan (annually, or at a cadence that is decided upon by the organizing entity and collaborative partners) ensures that the plan continues to engage the community effectively. This effort should involve collaboration with the organizations involved in developing the plan. A routine evaluation allows for quality improvement, transparency/accountability, and sustainability of the engagement plan.

The following community engagement goals can be used to guide the evaluation:

- Enhance community members' awareness about the community and the specific issue being addressed.
- Promote community member involvement in generating and applying new insights and understanding.
- Use this knowledge to develop strategies to address the identified issue.
- Foster future opportunities for community members to connect and collaborate.
- Make these engagement opportunities and effective communication a regular and ongoing part of the process.

Equitable Behavioral Health Crisis Care

SAMHSA defines behavioral health equity as the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, American Indian, Alaska Native and Indigenous and Native American persons, Asian Americans, Native Hawaiians and Pacific Islanders, and other persons of color; members of religious minorities; LGB persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[152] Health inequities are rooted in systemic disparities that have long affected marginalized communities. In pursuit of equity, it is necessary to acknowledge that access, experience, and outcomes for behavioral health services vary significantly for different populations. For example:

- Racial and ethnic minority groups are 20 to 50 percent less likely to seek mental health services and are 40 to 80 percent more likely to discontinue treatment prematurely.[153]
- A study that examined access to adolescent mental health services through a "secret shopper" approach in which Black, Latina, and White voice actresses posing as mothers sought appointments for their traumatized children, found that Black and Latina callers were significantly less likely to receive appointments compared to their

White counterparts despite calling to request appointments with the exact same script.[154]

Health equity should be factored into all aspects of the BHCSCC to ensure that all individuals receive fair and just access to necessary resources and support, including those with complex comorbidities.

Impacted Populations

There are many aspects of identity that influence access to behavioral health care. An overview is provided in Exhibit 1 on the next page.[155]

Components of a Health Equity Framework

The following components are critical to ensuring that a BHCSCC is firmly rooted in health equity:[156]

1. **Culturally & Linguistically Appropriate Services:** Providing culturally and linguistically appropriate services helps reduce health inequities. HHS developed national standards for providing culturally and linguistically appropriate services (CLAS)[157] in health and health care. CLAS standards aim to promote health equity, enhance quality, and reduce healthcare disparities. These include standards related to governance and leadership, communication and language assistance, and engagement and continuous improvement. Additionally, these standards include culturally appropriate services for American Indian/ Alaska Native populations, such as traditional practices and training crisis service providers on the IHS and their local tribes.
2. **Representative Behavioral Health Crisis Workforce:** A representative crisis workforce fosters trust with individuals, enhances communication, and ultimately leads to improved access to care and better health outcomes. This includes individuals with lived experience as well as other demographic factors. A study of clients with severe and persistent mental illness from community mental health centers found that clients reported better recovery outcomes when they were treated by an ethnically matched individual.[158]
3. **Quality Improvement & Accountability:** Maintaining an effective, equity-centered, crisis system requires a data-driven approach.[159] Meaningful outcomes to assess equity should focus on linkage to care and symptom improvement, among other outcomes and impacts, as opposed to strictly process outcomes such as response times.

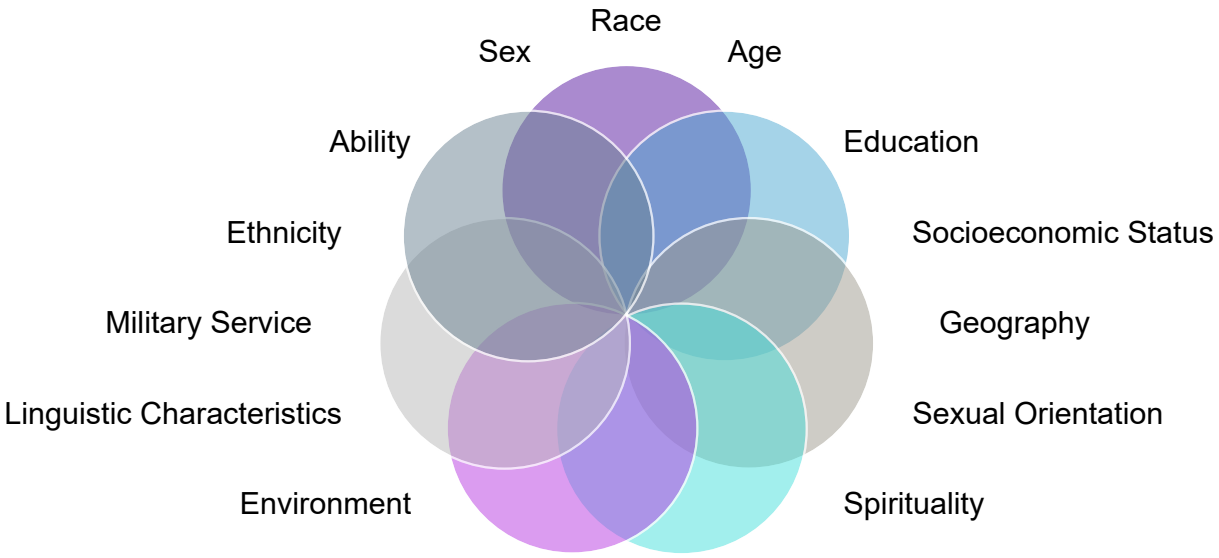
Health Equity Zones

Rhode Island's Health Equity Zone initiative uses funding from several federal, state, and local sources of prevention, categorical disease, and population health to create place-based "Health Equity Zones." These geographic areas are focused on addressing health disparities and creating health communities to progress towards health equity. Instead of the traditional model of providing communities with separate sources of funding to implement specific programs or address specific health issues, the Rhode Island Department of Health provides communities with combined funding. This enables them to work together to achieve shared goals for community health and well-being through was such as the alignment of staff, break down organizational silos, and the promotion of cross-sector collaboration.

More Information

- Rhode Island Department of Health, Health Equity Zones (PDF)

Exhibit 1. Identity Characteristics that May Impact Health Beliefs and Practices



4. **Addressing SDOH:** SDOH refers to a series of nonmedical factors and life experiences that influence health outcomes and health equity. These include factors such as stable housing, education, access to food, access to transportation, adverse childhood experiences, and others. An individual's SDOH has been found to have a significant influence on their health outcomes. By recognizing and addressing SDOH, providers can tailor care to meet an individual's specific needs.[160]

For additional resources on equity, please see:

- King County's Crisis Care Centers' Implementation Plan provides a more detailed explanation of the equity components described repviously.[161]

Evaluation and Data Collection

Data collection and evaluation of behavioral health crisis services is essential to developing and maintaining a BHCSCC that is responsive to the unique and evolving needs of the community. Evaluation also adds to the field of knowledge on evidence-based and evidence-informed practices and the degree of their effectiveness in different communities and contexts.

Data metrics for behavioral health crisis services should be identified based on their utility in supporting continuous quality improvement efforts. Communities should use data for early identification of community service needs and gaps, to develop an inventory of existing resources and assets, and to guide system improvement. Communities should select and apply an evaluation framework that will help achieve evaluation goals and provide results that can inform evidence-based decision-making. In addition to identifying local capacity and need, long-term outcomes and impacts should focus on the extent to which efforts contribute to the quintuple aim for health care by exploring impact on health, reduced costs, care

experience, implications on the crisis workforce, and the impact on advancing health equity for marginalized communities.

Standardized definitions are essential. It is important for there to be alignment both on how services are defined, and on the key operational and quality metrics that can support performance monitoring and evaluation of services. Introducing variability into data definitions and standards creates barriers to making cross-site comparisons or to evaluating the system in its entirety at the national level. In 2022, SAMHSA published *Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum,* which assesses the current state around data collection and provides examples of potential measures.

Guiding Principles

Crisis services in behavioral health rely on strong ethical and practice standards. Thorough, methodological evaluations and data collection approaches are crucial for improving public health actions. These evaluations should be useful, realistic, ethical, and accurate. To achieve this, evaluators should use the scientific method and have proper training to ensure their findings are credible and trustworthy. Stakeholder involvement is vital at every stage of the evaluation process, including conceptualizing the evaluation and selecting the approach.

In addition, evaluation data collection efforts should address health equity and seek to understand the broader context in which services are provided. This includes assessing both the intended outcomes of crisis services and any unexpected effects. It should involve input from partners, including those with lived experience, to ensure that the information is relevant and useful. This approach leads to better service delivery and improved health outcomes for diverse communities.

Transparency is also an important consideration; evaluators should identify the needs of service users early in the process and encourage open communication. When reporting results, it is essential to present a full picture, including positive and negative findings, while being clear about any conflicts of interest.

Steps in Evaluation

The six connected steps of the framework provide a starting point to tailor an evaluation for a particular program, at a particular point in time. The steps are as follows:[162]

- Assess the context.
- Describe the program.
- Focus the evaluation question design.
- Gather credible evidence.
- Generate and support conclusions.
- Act on findings.

Logic Models

Logic models are visual representations of the relationships among system or program inputs, activities, outputs, outcomes, and impacts.[163] They communicate the purpose of the system or program, who the contributors and partners are, the desired outcomes and impacts, and the specific mechanisms by which the goals will be achieved.

Evaluation of the BHCSCC and crisis services should begin with a logic model to provide a visual overview of the system or program depicting its resources, planned activities, and intended outcomes. This provides an invaluable resource to which leaders and evaluators can refer during implementation and continuous quality improvement.[164]

Data Governance

Data governance refers to the necessary frameworks, policies, and protocols developed by an agency or organization to manage all aspects of data collection.[165] Evaluation data collection should be anchored by a detailed data governance plan that should account for the following aspects:[166]

- **Data Quality:** Processes to ensure data is collected in an accurate and uniform manner.
- **Data Security:** Protocols in place to ensure data will be protected and only accessed by authorized individuals, including the handling of protected health information (PHI). Additionally, all data collection programs and protocols should respect Tribal Data Sovereignty.[167]
- **Data Sharing/Transparency:** List of audiences for each type of data and necessary considerations for each, processes and mechanisms for data sharing and data access, as well as routine measures in place to ensure data collection efforts are known and accessible to all relevant partners/community members. This may include data type, standards, and access/reuse considerations.[168]
- **Data Integration:** List of any external data sources and processes for data aggregation and usability.
- **Compliance:** List of any legal/regulatory requirements pertinent to data collection, storage, and sharing, and the measures taken to meet these requirements.

By maintaining an effective data governance plan, BHCSCCs can ensure transparent, effective, and safe data collection, sharing, and storage.

Quality Improvement

In addition to collecting data on program outcomes and impact, a key application of data in a BHCSCC is to drive continuous quality improvement. This involves collecting and analyzing data to pinpoint both strengths and weaknesses within services and operations, allowing for real-time corrections. Quality improvement evaluation processes should include the collection of both quantitative and qualitative data. In addition, it is important to assess how processes and procedures affect the overall BHCSCC and critical partners, including individuals with lived experience, crisis services workers across the three essential elements, EDs, law enforcement, and others.

Data and Evaluation Workforce Challenges

A significant challenge to evaluation and data collection efforts is the lack of funding to hire trained evaluators and facilitate effective data management. This can lead to an absence of evaluation and data collection efforts. Alternatively, using individuals who lack sufficient expertise could lead to efforts that are not rooted in evidence-based practices or that render inaccurate or incomplete data, all of which could contribute to programmatic decisions and management practices that are inconsistent with accurate evidence. Some agencies and organizations address this workforce challenge by partnering with local universities, which can offer expertise in data collection and provide the necessary infrastructure. These partnerships can help ensure that data are collected, managed, and analyzed in accordance with evaluation best practices and that data and evaluation results are made accessible to all participating entities.

Additional Resources

The following tools and resources can be used to support and inform data collection and evaluation efforts.

- The Centers for Disease Control and Prevention's (CDC) framework for evaluation is a guide for conducting evaluation for public health professionals. It is a nonprescriptive, practical tool, designed to summarize and organize the essential elements of program evaluation.[169]
- National Council for Mental Wellbeing's Quality Measurement in Crisis Services offers options for crisis services metrics from a human engineering, systems-level, performance improvement perspective. This resource provides a helpful framework for a person-centered approach to data collection.[170]
- The Equitable Evaluation Framework provides a structured approach to conducting evaluations that are grounded in the context and history of marginalization and disenfranchisement, incorporate diverse perspectives, enable analysis of data by groups for different outcomes and implications, and focus on promoting equity and justice.[171]

Optimizing Crisis Systems Through Technology

Technology enhances communication and coordination in the delivery of behavioral health crisis services. Technology, such as GPS-enabled mobile team services, real-time bed registry and coordination, centralized outpatient appointment scheduling, electronic health record integration with partner services and health information exchange networks, and the use of artificial intelligence in responder training and evaluation, all play an important role in expanding access to high-quality crisis care.[172]

This section discusses the use of technology to enhance the BHCSCC in the following areas:

- Technology to Coordinate Care;
- Technology to Facilitate Data Collection;
- Technology to Enhance Access to Care Through Telehealth;
- Privacy and Security Considerations; and
- Artificial Intelligence.

Technology to Coordinate Care

Technology enhances communication and coordination in the delivery of behavioral health crisis services. Some states, including Maine, Michigan, California, and Indiana, are establishing centralized platforms that facilitate seamless coordination among the partners in their BHCSCC, including initial crisis response through service delivery, referrals, and follow-up. Some of these states are developing a coordinated system for services so that all contacts flow into the same system and can be handled within a single platform to improve the quality and timeliness of services.

Coordination for the Overall BHCSCC

BHCSCCs that incorporate strategies for overall system and services coordination can increase efficiencies, communication among partners, and help seeker satisfaction with the BHCSCC. Offerings such as GPS-enabled mobile team dispatch, real-time bed registry with coordination of care, and appointment scheduling decrease crisis

response time and help individuals receive needed services quickly.[173]

Referral systems provide users with regularly updated information about bed availability. These systems also allow authorized users to submit HIPAA-compliant electronic referrals to a secure bed using predetermined forms and protocols. One benefit of this system is that it can be timed, documented, and monitored to ensure seamless care coordination.[174]

Another option is a referral network, where websites provide regularly updated information on bed availability, allow users to submit HIPAA-compliant electronic referrals to secure a bed, and support referrals for behavioral health crisis and outpatient services to and from service providers who are members of the same referral network. Like referral systems, referral networks can be monitored.[175]

Technology to Facilitate Data Collection

States that have used technology to consolidate their data between 988 and their other crisis services—from mobile dispatch to law enforcement collaboration—have been able to be transparent with their data and launch interactive dashboards to the public to visualize growth and outcomes throughout the crisis continuum. An example from Wisconsin is provided.

There are a number of technology providers which have supported data collection and sharing. This includes opportunities for referral management and linkage.

Data standardization and automation can help improve the care delivery process. However, having too many data fields can overwhelm providers and decrease the likelihood that they will submit complete and accurate data. Although technology can help improve access to data, BHCSCCs should communicate the types of data that are high-priority as opposed to data that is beneficial to have but not critical. Even with technology to aid in the data collection process, BHCSCCs should have individuals who are responsible for reviewing data to ensure accuracy and quality.

Wisconsin's Crisis Services: 988 Suicide & Crisis Lifeline Data Dashboard

The University of Wisconsin Population Health Institute Evaluation & Engaged Research Group developed the Crisis Services: 988 Suicide & Crisis Lifeline Data Dashboard, in collaboration and partnership with the Wisconsin Department of Health Services and Family Services of Northeast Wisconsin (operators of the 988 Wisconsin Lifeline). The dashboard provides a snapshot in time of 988 Wisconsin Lifeline contact volume, demographics, and other significant data metrics. The information is used only in summary form and allows for evaluating the needs, performance, and reach of the Wisconsin 988 Suicide & Crisis Lifeline over time. This includes addressing services gaps and helping ensure that everyone has an equal chance to benefit from the service.

More Information

- Wisconsin Department of Health Services, Crisis Services: 988 Suicide & Crisis Lifeline Data Dashboard

Technology to Enhance Access to Care Through Telehealth

One benefit of telehealth that has long been recognized is the ability to reach individuals in underserved locations, including rural, remote, and tribal areas. This allows the individual to receive

help without having to spend hours and possibly money on transportation to a health facility outside of their community and away from their support network. It is important to note that broadband access can be a barrier to the utilization of this modality in some communities as well as other potential technological hurdles. These concerns offer the opportunity for problem-solving and advocacy to ensure that this resource is available as broadly as possible.

Telehealth offers the opportunity to connect someone in crisis who is unable to receive in-person care to virtual assessment and clinical services. When in-person care is far away or not possible, telehealth can prevent tragedies and reduce the time for someone in crisis to receive services. Additionally, the use of telehealth provides for the expanded reach of services due to a limited licensed and/or otherwise credentialed workforce. Telehealth also can be a useful modality for follow-up crisis services. If an individual is leaving a crisis stabilization facility or an inpatient setting, the availability of telehealth follow-up care can reduce the chance of a return visit to the ED or hospital. Follow-up care through telehealth is valuable in rural, remote, and tribal areas where it may not be feasible for someone to travel regularly to a follow-up services provider.[176]

Privacy and Security Considerations

Privacy Expectations

For help seekers to trust responders during a behavioral health crisis, they should be able to understand the privacy framework for the help they are seeking. This means translating expectations and legal requirements around privacy and confidentiality into plain language with transparency so that everyone understands privacy protections.

Regarding the sharing of user data through 988, SAMHSA's 988 Quality and Services Plan specifies expectations and requirements related to data from help seekers. This requirement is not only for 988 crisis centers but also for states developing their own platforms to handle 988 calls to ensure a baseline of privacy expectations regardless of which center an individual contacts.

The expectations for privacy include requirements that contact centers will keep confidential any help seeker's personal information and that this information will not be used, communicated, disclosed, or disseminated, except in limited circumstances, such as cases of imminent risk or situations required by applicable law or judicial mandate.

Crisis providers should familiarize themselves with the federal, state, territory and tribal laws that pertain to their organization to ensure that policies and practices are consistent with these laws and regulations, and that there is clarity for the public on how these policies impact the person seeking help.

Cybersecurity Considerations

Behavioral health providers should increase their focus on cybersecurity throughout the BHCSCC, especially as systems are being linked and connected in new ways, which puts personal data more at risk with increased vulnerable entry points. Everyone working on related systems and platforms should ensure cybersecurity standards and protections are in place that will protect crisis-related infrastructure and user information. Policymakers and providers should ensure that they collect only the data necessary, anonymize whenever possible, and implement security measures.

SAMHSA's 988 Cybersecurity Requirements

In SAMHSA's *Saving Lives in America: 988 Quality and Services Plan (PDF)*, SAMHSA specified 19 requirements as a minimum baseline for all of the 988 crisis contact centers and states developing centralized platforms.[177] Examples of requirements include the following:

- Ensuring that systems and centers have formal information security and privacy policies, business continuity analysis, and incident response plans;
- Systems are monitored and tested to ensure privacy controls are operating as intended;
- User information and data are protected through encryption, multi-factor authentication, inventories of asset management, and records management; and
- Potential vulnerabilities are minimized to the extent possible by testing backup solutions, standing up a web application firewall, reviewing third party software for risk, and using automated tools to manage system vulnerabilities in a timely manner.

Crisis contact centers employ voice over internet protocol (VoIP), wireless, and computerized voice systems that introduce new vectors for bad actors, are susceptible to multiple distributed attacks with greater automation from a broader geography, and use computers and software applications that are vulnerable to malware and ransomware attacks. The level of diligence should increase across the space to ensure the protection of behavioral health crisis services and the information of the people who use them.

Artificial Intelligence (AI)

AI capabilities can improve the quality of the behavioral health crisis care through training stimulations and evaluation of contact conversations to offer counselors immediate feedback on how they can improve. AI solutions can involve the processing of confidential data; therefore, it is critical that AI vendors adhere to data security and privacy regulations, especially around sensitive healthcare data, and provide documentation around security practices. In addition, organizations should consider the establishment of an AI governance structure to oversee development and implementation of AI systems and their ethnical use. Organizations that use AI also should be able to communicate effectively about how the AI model works to build confidence and trust in AI results and insights.

Veterans Crisis Line (VCL) Simulated Training for Responders Using AI Personas

In 2023, the U.S. Department of Veterans Affairs (VA) revealed the winners of a $20 million challenge to reduce Veteran suicide. One of the winners was ReflexAI, an AI-powered tool that can help the VCL train counselors to meet the needs of their help seekers. ReflexAI uses an AI program for simulated crisis line scenarios to train cohorts of new counselors starting with the VCL. Even though VCL responders are already trained in other ways, these adjunctive tools provide additional skills and resources to responders. ReflexAI is a training tool only; it is never used directly to communicate with Veterans, service members, or those calling about a Veteran or service member.

More Information

- Fierce Healthcare, VA Announces 10 winners in $20M Challenge to Reduce Veteran Suicide

Challenges and Risks with AI

As stated in the 2024 SAMHSA publication, *Innovative Uses of Technology to Enhance Access to Services within the Crisis Continuum (PDF)*,

a mental health crisis is a profound human experience and one that AI inherently cannot have. Mental health systems have increasingly recognized the value of lived experience. Any human behavioral health crisis services provider, regardless of their experience with mental illness, has more shared experience with a person accessing care than AI, which has none. In addition, for crisis contact centers, there is a risk to having AI respond to crisis contacts because there is no human to monitor and adjust the AI response if necessary. For these reasons and the risks of bias, misinterpretation, and potential for harm to help seeker, the American Counseling Association has recommended that AI should not be used for direct crisis response.[178]

The potential for bias in AI tools for mental health is a concern, as it can impact the accuracy and fairness of the results and AI already has known biases.[179] Bias can emerge when AI is trained on data not representative of the broader population, leading to AI amplifying these biases. For instance, if AI is trained on data featuring individuals from a specific group, the algorithm may not be as effective in identifying mental health issues in people from other groups. To mitigate this, it is essential to develop AI algorithms using diverse datasets that account for various demographic factors, such as race, age, sex, ethnicity, and socioeconomic status.[180]

In addition, the pace of AI may outstrip existing regulatory frameworks. Clear policy and guidance are needed to make sure the benefits of AI can be adopted broadly while minimizing the dangers it presents. For these reasons, it is important that organizations that interface with AI technology in behavioral health services continuously monitor the quality, efficacy, accuracy, and fairness of the AI algorithms to ensure that they are providing value and do not perpetuate biases, misinformation, or create harms.[181]

Financing and Fiscal Sustainability

Overall Strategic Considerations

The overall financing strategy for behavioral health crisis services should be aligned with SAMHSA's vision for crisis care that is fully coordinated and integrated and provides the necessary emergency capable services that offer health first responses and reduce law enforcement response and ED usage. In this strategy, every partner has a role, including federal, tribal, and local governments and payers, among others. Developing a BHCSCC with a full continuum of services for all ages that corresponds with this vision requires investment at all levels—federal, state, tribal, and local. This investment is critical because an effective BHCSCC serves everyone, saves lives, and creates healthier communities, just as other essential services such as police, fire, and EMS do.

Successful financing requires attention to the financial needs associated with start-up and capital investments, as well as sustainability and ongoing operational support, maintenance, and upgrades.

SAMHSA's vision is that everyone will be able to access all types of behavioral health crisis services regardless of their ability to pay. In the current environment, essential behavioral health crisis services often lack adequate coverage and funding, and help seekers sometimes are unable to participate in services due to inability to pay. Although insurance may cover professional fees

for routine visits, insurance typically does not pay for the infrastructure needed to maintain a responsive BHCSCC. In addition, funding for behavioral health crisis services differs significantly across states, tribes, and territories. Often these funds are pieced together, lack consistent support, and are not aligned with financing best practices. Funding challenges are exacerbated by varying expectations regarding service delivery by crisis providers and payers, which results in a wide variety of misaligned and uncoordinated financing methods.[182]

The financial infrastructure for a Firehouse model provides a useful framework for this vision of behavioral health crisis services. The aspiration of the Firehouse model is to align behavioral health crisis services payment with that of existing public safety services (e.g., EMS, fire, police). This requires the crisis system to be funded around 24-hour capacity and access, in a way that is commensurate with the needs and size of the local community. With this approach, help seekers define their own emergencies and can expect to receive a prompt and thorough response regardless of insurance or diagnosis.[183] In addition, these services should be available even when they are not needed, making investment in infrastructure a key component. This vision includes recognition of the training and credentials necessary to deliver emergency care across the continuum. People generally do not question fees to support 911 services because they value and expect those services to be available when they need them. Though it is admittedly a shift to think of behavioral health crisis care in the same way, SAMHSA's vision is that communities will increasingly see the value that sustaining health first responses for behavioral health crises provides. Funding crisis care as an essential public health service using a Firehouse model may be an effective strategy in order to ensure that crisis care is widely available to "anyone, anywhere and at anytime"[184] in a manner that is consistent with public safety services. Braiding and blending of funding and examining any relevant parallels and opportunities to create equitable access to crisis services as comparable to physical health services are additional opportunities to continue to grow a robust crisis continuum. Utilization of such an approach could create sustainable funding for crisis services, reduce overall healthcare costs, and improve crisis response experiences and outcomes for individuals in crisis.

Additional lessons and direction can be gleaned from recent DOJ settlements that have addressed civil rights issues and required jurisdictions to build crisis systems that do not rely on law enforcement. For example, a recent settlement in Louisville, Kentucky, found that the Louisville Metro Government and the Louisville Metro Police Department discriminated against people with behavioral health disabilities when responding to them in crisis.[185] The findings report included several recommended remediation steps, including:

- Expand the reach and capacity of the MCT pilot program and transition to a behavioral health-led response to people experiencing a behavioral health crisis, and
- Improve coordination between Louisville's 911 communications center and crisis hotline to facilitate mobile crisis response.

Such investigations and recommendations serve to advance the mandate around improved crisis system infrastructure.

To inform local decision making, the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) developed a chart of funding opportunities across

federal, state, and county governments and non-government sectors.[186] Counties can use a variety of these resources to build robust, accessible, and sustainable behavioral health BHCSCCs. Different funding approaches also can be leveraged to address SDOH and upstream and downstream factors that intersect with the crisis experience.

There is significant momentum both at the federal and state levels, where there are emerging strategies (and multiple tactical efforts) to move toward financing a crisis system everywhere. Federal legislation for CCBHCs, direction from CMS to improve Medicare funding of the crisis continuum, efforts to better define the elements of the crisis system, plus existing Medicaid flexibilities, emerging local tax levies, Medicaid waivers and other flexibilities, and state legislation mandating insurance companies to cover these services are among the many examples. Every community in every state should be on this path.

Innovative Financing Models

States and other entities are implementing innovative financing models to fund BHCSCCs and behavioral health crisis services. Models with potential to improve availability of crisis services include value-based care arrangements, bundling for crisis episodes using the Diagnostic Related Group model or other mechanisms, and risk adjustment models such as the Patient Driven Payment Methodology utilized in nursing facilities, which provides acuity adjustments based upon the expected needs of the individual. As states, local governments, tribes, territories, and jurisdictions continue to implement BHCSCCs, new innovative funding and sustainability models will continue to emerge.

One excellent example of a comprehensive financing strategy is the CCBHC model. SAMHSA's vision is for continued growth of CCBHCs across the United States. CCBHCs are designed to provide comprehensive, coordinated care for mental health and substance use conditions that is trauma-informed and recovery-oriented. CCBHCs must provide nine required services including mobile crisis services, must have walk-in crisis stabilization capacity during extended business hours, and are required to coordinate with local crisis systems. CCBHC services should be tailored to meet the individual needs of their communities and must be provided in a timely way to anyone who expresses a need for services, regardless of their ability to pay or place of residence. CCBHCs

Oklahoma CCBHC PPS

Oklahoma has developed a statewide CCBHC program which has transformed outpatient mental health and substance use care delivery, including the crisis response. Under the CCBHC model, Oklahoma reimburses CCBHCs using a per person cost-based prospective payment system for Medicaid eligible individuals which covers a comprehensive package of services, including mobile crisis and other crisis services. This allows Oklahoma the flexibility to tailor delivery of crisis response and include innovations, such as remote access to mental health professionals through iPads in police patrol cars, as a part of their CCBHC funding. Oklahoma requires that CCBHCs have crisis services available 24/7/365 and that they must be able to provide a mobile crisis response within 1 hour for urban areas and 2 hours for rural areas from the time the services are requested. They must also make available either directly, or through an agreement, facility-based crisis stabilization, urgent recovery clinics, and outpatient substance withdrawal management.

More Information

- Oklahoma Department of Mental Health and Substance Abuse Services, CCBHC

are required to have care coordination partnerships in place with a range of entities including regional 988 crisis contact centers. In addition to providing crisis services, CCBHCs are well positioned to provide care following a crisis because of the CCBHC access and comprehensive service requirements.

CCBHCs are supported through Medicaid as well as through SAMHSA CCBHC expansion grants. CCBHCs must be certified by their state as meeting federal standards (CCBHC Certification Criteria)[187] as a part of a state CCBHC program or have submitted an attestation to meeting these standards to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. There are two tracks in the CCBHC Expansion grant program: Planning, Development, and Implementation (CCBHC-PDI) grants assist clinics to establish and implement new CCBHC programs, and Improvement and Advancement (CCBHC-IA) grants support existing CCBHCs to enhance and improve their programs.

The CCBHC model is also supported through Medicaid. Section 223 of the Protecting Access to Medicare Act of 2014 authorized a Medicaid CCBHC Demonstration program that provides cost-based reimbursement for the delivery of nine required CCBHC services, which include crisis services, through a Prospective Payment System (PPS). This PPS provides states and CCBHCs the opportunity to design a comprehensive package of behavioral health services that is paid via cost-based rates. This is different from the traditional way of financing services, which typically focuses on payment of individual services at rates which may not cover the full cost of providing services. In 2024, CMS released Section 223 CCBHC Demonstration PPS Guidance (PDF) for the CCBHC Demonstration as well as its Updated CCBHC Cost Report in support of new payment flexibilities provided to states participating in the CCBHC Demonstration.[188] Since 2019, some states have also supported the CCBHC model through existing Medicaid state plan options and waivers. A new CCBHC Medicaid state plan option was also authorized under Division G, Title I, Subtitle B, Section 209 of the Consolidated Appropriation Act, 2024. For more information on CCBHCs, you can visit the SAMHSA CCBHC. The National Council on Mental Wellbeing has also released, The Role of Certified Community Behavioral Health Clinics in Crisis Services and Systems, which describes how CCBHCs can be a vital part of crisis systems.[189]

Reimbursement Strategies

Expanded reimbursement opportunities can complement infrastructure and capital investment through coverage of professional and ancillary services in crisis settings. Optimal reimbursement will take an all-payer approach and should address issues of misaligned incentives and parity, particularly where there remains lack of clarity around how parity applies to crisis services. The crisis system is currently structured in a way to disincentivize treating the most under-resourced people and the most acute crises. Adults and youth with complex presentations, high levels of acuity, who are uninsured or with limited supports are disproportionately burdened with lengthier ED stays, seclusion and restraint, and poor connections to ongoing care. The current fiscal landscape also generally incentivizes the number of visits over quality of care. In addition, the overall specialty behavioral health system has not been at the forefront of value-based care payment model development. A BHCSCC that includes emergency capable care should be compensated appropriately to care for everyone in a way that achieves improved access to services and quality outcomes.

In addition, parity enforcement is a key priority with respect to financing crisis services. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits or prior authorization requirements) imposed on mental health and SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply substantially to all medical and surgical benefits in the same benefit classification.[190] However, 15 years after MHPAEA's enactment, people with mental health and SUDs still face barriers to treatment when benefits are denied that they reasonably expected to be covered by their health plan. Such gaps in care can potentially complicate existing crisis episodes and increase the risk of future episodes.

In order to pay for sustainability in crisis services, the payment has to be matched to the true cost of the service. This usually means bundled cost-based rates for services with flexibility to accommodate different levels of intensity within the same program. Reimbursement approaches will be only partially successful unless there is consideration of underwriting for service availability as well as recognizing the need to establish rates that will facilitate recruitment and retention of licensed and credentialed professional workers. In addition, current evidence-based services that generally are uncompensated, such as crisis care follow-up, need more explicit inclusion in health plans. Providers can structure service delivery to optimize reimbursement. Given that provider enrollment can be challenging for smaller provider organizations, one potential solution is to pool administrative resources to decrease burden. In addition, organizations can think creatively and have flexibility with staffing to make the best use of licensed professionals, including use of incident-to-billing.

Examples of State and Local Appropriations to Support BHCSCCs

- In Massachusetts, the state's Fiscal Year (FY) 2023 budget created the Behavioral Health Access and Crisis Intervention Trust Fund. This fund supports not only the Lifeline but also mobile and other community-based behavioral health crisis intervention services available 24/7 regardless of ability to pay.
- Through state legislation, Utah created the 988 Mental Health Crisis Assistance Account designed to strengthen and fund the crisis system. The account was appropriated to support all 988 services as well as the BHCSCC, including 988 contact centers, MCTs, and crisis stabilization services.
- The State of Washington, in addition to passing a cellular telephone fee, passed comprehensive legislation that requires coverage of behavioral health crisis services though commercial insurance payment vehicles.
- Tucson, Arizona developed its capital infrastructure for its high-intensity behavioral health emergency and high-intensity behavioral health extended stabilization centers through a local bond that permits facility construction.
- Counties in Michigan can use alcohol beverage tax funds to support SUD-related crisis care.
- A great number of states are supporting a wide array of services across the BHCSCC in their communities through the use of opioid settlement funds, acknowledging the importance of no and low barrier access to services such as emergency and crisis services to SUD-prevention and treatment as well as the great mental health comorbidity with that of SUDs.
- States, local governments, tribes, territories, and jurisdictions have engaged private partnerships, foundations, and philanthropy in order to fund their BHCSCCs.

Commercial Plans

Partnerships with commercial payers are at an early developmental stage in the crisis landscape and represent an opportunity to further strengthen payment for these services. Commercial plans cover the vast majority of people in the United States, either through group or direct purchase plans. Engaging them in this systems work is critical, both in terms of the value for their members but also the potential to decrease inpatient stays and implement BHCSCCs that prevent future crises. Some of this work is well underway. For example, Michigan has been working with Michigan Blue Cross, which provides coverage for about 40 percent of Michiganders, to define service benefits and codes to support commercial reimbursement.

Medicaid

As one of the largest sources of funding for mental health and SUD services, Medicaid has a significant interest in ensuring access to emergency and crisis stabilization. There are several authorities within Medicaid that can be used to provide services along the crisis continuum. The Medicaid option for providing enhanced payment for qualifying community-based mobile crisis intervention services (PDF) is one example.[191] Section 5124 of the Consolidated Appropriations Act, 2023 (CAA, 2023) requires the Secretary of HHS, in coordination with CMS and the HHS Assistant Secretary for Mental Health and Substance Use, to issue guidance to states on the continuum of behavioral health crisis services and how states may support implementing this continuum through Medicaid and CHIP.[192] This guidance that is under development and scheduled to be released in 2025 will provide more detail on opportunities to enhance crisis service sustainability.

Medicare

States and communities can consider models developed through CMS' Center for Medicare and Medicaid Innovation (Innovation Center). These models have been developed and research-tested through demonstrations across the United States to support healthcare system transformation. The Maryland Total Cost of Care approach is one such model.[193] This model has made a nearly $80M investment in the state's crisis services through the Health Services Cost Review System Regional Partnership Catalyst Grant Program. Building on the Maryland model, which has a focus on behavioral health crisis care, the CMS Innovation Center launched the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model to focus on multi-payer alignment for state and regional healthcare transformation with the goal of improving the total health of state populations and lowering costs.[194]

Additionally, Medicare has created new coding and payment for safety planning interventions for individuals at high risk for suicide or overdose, and also U.S. Food and Drug Administration-(FDA) cleared digital mental health treatments, which went into effect January 1, 2025. Starting January 1, 2024, CMS is paying for service performed by peer support workers under the supervision of a billing practitioner (these services are called principal illness navigation-peer support). Additionally, CMS is now enrolling Marriage and Family Therapists and Mental Health Counselors as Medicare providers, covering Intensive Outpatient Program Services, and have expanded billing for services, such as behavioral health integration services.[195]

On January 18, 2024, CMS announced the Innovation in Behavioral Health (IBH) Model. The IBH Model is focused on improving the quality of care and behavioral and physical health outcomes

for adults enrolled in Medicaid and Medicare with moderate to severe mental health conditions and SUDs.[196] The IBH Model provides whole-person, integrated care for beneficiaries with moderate to severe behavioral health conditions by supporting a long-term relationship between the beneficiary and a behavioral health provider, and can be a component of comprehensive crisis prevention and postvention services. As the IBH Model's care delivery and payment approach focuses on care integration, care management, and care coordination, the model does not encompass payment for physical or behavioral health procedures, tests, or other services, including crisis services. States could implement the IBH Model in a way that would support longitudinal care for beneficiaries coming out of the crisis system. Additionally, IBH Model infrastructure funding will allow practice participants to enhance their systems, which could allow for real-time tracking of beneficiary involvement with the crisis system.

Federal Grants

SAMHSA and its federal partners, including CMS, support behavioral health crisis services development through a number of mechanisms. States, local governments, tribes, tribal organizations. territories, and jurisdictions are able to apply for grants and other funding opportunities through federal partners that they can use to support BHCSCC infrastructure, build service capacity, and enhance the crisis continuum of care for communities. Federal programs such as the Community Mental Health Services Block Grant (including, but not limited to the five percent reserved for crisis care services), Substance Use Prevention, Treatment, and Recovery Services Block Grant, CCBHC Expansion Grants, Community Crisis Response Partnerships Cooperative Agreements, State Opioid Response (SOR) grants for crisis services that focus on opioids and/or stimulants and co-occurring conditions, and Children's Mental Health Initiative Grants, can be used as funding strategies to support the BHCSCC. In addition, SAMHSA and other federal agencies routinely provide grant support to communities through various programs. There are a range of resources across federal partners, including the Indian Health Service Suicide Prevention and Care Program and the Collaborative Crisis Response and Intervention Training Program offered through the DOJ's Bureau of Justice Assistance.[197,198] The U.S. Department of Agriculture's (USDA) Rural Health Grant Program furnishes loans and grants to provide funds for the costs of construction, improvement, or acquisition of facilities and equipment needed to provide broadband services.[199] All these programs and more that are supported through SAMHSA and other federal partners can be accessed through Grants.gov.

Additional State and County Based Approaches

States and counties employ a wide range of approaches to financing BHCSCCs and behavioral health crisis services. These approaches consider varying population demographics, available resources, state and local policies, and local community needs. Several states have enacted legislation to support sustainable funding mechanisms. As permitted with the Hotline Designation Act of 2020, states, local governments, tribes, territories, and jurisdictions are permitted to charge cell phone fees to support 988 and related crisis services. As of October 2024, 10 entities have enacted such legislation. States also have passed other legislation to direct appropriations to support BHCSCCs.

Making the Business Case for a BHCSCC

There has been considerable debate on the need to demonstrate return on investment or cost savings to justify the costs of behavioral health crisis services. SAMHSA's vision is that emergency capable services should exist across the crisis continuum without the need to demonstrate cost benefit (similar to 911 and EDs). However, there is broad recognition that partners, including payers, states, local governments, tribes, territories, and jurisdictions, can benefit from such business cases when considering burden on plan participants and taxpayers. It has been posited that more effective crisis care would have significant financial benefits that extend beyond the healthcare arena, including decreased disability, lower utilization of high-cost healthcare services, and decreased reliance on law enforcement and jails. Because costs and benefits are applied in different sectors, it is challenging to make direct inferences about cost savings.

However, if a community has success strategically engaging potential contributors and beneficiaries in a collaborative process of BHCSCC development, two things may become clear:

1. The more contributors there are, the less burdensome each required contribution will be to make a successful BHCSCC.
2. Each contributor, in a well-designed system, will gain value from their contribution. The value may be different, and it may or may not lead to a financial "profit," but it will be valuable in other ways. Insurers may reduce unnecessary hospitalizations and ED costs; hospital systems may reduce unnecessary burden on ED throughput and volume; local governments may find reduction of costly inefficient utilization of limited law enforcement resources; and foundations and other community investors may benefit from reductions in negative outcomes and community struggles that are associated with the lack of effective BHCSCCs.

Behavioral Health Crisis Workforce Recruitment, Retention, and Support

Behavioral health crisis workforce shortages are common in communities across the United States and are of particular concern with professions that require a high level of specialized training, including psychiatrists, addiction medicine specialist physicians, and licensed clinical staff.[200] These shortages impact BHCSCCs as well as the broader specialty behavioral health system, and they are expected to continue in the future.[201] It is important to identify and implement behavioral health crisis workforce strategies for recruitment, retention, and support, including approaches for certified peers, 988 and mobile crisis responders, care coordinators, counselors, and other trained crisis professionals. Addressing crisis workforce concerns and supporting crisis teams that reflect the communities they serve will help increase access, equity, and quality of crisis care for individuals and families. Improving BHCSCC workforce support also will help address the fourth goal of the quintuple aim to address worker well-being and improve the workforce experience.[202]

In 2023, the Action Alliance convened the Crisis Workforce Task Force, a group comprised of national crisis workforce experts from the public and private sector to delineate the issues affecting the crisis workforce and develop recommendations for addressing them. In 2024,

Action Alliance published *Sustaining the Crisis Workforce: A National Road Map* (Roadmap) based on input from the task force and results from key informant interviews across the nation examining the state of the crisis workforce.[203] The Roadmap outlined the goals of behavioral health crisis workforce recruitment, retention, and support. SAMHSA supports these three goal areas that are focused on improving crisis worker experience and well-being. A summary of crisis workforce recommendations and action steps applicable to states, tribes, local governments, territories, jurisdictions, and behavioral health crisis organizations and partners is presented in this section.[204] Input from SAMHSA, Action Alliance's Roadmap, and behavioral health crisis experts informs the following recommendations and suggested action steps.

Recruitment

Implement recruiting and hiring practices to ensure that the crisis workforce reflects the community it serves.

- Focus on a trauma-informed philosophy and transparent culture that understands that individuals working in crisis care have more adverse childhood experiences and trauma than the general population.[205]
- For states, tribes, territories, and local governments, consider implementing financial incentives or recognition for organizations whose crisis workers and leadership team reflect the communities in which they work.
- States, tribes, and territories may also consider creating centers of excellence or other workforce development centers to create opportunities for standardized training and competency building.

Develop and conduct innovative recruitment approaches, including partnerships with education institutions (e.g., high schools, colleges/universities), community organizations, local departments of labor, and professional associations and organizations.[206]

- Develop scholarship programs to recruit more individuals, including those with lived experience, into careers in the behavioral health crisis field.
- Establish internships and practicums for individuals with lived experience and others who desire training to work in behavioral health crisis to help them obtain credentials.
- Develop mentorship programs that provide support and resources to individuals that are new to the field.
- Implement strategies from Building New Horizons, a peer hiring guide, to support efforts to recruit, retain, and support peer workers in behavioral health crisis services.[207]

Support the use of loan repayment and tuition assistance programs for behavioral health crisis workers.

- Review any current programs to determine if they are applicable to the crisis workforce. Forbes Advisor provides information about loan repayment and tuition assistance programs by state.[208]
- Identify which types of crisis workers would qualify for specific programs.
- Collaborate with employers to ensure they are implementing any applicable loan repayment and tuition assistance programs.[209]

Create public awareness campaigns or include as part of 988 public awareness campaigns advertisements to increase visibility about career opportunities in behavioral health crisis.

- Develop a messaging and dissemination strategy that incorporates social media and other innovative methods to reach diverse and historically under resourced communities that may not be receiving information about opportunities in the behavioral health crisis workforce. Reference *Effective Messaging Strategies: A Review of the Evidence* for more information and ideas related to engaging and communicating with diverse communities.[210]
- Collaborate with trusted community partners, such as faith- and community-based organizations; educate state legislators and decisionmakers; and use community-based dissemination platforms such as social media groups and newsletters to share information about behavioral health crisis career opportunities.[211]

Make use of federal funding opportunities and programs designed to increase the number of behavioral health clinicians and their placement in crisis services.

- Use the American Counseling Association's *Federal Grants for Counseling to identify potential funding opportunities.*[212]
- Ensure that current grants and other funding sources are fully utilized to support crisis worker recruitment efforts.[213]
- For behavioral health crisis organizations, consider collaborating and partnering with states, local governments, tribes, territories, and jurisdictions that receive federal funding to increase the number of behavioral health professionals in crisis services.

Alaska Behavioral Health Aide Program

The Alaska Native Tribal Health Consortium's Behavioral Health Aide (BHA) Program supports mental health and wellbeing for Alaskan Native individuals, families, and communities through training and education for members of tribal communities to become BHAs. BHAs serve as health educators, counselors, and advocates and are trained to address behavioral health issues that affect their communities. The BHA Program also provides technical assistance to tribal partners to help them implement the program and increase access to training, resources, and support.

Regional Tribal Health Organizations employ BHAs to provide a variety of behavioral health services, including wellness promotion, psychoeducation, safety planning, crisis counseling/emotional support, skill-building, and warm hand-offs and referrals to community resources.. Being a member of the community means that the Since BHAs are a member of the community, the knowledge of the local culture and traditions and can support the provision of culturally relevant services.

BHAs help improve the health of Alaska Native people through education that reduces the stigma associated with behavioral health issues. BHAs develop relationships with community members and work to build awareness about mental health and substance use issues and how to find help. They are trusted community members who can provide needed services during a behavioral health crisis and help community members achieve improved mental health and wellbeing.

More Information

- Alaska Native Tribal Health Consortium, Behavioral Health Aide Program

Retention

Establish and communicate equitable career trajectories, including requirements for advancement, for the crisis workforce.[214]

- Ensure that information is shared with crisis workers at the time of hire and regularly thereafter about career paths, promotion opportunities and processes, and the trajectory to management and leadership positions.
- Establish and support a culture of career development and growth through creating professional development paths, conducting regular discussions with staff about career goals and growth, and having resources available for continuing education and training for all crisis workers.
- Use available resources to develop and implement policies to ensure equitable career pathways and opportunities for a diverse crisis workforce that values workers with lived experience, such as the Alignment for Progress *National Strategy for Mental Health and Substance Use Disorders and the National Association of Peer Supporters' (NAPS) National Practice Guidelines, developed in partnership with SAMHSA.*[215,216]

Develop, conduct, and assess professional training for crisis workers, including training on resilience, preventing burnout, wellness, mentoring best practices, and supervision.

- Implement policies and practices aligned with crisis worker expectations of professional training, mentoring, and supervision. Ensure proper employee to supervisor ratios to facilitate successful supervision and support.
- Provide incentives to experienced crisis workers to mentor other crisis workers, such as assistance with tuition and student loan repayment. Advocate for funding to compensate mentors for their time to train and offer guidance to students and early career workers.[217]

Make financial investments to offer equitable compensation with incentives, employee benefits, and flexibility for crisis workers.

- Establish and maintain sustainable funding streams (e.g., federal, state, local, private, and other) that provide adequate reimbursement for crisis services to support equitable compensation, incentives, and benefits for crisis workers. Collaborate with federal and state funders such as CMS regarding reimbursement for the full range of crisis services, including peer support and other community-based services.
- Support crisis worker choice in location and offer flexible scheduling options when possible to promote work-life balance and offer breaks from intense behavioral health crisis response work.[218]

Support

Establish and encourage a culture of well-being through a wellness program that includes crisis worker resource groups, peer support, education on mental wellness, and access to referral resources.

- Collaborate with human resources specialists to develop wellness programs and maximize use of available financial and staff resources.
- Encourage leaders to express themselves openly and authentically in support of a culture of transparency to help reduce the stigma associated with mental health and SUD symptoms and stressors among the crisis workforce.[219]

- Establish and maintain supports to help ensure the success of all crisis workers and particularly those from historically marginalized and disenfranchised communities. This could include but is not limited to assessing interests and needs for additional education and training, creating space for team activities outside of the workplace to build morale and team cohesion, and ensuring that supervisors mentors and provide feedback that is strengths-based, supportive, and that considers the whole person and their life circumstances inside and outside of work.

Vibrant Emotional Health Workplace Wellbeing Project

Vibrant Emotional Health, as the 988 Lifeline administrator, is offering access to the Well-Being Index, a validated tool created by the Mayo Clinic, to all contact centers in the network to support the assessment of their team's wellness and wellbeing and to provide actionable data for organizational-based change and resources for individual staff. The Well-Being Index is an online self-assessment tool that measures six dimensions of mental distress and well-being.

More Information

- Mayo Clinic, Well-Being Index

Conclusion

The 2025 National Crisis Guidelines represents a critical step in reimagining how the United States addresses behavioral health crises. By emphasizing a comprehensive, integrated, and equitable approach, these guidelines lay the foundation for a system that ensures no individual faces a behavioral health crisis without access to appropriate support and resources.

Through the development and strengthening of crisis services such as the 988 Lifeline, mobile crisis and outreach services, and crisis stabilization services, the nation can move toward a future where timely, person-centered, recovery-oriented, and quality care is the standard. This vision extends beyond immediate crisis intervention, aiming to address systemic inequities, reduce reliance on emergency services, and promote wholistic health and resilience for individuals and communities. The path forward requires the continued commitment of federal, state, tribal, and local governments, alongside community partners, service providers, and individuals with lived experiences. By working collaboratively, these partners can transform behavioral health crisis response into a system that is not only effective but also compassionate and inclusive.

The guidelines are not an endpoint but a roadmap for ongoing progress. They provide a vision for the future—a future where behavioral health crises are met with understanding, support, and actionable care, ensuring the well-being and dignity of all individuals. Together, we can build a crisis care system that truly provides "Someone to Contact, Someone to Respond, and a Safe Place for Help" and serves "anyone, anywhere, at any time."[220]

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