Washington
988 Lifeline Crisis Center
Best Practice Guidelines

Guidelines for deployment of appropriate and available crisis response services

Washington State Health Care Authority

Washington State Department of HEALTH

Contents

Washington 988 Lifeline Crisis Center Best Practice Guidelines acknowledgements

Washington State Health Care Authority

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Introduction to Washington's 988 Lifeline Crisis Center Best Practice Guidelines

A mental health crisis can be devastating for people, families, and communities. Although we cannot know when a crisis may occur, we can create and maintain a system that is agile and responsive when the need arises. A strong crisis response system in Washington state minimizes delays, reduces reliance on law enforcement (LE) and emergency departments, and only uses restrictive responses when no other safe solution can be found. These Washington 988 Lifeline Crisis Center Best Practice Guidelines support aligning Washington's crisis services with the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, published by the Substance Abuse and Mental Health Services Administration (SAMHSA), SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care[1], and its companion report from the National Association of State Mental Health Program Directors, (NASMHPD), A Safe Place to Be, Crisis Stabilization Services and Other Supports for Children and Youth[2]. SAMHSA's vision is to provide people in crisis with "someone to talk to, someone to respond, and somewhere to go or a safe place to be," so they can get support quickly with minimal barriers. 988 Lifeline crisis centers serve as the "someone to talk to" piece of this vision. They also help people in crisis connect with "someone to respond" and "somewhere to go" or "a safe place to be."

There are two types of crisis centers that operate in the state of Washington. These include 988 Suicide & Crisis Lifeline Centers (formerly known as National Suicide Prevention Lifeline [NSPL] providers) and Regional Crisis Lines (RCLs). These crisis centers offer free, confidential services by phone, text, and chat to people in Washington.

People experiencing a mental health crisis deserve a response that will support their needs. First responses by crisis services can reduce interventions from law enforcement (LE) and emergency responders. This can help improve outcomes for people experiencing a mental health crisis or thoughts of suicide.

Services must be responsive and available when people initially need them before there's a need for involuntary services or emergency services. Voluntary services should be used whenever possible, with more restrictive options only used when safety makes them necessary. In practice, this means:

- Working to resolve crises for people contacting the 988 Lifeline
- Offering Mobile Crisis Outreach, stabilization services, next-day appointments (NDAs), and referrals
- Following the Mobile Response and Stabilization Services (MRSS) model for youth and dispatching mobile crisis youth teams for in-person response and in-home stabilization

Purpose

Engrossed Second Substitute House Bill 1477, passed by the Legislature and signed into law in 2021, directed the Washington Health Care Authority to:

> Create best practices guidelines by July 1, 2023, for deployment of appropriate and available crisis response services by crisis call center hubs (now referred to as designated 988 contact hubs) to assist 988 Lifeline callers to minimize nonessential reliance on emergency room services and the use of law enforcement, considering input from relevant community partners and recommendations made by the crisis response improvement strategy committee.

[1] https://store.samhsa.gov/product/national-guidelines-child-and-youth-behavioral-health-crisis-care/pep22-01-02-001

[2] https://store.samhsa.gov/sites/default/files/nasmhpd-a-safe-place-to-be.pdf

As of the publication date of this 988 Lifeline Crisis Center Best Practice Guidelines in 2023, 988 contact hubs have not yet been designated. These guidelines serve to provide best practices to Washington's current crisis centers (both 988 and RCLs) and will do the same for 988 contact hubs when they are designated in 2026.

Scope

These best practice guidelines do not override any statutes or rules and are not meant to override any agency policies or clinical judgment.

These best practice guidelines apply only to 988 Lifeline crisis centers contracted by regional Behavioral Health Administrative Service Organizations (BH-ASOs) or the Department of Health (DOH). The best practices are meant to be adopted by crisis centers and the future 988 contact hubs as training and infrastructure support and allow.

Goals

Washington Health Care Authority (HCA) is committed to implementing nationwide best practices for crisis care in alignment with SAMHSA, National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit,[3] SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care[4], and its companion report from NASMHPD, A Safe Place to Be, Crisis Stabilization Services and Other Supports for Children and Youth[5] to include MRSS for youth.

The 988 Lifeline Crisis Center Best Practice Guidelines support the goal of a crisis system with less reliance on emergency services such as LE and emergency departments. They also support better standardization and coordination of practices across the state. They are developed as a reference point for crisis centers as well as other crisis services and system partners. They serve to increase awareness and use of crisis centers by people in crisis. They also help inform and encourage emergency responders such as LE, fire, and Emergency Medical Services (EMS) to use crisis centers as an initial contact point and resource to get people help.

[3] **https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf**

[4] https://store.samhsa.gov/product/national-guidelines-child-and-youth-behavioral-health-crisis-care/pep22-01-02-001

[5] https://store.samhsa.gov/sites/default/files/nasmhpd-a-safe-place-to-be.pdf

Guidance and applications for the larger crisis system

988 Lifeline crisis centers are one part of Washington's larger crisis system. It's important for crisis center staff to understand the context of the larger system as it applies to their work. This section outlines ways to align Washington's larger crisis system with SAMHSA's National Guidelines, along with keys to success for 988 Lifeline crisis centers and the crisis system.

Aligning Washington's crisis system with SAMHSA's National Guidelines

A main goal for Washington's crisis system is aligning with SAMHSA's best practice toolkit, which emphasizes the importance of a responsive crisis system for anyone in the state experiencing a crisis.

Elements of SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit include:

- Providing services from licensed and credentialed clinicians
- Responding to the person's location within one hour
- Providing or coordinating transportation if needed
- Training staff to follow the three core competencies of:
    1. Trauma Informed approach (TIA)
    2. De-escalation
    3. Harm Reduction
- Including peers in crisis response
- Responding without uniformed staff unless under special circumstances
- Scheduling or connecting someone to outpatient services including NDAs
- Providing in-home stabilization where possible

These key elements fit into a framework that defines the necessary parts of an effective crisis response system: "someone to talk to, someone to respond, and somewhere to go."

- **Someone to talk to:** Implementing crisis centers with a robust technical platform to coordinate with partners and share information
- **Someone to respond:** Implementing and expanding Mobile Crisis Outreach to respond to people in mental health crisis
- **Somewhere to go/a safe place to be:** Receiving crisis stabilization at home or in a safe place

Additional goals include creating a coordinated statewide system with equitable services to meet the unique cultural needs of the people being served.

- **Equitable coverage:** Ensuring services are available statewide from providers who are culturally competent, local, and able to engage in the diverse populations of their regions
- **Integrating lived experience expertise:** Adding people with lived experience, working as peers or clinicians, to bring their unique perspective to their community, help reduce barriers, and improve empathy in care.

Core principles

There are several core principles important to services and service delivery in the crisis response system.

Equity

Services must be available to anyone in need, everywhere in the state, and in a manner that speaks to each person and works best for their circumstances.

People need to receive culturally appropriate, timely, and accessible care during a crisis. This means the crisis response needs to focus on their needs in the moment and come from someone they can trust, with the least restrictive intervention possible.

Support without stigma

Washington's crisis system must deliver services and support in a way that reduces mental and behavioral health stigma.

Stigma can prevent people who need help from reaching out, but everyone within the crisis system can take steps to reduce stigma. This can include listening to people who use these services and adapting services to meet their needs and improve their experience. The system must partner with communities to build relationships and provide education.

The help-seeker defines the crisis.

The crisis system must be available and responsive to all levels of crisis severity. Unintended gatekeeping can have a negative impact, and people may:

- Avoid reaching out until their distress becomes more serious
- Seek help from 911 and other emergency services instead of contacting the 988 Lifeline
- Try to manage things on their own instead of seeking help

The crisis system must be proactive and support people who reach out for support in any type of crisis. A person in crisis, not the crisis worker, should define the crisis so someone can respond if they need help.

No wrong door

It can be difficult for people in crisis to navigate the complex crisis system, especially in times of intense emotional distress and other psychological strain. A person may call or present at any entry point of the crisis system, and staff must be willing and able to assist by connecting them to services and resources that meet their needs.

Trauma-informed support

A trauma-informed crisis system recognizes a person's trauma and its potential effects. The system must be aware that accessing help can re-traumatize people. Using and recommending appropriate trauma-informed resources and skills can help minimize re-traumatization.

Trauma is a widespread experience, whether it's caused by a large-scale disaster, a major life event, historical trauma, or other circumstances. Trauma can affect people mentally, emotionally, and physically for years after the event.

Research has found strong links between the number of traumatic events a person experiences in childhood and effects on health outcomes throughout their life.[6] Most adults will experience a traumatic event in their life, but not everyone who experiences a traumatic event will develop a long-lasting trauma response. According to SAMHSA's Concept of Trauma and Guidance for Trauma-Informed Approach:

> Individual trauma results from an event, series of events, or set of circumstances that someone experiences as physically or emotionally harmful or life threatening. Trauma can have lasting adverse effects on a person's function, as well as their mental, physical, social, emotional, or spiritual well-being.[7]

[6] **https://www.cdc.gov/violenceprevention/aces/index.html**
[7] **https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf**

It is important for crisis service providers to be trauma informed. This means acknowledging that trauma is common and produces different responses. Being trauma-informed means adopting key assumptions about trauma. Sometimes referred to as the four "Rs," these include:

A program, organization, or system that is trauma-informed:

- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively **resist** re-traumatization[8]

Organizations that adopt these assumptions should adhere to the six core principles of being trauma-informed:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender Issues

Being trauma-informed means taking an organizational approach to adopting the key assumptions and principles into the internal support structures of the organization. It also includes supporting the people we serve and work with. This structure can empower those who have experienced trauma and help them heal.

- **Awareness and mindfulness of the nature and impact of trauma:** People respond to different events in many ways. Some will experience a traumatic situation with no long-term effects, and others may experience long term effects. Trauma can affect a person's outlook and perspective on life. It can cause physical issues and interrupt daily functioning. Trauma can affect emotional, cognitive, and behavioral responses, which may seem like overreacting or underreacting to situations. A trauma-informed approach is important to employ in crisis situations to increase understanding and provide appropriate services.
- **Provide safety and empowerment:** A person who has experienced trauma needs a safe and stable place to be while in crisis. Explaining each step of the process in crisis resolution can promote a feeling of safety. Empowering a person to take charge of their situation and help determine how they will resolve the crisis can promote healing for those affected by trauma.
- **Avoid re-traumatization:** One of the most important parts of a trauma-informed approach is avoiding re-traumatization of a person in crisis by recognizing the signs of trauma and acting accordingly. A person's trauma reaction to a crisis may make it harder for them to resolve the crisis. Creating a safe environment and empowering people in crisis to make decisions on their terms can lead to more successful outcomes. It's also important to use de-escalation techniques that do not involve force or coercion when a person expresses strong emotions.

Services should support harm reduction principles

Reducing the harmful effects of behavior is important when working with people in crisis. Harm reduction involves a range of non-judgmental approaches and strategies that provide and enhance knowledge, skills, resources, and supports for people to make safe, informed, and healthy decisions.

According to Harm Reduction International:

[8] **https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf**

- Harm reduction refers to policies, programs, and practices that aim to minimize the negative health, social, and legal impacts associated with drug use, drug policies, and drug laws.
- Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support.[9]

At its core, harm reduction is about recovery and empowerment to help people reduce the negative effects of their substance use. Interventions are tailored to a specific person's needs to reduce the negative effects of substance use and promote safe choices. Harm reduction can include encouraging a person to reduce substance use or use needle exchanges or providing housing and employment interventions.

Services should be developmentally appropriate

Interventions should be developmentally and age appropriate. It's important for crisis staff to understand that brain development continues into a person's 20s. Teenagers have emotional, cognitive, and psychological differences, including heightened sensation-seeking, impulsivity, risk taking, and risk perception.

Increased behaviors of concern can signal early symptoms of a mental health condition, which may lead to contact with LE. When youth are contacted by LE, trauma symptoms may arise, including fight, flight, or freeze responses. These can manifest as hostility, running away, forgetting vital details, or inability to focus when questioned. These actions can be perceived as hostile, uncooperative, or non-compliant, which may lead to juvenile justice processes.

In older adulthood, cognitive functions like conceptual reasoning, memory, and processing speed may begin to decline. Mental health symptoms in older adults may resemble age-related changes, which can get in the way of prevention, early intervention, diagnosis, and treatment of underlying medical and psychiatric concerns. Interventions that help reduce barriers for older adults, including navigating technology, transportation, or access to resources should be tailored to their needs.

Youth moving from the custody of their parents to their grandparents may experience greater developmental, physical, behavioral, academic, or emotional difficulties. As a result, when grandparents raise young children or teens, the entire family can benefit from access to developmentally appropriate crisis care and resources. For example, learning more about technology safety, current trends in child development, and communication and de-escalation strategies can all help grandparents provide trauma-informed care.

People with developmental or intellectual disabilities, brain injury, or illnesses affecting the brain and cognitive functions will also benefit from flexible crisis interventions. Crisis staff who are knowledgeable about these conditions can recommend appropriate resources.

Services should be culturally responsive

Cultural responsiveness not only applies to cultural norms and differences but also extends to honoring the rules and shared values of a person in crisis and their families. Crisis responders must be mindful of a person's culture and avoid imposing their own values, rules, or practices upon the people they help.

Integrating peers into crisis work

People with lived experience can meet a person empathetically through shared experience. Peers can be an invaluable tool in reaching people in crisis. Expanding the use of peers in crisis work provides another option for people to express themselves and feel heard in a crisis.

Keys to success

Many factors play a part in a successful mental health crisis system.

[9] **https://hri.global/what-is-harm-reduction/**

Providing education

There can be misconceptions about behavioral and mental health, mental health crises, and the crisis response system. This makes it essential to educate system partners and the public about:

- What mental health crises are
- What the crisis response system does
- How to access services
- What to expect when services arrive

Educating system partners and people who use the crisis system can help reduce frustration and decrease stigma.

Building partnerships

Partnerships are key to education about the crisis system, referrals to and from the system, communicating changes, and identifying gaps and barriers. It's essential to build and maintain good relationships with key partners, such as:

- Local decision makers
- School districts
- First responder personnel and administrators, including emergency medical services, fire departments, and LE
- Co-responders
- Hospitals and emergency departments
- Tribal partners
- Medical systems
- Outpatient mental health care workers
- Public Safety Answering Points (PSAPs)/911
- Youth System of Care partners
- Courts
- Jails and Juvenile Justice Centers

Developing trust

The people of Washington, first responders, and system partners must trust that the crisis system can effectively support people in need. Education, good partnerships, and demonstrating skill through action are keys to building this trust. Each encounter with a partner or person needing services must be treated with the necessary respect and understanding. This can help build trust in the responsiveness and effectiveness of the crisis system and its staff.

Crisis Center requirements

Comparison of 988 Lifeline crisis centers and RCLs

In the state of Washington there are two major crisis contact systems serving people in crisis: 988 Lifeline crisis centers and RCLs. The systems are currently separate, even though many 988 Lifeline crisis center operators also operate an RCL. This is because of different certification or licensing standards, separate funding streams, and most importantly, role in the system. Below is a quick summary of the key differences between 988 Lifeline crisis centers and RCLs.

	988	RCL
Federal Oversight	National 988 administrator: Vibrant Emotional Health	For Medicaid: CMS Block Grant: SAMHSA
State Oversight	Department of Health	Health Care Authority
Regional Oversight	N/A	BH-ASO
Subnetworks	Veterans Crisis Line, Spanish Language Line, Native and Strong Lifeline, and LGBTQI+ Youth Subnetwork Line	N/A
Where does funding come from?	SAMHSA, state funds	Braided funding of Medicaid, Mental Health block grant, state funds.
Summary of role	Anonymous and confidential support for people having thoughts of suicide, mental health crises, substance use concerns, or any other kind of emotional distress	Primary point of contact for people trying to access the formal crisis system. Many contacts are for specific resources like Mobile Crisis Outreach, Youth Mobile Crisis Outreach, DCR, or even to the contact center as part of a treatment plan
How to contact:	Call or text 988, or chat with the 988 Lifeline	1-800 number or local numbers for connection with community partners

Minimum requirements for Crisis Centers

Part one covers general requirements. Part two covers requirements for 988 Lifeline crisis centers. Part three covers requirements for RCLs.

General Crisis Center requirements

Availability

Crisis center services must be available 24 hours a day, every day of the year with the appropriate level of staff to meet the demand. Due to 24/7 availability requirements and the unpredictability of community crisis needs, staffing should be flexible to accommodate sudden and predictable changes in demand.

Community coordination

Crisis centers need to establish firm ties with communities in their service areas. This has several purposes, including:

- Ensuring access to emergency services for situations that need an emergency response
- Raising visibility of the contact center
- Coordinating ongoing services to help people stay safe and avoid reaching a point of crisis

Privacy and confidentiality

Crisis centers must maintain privacy and confidentiality of information consistent with federal and state requirements. Youth between the ages of 13 and 17 may seek and consent to evaluation and treatment for mental health, substance use disorders (SUD), or withdrawal management without parental knowledge or consent. Crisis centers have a duty to allow people contacting them to remain anonymous if they choose and if no safety risks require the need to break this confidentiality.

Documentation

Crisis center staff must keep documentation of their calls. These notes must be reviewed by supervisors regularly to ensure documentation meets minimum standards and that any issues in practice are corrected. Documentation must include the following,[10] as applicable to the crisis service provided:

- A summary of each crisis service encounter, including the date, time, nature of the crisis, and duration of the encounter
- Call (or contact) duration
- The names of the participants, if disclosed
- A follow-up plan or disposition, including any referrals for services, including emergency medical services
- Whether the person has a crisis plan and any request to make one
- The outcome, including the basis for a decision not to respond in person when a telehealth intervention was provided
- The name and credential of the staff member providing the service

Crisis center workers should document services provided as soon as possible. Concurrent documentation is encouraged. This will ensure they can provide notes to any follow-up services about the encounter. Documentation should be done in an electronic health record following employer guidelines and procedures and within confidentiality laws.

Trauma-informed approach

Being trauma-informed in a crisis center means recognizing two main things:

1. Many people have experienced trauma.
2. Everyone experiences trauma differently.

It's important to support help-seekers in feeling safe and empower them to share their experiences openly if they feel comfortable doing so. It's vital to avoid re-traumatizing someone, which may mean allowing a person to talk about previous triggering contact situations and avoiding triggering comments.

It is also important that contact center staff understand the effects of their own trauma and the possibility of their work causing vicarious trauma. Crisis centers should have a robust system that:

- Allows staff to self-identify when trauma affects them, or they feel burned out
- Provides assistance and support for staff.

Harm reduction

Effective crisis services are grounded in the principles and practices of harm reduction. Harm reduction offers a non-punitive approach to substance use that is not bound to any current or future goal of abstinence. These

[10]WAC 246-341-0901 and WAC 246-341-0910

features can be controversial. Harm reduction is evidence-based, person-centered, and lifesaving. You do not need to agree with or support the person's actions to practice harm reduction. According to Harm Reduction International:

> Harm reduction refers to policies, programs and practices that aim to minimize the negative health, social and legal impacts associated with drug use, drug policies, and drug laws.
>
> Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support.
>
> At its core, harm reduction is about recovery and empowerment to help people reduce the negative effects of their substance use. Interventions are tailored to a specific person's needs to reduce the negative effects of substance use and promote safe choices. Harm reduction can include encouraging a person to reduce substance use or use needle exchanges or providing housing and employment interventions.

988 Lifeline crisis center requirements

All 988 Lifeline crisis centers must meet the accreditation standards set forth by the federally designated 988 administrator: Vibrant Emotional Health.

Certification/accreditation

They must show proof of certification/accreditation from at least one entity. Each entity has its own standards and practices that the center must follow to keep their certification/accreditation. In Washington, 988 Lifeline crisis centers are certified by the American Association of Suicidality and/or the International Council of Helplines.

Training and personnel

Initial training is required for all 988 Lifeline crisis center staff before they take a call, text, or chat. Many standards require this training to be interactive and delivered in a variety of formats to ensure skill learning. Skills checks are often used to ensure competency, and staff are required to undergo regular training to keep skills up to date.

Support for crisis counselors is required in the form of programs and immediate support from supervisors or designated staff to help crisis counselors deal with stress. Supervisors are required to support their crisis counselors by coaching and providing recognition of contact. They are also required to assist crisis counselors in certain situations to ensure the best outcome for both the person in need of support and the crisis counselor.

Community connections

Accreditation requires 988 Lifeline crisis centers to maintain sufficient community connections and provide outreach about the services their centers offer. This is to ensure that if a person needs resources from either a community partner or another crisis center, partners can refer to each other and feel secure the person's needs will be met.

Quality assurance

As part of their accreditation standards, 988 Lifeline crisis centers are required to keep and track key metrics that allow evaluation of the center's performance. Examples of these metrics are:

- Number of calls, texts, and chats initiated
- Number and rate answered in-state
- Number answered out-of-state
- Number and rate of calls, texts, and chats abandoned
- Number of calls transferred

- Average answer time
- Average handle time
- Routing of calls
- Call outcomes (e.g., follow up, cross-system coordination, accountability, any immediate services dispatched)

988 Lifeline crisis centers are required to regularly review their metrics and practices that influence these metrics to make necessary improvements through updates in other business practices.

Vibrant Emotional Health, the national administrator of the 988 Lifeline, tracks metrics for all 988 Lifeline crisis centers in the nation. They measure many of the quality assurance metrics and update goals for in-state answer rates as capacity grows. Call centers may also track additional metrics that are different from Vibrant's to ensure effective and efficient operations. These metrics may include things like the time staff spend on calls and the number of calls escalated for support.

Suicide risk and emergency situations

988 Lifeline crisis centers have always focused on preventing suicide and helping people with their distress. Robust training and screening for suicide or threats to others are built into the contact process, with the goal of reducing thoughts of suicide and suicide attempts. The decision to initiate an emergency response should be made with a supervisor.

Staff roles and descriptions

988 Lifeline crisis centers rely on well-trained staff with appropriate credentials and experience to support a person in crisis. It's important for staff in all centers to identify their counterparts in other centers to ensure they can hand off contacts and learn from each other.

- **General requirements:** Staff in all centers must be appropriately licensed and certified for the work they do. This may include education requirements for certain roles.
- **988 Lifeline crisis center staff:**
    - **Supervisor:** No education requirements. Supervisors provide support to the crisis counselors and manage escalated issues like safety concerns and difficult calls.
    - **Crisis contact taker:** Must be fully trained in interventions for people making contacts but does not require any formal education. Many centers will employ either someone with a bachelor's degree or with lived experience. For elevated risk calls, an escalation strategy can ensure clinically trained and/or educated staff complete risk assessments and make determinations.

RCL requirements

Minimum requirements for RCLs are established in the Health Care Authority's (HCA) contracts with BH-ASOs, state laws and rules, and statewide practices.

Licensing standards

RCLs must be operated by Behavioral Health Agencies (BHAs),[11] which are licensed by DOH and certified to provide "Behavioral Health Information and Assistance Services"[12] following the standards for the service, "Crisis Telephone Support Services."[13]

The basic requirements in these service standards are:

- Make services available 24 hours a day, 7 days a week.

[11] **RCW 71.24.037**
[12] **WAC 246-341-0660**
[13] **WAC 246-341-0670**

- Maintain a resource directory to coordinate referrals for voluntary and involuntary crisis services and assist in connecting people to resources and potential follow-up with the person's clinician.
- Staff must be trained to triage, assist, and identify appropriate interventions for the help-seeker while providing support until achieving an outcome.
- The crisis counselor documents the encounter with their appropriate credentials listed and time and duration.
- Documentation includes a summary of the intervention. This summary should include names of the people involved, whether they were able to access crisis plans, outcome of the call, and/or follow up services.

HCA standards

In addition to licensing standards, HCA has some key standards for RCLs regarding call response and abandonment that are reported by BH-ASOs to HCA on regular intervals to ensure quality:

- RCLs must answer any phone contact within 30 seconds at least 90% of the time.
- RCLs must not have a contact abandonment rate higher than 5%.

RCLs may have other standards due to Medicaid funding and contracts with Managed Care Organizations (MCOs) that require different reporting, services connections, and/or documentation standards. Additionally, many other functions such as referrals and outcome data are tracked at the regional level to identify any quality assurance issues.

Staff roles and descriptions

RCLs rely on well-trained staff with appropriate credentials and experience to support a person in crisis. It is important staff in all centers can identify their counterparts in other centers to ensure they can hand off contacts and learn from each other.

- **General requirements:** Staff in all centers must be appropriately licensed and certified for the work they do. This may include education requirements for certain roles.
- **RRCL staff:**
    - **Supervisor:** The supervisor for an RCL must be a Mental Health Professional (MHP) and provide supervision for Mental Health Care Practitioner (MHCP) working under them.
    - **Crisis contact takers and shift leads:** Must meet the definition of an MHCP and be licensed or credentialed by DOH to work in a BHA.

Privacy, confidentiality, and mandatory reporting

Everyone in Washington has the right to access crisis services anonymously and safely. Steps need to be taken to secure any information or records related to a person accessing crisis services.

Legal guidelines for privacy

Crisis services are medical services that fall under the jurisdiction of federal and state laws. Services must be delivered in a manner that preserves the privacy and confidentiality of a person in crisis. The key authorities for legal guidelines are:

- The Health Insurance Portability and Accountability Act (HIPAA)[14]: Federal law that establishes the minimum standards for protection, privacy, and security of Protected Health Information (PHI).
- Uniform Health Care Information Act, Chapter 70.02 RCW[15]: State law that governs privacy.
- 42 CFR part 2[16]: Federal law that establishes standards for protection of most data related to SUD treatment and programs. More information on these standards can be found here: **Sharing Substance Use Disorder (SUD) Information: A Guide for Washington State**
- RCW 18.225[17] for Counselors, and RCW 18.19[18] Agency Affiliated Counselors.

Confidentiality and crisis care coordination

For the purposes of care coordination, crisis system providers may share PHI without consent, as needed, to any person the crisis provider believes is providing health care to the person experiencing a crisis.

Best practice: Getting a release of information (ROI) from the person in crisis or their guardian is a best practice to support trust between crisis system staff and those receiving crisis services. This is equally true for care coordination between agencies.

HIPAA and RCW 70.02 generally prohibit PHI from being disclosed without the person's consent unless an exception applies.

Confidentiality and adolescents

Under Washington state law and in accordance with RCW 71.34, adolescents between the ages of 13 and 17 may request and receive outpatient treatment, including voluntary crisis services, without parental consent. It's best practice to include parents/caregivers in the intervention, but the adolescent may not always agree to this. In some cases, including parents/caregivers may not be safe for the adolescent, so it's essential to balance confidentiality and safety. When adolescents need in-person response, a park, school, or community location may offer a safe meeting location. If the youth is in severe distress or at risk of harming themselves or others, safety considerations override confidentiality concerns, and the youth should not be encouraged to leave their present location.

Just like adults, adolescents have the right to decide who can be given information through ROIs. Responders should understand and comply with all confidentiality laws listed herein, to include limits of confidentiality, or when a responder is required to disclose for the safety of the person in crisis, others, and/or mandatory reporting requirements.

[14] **https://www.hhs.gov/hipaa/index.html**
[15] **https://app.leg.wa.gov/rcw/default.aspx?cite=70.02**
[16] **https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2**
[17] **https://app.leg.wa.gov/rcw/default.aspx?cite=18.225**
[18] **https://app.leg.wa.gov/rcw/default.aspx?cite=18.19**

Confidentiality and coordination with PSAPs

According to the 988 Convening Playbook for Public Safety Answering Points[19] (the standard for the NENA Suicide/Crisis Line interoperability):

> Sharing of data between 911 and other entities within the crisis ecosystem can be critical for enabling the right response at the right time for individuals in crisis. Both critical incident data and caller information (e.g., caller ID, address, IP address) would ideally be able to be shared with partners, including Lifeline contact centers and first responder agencies…. There is no reasonably foreseeable legal risk (including regarding HIPAA) to a PSAP for requesting that a carrier ping the imminent risk user's location during exigent circumstances that threaten the user's life or that of a third party. Nor is there a reasonably foreseeable legal risk (including regarding HIPAA) for the PSAP to provide the crisis line with disposition information relating to the attempted rescue of such user.

This means information from a 988 Lifeline crisis center can flow to a PSAP if an activation of emergency services is needed. This also allows PSAPs to let the crisis center know about the outcome of a response for the contact center to follow up.

Best practice: If a call is transferred from a PSAP to a 988 Lifeline crisis center or crisis response services take over a call, let the PSAP know of the outcome of the contact by debriefing with them. This will build trust with the PSAP to hand off more calls.

Stigma and personal privacy

Accessing the crisis system can be stigmatizing for many people. In many communities around the state, some people consider reaching out for help through a crisis line as a personal or moral failing. Some cultures do not recognize mental health concerns the same way that Western cultures do. If someone from one of these situations does reach out in a crisis, they must feel safe, and their privacy should be respected. It's important to clearly communicate about the privacy and confidentiality of a service. It's especially important to let them know of the limits of confidentiality if the person reaching out faces a risk of repercussions. This allows the person in crisis to navigate how they wish the encounter to go.

Sharing information when there is imminent risk

In the crisis system, a common exception to obtaining patient consent is the ability to share information if:

- The provider believes doing so will prevent or lessen a serious and imminent threat to the health and/or safety of a person or the public *and*
- The information is disclosed only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.[20]

This exception is narrow and does not apply to everyone in crisis. It only applies to people at imminent risk of harm. There is no obligation for a provider to disclose this information, and providers should rely on general standards of ethical conduct.

Duty to warn

All mental and behavioral health professionals have a duty to warn someone if they believe there is a credible threat. The statutory standard is established in RCW 71.05.120(3) and states:

[19] **https://www.nasmhpd.org/sites/default/files/988_Convening_Playbook_Public_Safety_Answering_Points_PSAPs.pdf**

[20] **RCW 70.0230(h)(i) and 70.02.240(10),(11).**

> …the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.[21]

This requirement is the result of several court cases involving professionals who became aware of a valid potential harm and did not act to warn the person or people being threatened. The current scope of the duty warn is established by The Washington Supreme Court decision in *Volk v. DeMeerleer*, 187 Wn.2d 241, 386 P.3d 254, (2016).[22]

Mandatory reporting

Mandatory reporting is required under certain circumstances for all mental health care professionals. The two categories for mandatory reporting are child abuse and neglect and abuse or neglect of a vulnerable adult. If a crisis worker learns of or witnesses abuse against these protected classes during a crisis encounter, they must report the abuse to the appropriate authorities. Mandatory reporters are protected when making a report if they act in good faith, even if it is later found the abuse did not occur. Even if the reporter is not sure the abuse is taking place, it is best to report and let authorities investigate. Reporting is confidential in most situations. Failure to report could result in criminal charges.

- **Children:** Mandatory reporting for a child experiencing abuse and neglect is defined in RCW 26.44.030.[23] The statute protects all children under the age of 18. The purpose of this mandatory reporting is to protect children from injury, sexual exploitation, or being denied the most basic nurture or safety from adults who are supposed to care for them. The Department of Children Youth and Families (DCYF) put together a guide to help navigate the process of reporting that you can read **here**. To make a report, you can call the DCYF hotline at 1-866-363-4276.
- **Vulnerable adult:** Mandatory reporting for the abuse, neglect, or financial exploitation of a vulnerable adult is mandated under RCW 74.34.[24] Reporting must be made to Adult Protective Services (APS) who are responsible for screening and investigating abuse. Vulnerable adults can be harder to define than children. A list of vulnerable adults includes:
    - A person who is 60 years of age or older and has the functional, mental, or physical inability to care for themselves
    - A person subject to a guardianship
    - A person with an intellectual and/or developmental disability
    - A person who is admitted to any facility
    - A person who is receiving services from home health, hospice, or home care agencies
    - A person who is receiving services from an individual provider
    - A person who self-directs their own care and receives services from a personal aide[25]

Abuse, neglect, and financial exploitation of a vulnerable adult can be done by a family member, friend, or medical professional and in all cases must be reported. Information from the Department of Social and Health Services (DSHS) on reporting abuse of vulnerable adults can be found **here** and you can fill out an **online incident report**. or by calling APS at 1-833-866-5595.

[21] **http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.120**
[22] **https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=FinalVolkReport_9b39fb66-e26f-40de-96b9-56f28b48ff90.pdf**
[23] **https://app.leg.wa.gov/RCW/default.aspx?cite=26.44.030**
[24] **https://apps.leg.wa.gov/RCW/default.aspx?cite=74.34**
[25] **https://app.leg.wa.gov/RCW/default.aspx?cite=74.34.020**

988 Lifeline Crisis Center service delivery and modalities

Crisis center services consist of many methods to ensure services are delivered in a safe and effective manner.

Triage

The initial step in providing any services is to get information about the person, their risk level, any safety concerns, and the crisis. This crucial part of the crisis resolution processes should be done as thoroughly as the situation allows to make sure the person can be connected to the most helpful resources and services. This process should be done organically and through the course of the contact using clinical practices and techniques to elicit information to help the person in crisis. Key information to triage and screen for in any contact are:

- Strengths of the person in crisis and their supporters
- Causes leading to the crisis event
- Safety concerns for the person or others
- Age and basic demographics that can help connect the help-seeker to resources

Other information to triage for, based on the situation, may include:

- The location of the person (can be a general location like city or county)
- Intimate partner violence
- Resources available to the person in crisis
- Recent inpatient hospitalizations
- Enrollment with mental health care workers
- Use of any prescribed medication
- Any related medical history

Best practice: Try to find out the age of the help-seeker early in the contact. For youth and families, dispatching a mobile crisis team early is a national best practice. It has been shown that in-person response works best for youth and family to begin an intervention and resolve the crisis.

Assessment

Contact center crisis counselors should complete assessments as situations warrant. These do not need to be formal assessments, but they should address causes of the crisis and any risks to the person in crisis or the person calling on their behalf.

Best practice: Try to find out the age of the help-seeker early in the contact. For youth and families, dispatching a mobile crisis team early is a national best practice. It has been shown that in-person response works best for youth and family to begin an intervention and resolve the crisis.

Best practice: When assessing for risk and safety concerns, screen for protective factors including natural and formal supports who can help lessen concerns and act as backup contacts. Provide support when bringing them into planning. People supporting other people in crisis are affected and may also need support. Supporting them can help resolve the crisis more quickly with better outcomes.

De-escalation/resolution

De-escalation is typically the first step in the process. Significant de-escalation and initial safety planning often happen within the first 10 minutes of contact.[26] This does not mean a contact should end before 10 minutes

[26] **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8485743/**

because ongoing support and de-escalation are often needed. The goal should be to try to de-escalate a person to start problem solving.

988 Lifeline crisis counselors engage in counseling throughout the encounter and actively work to de-escalate the crisis. Counselors may utilize therapeutic models such as Motivational Interviewing to help resolve the crisis and avoid the need for a higher level of care if possible.

Coordination

An important focus for crisis counselors should be identifying and addressing the recovery needs of people and families by linking them with needed medical and mental health services. The right care can help resolve the current crisis and help prevent a return to a crisis state in the future. Include family members, significant others, and treatment providers, as necessary, to provide support to the people in crisis.

Mental Health Advance Directives (MHADs) are written documents that outline directions and preferences for care during a mental health crisis. Both adults and youth between the ages of 13 and 17 can create a proactive MHAD. Crisis centers should reference available MHADs and ask the person in crisis if they have an MHAD if none is documented.

People in crisis may also have Wellness Recovery Action Plans (WRAPs). WRAPs are created by people with their health care teams and include indications of crisis/mental health escalations, triggers, effective interventions and coping strategies, and guidance for specific supports. When available, WRAPs can provide helpful information for crisis centers during a crisis contact.

Follow-up and crisis planning

After the crisis counselor has helped the person in crisis de-escalate and feel less in distress, they should ask if the person would like a follow-up contact. If the person consents, gather contact information and ask if they have a preferred time for the follow-up contact. If they can't give their consent or say they don't want a follow-up contact, the counselor should make sure they feel safe to make future contacts and provide them with appropriate follow-up options.

As part of 988 Lifeline interventions, crisis center staff should engage the person in the crisis planning process that can help prevent future crises. This process may include the development or modification of a safety plan. At this point, you may introduce MHAD, if the person does not already have one. When appropriate, telephonic, or in-person follow-ups should be provided to determine if any services or resources provided met their needs.

Best practice: For youth and families, dispatching a mobile crisis team early is a national best practice. It has been shown that in-person response works best for youth and family to begin an intervention and resolve the crisis.

Best practice: Have a crisis center peer follow up with the person the next day or at a scheduled time to show support and continue to help the person through their crisis.

Support for staff during contact

Creating platforms for contact takers to communicate with other staff helps improve service delivery and reduce burnout. 988 Lifeline crisis centers should have escalation processes to signal for support in difficult or emergent situations. These processes will alert a supervisor or designated escalation point that the contact taker needs support. It is important to support the contact taker and staff involved in these situations by debriefing after the contact concludes.

Special considerations for service delivery

Caregivers

When caregivers are making contact for help with the person they support, always screen for interventions for the caregiver and provide support to them. It's best practice to get their contact information, both for follow up and in case the person they support is transported to a facility for ongoing care.

Best practice: Try to find out the age of the help-seeker early during the contact. For youth and families, dispatching a mobile crisis team early is a national best practice. It has been shown that in-person response works best for youth and family to resolve the crisis and begin an intervention.

Managing high conflict or disordered calls

Parents/caregivers/guardians and their family members can become escalated, especially when a youth or young adult is in crisis. There may be multiple people escalated in the home, including the person making contact. Counselors can offer support by:

- Focusing the de-escalation on the person making contact
- Redirecting them to your voice
- Staying calm yourself
- Offering in-person Mobile Crisis Outreach

All efforts should ensure that contact with LE is a last resort. Offering an in-person Mobile Crisis Outreach response to these calls helps build trust in the crisis system and works to reassure families that help is on the way.

Contacts regarding relational violence

Domestic violence, also called relational violence, includes child abuse, vulnerable adult abuse, abuse between current or former family or household members, and intimate partner violence (IPV). People commonly contact crisis lines due to relational violence.

Relational violence is based on patterns of power and control. It may involve threats or acts of:

- Coercion, manipulation, and other types of emotional abuse
- Physical abuse
- Sexual abuse
- Economic or financial abuse
- Verbal abuse

Both the person experiencing or using relational violence may call.[27] It is important to screen for red flags during the contact if the violence is not directly identified. Red flags are common words, phrases, or cues that a person may say during a call. These can include common phrases like:

- "It's my fault my partner treats me like this."
- I can't do anything right. My partner always has to fix everything."

Or reports of their situation or partner's behavior:

- They report not seeing family or friends for an extended period.
- They report being afraid all the time.

[27] **http://www.nationalcenterdvtraumamh.org/publications-products/recommendations-for-suicide-prevention-hotlines-on-responding-to-intimate-partner-violence/**

Best practice: If you suspect relational violence, always ask if the person making contact is alone. Then, ask if they're in a safe situation where they can talk. Keep in mind that the person using violence may be nearby or listening to the conversation.

It's important to let people experiencing relational violence maintain control of the contact. Stay empathetic and supportive while letting them voice their needs. Always let them decide the course of action, especially when considering a response or connection to services.

Never send any resource without the person experiencing relational violence agreeing to it.[28]

Relational violence can affect anyone and touch those in crisis at all points in the system. It's associated with an increased risk of suicide and more frequent contact with crisis hotlines. People living with mental health conditions may experience relational violence at higher rates and may have their treatment or access to care restricted. People may also use relational violence to target people living with mental health conditions to belittle, undermine, harass, coerce, or isolate them. However, people who experience relational violence don't necessarily have a mental health diagnosis or a need for mental health treatment.[29]

When people seek help for situations involving relational violence, crisis staff should:

- Validate and support their emotional and mental health needs
- Affirm their ability to make their own choices and take action
- Offer support with safety planning
- Offer connections to relational violence resources

Communication from crisis staff should work to reduce shame, assure survivors that the violence is not their fault, and remind them they're not alone. Crisis staff should be familiar with hotlines, shelters, and advocacy services for domestic, sexual, and interpersonal violence. These services can provide specialized responses to meet the emotional, safety, and legal dimensions of relational violence interventions.

People who contact crisis services may not directly disclose relational violence.

Some possible signs of relational violence include:

- Communicating self-blame for a partner's behavior
- Saying their partner limits the time they spend with friends and family or dislikes them spending time with friends and family
- Expressing constant fear

If you think someone may be experiencing relational violence, you can try asking questions like, "From what you told me, are you concerned about your safety?" If they say yes, check if they're alone and in a safe place to speak before continuing the conversation.

Survivors are the experts on their unique situations. If you ask questions and give them the space to answer, they can provide valuable insight into strategies to promote their own safety and meet their needs. Leaving the relationship is often the most dangerous time for those experiencing relational violence. If you suspect relational violence, it may be best to avoid including the person using relational violence in safety planning for the person in crisis.

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[28] **http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2019/04/NCDVTMH_NDVH_NSPL_UR_09.2018_SuicidePreventionHotlinesIPV_WarshawEtAl.pdf**

[29] **https://ncdvtmh.org/wp-content/uploads/2022/10/NCDVTMH_NDVH_NSPL_UR_09.2018_SuicidePreventionHotlinesIPV_WarshawEtAl.pdf**

In-person response to calls involving relational violence can also be dangerous for responders. It may not be safe for Mobile Crisis Outreach to respond to a location when relational violence is involved, especially if the person using violence is present. When making referrals, crisis staff should:

- Discuss risks and options for safer contact with survivors
- Inform survivors of what information they'll need to share with other organizations
- Communicate the situation clearly to the organizations they refer survivors to

Best practice: If LE intervention becomes necessary, it's best practice to support survivors in contacting LE themselves. This may include connecting the call to 911. Crisis staff may also provide a code word for survivors to use that informs the staff member to call 911 on their behalf.

Except as covered under situations involving children, vulnerable adults, or the duty to warn, Washington does not have mandatory reporting requirements for relational violence. Crisis staff should:

- Maintain confidentiality to the maximum extent possible
- Openly communicate any limitations to confidentiality
- Consider confidentiality and safety concerns when documenting contacts involving relational violence

A person in crisis may behave in ways that appear violent or cause harm. It's important to keep in mind that relational violence is a pattern of violence used within an overarching context of power and control. In some cases, people who use relational violence may also have a mental health condition. But mental health conditions do not cause people to use relational violence, and not all behaviors that cause harm in relationships are relational violence. However, these behaviors can still have a very real impact, and ensuring safety is a top priority in all contexts.

However, strategies and responses to relational violence will vary. State and local laws and protocols may include various requirements for responding to calls involving relational violence, including mandatory arrest laws. Officers may apply these requirements for all behaviors that fit the legal definitions of crimes of relational violence, regardless of the origin of such behavior. Crisis staff should consider how LE may respond if involved in crisis situations that may be interpreted as relational violence and work with the person in contact to develop the safest and most appropriate response.

Finally, relational violence can affect anyone, including crisis staff. It is vital to use the principles of trauma-informed approach in the workforce and regularly support coworkers who share experiences of relational violence.

Persons in need of frequent support

Some people will contact a crisis center frequently for a variety of needs. Some will contact the center as part of their care plan they developed with their care team. Many will also make contact for ongoing support. It is important to keep records of these contacts.

It's also important for the staff receiving the contact to look up previous contacts to ensure the person feels heard across multiple contacts and staff can avoid any immediate triggers they present with. Creating a plan accessible to staff can help ensure coordination when working with people who frequently seek crisis support.

Some people may also engage in multiple contacts to better manage the challenges they're dealing with. In these cases, it may help to create a plan to prevent triangulation and possible escalatory situations. Crisis center staff should develop these plans with an experienced clinical team and any of the person's outpatient providers, if possible.

Interpreters

Many people contacting a crisis center do not speak English well and may prefer to talk with someone in a different language. In these instances, the person must relate to an interpreter. Use crisis center policies and procedures to connect someone with an interpreter.

If you provide crisis support to someone using an interpreter, keep speaking directly to the person in crisis, just as you would if you were helping someone speaking English.

Best practice: Inform any response or follow-up of interpreter needs. If possible, connect them with the same interpreter used in the contact.

Multiple people in crisis on the same device or multiple contacts

Dealing with multiple people in crisis at the same time can be difficult to manage. Contacts can often be chaotic and difficult to track. In these situations, it is best to try to connect each person to a separate crisis counselor. This is easier if all people involved use different devices.

When multiple people seek crisis support using the same device, encourage them to use multiple devices. If they can't, ask them to identify themselves each time they speak. It's also best practice to ask a supervisor for support with coordinating the contact.

Working with youth and families

Youth and young adults

MRSS should be offered for an in-person response to any person contacting a crisis center for a minor. MRSS can be offered up to age 20.

Youth under 12 years of age

Youth ages 12 and under require parental consent for evaluation and treatment for mental health, SUD, or withdrawal management. If a parent/caregiver/guardian calls on behalf of a youth, offer an in-person response. If a third party calls on behalf of a youth aged 12 and under, request that the parent/caregiver/guardian meet the youth Mobile Crisis Outreach at the identified location. Youth under 12 can still call any crisis contact line without parental permission.

Young adults between 13 and 17 years of age

If a young adult between the ages of 13 and 17 calls on their own behalf, they can decide if they want an outreach. They can also set the location and time to meet the mobile response team to ensure confidentiality.

Under Washington state law and in accordance with RCW 71.34, adolescents between the ages of 13 and 17 may request and receive outpatient treatment, including voluntary crisis services, without parental consent. While including a parent/caregiver in the intervention is best practice, youth may not always agree to this. In some cases, this isn't safe. For this reason, it's essential to balance confidentiality and safety.

When adolescents need in-person response, first determine whether it's safe to meet in an agreed-upon location, like a park, school, or community space. If the youth is experiencing serious distress, safety considerations override confidentiality concerns, and the youth should not be encouraged to leave their present location.

If a parent/caregiver/guardian or third-party person makes contact on behalf of a young adult between the ages 13 and 17 who is with them, the team should be dispatched and work to engage the adolescent and get a risk assessment in person. If the person making contact is not with the adolescent, gather relevant contact information to relay to the Mobile Rapid Response crisis team for outreach, including the youth's location, if known.

Family interventions

When a parent/caregiver/guardian calls with concerns for a youth or young adult aged 0-17, an in-person response should be offered to the family when the youth is present. People between the ages of 18 and 20 years old can decline a response.

Connecting a person to services during a contact

Most contacts to a crisis center will be resolved during the contact. Historically, most calls to a crisis center were resolved by phone.

Enhancements to the crisis system continue to emphasize the importance of connecting people with face-to-face crisis services and follow up. Crisis counselors should continuously check in on the person's needs and offer resources to support them and help prevent another crisis.

PSAPs/911

Dangerous and emergency situations where there is an active threat to life and safety of the person in crisis or others will need immediate intervention from a first responder. In these situations, it's important to act fast. Escalating the situation to a supervisor for further support is the typical first step. Follow the procedures for locating and contacting the correct PSAP/calling 911.

When contacting the PSAP, clearly say that you're calling from a 988 Lifeline crisis center and provide the following information:

- Specific location of the person in crisis and/or of the person contacting the crisis center on their behalf
- General overview of the situation
- Safety concerns
- Escalation points like triggers or actions
- Other relevant information

After sharing this information, let the PSAP take the lead on how they wish the call to proceed. They may conference in any responders or ask to conference in the help-seeker. If either of these steps aren't clinically appropriate, clearly communicate this to the PSAP.

Stay on the contact until a first responder arrives, the PSAP takes over the contact completely, or the contact is terminated. If the contact is terminated, let the PSAP know. After the responders arrive, document any tracking or reference number for follow-up.

Best practice: Notify the local Mobile Crisis Outreach team of the situation. Provide them with any information about the response and places to follow up.

Coordinating with PSAPs helps ensure safety in the community, for responders, and for people in crisis. The key to this coordination lies in building strong partnerships with PSAPs. Building strong relationships will help educate PSAPs about changes and available resources. Developing understanding can also promote trust in handing off between systems.

Best practice: Develop local protocols and business associate agreements on how to share information between 911 and the crisis system. These protocols should include specific contacts, phone numbers, and escalation measures.

NDAs

An NDA is an intervention to connect people with services outside of the crisis system to resolve urgent mental or behavioral health conditions contributing to a crisis. These appointments have been available for people on Medicaid and were available for people without medical insurance. As of January 1, 2023, many commercial plans are required to connect their members with NDAs. Many people with self-funded plans may not have access to NDAs.

988 Lifeline crisis counselors can connect people to NDAs directly if it is clinically determined to be an appropriate intervention. Someone who receives an in-person response can still receive an NDA. If the person can't stay safe or meet some of the requirements for NDAs, that person can still be connected to an NDA once safety concerns are resolved, by an in-person response or other service intervention.

Crisis centers should follow tribal crisis coordination plans and work with the Native Resource Hub to make connections for tribal members to tribal health providers.

NDAs provide immediate follow-up. These appointments are not intended as ongoing crisis interventions or stabilization provided by crisis workers. They serve as a step to resolving the crisis and helping the person get additional services. Appointments may be provided by telehealth or by any medical professional operating within their scope of practice. Examples may include:

- Medication consults
- Appointments with Primary Care Provider (PCP), clinician, or prescriber
- Intake assessments
- Tribal health services
- Other consults

Other resources

Many people making contacts in distress will report they need help accessing resources due to life changes or an emergency. Common examples include needing to find food for themselves or family, help with rent, and help accessing unemployment resources. Crisis counselors should triage the person for any resources the person could need as part of the intervention they provide.

In many cases, helping a person connect with resources can help de-escalate the crisis situation. You can use databases like 211 and local resource guides to help the person find a resource that can help them. Connect a tribal member to their tribal system following the tribal coordination plan and using the Native Resource Hub.

Native Resource Hub and tribal partners

For those affiliated with the American Indian and Alaska Native (AI/AN) communities in Washington, the Native Resource Hub can help link them to tribal services. The Hub was developed as a partnership between the Tribal Centric Behavioral Health Advisory Board, the American Indian Health Commission, HCA, and DOH to better support AI/AN people in crisis. The Hub will connect any Indigenous person in crisis to tribal services. The Hub can also provide referrals, temporary case management, and connect people to inpatient services.

There are 29 federally recognized tribes in the state of Washington. Tribes are sovereign governments and have sovereign authority over their tribal lands. Working with tribes means working with a sovereign government that has domain over its territory and tribal members on it. Tribes have the right to restrict access to lands and limit which services the state system will provide. As a result, it's important to have strong relations with local tribes to help navigate the separate ways tribes will work with the state system. Tribal coordination plans are currently being developed. These plans will have key information on limitations and how tribes want the state system to interact with them.

Best practice: Ensure all 988 Lifeline crisis centers and system partners who interact with tribal members have a tribal coordination plan and know how to use them.

Connections between 988 Lifeline crisis centers and RCLs

988 Lifeline crisis centers and RCLs have historically done different jobs for people experiencing a crisis. 988 Lifeline crisis centers have often provided anonymous support via phone call, text, and chat. RCLs offer a regional hub for people to get services and support. It may be necessary for a person who contacts a 988 Lifeline crisis center to be connected to an RCL for ongoing support, including Mobile Crisis Outreach team dispatch, connections to regional resources like NDAs, and involuntary treatment investigations.

If a person who contacts a 988 Lifeline crisis center needs a connection with an RCL, then crisis counselors should make a warm hand off to the RCL with a quick summary of the presenting concerns. This will minimize the need for the person to retell their story. The RCL should take over the contact, tell the person about resource options, and get their consent for any voluntary services.

Specialty crisis centers

Some people in need of support, especially those not familiar with the crisis system, may contact the 988 Lifeline or an RCL number seeking support when specialty crisis centers may better meet their needs. These centers can be for special populations, people needing specific support, and people living in different regions. Specialty crisis centers can provide support tailored to the person's specific needs.

Specialty contact centers can include:

- **Native Resource Hub** – for Washington tribal members or those supporting them accessed by calling 1-866-491-1683
- **Native and Strong Lifeline** – for American Indian and Alaska Native people in crisis accessed by calling 988 and choosing option 4
- **Healthy Native Youth text line** – text line for Native youth accessed by texting INSPIRE to 94449
- **Veterans Crisis Line** – for veterans in crisis accessed by calling 988 and choosing option 1, texting 838255, or chatting with **a Veterans Affairs responder**
- **Teen Link** – for youth and young adults in crisis accessed by calling 1-866-833-6546
- **Trevor Project** – LGBTQI2S+ youth access by calling 988 and choosing option 3
- **Farm Aid** – for rural and agricultural community members
- **National Domestic Violence Hotline** – for people experiencing domestic/relational violence
- **Washington Recovery Helpline** – for people needing help connecting to SUD support
- **Problem Gambling Helpline** – for people needing help with problem gambling

If someone in crisis requests or accepts a connection to one of these lines, attempt a warm hand off or ensure they have the information they need to contact one of these lines.

Other contact centers

In some regions there are other types of local crisis contact lines that can support people (i.e. warm lines, shelter lines, LGBTQI2S+ lines).

Maintaining a good relationship with these lines can help support them if they need to escalate a contact for in-person response or need assistance with resources accessible through 988 Lifeline crisis centers.

Facilitating in-person responses

Crisis counselors should offer in-person responses to people experiencing a crisis that can't be resolved during the contact. In-person responders can spend more time with the person problem solving and working to resolve the crisis. They can do this by providing face-to-face contact with the person in their environment. When clinically appropriate, in-person response can provide consistent follow up.

In most situations, the person will need to consent to the response. The only exception for initiating an emergency intervention is a situation where someone's life or the public is at risk. In these uncommon situations, crisis counselors should connect to the local PSAP as soon as possible. If the person in crisis is hesitant about an in-person response, motivational interviewing and other clinical interventions may help them decide whether this type of response may help with their crisis.

Best practice: Mobile Crisis Outreach should be the default response unless the situation has significant safety risks for Mobile Crisis Outreach responders, there is concern that the person needs medical attention, or there is no Mobile Crisis Outreach team available.

Mobile Rapid Response Crisis Teams

Mobile Rapid Response Crisis Teams (MRRCTs) are being implemented as the primary crisis outreach service for the crisis system. These multi-disciplinary teams of mental health professionals and peer support trained in crisis work provide community-based face-to-face initial crisis interventions. Teams (including MRSS teams) are dispatch-based and will travel to the location of the person in crisis to work with the person. Teams may also provide post-crisis follow-up and ongoing stabilization.

Consider connecting a person in crisis to a MRRCT if they request an MRRCT response or it seems that the crisis may not be resolved with the contact alone. The role of a 988 Lifeline crisis center is to determine how acute the situation is, the best response for the help-seeker, and how fast the response needs to be.

Best practice: MRRCT is the primary in-person response for people contacting a 988 Lifeline crisis center. MRRCT should be considered for any in-person response before other responses, except when immediate safety concerns require emergency intervention, the person has medical concerns, or no MRRCT can respond.

Best practice: Offer MRRCT as a response option to persons making contact who need assistance even if they can resolve most of their crisis over the phone, text, or chat. Offer MRRCT as a follow-up option for ongoing support.

Important note: MRRCT is a new name for a service that has existed in various forms throughout the state for many years. At the state level, the service is called mobile crisis response (MCR) but goes by many different names across the state. MCR varied from team to team in staffing composition and services offered.

Statewide standards developed in the last year make it easier to define MCR. Teams have been renamed to MRRCT to highlight this transition and follow mandates in Engrossed Second Substitute House Bill 1477. This change does not reflect any of the endorsement requirements in Engrossed Second Substitute House Bill 1134 passed in 2023.

Endorsement requirements that will set minimum staffing and training for MRRCT will be developed over the next year. These requirements will be a voluntary option for teams wishing to receive the corresponding enhanced funding.

Youth rapid MRSS

Youth rapid MRSS teams provide a child- and family-specific crisis intervention model that recognizes the developmental needs of children, young adults, and their parents and caregivers. Caregivers and children are interconnected in their relationship and thus, crisis situations for children can affect the parent's ability to

respond to the crisis and de-escalate the situation. Supporting the caregiver's response to the crisis decreases the likelihood of child welfare and juvenile justice involvement.

Best practice: Offer an outreach response from an MRSS team immediately after learning the person is calling on behalf of a youth or young adult. For youth, prioritize MRSS teams whenever possible, but if not available, send an MRRCT.

Youth under 12 years of age

Youth aged 12 and under require parental consent for evaluation and treatment for mental health, SUD, or withdrawal management. If a parent/caregiver/guardian calls on behalf of a youth, offer an in-person response. If a third party calls on behalf of a youth aged 12 and under, request that the parent/caregiver/guardian meet the youth Mobile Crisis Outreach at the identified location. Youth under 12 can still call any crisis contact line without parental permission.

Young adults between the age of 13 and 17

If a young adult between the ages of 13 and 17 calls for themselves, they can decide if they want an outreach and dictate the location and time to meet the mobile response team to ensure confidentiality.

Under Washington state law and in accordance with RCW 71.34, adolescents between the ages of 13 and 17 may request and receive outpatient treatment, including voluntary crisis services, without parental consent. It's best practice to include parents/caregivers/guardians in the intervention, but the adolescent may not always agree to this. In some cases, including parents/caregivers/guardians may not be safe for the adolescent, so it's essential to balance confidentiality and safety.

When adolescents need in-person response, a park, school, or community location may offer a safe meeting location. If the youth is in severe distress or at risk of harming themselves or others, safety considerations override confidentiality concerns, and the youth should not be encouraged to leave their present location.

If a parent/caregiver/guardian or third-party person making contact is calling, texting, or chatting on behalf of a young adult between the ages of 13 and 17 who is with them, the team should be dispatched and work to engage the adolescent and get a risk assessment in person. If they aren't with the adolescent, gather relevant contact information, including the youth's location, to relay to the MRRCT for outreach.

Family interventions

When a parent/caregiver/guardian calls with concerns for a child or young adult between the ages of 0 and 17, an in-person response should be offered to the family when the youth is present. If the identified client is aged 18–20 years old, they can decline a response.

Tribal crisis services and response

When a response is needed for a member of a federally recognized tribe, it's essential to provide culturally appropriate available support and resources. This can be done by supporting the person on the phone while connecting them to their tribe's resources. Refer to the tribal coordination plan for that tribe. If there is not one, then contact the tribe's Indian Health Care Provider (IHCP) to consult with them and identify the appropriate contact to set up a response. If there is no IHCP, then consult with the Native Resource Hub.

Best practice: Follow the tribal coordination plan whenever possible. If no tribal coordination plan is available, then contact the tribe's IHCP to arrange services for the person in crisis.

First responders

Some situations will need an immediate response that is faster than a mobile crisis team or because there are safety issues. In these situations, it is important to engage with the local PSAP and if possible, the responding personnel about the situation. This should include:

- Safety concerns
- Escalation points (triggers, verbal cues, previous experiences)
- Relevant information about the situation
- Preferred outcomes of the person in crisis, if known

Document follow-up information to verify contact was made and determine the outcome for Mobile Crisis Response follow up.

Best practice: Make connections with local responders to determine how they want information shared and develop relationships to improve understanding across systems. During their duties, first responders may contact youth experiencing symptoms of a mental health crisis. In this instance, the best practice is to avoid transporting youth out of the home, as safety allows. Instead, it's important to prioritize referrals and warm handoffs to the MRSS or MRRCTs in the region.

Co-responders

Co-responders are a unique service delivery team that is part of the emergency response system and dispatched by PSAPs and individual departments. Co-response refers to a diverse set of programs where a mental health care worker responds with LE or EMS.

Examples include:

- A ride-along where a mental health clinician responds with an officer
- Mental health personnel who are embedded or part of a department that responds with or without other personnel in clothing that identifies them as part of that department
- A team that follows up with a person in crisis after contact by a first responder

Co-responders can provide crisis services to more acute or dangerous situations and can often respond quicker than Mobile Crisis Outreach due to their position in the system. If co-responders make contact, they may notify a 988 Lifeline crisis center and hand off to Mobile Crisis Outreach for follow-up.

During their duties, co-responders may contact youth experiencing symptoms of a mental health crisis. In this instance, the best practice is to avoid transporting youth out of the home, as safety allows, and should prioritize referral and warm handoffs to the MRSS or MRRCTs in the region.

DCR/involuntary treatment

People in crisis may present an immediate or serious risk of harm to themselves or others and be unable to care for their basic needs of health and safety due to their symptoms. If someone can't follow their safety plan and remains at risk of harm, it's important to work with DCRs to make sure an Involuntary Treatment Act (ITA) investigation is completed. An ITA can help determine whether the person meets criteria for involuntary treatment or inpatient care.

Best practice: Whenever possible, 988 Lifeline crisis counselors should engage a help-seeker first and attempt to resolve the crisis with voluntary interventions that are less restrictive than hospitalization, such as MRRCT, before making a referral to a DCR for an ITA investigation.

People in crisis may respond best to a Mobile Crisis Outreach intervention that avoids the legal authority dynamic inherent to the DCR role. It's best to refer to a Mobile Crisis Outreach team when possible, unless, in some cases, the person requesting a DCR is a:

- Mental health professional who has attempted to find less restrictive alternatives and still believes the person is at risk
- A case manager
- A hospital or jail with a person on a police hold
- Someone requesting an evaluation prior to filing a Joel's Law petition.

Tribal members should be referred to a tribal DCR (when available), tribal health care, or other tribal service based on the tribe's tribal coordination plan.

Best practice: Do not make a referral to a DCR if the person in crisis has not received a mental health evaluation (except for less common situations as described above). Offer Mobile Crisis Outreach as a response and let the requester know that the mobile team can initiate the DCR evaluation if the situation warrants.

PACT and WISe teams

Some behavioral and mental health care programs in the state already provide comprehensive services for people enrolled in these programs. The services include 24/7/365 crisis response by the team working with the person or family, such as:

- For youth, adolescents, and young adults up to age 20: Wraparound with Intensive Services (WISe)
- For Transition Age Youth (TAY) aged 15–25: (TAY-WISe)
- For adults 18 and older: Program for Assertive Community Treatment (PACT)

People may request Mobile Crisis Outreach for clients enrolled in these programs for a "no wrong door" approach or when things escalate. Having Mobile Crisis Outreach teams in the state does not replace the obligation for these programs to provide crisis response, but the goal is to address the crisis within the protocols above. There should not be any delay in the response by Mobile Crisis Outreach if needed or requested. If safe to do so, it's always good practice to ask if the person is enrolled with a provider under one of these three programs.

Other outreach considerations

When an in-person response is requested by a third party, consider additional variables, especially when the third party is calling about a stranger.

Always offer appropriate services without setting standards around what makes something a "real" crisis. Mobile Crisis Outreach is effective and appropriate for a variety of situations. Mobile Crisis Outreach should not be used as a coercive measure or harassment.

When offering Mobile Crisis Outreach to a third party contacting the crisis center, it may help to ask if the person in crisis knows the person is contacting the 988 Lifeline for them and if they know or will be told about the Mobile Crisis Outreach response. Some third parties who contact crisis centers may wish to remain anonymous. A person wishing to remain anonymous may need additional conversation about concerns or risks. If safety is a concern, discuss the possibility that the person in crisis may find out who initiated the contact on their own.

Best practice: Defer to non-uniformed response whenever possible. If the person has enough protective factors to help them stay safe until the in-person response arrives, then it is appropriate to send a mobile crisis team. If needed, a non-uniformed co-responder team can respond if the person can't stay safe or has a medical complication.

Other local resources

Other local resources may provide outreach for people in crisis. These could include specialized interventions such as:

- Outreach resources for people experiencing relational violence
- Homeless Outreach Stabilization and Transition (HOST) programs
- Recovery navigators
- Youth regional behavioral health navigation services

Creating and maintaining these local lists is essential to getting a person the critical support they need.

Appendix List

(2021) Engrossed Second Substitute House Bill 1477 §102 (8)(c)

(8) The authority shall:

(c) Create best practices guidelines by July 1, 2023, for deployment of appropriate and available crisis response services by crisis call center hubs to assist 988 hotline callers to minimize nonessential reliance on emergency room services and the use of law enforcement, considering input from community partners and other relevant parties and recommendations made by the crisis response improvement strategy committee created under section 103 of this act

Acronym list

APS – Adult Protective Services

BH-ASO – Behavioral Health Administrative Service Organization

BHA – Behavioral Health Agency

DCR – Designated Crisis Responder

DCYF – Department of Child Youth and Family

DOH – Department of Health

DSHS – Department of Social and Health Services

EMS – Emergency Medical Services

HCA – Health Care Authority

HIPPA – Health Insurance Portability and Accountability act

ITA – Involuntary Treatment Act

LE – Law Enforcement

MCO – Managed Care Organization

MCR – Mobile Crisis Response

MHAD – Mental Health Advance Directive

MHP – Mental Health Professional

MHCP – Mental Health Care Provider

MI – Motivational Interviewing

MRRCT – Mobile Rapid Response Crisis Team

MRSS – Mobile Response and Stabilization Services

NASMHPD – National Association of State Mental Health Program Directors

NSPL – National Suicide Prevention Lifeline

PCP – Primary Care Provider

PHI – Protected Health Information

PSAP – Public Service Access Point

RCL – Regional Crisis Line

ROI – Release of Information

SAMHSA – Substance Abuse Mental Health Services Administration

TAY – Transition Age Youth

TAY-WISe - Transition Age Youth Wraparound with Intensive Services

TIA – Trauma-informed Approach

WISe – Wraparound with Intensive Services

WRAP – Wellness Recovery Action Plan

Glossary

23-hour crisis outreach services - An encompassing term for units or facilities open 24/7 that provide outpatient mental and behavioral health crisis outreach, observation, and intervention services for no more than 23 hours and 59 minutes at a time. These services are certified under WAC 246-341-0901 and are distinct from 23-hour Crisis Relief Centers. A location operating as a 23-hour crisis outreach service model may be described as a living-room model, drop-in center, or mental or behavioral health minor emergency.

23-hour Crisis Relief Center (CRC) - A community-based facility or portion of a facility serving adults, which is licensed or certified by DOH and open 24 hours a day, 7 days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all mental health crisis walk-in drop-offs from first responders and people referred through the 988 Lifeline system.

911 - The phone number used to reach emergency medical, fire, and police services.

988 - The 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing thoughts of suicide, substance use concerns, a mental health crisis, or any other kind of emotional distress. People can also contact 988 if they are worried about a loved one who may need crisis support.

Assisted outpatient treatment (AOT) - Uses a court order to provide mental health treatment to adults with severe mental illness or SUD. Those receiving treatment in this way must meet specific criteria, including factors like a history of hospitalization or lack of previous treatment.

Best practice - A procedure shown by research and experience to produce optimal results and established or proposed as a standard suitable for widespread adoption.

Certified peer counselors – Peer counselors work with their peers (adults and youth) and the parents of children receiving mental health or SUD services. They draw upon their experiences to help peers find hope and support their recovery. The peer's own life experience uniquely equips them to provide support, encouragement, and resources to those with mental health or SUD challenges. Peer counselors work in various settings such as community clinics, hospitals, and crisis teams.

Children's Long-term Inpatient Program (CLIP) - The most intensive inpatient psychiatric treatment available to Washington State residents aged 5–17.

Conditional release (CR) - A revocable modification of a commitment, which may be revoked upon violation of any of its terms. RCW 71.05.020

Co-response programs - Co-response programs are a partnership between first responders (including LE, fire/EMS, or EMS agencies) and human services professionals (such as mental health professionals, social workers, community health workers, or peer support workers). Co-response programs respond to behavioral- and mental health-related calls and calls involving people with complex medical conditions. They provide in-the-moment response and follow-up community-based care coordination. Co-response can involve direct 911 response, outreach to target populations, and/or follow-up depending on each agency’s program design. Co-response programs draw on combined expertise and trusted community-based workers to de-escalate situations, intervene as appropriate, and support people with complex mental health and medical needs. The ultimate goal is to connect people with appropriate community resources to reduce the use of emergency services.

Co-occurring disorder - When a person has an SUD and a mental health disorder either simultaneously or one after the other. Co-occurring also suggests that these health conditions interact with one another and affect the course of both illnesses, as well as the prognosis and treatment of each. Oftentimes, when a person has co-occurring disorders, symptoms of one can make symptoms of the other worse.

Crisis follow-up - When indicated, mobile crisis service providers should also follow up with people served to determine if service referrals were provided in a timely manner and meet their needs. This activity is typically completed through phone outreach, but there may be times when further face-to-face engagement may be warranted or even necessary when the person cannot be reached by phone.

Crisis Intervention Team (CIT) - This is a community partnership of LE, mental health and SUD professionals, people who live with mental health conditions (including SUD), their families, and other partners to improve community responses to mental health crises. While CIT programs are known for CIT-trained officers, successful programs also focus on improving the crisis response system, advocating for needed services, and strengthening partnerships across the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness and/or addictions. The CIT model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

Crisis plan - A mental health crisis plan is a plan of action that's made before a crisis occurs, so the both person in crisis and their support system know how to handle an emergency. Anyone can create a crisis plan by putting together a list of resources, information, and directions.

Crisis stabilization - A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with SUD or mental health disorder. Crisis stabilization services are designed to prevent or ease a crisis and reduce symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services.

Crisis Stabilization Unit (CSU) - This is a short-term facility, or a portion of a facility licensed or certified by the Department of Health, such as an evaluation and treatment facility or a hospital, designed to assess, diagnose, and treat people experiencing an acute crisis without the use of long-term hospitalization (RCW 71.05.020). CSUs must meet the residential and inpatient mental and behavioral health services standards in WAC 246-41-1105. CSUs providing involuntary crisis stabilization services must also meet the applicable standards in WAC 246-341-1131.

De-escalation - These therapeutic interventions may help prevent severe emotional distress, which may include violence and aggression to the self or others in some cases. Effective de-escalation strategies can help reduce the level of stress and frustration that a person is experiencing.

Designated Crisis Responder (DCR) - A mental health professional appointed by the county, an entity appointed by the county, or HCA in consultation with a federally recognized Indian tribe or after meeting and conferring with an IHCP, to perform the duties specified in RCW 71.05. (RCW 71.05.020)

Domestic/relational/intimate partner violence - This pattern of abusive behavior in any relationship is used by one person to gain or maintain power and control over a current or former intimate partner, family member, or household member. Domestic/relational/intimate partner violence can be physical, sexual, emotional, economic, psychological, or technological actions or threats of actions or other patterns of coercive behavior that influence another person in an intimate partner relationship. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. For example, physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. IPV, in particular, can happen in any romantic or sexual relationship, including marriage, engagement, and domestic partnerships. IPV can vary in how often it happens and how severe it is. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years. (Centers for Disease Control and Prevention (CDC))

Dual response - A response that includes Mobile Crisis Outreach and a first responder due to a safety

or medical concern outside of the Mobile Crisis Outreach team's ability to manage.

Emergent care - Services that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.153.

Evaluation and treatment facility (E&T) - Any facility that can provide direct, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by DOH. HCA may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the Department of Social and Health Services or any federal agency will not require certification. No correctional institution or facility or jail shall be an evaluation and treatment facility within the meaning of RCW 71.05.020(23).

Family Initiated Treatment (FIT) - A parent or guardian may bring their youth to a participating outpatient behavioral or mental health provider, E&T facility, inpatient facility (licensed under RCW 70.41, 70.12, or 72.23), a secure withdrawal management facility, or approved SUD treatment program and request an evaluation to determine if the youth needs mental health and/or SUD treatment. The youth's consent is not required.

Family navigators or "parent navigators" - The Center of Parent Excellence project is staffed by lead parent support specialists, hired for their lived experience as a parent/caregiver. If you are a Washington parent/caregiver of a child/youth who may benefit from assistance accessing and navigating behavioral and mental health services, please contact your regional lead parent support specialist.

Harm reduction - Incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs "where they're at," and addressing conditions of use along with the use itself.

Homeless Outreach Stabilization and Transition (HOST) program - The HOST program provides outreach-based treatment services to people living with serious mental health challenges, including SUD. Multidisciplinary teams can provide SUD, medical, rehabilitative, and peer services in the field to people who lack consistent access to these vital services. HOST eligibility means the person has a mental health condition, which can include SUD with or without co-occurring mental illness, that is untreated, under-treated, or undiagnosed. Other eligibility criteria include experiencing literal or chronic homelessness and having mental health symptoms that pose a barrier to accessing and receiving conventional mental/behavioral health services and outreach models.

In-home stabilization - A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a mental health condition. This service supports the youth, adolescent, or young adult's ability to stay safe in the home, school, and community. Teams including a clinician and peer support have the ability to manage daily activities and establish clear connections to natural, community, and clinical support through warm handoffs to reduce the likelihood of ongoing crises. Stabilization can also involve brief evidence-based therapies and psychoeducation.

Inpatient treatment (for minors) -24-hour per day mental health care provided within a general hospital, psychiatric hospital, or residential treatment facility. This facility must be licensed or certified by DOH as an evaluation and treatment facility for minors, secure withdrawal management and stabilization facility for minors, or approved SUD treatment program for minors.

For purposes of FIT under RCW 71.34.600 through 71.34.670, "inpatient treatment" has the meaning included in (a) of this subsection and any other residential treatment facility licensed under chapter 71.12 RCW. (RCW 71.34)

Involuntary Treatment Act (ITA) - State laws that allow for people to be committed to a facility for a limited period of time by court order. Involuntary civil commitments aim to help people get evaluation and treatment for serious mental health conditions or severe emotional distress,

particularly when they may pose a risk to their own safety or the safety of others and refuse treatment or can't enter treatment on their own. An initial commitment may last up to 120 hours, but, if necessary, people can be committed for additional periods of 14, 90, and 180 calendar days of inpatient involuntary treatment or outpatient involuntary treatment. (RCW 71.05.180, RCW 71.05.230, and RCW 71.05.290)

Involuntary Treatment Act (ITA) Services – ITA services include all services and administrative functions required for the evaluation and treatment of individuals civilly committed under the ITA in accordance with chapters 71.05 and 71.34 RCW and RCW 71.24.300.

Law enforcement (LE) - The agencies and employees responsible for enforcing laws, maintaining public order, and managing public safety.

A member of the State Patrol; a sheriff or deputy sheriff; a member of the police force of a city, town, university, state college, or port district; park rangers; border patrol officers; immigration and customs enforcement; tribal police; or a wildlife enforcement officer or ex officio wildlife enforcement officer as defined in RCW 77.08.010.

Less restrictive alternative (LRA) treatment - A program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585. This term includes treatment pursuant to a less restrictive alternative treatment order under RCW 71.05.240 or 71.05.320, treatment pursuant to a conditional release under RCW 71.05.340, and treatment pursuant to an assisted outpatient treatment order under RCW 71.05.148. (RCW 71.05.020)

Less restrictive order (LRO) - A court order for outpatient treatment which includes services to be provided and conditions the person receiving care must follow. Can be called LRA in some parts of the state.

Level of care - The intensity of effort required to diagnose, treat, preserve, or maintain a person's physical or emotional status.

Lived experience - Lived experience refers to in-depth experience of the social and human rights impact of living with a mental health condition. This may include the experience of being ostracized, marginalized, segregated, and discriminated against while also working to navigate the mental health system to seek services or support programs and work toward recovery. The mental health system is not the only societal system that poses obstacles through which to navigate. People with lived experience also often have a harder time accessing other life opportunities such as education, employment, and housing. People with lived experience's unique and in-depth perspectives can help reduce stigma and discrimination and promote inclusion, a sense of community, improved quality of life, respect for human rights, and empowerment of everyone with lived experience. Ultimately, an understanding of lived experience can help improve overall health and mental health outcomes for all.

Means restriction - This means making it harder to get lethal methods used for suicide, non-suicidal self-harm, or harm toward others. For youth and adolescents, this can include securing medications, sharps, household chemicals, alcohol, car keys, and/or firearms in lock boxes, gun safes, trigger locks, or in a secure area such as a locked closet, the locked trunk of a car, or temporarily to another home. This generally requires appropriate adult supervision. A risk assessment can provide more information about what to restrict.

Medical clearance - A physician or other health care provider has determined that a person is medically stable and ready for referral to the DCR. (RCW 71.05.020(37))

Mental Health Care Provider (MHCP) - The person with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are bachelor's level in a related field or associate's level with two years of experience in mental health or related fields. Additionally, this person would be an Agency Affiliated Counselor and supervised by a provider who meets the definition of a mental health professional.

Mental Health Professional (MHP) - A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in RCW

71.05.020. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. They will have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of an MHP. A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986. A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist or marriage and family therapist associate, a person who has an approved exception to perform the duties of an MHP, or a person who has been granted a time-limited waiver of the minimum requirements of an MHP.

Mobile Crisis Outreach - Offering community-based intervention to people in need wherever they are, including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two-person teams should be put in place to support emergency department and justice system diversion. EMS should be aware and partner with these teams as needed.

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis to achieve the needed and best outcomes for that person. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

Mobile Rapid Response Crisis Team (MRRCT) - A team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for people in crisis. This support includes certified peer counselors as a best practice (when possible, based on workforce availability) and meets standards for response times established by the authority. (RCW 71.24.025). MRRCTs can include MRSS teams

Mobile Response and Stabilization Services (MRSS) - A mobile rapid response crisis team that utilizes a home and community-based crisis intervention model customized to meet the developmental needs of children, youth, young adults, and their families. It has two distinct phases: (1) Crisis intervention for up to 72 hours and (2) A separate but connected in-home stabilization phase for up to 8 weeks (14 days in the current state plan). MRSS is designed to keep kids safe at home, in school, and in the community while reducing costly out-of-home interventions.

Next-Day Appointment (NDA) - Appointments a person can access the next day. If the person declines an NDA, the appointment can be scheduled in a timely manner, based on their needs, that will help them resolve issues contributing to the crisis. These appointments are not intended to be ongoing crisis interventions or crisis support provided by crisis workers. They serve as a step to resolving the crisis and lead to further services.

Appointments may be provided by telehealth or by any medical professional operating within their scope of practice. Examples may include:

- Medication consults
- Appointments with a primary care provider, clinician, or prescriber
- Intake assessments to start services
- Other consultants to resolve a crisis

Outpatient services - Mental health treatment services provided in a nonresidential setting.

Peer support - Services provided by people in recovery who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of a return to substance use. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Program of Assertive Community Treatment (PACT) - A self-contained mental health program made up of transdisciplinary mental health staff, including a peer specialist, who work as a team to

provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. PACT services are individually tailored to each person through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, manage symptoms, achieve goals, and maintain optimism and recover. The PACT team is mobile and delivers services in community locations rather than expecting the consumer to come to the program. At least 75% of these services are provided outside of program offices in comfortable and convenient locations for people who may have severe and persistent mental health symptoms and lack access to other services. There should be no more than 10 consumers to 1 staff member on each full team and no more than 8 consumers to 1 staff member on each half team.

Public Safety Answering Point (PSAP) - A point that has been designated to receive 911 calls and route them to emergency service personnel. (**47 CFR § 20.3**)

Recovery Navigator Program (RNP) - A statewide effort in partnership with BHASOs to provide community-based outreach, intake, assessment, and connection to services. These services support people with SUD, including people with co-occurring SUD and mental health conditions. Before receiving funding, each BHASO submitted a regional recovery navigator program plan that demonstrated the ability to implement statewide program standards. The RNP framework incorporates harm reduction and trauma-informed care principles to support the individual throughout their recovery journey. Coordination and communication between regional RNP staff, LE, prosecutors, medical providers, and community partners is essential to the success of each person. RNP staff facilitate and coordinate connections to a broad range of community resources for youth and adults including treatment and recovery support services.

Regional Crisis Line (RCL) - A toll-free line that is available 24 hours a day, 7 days a week, to provide crisis intervention and triage services, including screening and referral to a network of providers and community resources.

Resource - Resources are provided to assist people with needs related to their crisis, which may include anything identified by the person, their family, or mobile crisis staff as supportive in resolving the crisis and facilitating recovery. For the most updated list of resources in Washington, contact 211.

Response time - The total amount of time between an MRRCT receiving a referral to respond to a person in crisis and the team arriving at their location. This does not include the time between a 988 Lifeline crisis center or the RCL receiving the contact and making the referral to the MRRCT. The current response standards are:

- No response required/routine – non-urgent and non-emergent crisis.
- Urgent – response within 24 hours
- Emergent – within 2 hours.

Safety plan - A safety plan is a document that supports and guides someone experiencing thoughts of suicide or other extreme emotional distress. This plan can help them stay safe during the crisis.

Secure withdrawal management and stabilization (SWMS) facility - A facility operated by either a public or private agency or by the program of an agency that provides care to both people voluntarily seeking support and people involuntarily detained and committed under RCW 71.05.

Service encounter - A single health care service or a period of examination or treatment. HCA requires all contracted entities to report encounter data for services delivered to clients who may or may not be enrolled in managed care.

Substance Use Disorder (SUD) - Treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use. It is a cluster of cognitive, behavioral, and physiological symptoms indicating that the person continues using the substance despite harmful consequences. CDC considers the term “drug use” more appropriate for youth and adolescents.

Trauma-informed care (TIC) - TIC takes a trauma-informed approach to the delivery of mental health services. This approach includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how people perceive and process acute and chronic traumatic events. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize people who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services.

Urgent behavioral health situation - A behavioral health condition that requires attention and assessment within 24-hours, but which does not place the person in immediate danger to self or others and the person can cooperate with treatment.

Wraparound with Intensive Services (WISe) - An approach to helping children, youth, and their families with intensive mental health care. Services are available in home and community settings and offer a system of care based on the specific needs of the child or youth. WISe is a voluntary service that takes a team approach to support you and your family in meeting your goals.

Youth behavioral health navigators - Also referred to as “inpatient navigators.” Regional youth behavioral health navigator teams will explore the local impact of how they’re improving collaborative communication and service connection processes and deploying multidisciplinary teams to improve access and coordination of behavioral health services for children and youth.