

Mobile Rapid Response Crisis Services: Best Practice Guidelines for Washington State

**Guidance for the deployment
and delivery of mobile rapid response
crisis team services**

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Washington Mobile Rapid Response Crisis Team Best Practice Guidelines acknowledgements



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Introduction Washington's Mobile Rapid Response Best Practice Guidelines

A behavioral health crisis can be devastating, and even traumatic, for individuals, families, and our communities. Although we cannot know when a crisis may occur, we can create a system that is agile and responsive when the need arises. We imagine a crisis system in Washington State that minimizes delays, reduces the use of law enforcement and emergency departments, and only looks to the most restrictive responses when no other safe solution can be found. A key component of our state's crisis system is having someone to respond to a help-seeker. This service is provided by mobile rapid response crisis teams (MRRCT). MRRCTs are deployed to anyone, anywhere, and at any time.

Goal of implementing new models

HCA is committed to implementing nationwide best practices for the crisis care continuum. These practices align with the essential elements of the Substance Abuse Mental Health Services Administration (SAMHSA) 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, and the National Association of State Mental Health Program Directors (NASMHPD) publication, Crisis Services, Meeting Needs and Saving Lives. These best practice guidelines for mobile rapid response crisis teams are intended to provide guidance and begin to standardize practices across the state. As more teams become available, we hope to increase use and improve awareness of mobile rapid response crisis teams. We want communities across Washington to trust that when they or someone in their community is experiencing a behavioral health crisis, they can expect a voluntary, rapid behavioral health response that minimizes the involvement of emergency responders such as law enforcement, fire, and EMS, while reducing the need for more involuntary processes, including detaining people under the Involuntary Treatment Act (ITA).

SAMHSA’s vision for a comprehensive crisis system is to provide “someone to talk to, someone to respond, and a safe place for help” for a person in crisis, quickly and with minimal barriers. For youth, adolescents, and young adults, a “safe place for help” prioritizes face to face mobile response and stabilization in the home or community whenever possible.

Some of the goals of these models are:

- Reduce dependence on law enforcement, fire, EMS, and emergency departments for behavioral health crisis situations
- Provide a robust crisis workforce who are well trained to respond to and address urgent and emergent needs
- Include peers in crisis work to build rapport and give people someone to connect with who has similar experience/s
- Allow individuals, families, and communities to define what a crisis means to them and remove any barriers – intentional or unintentional – that prevent them from getting help.
- Default to an in-person response by MRRCT that focuses on voluntary services provided in the location preferred by the person experiencing the crisis
- Reduce or eliminate Designated Crisis Responders (DCR) from MRRCTs, allowing them to focus their unique skill set on conducting Involuntary Treatment Act (ITA) investigations
- Address systemic barriers for anyone experiencing a crisis in Washington

As our state implements these best practice models, we will learn from the examples provided by other states while continually working with system partners to make adjustments that meet the unique needs of Washington.

Scope

Mobile Rapid Response Crisis Teams provide voluntary community-based interventions to individuals in need wherever they are, including at home, work, school, juvenile courts, or anywhere else in the community where the person is experiencing a crisis. The help-seeker, not the provider, defines the crisis.

Keys to success

- Triage/screening, including explicit screening for suicidality and risk of harm to others
- Respond without law enforcement accompaniment, unless special circumstances warrant involvement to support justice system diversion
- Reduce the use of emergency departments
- Assess risk and identify opportunities to resolve the crisis in the least restrictive setting
- Developmentally appropriate de-escalation/resolution
- Peer support, including family peers or youth peers
- Coordination with medical and behavioral health services
- Crisis planning and follow-up
- Home and community-based stabilization

Guidance and applications for the crisis care continuum

Designated 988 contact hubs are one part of Washington's behavioral health crisis care continuum. It's important for hub 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 contact hubs and the crisis care continuum.

Aligning Washington's crisis system with national best practice standards

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

Elements of the best national practice standards 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:
 - Trauma-Informed approach (TIA)
 - De-escalation
 - Services that prevent overdose and injury
- Including peers in crisis response
- Responding without uniformed staff unless under special circumstances
- Scheduling or connecting someone to outpatient services including Next Day Appointments
- 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 a safe place for help."

- **Someone to talk to:** Implementing crisis contact centers with a robust technical platform to coordinate with partners and share information
- **Someone to respond:** Implementing and expanding MRRCT to respond to people in behavioral health crisis
- **A safe place for help:** Receiving crisis stabilization at home or in a safe place like a Crisis Relief Center or crisis stabilization facility

Additional goals include creating a coordinated statewide system with expanded access to timely, community-based behavioral health services and reducing gaps in availability for Washingtonians.

- **Comprehensive coverage:** Ensuring services are available statewide from community-informed providers attuned to local values and trusted practices to increase engagement in behavioral health services."
- **Integrating lived behavioral health system experience expertise:** Adding people with experience navigating the behavioral health system who work as peers or clinicians and bringing their unique perspective to their community, helps to 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.

Individualized access

Services should 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.

An individualized approach to access includes the right to access high-quality crisis services for all populations. Services are tailored to a person's unique preferences, values, needs, and experiences.

HCA recognizes the importance of providing services with skill and awareness of each person's experience, including the effects of disparities in the use of law enforcement in crisis situations, which can lead to distrust and trauma for individuals and communities, access in low-income areas, and geographic differences.

People need to receive quality, timely, and accessible care during a crisis that is responsive to their health beliefs. 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 services are intended to reduce behavioral health stigma.

Stigma can prevent people who need help from reaching out. Ways to reduce stigma 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 should be available and responsive to all levels of crisis severity. Unintended gatekeeping can have a negative impact and is not in alignment with the Crisis Now model¹, and people may:

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

The crisis system should be proactive and support people who reach out for support in any type of crisis. The help seeker, not the crisis worker, should define the crisis so someone can respond if they need help. For youth and young people, the call center acts as the single point of access to MRSS services. See the MRSS section below on the role of the single point of access in MRSS.

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 be present at any entry point of the crisis system, and staff should 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 understands that accessing help can re-traumatize people. Using and recommending appropriate trauma-informed resources and skills can help minimize this risk. Trauma is a widespread experience, whether it's caused by a large-scale disaster, a major life event, chronic stressors, 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.² 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.

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.

This is sometimes referred to as the four "Rs," these include:

- **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

¹ Crisis Now

² CDC - Violence Prevention

- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively **resist** re-traumatization³

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

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice

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 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 help seeker by recognizing the signs of trauma and acting accordingly. A person's trauma response 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 overdose prevention principles

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

At its core, overdose prevention 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. This can include encouraging a person to reduce substance use and distribution of overdose reversal supplies or providing housing and employment interventions.

Services should be developmentally appropriate

Interventions should be developmentally and age appropriate. Children, including pre-school and school age children, experience crises that should not be dismissed as parenting problems. It's important for crisis staff to understand that brain development continues into a person's 20s. Adolescents have emotional, cognitive, and psychological differences, including heightened sensation-seeking, impulsivity, risk taking, and risk perception. Populations with Intellectual or developmental disability require developmentally appropriate services well into adulthood, when risk of contact with law enforcement (LE) can increase during a crisis event.

³"The Four R's" (Realize / Recognize / Respond / Resist) - Trauma Informed Educational Practice - Library Guides at University of Portland

Increased behaviors of concern can signal early symptoms of a behavioral 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. Behavioral 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.

If grandparents are raising young children or teens, the family can benefit from access to developmentally appropriate crisis care. Youth moving from parental to grandparent custody can experience an increase in developmental, physical, behavioral, academic or emotional difficulties. To be effective surrogate caregivers, access to current trends in childhood development, technology safety, effective communication and de-escalation strategies while navigating complex systems provides trauma-informed care.

People with developmental or intellectual disabilities, brain injury, or illnesses affecting the brain and cognitive functions benefit from flexible crisis interventions. Crisis staff who are knowledgeable about these conditions can recommend appropriate resources. Crisis staff should work closely with all resources in their region, including Developmental Disabilities Administration (DDA) to follow best practices for those populations.

Services should promote health, improve quality and help eliminate health care disparities

The goal is to provide effective, understandable, and respectful quality mobile response services that respond to health beliefs and practices, languages, health literacy, and other communication needs. It also extends to honoring the rules and shared values of help-seekers and their families. Crisis responders should be mindful of a person's culture and avoid imposing their own values, rules, or practices upon the people they help. Providers can find free training and resources on the National Standards for Culturally and Linguistically Appropriate Services (The National CLAS Standards) [here](#).

Integrating peers into crisis work

People with lived behavioral health 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 understood in a crisis.

Keys to success

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

Providing education

There are misconceptions about the behavioral health crisis response system. This makes it essential for providers to educate system partners, families, youth and family led organizations and the public about:

- What crisis services are
- Least restrictive to most restrictive options
- What the crisis response system does
- How to access services, including in-person responses
- What to expect when services arrive
- Legal considerations and education on the involuntary treatment process

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 and universities
- First responder personnel and administrators, including emergency medical services, fire departments, and law enforcement.
- Co-response teams, such as CARES and other models with first responders
- Hospitals and emergency departments
- 23-hour crisis relief centers and crisis stabilization units
- Tribal partners
- Medical systems & primary care providers
- Outpatient behavioral health care workers
- Public Safety Answering Points (PSAPs)/911
- Youth System of Care partners – see MRSS section
- 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 respect and understanding. This can help build trust in the responsiveness and effectiveness of the crisis system and its staff.

Minimum requirements and mobile rapid response crisis team standards

Team Composition

A mobile rapid response crisis team should provide MRRCT services with at least one pair of two staff per shift. These two-person teams should include a Mental Health Professional (MHP) or a Mental Health Care Provider (MHCP), with approved DOH exemption⁴ and a Certified Peer Support Specialist (CPSS) responding together to crisis referrals. When a MRRCT experiences a staff shortage, there can also be a combination of two staff members who are MHPs or MHCPs.

HCA acknowledges that at times, public locations such as emergency departments, schools, primary care physicians, agencies, etc. may benefit from a clinician only response. For staff safety, responses to non-public locations should prioritize a two-person response. Each MRRCT must have at least one mental health professional (MHP) supervisor (more supervisors may be needed depending on total team size) available 24 hours per day for clinical consultation. At the discretion of the provider, teams may also include other professional or paraprofessionals with expertise in behavioral health crisis intervention.

Supervisor MHP

Provides clinical supervision and oversight of the mobile rapid response crisis team. The MHP is responsible for ensuring the services provided by the team meet medical necessity, are clinically appropriate, and meet all necessary requirements. The help-seeker is assumed to need crisis intervention based on their decision to seek help. Follow-up services will be provided, as needed, based on clinical judgement.

Minimum position requirements

A Mental Health Professional shall meet all licensure or credentialing requirements from DOH to provide services, experience supervising and overseeing crisis services is recommended. Supervisors should be trained in developmentally appropriate interventions when supervising youth teams.

Clinician

Provides crisis services and uses clinical judgement within the scope of their education and training to de-escalate and stabilize the individual in crisis and assist them in next steps. These positions may be filled by MHPs or MHCPs that meet the additional requirements below. Mobile crisis response staff **must** have immediate access to an on-call MHP, 24/7, to provide clinical oversight and supervision when needed.

Minimum position requirements

MHCP: individual working within a Behavioral Health Agency, under the supervision of a Mental Health Professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. To provide services as a Mental Health Care Provider, this person must be a Registered Agency Affiliated Counselor and have a minimum of one year of education or experience in mental health or a related field.

MHCP exemption requirements

For the clinician who qualifies as an MHCP to provide initial services with a peer, the provider agency **must** obtain an exception from the rule from DOH using the process outlined in WAC 246-341-0302.

MHP: means an individual practicing within the mental health professional's statutory scope of practice who is:

⁴ [WAC 246-341-0302](#)

- a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, as defined in this chapter and chapter [71.34](#) RCW;
- b) A mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate, as defined in chapter [18.225](#) RCW;
- c) A certified or licensed agency affiliated counselor, as defined in chapter [18.19](#) RCW; or
- d) A licensed psychological associate as described in chapter [18.83](#) RCW

Certified Peer Support Specialist (CPSS)

Provides peer support to the help-seeker and builds rapport with the person in crisis. Peers foster hope and resiliency for people in crisis due to their own lived behavioral health experience in utilizing or navigating behavioral health support. Peer Support Specialists use their own stories in helping others develop hope and improve their lives. For youth teams, parent peers with personal experience supporting a youth with behavioral health needs, or youth peers with experience receiving behavioral health services, will be utilized to foster hope and recovery.

Minimum position requirements

Certified Peer Support Specialist: someone who has completed at least 1,500 hours of work as a fully certified peer support specialist engaged in the practice of peer support services, with at least 500 hours attained through the joint supervision of peers in conjunction with another approved supervisor; and the training developed by the Health Care Authority under the [RCW 71.24.920](#). On the initial crisis response only, a CPSS must be accompanied by a licensed or credentialed staff. All services provided by CPSS must be provided under the oversight of the MHP supervisor.

[Chapter 18.19 RCW – Counselors](#)

Endorsement

Endorsements were established through House Bill 1134 to meet the need for more accessible and effective behavioral health emergency services within our state. The goal of the endorsement program is to enhance the statewide behavioral health crisis response system and ensure individuals experiencing a crisis can access help quickly and easily in their regions.

The endorsement is a voluntary credential that a mobile rapid response crisis team may obtain to indicate that it maintains the capacity to respond to people who are experiencing a significant behavioral health emergency requiring an urgent, in-person response. Teams that receive an endorsement credential have demonstrated they meet state standards for staffing, training, transportation, communication and other equipment.

New or existing mobile rapid response crisis teams and community-based crisis teams who meet the state minimum standards to provide services under [WAC 182-140](#) are eligible for endorsement. Eligible organizations seeking endorsement must follow the application process outlined in [WAC 182-140-0030](#).

Location of services

MRRCT services should be provided wherever the individual in need is located, including at home, school, work, or anywhere else in the community where the person is experiencing a crisis. Teams will assess the individual for risk and opportunities to resolve in the least restrictive setting.

MRRCT services reduce unnecessary contact with law enforcement, other first responders, and emergency departments for behavioral health needs by quickly responding to crises in the community. However, as the system grows and changes it is likely that many help-seekers will continue to seek crisis support at emergency departments. MRRCTs can support emergency departments by responding as quickly as possible. MRRCTs should not request emergency departments to provide medical clearance before responding.

Availability and response time

MRRCT services must be available 24 hours a day, every day of the year, and be able to respond to a behavioral health emergency within one hour of the referral, an emergent crisis within 2 hours of the referral and within 24 hours for an urgent crisis referral. Telephone support will be provided until in-person response arrives⁵. This telephone support can include providing the caller with a call back number, the 988 contact hub or regional crisis line (RCL) call center staff staying on the line or providing a direct call back option to the responding mobile rapid response crisis team.

Referral type	Definition
Behavioral Health Emergency	A behavioral health emergency is the most acute risk and requires a 1- hour response or less response time
Emergent	An emergent crisis is a high risk and requires a 2-hour response time
Urgent	Urgent crises are moderate to serious risk and require a 24-hour response
Routine/Follow-up	Routine/Follow-up care occurs after crisis response services are provided

Best Practice: Best practice response time to all crisis referrals is 60 minutes or less.

Scheduling

To ensure safety for responders and clients, mobile rapid response crisis team shift schedules must be designed to build in respite and downtime in lieu of responders being “on call” for days at a time. These schedules should be focused on workforce self-care and stress reduction to improve retention. Schedules can be adjusted according to outreach activities or peak times for calls, and rural vs. urban demand. Whenever possible, teams should utilize schedules of 12 hours or less per shift. This staffing pattern will support safety, improve critical decision making and rapport building with clients, support work life balance, and improve recruitment and retention. Due to 24/7 availability requirements and the unpredictability of community crisis needs, mobile rapid response crisis team staff are not expected to maintain a quota of direct contact hours.

Training

All members of the team must complete the training required in BH-ASO contracts. These include FMAP specific requirements, including HCA sponsored training in trauma-informed care de-escalation strategies, and overdose prevention. Youth mobile rapid response crisis teams must be trained in developmentally appropriate trauma-informed care, de-escalation and safety planning for youth and families, and overdose prevention. Additional recommended training for team members will continue to be developed and may include developmentally appropriate nonviolent crisis intervention, conflict resolution, interpersonal violence, Motivational Interviewing, MRSS, risk management and crisis planning (including WRAP and crisis safety planning tools), cultural awareness and responsiveness, CPR/First Aid, and basic overview of psychiatric medications and side effects.

Community coordination

MRRCT services often function best when there has been strong community coordination and relationship building through outreach and engagement activities. These efforts increase community providers’ awareness and understanding of the service, help foster appropriate referrals, and support care coordination. These efforts work to educate the public and providers about MRRCT services and create opportunities for early, preventative support. Building relationships with 988 contact hubs, RCLs, emergency departments, schools, providers, primary care clinics, Indian Community Health Programs (ICHP), Tribal Nations, juvenile justice, probation officers, community corrections officers, respite care providers, community health care facilities, behavioral health care facilities, universities, rural and agricultural extension offices, fire departments, EMS responders, law enforcement, probation officers, inpatient discharge planners, 23-hour crisis relief centers and stabilization

⁵ [WAC 246-341-0900](https://www.wac.wa.gov/246-341-0900)

facilities, substance use providers, foster care social workers, parents, caregivers and managed care organizations (MCOs) will encourage use of MRRC teams instead of 911 services and emergency departments.

Documentation

Documentation of MRRCT services for the initial response must be completed by the on-scene clinician responding. This can be an MHP or MHCP (with approved DOH exemption) under the supervision of the MHP supervisor⁶. Documentation must include the following⁷, 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
- The time elapsed from the initial deployment to the in-person or telehealth response
- The names of the participants
- A follow-up plan or disposition, including any referrals for services, including emergency medical services
- Whether the individual has a crisis plan and any request to obtain the crisis plan
- Any crisis and/or safety plan that was developed during the encounter
- The outcome, including the basis for a decision not to respond in person when a telehealth intervention was provided; and
- The name and credential of the staff person providing the service
- If the individual has a current Mental Health Advance Directives (MHAD)

Teams should document the services provided as soon as they are able to do so. This will ensure they are able to provide notes to any follow-up services about the encounter. Peers may submit encounters after the initial response. Documentation should be done in an EHR following employer guidelines and procedures and in compliance with applicable confidentiality laws.

⁶ [WAC 246-341-0910](#)

⁷ [WAC 246-341-0900](#) and [WAC 246-341-0910](#)

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 behavioral health 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 the help-seeker and the person in crisis. The key authorities for legal guidelines are:

The Health Insurance Portability and Accountability Act (HIPAA)⁸: 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 RCW⁹: State law that governs privacy.

42 CFR part 2¹⁰: 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](#)

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. If providing care on Tribal land, one must review specific Tribes Crisis Coordination Protocols to determine who to share crisis information with and how to gain access to the person for crisis services.

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 42 CFR Part 2 and RCW's 70.02 71.34 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 to disclose for the safety of the adolescent or others under allowable disclosures in RCW 70.02.050¹¹ or required under mandatory reporting.

⁸ [Health information privacy](#)

⁹ [Chapter 70.02 RCW Healthcare information access and disclosure](#)

¹⁰ [Code of Federal Regulations – Title 42](#)

¹¹ [RCW 70.02.050: Disclosure without patient's authorization—Need-to-know basis.](#)

Limits of confidentiality for active rescue

According to the 988 Convening Playbook for Public Safety Answering Points¹² (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 with regard to 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 with regard to 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 Crisis Contact Center can flow to a PSAP if an activation of emergency services is needed. This also allows PSAPs to let the Crisis Contact Center know about the outcome of a response for the contact center to follow up.

Stigma and personal privacy

Accessing the crisis system can feel 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. Concepts related to behavioral health and wellness differ between individuals, families, and geographic locations. 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 about the limits of confidentiality if the person reaching out has privacy concerns. This allows the help-seeker 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 people reasonably able to prevent or lessen the threat, including the target of the threat.¹³

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

Behavioral health professionals have the 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:

...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.¹⁴

This requirement is the result of several court cases involving professionals who became aware of credible potential harm and did not act to warn the person or people being threatened. The current scope of the duty

¹³ [RCW 70.0230\(h\)\(i\) and 70.02.240\(10\),\(11\)](#).

¹⁴ [RCW 71.05. 120 – Involuntary Treatment](#)

warn is established by The Washington Supreme Court decision in *Volk v. DeMeerleer*, 187 Wn.2d 241, 386 P.3d 254, (2016).¹⁵

Mandatory reporting

Mandatory reporting is required under certain circumstances for all behavioral 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 if 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 and Adolescents:** Mandatory reporting for a child experiencing abuse and neglect is defined in RCW 26.44.030.¹⁶ 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](#). Reporting can be done by calling the DCYF hotline at 1-866-363-4276. Neither suicidal ideation nor self-harm in a minor is a reason for a mandatory report. If a call is made on behalf of a minor, it should be done transparently with the family when possible and safe to do so.
- **Vulnerable adult:** Mandatory reporting for the abuse, neglect, or financial exploitation of a vulnerable adult is mandated under RCW 74.34.¹⁷ 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 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 aide¹⁸

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](#), enter reporter information [here](#) or call APS at 1-833-866-5595.

¹⁵ [Washington State Final Volk Report \(pdf\)](#)

¹⁶ [RCW 26.44.030 – Reports- Duty and authority to make – Duty of receiving agency](#)

¹⁷ [RCW 74.34 Abuse of Vulnerable Adults Act](#)

¹⁸ [RCW 74.34.020](#)

Service delivery and modalities

MRRCT services consist of many different modalities to ensure services are delivered in a safe and effective manner. These modalities include but are not limited to the following:

Triage

The initial step in providing MRRCT services is to determine the level of risk present in the crisis and determine the most appropriate response. This triage process must include monitoring for suicide or self-harm and risk of harm to others. The triage process may be completed by crisis call line staff, with care to avoid asking individuals to repeatedly provide the same information.

Best practice: Minors should have a risk assessment in person by MRRCT teams whenever possible.

When the initial triage is done by crisis call line staff, they must share this information with the mobile rapid response crisis team. As part of the triage process, a determination should be made regarding the need for support from law enforcement and/or emergency medical personnel. When making this decision, special consideration should be given to any risk of harm to self and/or others and whether the individual is known to have the means to act on those thoughts and any previous history of violent acts.

Acuity of the crisis can be determined using the Washington Crisis Care Acuity Guide (WCCAG). The WCCAG is a statewide standardized tool that is used to determine the acuity of the help-seeker's crisis. The WCCAG lays out different acuity levels from “no dispatch needed” to a higher acute response of one hour or less. The WCCAG lays out best practices for different populations in our state including Tribal governments, veterans, youth and families, and people with developmental and intellectual disabilities. This tool can be used with all calls but is most appropriate when an in-person response is needed. Although the WCCAG is a tool to help triage acuity, if no referrals are pending, MRRCT staff should implement a “just go” approach and get out of the door as soon as possible (or as scheduled with an individual/their family).

Best Practice: To support true justice system diversion, respond without law enforcement accompaniment unless special circumstances require their participation.

Safety

Providing MRRCT services wherever they are needed while limiting the involvement of law enforcement can lead to safety concerns for the staff providing these services. These safety concerns are not unfounded but in most situations research, careful preparation and planning, and clear agency safety policies and practices can mitigate the risks, allowing mobile rapid response crisis team staff to provide these services safely without the presence of law enforcement.

Research and planning before leaving for an outreach can help you identify safety concerns and make plans to mitigate those risks.

Complete the following steps before leaving on an outreach:

- Ask the 988 contact hub or RCL crisis counselor about any known safety concerns
- Review agency records to identify any safety issues during previous encounters
- Provide regular briefings to staff on known safety issues in different areas in the community
- Map out the area and route before you go
- Always notify a co-worker or supervisor about where you are going and when you will check in with them
- Plan for what they should do if you do not check in as scheduled
- If you speak to the help-seeker or a referent let them know when you expect to arrive
- Ask if anyone else will be there and if they have been notified that you are coming so they are not surprised
- Ask about any pets or animals in the area that may present a safety concern
- Dress appropriately for the situation and weather conditions
- Put any valuables in the trunk of your vehicle before you leave your office
- Notify the client or referent if you are running late

- Make sure you have phone numbers for the client or referent and for your supervisor and coworkers

When you arrive at the location of the outreach:

- Always respond with a second person
- Look for potential hazards such as damaged sidewalks and streets, public drinking or drug use and stray dogs
- Park as close as possible to where you are going, and in a well-lit area, if possible
- Park in a location that minimizes opportunities to block you in
- Keep your cell phone in your pocket or somewhere that you can reach quickly
- Be aware of your surroundings and look for hazards as you approach the outreach location
- Knock firmly but not aggressively
- After knocking take a few steps back from the door
- Identify yourself and confirm that client and/or referent are still interested in services
- Ask who else is in the home so that no one is surprised
- Scan the home for any visible weapons or items that could be used as weapons
- Position yourself so that you are not blocking any exits but also have easy access to an exit yourself

Safety for the person needing services

Crisis services are voluntary and consensual until the point the person is experiencing behavioral health symptoms that cause them to be gravely disabled or to present a likelihood and/or imminent risk of harm to themselves or someone else, is not being supervised by a responsible party, and is refusing voluntary services. Responders need to be mindful of this and understand that the person has a right to confidentiality, and to refuse help. Just like a person who is alert and oriented has the right to refuse medical care, a person in crisis has the right to refuse behavioral health services, including crisis services.

Crisis responders can create safety by maintaining confidentiality, remembering that accepting help is voluntary, not imposing beliefs or values on someone, explaining clearly why they are there, and what they are doing in a way the individual can understand. This includes providing trauma-informed care and effective, understandable, and respectful quality mobile response services that respond to health beliefs and practices, languages, health literacy, and other communication needs services, and being mindful that in this situation, the responder is in a position of power that should not be misused or imposed upon others.

Assessment

The MHP, MHP supervisor, or clinician responding to the crisis are responsible for completing an assessment. This assessment should address the causes leading to the crisis, any safety concerns for the individual or others, strengths, resources available to the person in crisis, recent inpatient hospitalizations and/or enrollment with behavioral health providers, any prescribed medication and compliance with those medications, and any related medical history. Determine if the individual in crisis has a crisis plan or mental health advance directive (MHAD) and request a copy, if available.

Best Practice: Assess collateral contacts for distress and provide support when possible. People supporting other people in crisis are affected and need support too. Supporting them can help resolve the crisis sooner with better outcomes.

De-escalation/Resolution

Mobile crisis response providers engage the individual in counseling throughout the encounter and actively work to de-escalate the crisis. Providers may utilize therapeutic models such as Motivational Interviewing and Brief Therapy to help resolve the crisis and avoid the need for a higher level of care.

Crisis peer response

Incorporating peers into mobile crisis response teams can provide the individual in crisis with someone to relate to who has their own experience with behavioral health symptoms and the crisis system. Peers should focus on

building rapport, sharing experiences, and strengthening engagement. They may also engage family members or other natural supports to provide ideas around self-care and additional help. When engaging the individual in crisis, it is often most effective for the certified peer support specialist (CPSS) to take the lead. Documentation for the initial crisis encounter should be completed by the clinician, noting the peer's presence and interactions with the person in crisis. Peers may work with the person on follow up and encounter the peer code in SERI.

Engaging natural and formal support

Engaging natural support in Mobile Crisis Outreach can be incredibly beneficial for individuals in crisis. Natural support can consist of family, friends, neighbors, peers, and community members who have an existing relationship with the individual in crisis. These individuals may have a better understanding of the person's needs, preferences, and behaviors, as well as having knowledge about past symptoms and treatment, allowing for more personalized and effective interventions. Furthermore, natural support networks often have a greater likelihood of being available and responsive, providing immediate support when it is needed.

Another benefit of engaging natural support is that it can reduce reliance on formal behavioral health services, such as emergency departments and crisis hotlines. Many individuals in crisis prefer to seek support from someone they know and trust, rather than from a stranger. By tapping into natural support networks, individuals in crisis may be more likely to seek help before the situation escalates to the point of needing formal services. This can reduce the burden on emergency services and improve outcomes for individuals in crisis.

Natural support can also promote recovery and resilience. For individuals who experience a crisis, feeling supported and connected to others can be an important factor in their ability to recover from the crisis. Natural support networks can provide a sense of belonging, social connection, and emotional support that can be crucial for individuals in crisis. By leveraging these natural supports, behavioral health providers can help individuals build a stronger foundation for long-term recovery and overall well-being.

Engaging formal support in MRRCT can be an essential part of managing the crisis and reducing the risk of harm. Formal support may include healthcare professionals, therapists, care coordinators, child welfare organizations, and many others. When a crisis occurs, it is important to contact these formal supports as soon as possible to ensure that the individual in crisis receives the appropriate care.

Formal support can provide a variety of services in a behavioral health crisis, including assessments, interventions, and referrals to appropriate resources. Healthcare professionals can provide medical care, medication management, and psychotherapy services. By engaging these groups, mobile rapid response crisis teams can ensure that individuals and their families receive the most appropriate care and treatment available and can reduce the risk of harm and negative outcomes in crisis situations.

Coordination

An important focus for mobile crisis outreach teams should be identifying and addressing the recovery needs of individuals and families by linking them with needed medical and behavioral health services to address the current crisis and help prevent one in the future. Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.

Tribal crisis coordination protocols

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 relationships with local tribes to help navigate the unique ways tribes will work with the state system. Each Tribe may have a Tribal Crisis Coordination Protocol in place, which is an agreement between the state and Tribes that is followed by their crisis contractors (crisis providers & BH-ASOs). These protocols will have key information on limitations and how tribes want the state crisis system to interact with them.

It is important to ensure that MRRCTs appropriately identify if they are working with someone who they know or have reason to know is American Indian/Alaska Native and take the steps necessary to ensure the individual has access to individualized care, appropriate protocols are followed for providing services on tribal lands, and steps are taken for follow up care coordination, as outlined in the Tribal Crisis Coordination Protocols. When a response is needed for someone who is American Indian/Alaska Native, it's essential to provide culturally responsive support and resources. This can be done by supporting the person on the phone or in person while connecting them to their Tribe's/Indian Health Care Provider's (IHCPs) resources. Refer to the Tribal Crisis Coordination Protocols 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.

Tribal law enforcement and emergency management is an important role in Tribal communities and is generally community focused. It is likely that these entities will be a key resource to support MRRCTs in a crisis response. coordination and collaboration with Tribal LE and EMS are outlined in the Tribal Crisis Coordination Protocols.

Other Tribal/Native serving organizations

Not all AI/AN individuals are members of the federally recognized Tribes in Washington state or closely connected to an Urban Indian Health Program. The Native and Strong Lifeline (988 option #4) and Native Resource Hub provide services to anyone living in Washington who is affiliated with a Tribe, regardless of that person's homeland. 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.

The Native and Strong Lifeline is part of the Volunteers of America of Western Washington and a lifeline for all indigenous people in Washington state. The Native and Strong Lifeline is run by Native Counselors who are Tribal members and descendants and understand Native cultures and healing. The Native and Strong Lifeline can be reached by dialing 988 and pressing #4.

Transport

When working with individuals in crisis, they may need transportation to a place that can help resolve their crisis. These places can be pharmacies, food banks, crisis relief centers, crisis stabilization units or other facilities, or other locations relevant to their current challenges. MRRCTs may arrange for transport or provide transportation to these places when safe. Transportation should only occur when the person in crisis agrees to services and safe transport voluntarily.

Best Practice: for youth, a best practice is delivering services to the youth in the home and community to promote diversion from emergency departments or facility-based care whenever possible.

ITA Investigations

Individuals in crisis may present imminent or serious risk of harm to themselves or others or be unable to care for their basic needs of health and safety due to their behavioral health symptoms. When they are unwilling to engage in safety planning and other stabilization efforts by MRRCT members - or there is no appropriate or available alternative that could mitigate the level of risk-it is important to work with DCRs to ensure that an Involuntary Treatment Act (ITA) investigation is completed, if appropriate. Tribal members should be referred to a tribal DCR, Tribal health care, or other Tribal service based on the Tribe's Tribal Crisis Coordination Protocols

Best Practice: Whenever possible, MRRCT should engage a person in crisis first and attempt to resolve the crisis with interventions less restrictive than hospitalization, before bringing in a DCR for an ITA investigation.

Crisis planning and follow-up

As part of the MRRCT intervention, team members should initiate a crisis planning process that can help the individual prevent future crises and outline steps to take if they return to a crisis state. This process may include

the development or modification of a safety plan. This is a good time to ask if the person has Mental Health Advance Directives (MHAD) and inform them about the benefits of a MHAD if one does not exist. Youth 13-17 can create a MHAD, and have it executed, and teams should work with the youth and/or families to create this when clinically appropriate. When appropriate, telephone or in-person follow-up should be provided to determine if any services the individual was referred to were provided and if they met their needs.

The process of behavioral health crisis planning involves developing a comprehensive and individualized plan for managing crisis situations. This plan should be developed in collaboration with the individual in crisis, their natural support, and their behavioral health provider, whenever possible. The goal of crisis planning is to identify triggers and early warning signs of a crisis, develop strategies for managing these triggers, and identify resources that can be used in the event of a crisis.

The first step in behavioral health crisis planning is to assess the individual's specific needs and risk factors. This might involve considering their medical history, previous experiences with crisis, and any existing behavioral health diagnoses. From there, the individual and their team can identify triggers that may lead to a crisis, such as stress, trauma, or substance use. Once triggers have been identified, the team can develop a plan for preventing or managing these triggers, such as stress management techniques, coping skills, or medication management. Finally, the plan should identify specific resources that can be used in the event of a crisis, such as emergency contacts or crisis hotlines. By developing a comprehensive and individualized crisis plan, individuals and their teams can be better prepared to manage crises as they arise, reducing the risk of harm and promoting recovery.

A mental health advance directive is a legal document in which an individual can specify their wishes and preferences for behavioral health treatment if they are unable to make decisions for themselves. This document can include details such as preferred medications, treatment settings, and therapeutic approaches. By creating a mental health advanced directive, individuals can ensure that their wishes are known and respected in crisis situations and can have a greater sense of control over their behavioral health outcomes.

Mental health advance directives can be particularly important for individuals who have experienced past trauma or negative experiences with behavioral health treatment. By specifying their preferences and needs in advance, they have a greater sense of empowerment and control in their behavioral health care. Additionally, a mental health advanced directive can be helpful for family members and providers, as it provides a clear understanding of the individual's wishes and can help guide decision-making. Mental health advance directives can serve as a valuable tool for individuals seeking to maintain autonomy and control over their behavioral health outcomes.

Guardianship and Power of Attorney

When providing behavioral health crisis care to someone who has a legal guardian or health care power of attorney, it is important to involve the guardian or power of attorney in the care process. The guardian or power of attorney can provide valuable information about the individual's medical history and any medications they are taking. They can also help make decisions about treatment options and provide support during the recovery process. However, it is important to remember that the individual still has rights and should be involved in the decision-making process as much as possible.

Mobile Response and Stabilization Services (MRSS) for Children, Young People, and their Families*

*In collaboration with: Washington State Community Connectors (WSCC), A Common Voice C.O.P.E. Project, Students Providing and Receiving Knowledge (SPARK), and Innovations Institute at the University of Connecticut School of Social Work. For more information on the MRSS model go to [Innovations Institute MRSS](#)

Purpose

HCA requires youth MRRCTs to follow the MRSS model. MRSS is a child and family specific crisis intervention that recognizes the unique developmental needs of children, adolescents, young adults, and their parents/caregivers. Caregivers and children are interconnected in their relationship and thus, crisis situations for children impact the parent's ability to respond to and de-escalate the situation. Supporting the caregiver's response to the behavioral health crisis when they call decreases the likelihood of a caregiver calling 911 or going to the emergency department. Calling 911 typically creates a uniformed response from EMS, fire or law enforcement. This can result in transport to the emergency department, and risks child welfare and/or juvenile justice involvement.

A comprehensive crisis care continuum acknowledges that youth can be supported early during a crisis event and be stabilized and connected to resources and supports in their regional service area. This reduces return to an acute crisis phase, improves outcomes, and offers a cost-effective alternative to the re-traumatization and stress of costly out of home interventions and emergency department use for behavioral health needs.

Since MRSS may be the first point of contact a family has with the behavioral health system, the team should build a trusting relationship of mutual respect and provide individualized care that incorporates family voice. Services are necessarily trauma-informed and provide effective, understandable, and respectful quality mobile response services that respond to health beliefs and practices, languages, health literacy, and other communication needs. MRSS coordinates with the larger children's System of Care (SOC) linking children, young people, and families to the right help, at the right intensity, and at the right time.

Crisis & Safety Planning for children & families

Developmentally informed crisis planning accounts for family-defined crisis and/or things that compromise safety. Planning around suicide risk and/or danger to self-danger to others (DTS/DTO) alone is not adequate. Examples of elements that make crisis plans effective for children and families include:

- **They include all family members and plan across strengths and needs, and are written in the families' own words**
- **Include both proactive and reactive steps that are connected to the identified triggers and family-defined crisis, all family members know who is responsible for each step and when to use it**
- **They are collaborative, represent voice and choice of young people and their families, and build from what has previously been helpful**
- **Plans attend to safety concerns and include clear action steps to keep young people and their families safe, including how to follow up with MRRCT/MRSS or another resource**

The MRSS episode of care:

MRSS includes three service components: Access points, mobile response services (crisis intervention), and crisis stabilization services. The services, while distinct in purpose and definition, should represent a seamless continuum of care that feels like a single episode for the young people and families that access them. All services are voluntary and honor the unique needs, strengths, preferences, and cultural contexts of young people and their families. Services occur in homes, schools, and other community settings.

Access points

Young people and their families should enter the MRSS continuum of care from a point of access that is not 911. Access points can include 988 contact hubs and regional crisis lines that operate 24/7 every day of the year. Young people and their families should receive a uniform experience across all access points, including offering in-person mobile responses to every child, youth and/or caregiver regardless of presenting concern or acuity level. When available, this mobile response should be from a youth MRRCT/MRSS team.

It is important that 988 contact hub and regional crisis line staff do not prioritize only de-escalation by phone for children, youth, and families instead of offering deployment of a MRSS or MRRC team. Sending help quickly for any youth and/or family-defined crisis prevents unnecessary calls to 911 and trips to emergency departments. Using danger to self/danger to others (DTS/DTO) criteria as a standard of care is **not** recommended and will exclude a large number of children/youth with complex or acute behavioral health needs that create real risk of change in living environments, school or daycare disruption, or ability to function in recreational and social activities, all of which impact the family as a whole. Instead, young people and their caregivers define the crisis and what will be helpful. Offering in-person responses through MRSS does not preclude youth from utilizing any crisis line confidentially if they choose to do so. Offering choices allows young people and caregivers to choose the response that is best for them.

Access points provide warm handoffs to youth MRRCT for mobile response. To prevent young people and their families from having to repeat their story multiple times, access points should prioritize quick handoffs to mobile providers as soon as it becomes clear that a mobile response is desired.

Mobile response services

Mobile response services are provided in-person by youth MRRCT/MRSS teams wherever the crisis is occurring (e.g. homes, schools, community, BRS homes, group homes, shelters, emergency departments for hospital diversion, or 23-hour crisis relief centers for safe discharge home). This service may be provided for up to 72 hours. Services include:

- An initial in-person mobile response from a team of two MRSS staff as soon as possible but no more than two hours from the initial access point contact. The exception to this timeframe would be a delayed response to the request of the young person or family and then within 24 hours at the time most convenient to them.
- Assessment and safety planning.
- Short-term care coordination for up to 72 hours.
- Brief clinical support including additional in-person visits, as needed for up to 72 hours.

Peer support for up to 72 hours. During the initial mobile response visit, staff focus on assessing and establishing safety for the young person and their family. This includes the development of a written crisis and safety plan that is provided to the young person and/or their family before the MRSS team leaves. Assessments should include universal suicide screening using a standardized tool such as the [PHQ-9 or GAD-7](#), e.g. Columbia-Suicide Severity Rating Scale (C-SSRS) or Ask Suicide-Screening Questions (ASQ) and assess needs and strengths across multiple domains including substance use, risk behaviors, educational settings, relationships, and systems involvement (e.g. I/DD, Juvenile Justice, Child Welfare). The [Crisis Assessment Tool](#) (CAT) and [The Child and Adolescent Needs and Strengths](#) (CANS) are examples of developmentally appropriate tools. Assessments should support MRSS staff, young people, and families to make data informed decisions related to resources and next steps.

During the initial visit, necessary consents, releases of information (ROI), and disclosures about confidentiality and the limits thereof are completed. When time allows, MRSS begins gathering the information needed to complete an assessment around strengths and needs to understand what support will be helpful to the young person and their family to remain safe and thrive in their home and community. While services are available for up to 72 hours, some families will only desire or require this initial response.

ROIs are critical to engagement when working with young people. Releases for schools, primary care providers, parents and caregivers, and natural and clinical support will ensure robust care coordination. At times, parents

may only want the youth seen at school or may not want any services. Youth aged 13+ have the right to request and receive MRSS without the parent or caregiver's permission. School ROIs are critical in that case. Teams shall ensure confidentiality for these adolescents and follow the limits of confidentiality for safety concerns to self or others. For confidentiality reasons, the team should make every effort to work with these adolescents outside of the sight of the student body when at school, and by being available to meet the adolescents in community locations and include trusted adults they have identified on their safety plan.

For up to 72 hours, MRSS staff continue to offer intervention, gather information, and assist the family in identifying the support and services that will be most helpful to them. MRSS staff collaborate with existing providers and provide a warm handoff to identified supports, including stabilization services, when appropriate. MRSS staff work to connect youth and families to a mix of natural, community, and formal supports as indicated by their individual needs and preferences. During this time, MRSS staff may also focus on additional visits to address identified safety needs, offer peer support (youth and/or caregivers), provide brief clinical interventions, work on skill development, and assist in making the environment safe. The family continues to have 24/7 access to their MRSS care team throughout their enrollment in services. While most young people, even those with moderate to high levels of risk, can be kept safe at home, MRSS staff should be knowledgeable of the resources available and procedures to access higher levels of care, when necessary. Whenever possible, caregivers and/or MRSS staff should provide transportation and warm handoffs as opposed to law enforcement transports and/or emergency department assessments.

There is no limit to the number of times a young person/or caregiver can access mobile response services. Organizations should have quality measures in place to identify children/young people who require frequent responses. MRSS staff should work with the young person and their supports to identify and remove barriers.

Mobile response services are Medicaid reimbursable under crisis intervention services (up to 72 hours) and include peer support services.

Stabilization services

Stabilization services begin on day 4 and can last for up to 8 weeks. They are typically provided by the same team who provides mobile response services, but organizations may make staffing decisions that support their operational needs and are most effective for the young people and families they support. Either way, stabilization services should be a seamless transition for young people and families. There should be no waitlist between mobile response and stabilization services.

Stabilization services are short-term, intensive services focused on helping young people stabilize in their homes and communities and participate in routine activities like school, home-life, recreational, and social events. They are available both to young people with immediate risk of entry into higher levels of care (e.g. psychiatric hospitalization) and as an early intervention for new or worsening behavioral health concerns. Early intervention can offset the need for future, more intensive services by determining needs and supports before problems become more complex. At minimum, stabilization services include up to eight weeks of care coordination to include weekly in-person engagement and connections to ongoing support.

Keeping children and young people safe at home

MRSS operates from the principle that most young people, even those with moderate to high levels of risk, can be kept safe at home. This means that MRSS staff must be skilled at identifying risk and protective factors and assist families in making environments safe. Teams can:

- Provide lock boxes, trigger locks, and locking doorknobs for firearms, sharp objects, poisons, etc.
- Provide and/or educate about contact alarms for windows and doors for jumping or elopement risk
- Help families develop increased supervision plans, including partnering to provide direct 1:1 supervision, when indicated

Many young people and their families will also benefit from other direct care and intervention provided by stabilization staff to assist them in remaining safe at home during periods of acute crisis: These include:

- Brief clinical intervention
- Peer support (youth and/or caregiver)
- Skill building (coping, parenting, psychoeducation, etc.)
- Family and team meetings (with the young person and their identified supports)
- Increased supervision
- Making the environment safe

Services may need to be provided at greater frequency, especially immediately following the crisis event. For example, teams may support families to keep their young person safe at home through daily contact for a period of time. All young people and families can access immediate support from their MRSS team 24/7 while they are enrolled in services. Services should be offered at the frequency and duration that support the assessed needs of the young person and family.

Types of Support
MRSS emphasizes plans and connections that include a mix of natural, community and system supports.
Natural Supports: people who are already connected to the youth or family and have a natural relationship or could develop a connection in support of the youth and family. These people can provide ongoing support to the family and include family, friends, neighbors, librarians, coaches, and faith-based and culturally specific supports.
Community Supports: are non-clinical/system supports that help children, young people, and their caregivers to discover their strengths, connect to their peers, enjoy recreational activities and find community. They can include recreation centers, clubs, sports teams, arts programs, youth groups, etc.
System Supports: are formal supports who provide direct or indirect services to youth and families and can include Department of Children, Youth & Families, juvenile justice, DDA, schools, primary care providers, behavioral health providers and services, and peer-led organizations.

Eight weeks of care coordination will be enough for many young people to link to the support and services that they need for long-term stability in homes and communities. Some young people will benefit from additional care coordination. Stabilization staff should work to identify this need as quickly as possible to prevent any lapse in services between stabilization and a longer-term care coordination model like WISE.

If the youth is enrolled in Apple Health, MRSS teams should ask the family if they want a WISE referral. If so, this should be initiated in the first 72 hours whenever possible. Teams should have WISE handouts and referral paperwork on hand to fill out with the family. There are limited non-Medicaid wraparound slots in some counties funded by local tax dollars, so teams should partner with local WISE agencies regarding eligibility. The CANS screen for WISE eligibility is the responsibility of the WISE provider. MRSS teams are not required to determine nor establish WISE eligibility.

Families transition out of stabilization services at 8 weeks or sooner if the concerns that brought them to MRSS services have been addressed, or they no longer want the service. At the time of transition, young people and caregivers should have a clear understanding of next steps, including how to follow-through with any new connections and how to reach back out for help in the future should this or another crisis occur. Because services are short-term, it is important that stabilization staff begin partnering with families from day one to establish ongoing resources and supports.

Stabilization services are reimbursable by Medicaid (up to 8 weeks) and include peer support services. MRSS can be open and billed concurrently to any outpatient provider, a school provider, a group home, a Behavioral Rehabilitation Services (BRS) home or Out-of-Home-Services (OHS) home. MRSS cannot be open concurrently with WISE or PACT, as both programs are funded 24/7.

Team composition

Team composition should mirror all MRRCT requirements with a clinician and a peer responding in a pair for initial mobile responses. For MRSS teams, peer support should be tailored to people with lived behavioral health experience as either a parent of a child who has/is receiving behavioral health treatment, or a young person with experience in the behavioral health system.

Other team members that can be utilized as needed include parents with personal experience supporting youth with complex needs, like autism spectrum disorder (ASD) or intellectual and developmental disabilities (I/DD), behavioral support specialists, care coordinators, prescribers, etc.

The provider can determine staffing patterns for crisis intervention or crisis stabilization components. The family should have access to a MHCP or MHP clinician 24/7 for crisis response. An MHP supervisor must be available for consultation 24/7 to any team member responding to a youth or family.

Special considerations for youth crisis care

Youth's right to independently consent to treatment

Teams should intentionally include parents/caregivers, family members, natural supports, primary care providers, schools, and relevant treatment providers to stabilize the person in crisis. This should be in accordance with Washington state law and RCW 71.34 when encountering adolescents aged 13-17¹⁹, and within the limits of confidentiality. Youth aged 13+ have the right to request and receive MRSS without the parent or caregiver's permission. Disclosure is allowable only as described above under Confidentiality and Adolescents - on page 15.

Family Initiated Treatment (FIT)

Family Initiated Treatment (FIT) provides a way for a parent or caregiver to initiate outpatient treatment, including MRSS, on behalf of youth aged 13 to 17. As a provider, be aware that parents may consent to family-initiated treatment (FIT) on behalf of youth who meet medical necessity. Consent from the youth is not required. MRSS providers who participate in FIT for outpatient services allow for the caregiver to initially consent to services. In that case the team should work with the youth to ultimately sign for and direct their own treatment.

Youth who need services have the right to get those services in the least restrictive setting that best meets their needs and keeps them within their community whenever possible, including MRSS.

You can find more information about FIT [here](#).

Transportation

Transporting youth out of the home to a facility should be a last resort and only if safety cannot be maintained by the partnership of the MRSS team and the adults in that young person's life. While a last resort, when necessary, transportation by the youth's caregiver or MRSS staff is preferable over transportation by law enforcement. Sometimes, a youth may prefer to stay overnight with another family member for a cooling off period. This is a good example of bringing in natural supports to help keep the youth safe in the community where they can continue routine activities like school, recreational activities, and community and outpatient care.

Transportation for youth in an MRSS episode of care should be geared towards connecting them with natural or clinical supports. These activities in their lives give young people an opportunity to make friends, find communities of shared interests, and feel successful. They also provide opportunities for brief respite. These community resources are hyperlocal, and the teams should have a good understanding of where they are and

¹⁹ [Chapter 71.34 RCW](#)

whether they are sustainable. Activities and resources that are free or have reduced rates or sliding scales to attend work best for sustainability after the episode of care closes.

Transporting a youth and/or caregiver to support them through an intake with a community provider is a great use of a vehicle on the MRSS team. Parents should provide consent for transport of a minor by the team. A parent may also transport the youth to the intake and meet the team member there for support during the intake appointment.

Peer support

Peer support is an integral part of crisis care. Peer support in MRSS is provided by either a parent certified peer support specialist or youth certified peer support specialist. These certified peer support specialists use their lived behavioral health experience to offer important perspective, expertise, and support while modeling recovery and hope.

- **Parent certified peer support specialist or family certified peer support specialist** - A formal member of the behavioral health treatment team whose role is to serve the family, help them engage and actively participate with their team, in their community, and make informed decisions that drive the MRSS episode of care. They are qualified through their lived personal experience as the parent/caregiver of a youth with complex emotional/behavioral needs and hold a certified peer support specialist certification.
- **Youth certified peer support specialist** - A formal member of the behavioral health treatment team, likely between the ages of 18-30, whose role is to serve the youth and help them engage and actively participate with their team, in the community, and make informed decisions that drive the MRSS episode of care. They are qualified through their lived personal experience as a youth in the behavioral health system and hold a certified peer support specialist certification.

Peers should receive the same training as the other staff employed in MRSS work. Organizations should support the peer workforce by providing flexibility for them to maintain their own connections to care for themselves and their family as well as links to other peers. One way to do this is to connect peers to peer run organizations for support. One resource is [Washington Peer Network](#). Peers' supervisors can also benefit from regular consultation and support.

Young person and family voice and choice

Young people and their families have the right to make decisions related to their own care. Additionally, allowing young people and families to be the drivers of their own care improves outcomes, including engagement and effectiveness of the use of crisis plans. MRSS staff should partner with families to build collaborative plans that acknowledge their unique preferences, needs, strengths, cultural contexts, and goals. MRSS staff should be knowledgeable in community resources, evidence-based practices, and service choices to provide young persons and families with options that best match their needs. These options should include a mix of natural, community, and system supports tailored to their individual stories. The young people and families select the options that work best for them.

Cross system coordination

Adult or mixed-age MRRCT, Endorsed MRRCT or CBCT, co-response teams, law enforcement, fire and EMS response units should all be aware of how to access the youth MRSS team in their area for a warm handoff. This should be prioritized and implemented in protocols over transporting the youth out of the home, to the emergency department or to juvenile detention as a first intervention whenever safe and possible to do so. Often this cross-system understanding will require that MRRCT staff outreach and engage with these community partners to build this understanding and coordination.

Additionally, inpatient and residential settings in the regional service area (RSA) should be aware of and how to contact youth MRRCT in the regions for robust discharge planning to return a youth home. This helps to reduce facility-based care and shifts care to in-home and community stabilization, whenever possible. These settings include hospital emergency departments or youth "holding" on medical floors for inpatient beds, 23-hour crisis relief centers, adolescent inpatient units, residential crisis stabilization programs (RCSP), Children's Long-Term

Inpatient (CLIP), or residential treatment in or out of state. MRRCT programs should develop relationships with these settings and establish how they will coordinate.

Outreach and engagement

Successful MRSS teams perform robust outreach and engagement to inform regional, family, community, and system partners about the availability of MRSS crisis response. School districts may differ in that one will want a memorandum of understanding for the team to respond to and meet with youth on school grounds. Each district can differ. Leadership should work with school district leadership in the service area to arrange for the team to be allowed on site.

Law enforcement should consider the team a reliable, consistent referral for any youth encounter, day, or night. Other outreach areas for consideration include pediatric primary care providers, emergency departments, 23-hour crisis receiving centers, inpatient adolescent units, juvenile justice centers, schools, Department of Children, Youth, and Families (DCYF), foster parents, after school programs, substance use and co-occurring disorder providers, group homes, and shelters. The team can respond to all these facilities to offer MRSS or provide MRSS support for safe discharge home for most youth.

System of Care implementation

Shared understanding of the MRSS model with System of Care (SOC) partners will help these partners understand what the MRSS team does and how to access them. Collaboration with community partners and stakeholders to understand care pathways and interruption points will provide early identification and prevention of more costly interventions or emergency department utilization for behavioral health needs. Provider awareness campaigns with the following systems is essential to the success of MRSS in hospital diversion:

- Behavioral Health Administrative Service Organizations
- Department of Children Youth and Families
- Department of Social and Health Services
- Managed Care Organizations
- Juvenile justice
- Law enforcement
- Probation officers and family courts
- Schools and universities
- Primary care providers
- Department of Health
- Emergency Departments, Inpatient Adolescent Units, 23-hour crisis relief centers, and Children's Hospitals for safe discharge home whenever possible
- Community Behavioral Health Providers and Behavioral Health Agencies
- After-school programs, childcare centers, and sports programs
- Community Organizations, Shelters
- Youth and Parent led organizations

Acronym list

APS – Adult Protective Services

BH-ASO – Behavioral Health Administrative Service Organization

BHA – Behavioral Health Agency

CCC – Crisis Contact Center

CPSS- Certified Peer Support Specialist

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

IHCP – Indian Health Care Provider

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 Answering Point

RCL – Regional Crisis Line

ROI – Release of Information

SAMHSA – Substance Abuse Mental Health Services Administration

SOC – System of Care

TAY – Transition Age Youth

TAY-WISe - Transition Age Youth Wraparound with Intensive Services

TIA – Trauma-informed Approach

WCCAC- Washington Crisis Care Acuity Guide

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 **contact hub**.

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

988 contact hub - 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 contact hubs 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 Support Specialist: someone who has completed: at least 1,500 hours of work as a fully certified peer support specialist engaged in the practice of peer support services, with at least 500 hours attained through the joint supervision of

peers in conjunction with another approved supervisor; and the training developed by the Health Care Authority under the RCW 71.24.920

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

Community-based crisis team (CBCT) means a team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site, community-based interventions of a mobile rapid response crisis team (MRRCT) for people who are experiencing behavioral health emergencies.

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 person in crisis and their support system know what to do when an emergency comes up. 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. Intimate Partner Violence (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. (CDC)

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.

Endorsement: means a voluntary credential issued by the authority to a mobile rapid response crisis team (MRRCT) or a community-based crisis team (CBCT), which allows the team to become eligible for supplemental performance payments.

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 stabilization 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 personal 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.

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.

Indian health care provider (IHCP) - Health care program operated by the Indian health service or by a Tribe, Tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. § 1603. Depending upon the Indian health care provider's eligibility requirements, certain Indian health care providers may serve non-Tribal member patients and/or individuals who are not community members

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 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 behavioral health 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. Ultimately, an understanding of behavioral health system 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) - an individual working within a Behavioral Health Agency, under the supervision of a Mental Health Professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. To provide services as a Mental Health Care Provider, this person must be a Registered Agency Affiliated Counselor and have a minimum of one year of education or experience in mental health or a related field.

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 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). Youth MRRCT follow the MRSS model.

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. 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 overdose prevention 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 help seeker and the team arriving at their location. This does not include the time between a 988 **contact hub** 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. For youth and adolescents, the term drug use vs. SUD is more appropriate, per CDC.

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.

Tribal land - means any territory within the state of Washington over which a Tribe has legal jurisdiction, including any lands held in trust for the Tribe by the federal government.

Tribe - means any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village, group, region or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. § 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Tribal crisis coordination protocols - means the protocols that HCA, DOH, and a Tribe or non-Tribal

IHCP develop and agree on, with input from the crisis entities, for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning.

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.