
nce Abuse and Ment
tion

Acknowledgments

This document was produced for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), under contract number HHSS23820170000741/75S20319F42002. Lora Fleetwood, served as contracting officer representative.

Electronic Access and Copies of Publication

This publication may be downloaded or ordered at www.samhsa.gov. Or you may o o ^ D , ^ [• , o š Z Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Suggested Citation

Substance Abuse and Mental Health Services Administration

From the desk of Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services

Children, youth, and young adults across the nation are experiencing a rising wave of emotional and behavioral health needs. All too often, these young people are subjected to unnecessary hospitalizations, long stays in inpatient facilities, justice system involvement, disproportionate school discipline, and out-of-home placements. There are also pronounced disparities impacting young people of color, families from low-income communities, and sexual minority youth. For too many youth, these crises end tragically.

All youth and families should have access to a robust crisis response system that has developmentally appropriate policies, staffing, and resources in place to respond to their needs equitably and effectively with the right supports, at the right time, delivered the right way.

As of July 2022, people in every state, tribal nation, and U.S. territory can access the Suicide and Crisis Lifeline network by calling or texting a simple three-digit number, 988. SAMHSA aims to provide as much support as possible to facilitate the development of a spectrum of services that are effective in addressing the needs of individuals in crisis, including [illegible]

[illegible] National Guidelines for Child and Youth Behavioral Health Crisis Care describes a framework that states and localities across America can consider as they develop or expand their crisis safety net for youth and families. Ultimately, SAMHSA envisions 988 as part of a robust crisis response system that is as widely recognized and understood as 911.

This document [illegible] is not the final word but it is a beginning. With the implementation of 988, we will continue to learn better ways of engaging, serving, and supporting young people in crisis and their families. Together, we can build a crisis response system that both responds effectively to all youth in crisis and prevents emotional and behavioral health needs from escalating to crisis.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

The National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline in July 2022. This free, confidential system provides 24/7/365 behavioral health crisis response through text, chat, and voice calls. Congress increased its appropriation for the crisis center service to address rising rates of behavioral health crises across America. This transition represents an unparalleled opportunity to improve the delivery of crisis care in every community in the country. It also elevates our responsibility to ensure that crisis response services meet the needs of children, youth, and young adults, and their families and caregivers.

The need for developmentally appropriate crisis response services for youth is acute. Yet, while many crisis response systems have robust services in place for adults, there are often considerable gaps in capacity to serve youth and families. Too often, youth experiencing behavioral health crisis face hospitalization or justice system involvement, instead of the home- and community-based services they need to de-escalate and stabilize. This is especially true for youth populations that have experienced high unmet behavioral health needs, including LGBTQ+, Black, and American Indian and Alaska Native youth.

The National Guidelines for Child and Youth Behavioral Health Crisis Care provides guidance on how states and communities can address these gaps. It offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of American children and their families experiencing a behavioral health crisis.

Core Principles for Delivering Crisis Response to Children, Youth, and Families

The first priority is keeping youth in their own homes and keeping families intact whenever possible. Youth and families should receive the most effective, least restrictive services that will meet their needs. To the extent it can be safely done, children and youth should receive services in home- and community-based settings. When needed, crisis stabilization facilities should have child-, youth-, and family-specific policies, staff, and physical spaces to meet a full range of developmental needs. Across all contexts, crisis responders should collaborate with, engage, and empower youth and families as early as possible to prevent avoidable hospitalizations and justice system involvement.

SAMHSA strongly encourages youth crisis systems to:

- Keep youth in their home and avoid out-of-home placements, as much as possible.
- Provide developmentally appropriate services and supports that treat youth as youth, rather than expecting them to have the same needs as adults.
- Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meet the needs of all families by providing culturally and linguistically appropriate, equity-driven services.

Youth crisis systems should also adopt the core principles outlined in the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit:

1. Addressing Recovery Needs
2. Trauma-Informed Care
3. Significant Role for Peers

4. Zero Suicide/Suicide Safer Care
5. Safety/Security for Staff and People in Crisis
6.

Terms for discussing people and populations also change over time. Wherever specific racial, ethnic, cultural, or other identity-based groups are discussed in this document, we have tried to use language

In the past year, President Biden, U.S. Surgeon General Vivek Murthy, and a collective comprised of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Z]o Œ v[• ,}•‰]š o •• called attention to urgent youth mental health needs (Biden, 2022; Office of the Surgeon General, 2021; American Academy of Pediatrics, 2019).

Up to one in five children has a reported mental, emotional, developmental, or behavioral disorder (Perou et al., 2013), and youth mental health has worsened over the past decade (Centers for Disease Control and Prevention, 2020). During the pandemic, rates increased for positive suicide risk screens, anxiety symptoms, and depression symptoms among youth (Lantos et al., 2022; Mayne, 2021; Office of the Surgeon General, 2021). Youth with mental health challenges also experience higher risk for early substance use, regular substance use, and substance use disorders (Welsh et al., 2020).

Although the national rise is alarming on its own, some historically underserved youth populations are disproportionately burdened by behavioral health crisis. For example, non-Hispanic American Indian or Alaskan Native (AI/AN) children have the highest rate of suicide.

- Many youth are brought to the ED repeatedly for costly crisis visits, rather than transitioning to ongoing care and community-based alternatives.

There are also important racial and ethnic disparities related to ED boarding. Youth visits to the ED for psychiatric reasons are rising most quickly for Black and Hispanic or Latino youth (Kalb et al., 2019). In a study of more than half a million youth who were physically restrained in the ED, Black youth were almost

engaging in public displays of affection, or defending themselves against bullying and harassment (Snapp et al., 2014; Snapp & Russell, 2016).

This section discusses each of the three core services in more detail. Across all services, SAMHSA strongly encourages:

- Keep youth in their home and avoid out-of-home placements as much as possible.
- Provide developmentally appropriate services and supports that treat youth as youth, rather than expecting them to have the same needs as adults.
- Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
-

Crisis call centers provide developmentally appropriate, brief screening and intervention via telephone call, text, and chat. Contact centers

- The National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit also directs Lifeline

Staffing and Training

- Have access to a licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with youth populations. The clinician may be onsite, or they may consult over the phone or through video (Bostic & Hoover, 2020; SAMHSA, 2020a).
- Incorporate youth and family peers within the response team (SAMHSA, 2020a).
- Respond without law enforcement accompaniment unless special circumstances warrant their inclusion. Safe reduction of unnecessary police involvement is critical for youth of color, who are more likely than their White peers to face harsh consequences like school exclusion and arrest (Bunts, 2021; Maryland State Department of Education, n.d.; McFadden, 2021; U.S. Commission on Civil Rights, 2019). Additionally, avoiding unnecessary police engagement during a mental health crisis allows for more efficient use of scarce law enforcement resources.
- Provide staff training about how to describe mobile response services to youth, their caregivers, and other callers. The entire approach should be framed in terms of acceptance and help, never blaming youth or families. Situations which result in frequent calls for the same young person should be framed as special challenges that need to be addressed with action plans that support transition to community-based or wraparound services.

The following are examples of required training topics that some states (New Jersey, Nevada) have implemented for certifying their mobile response staff.

- Developmental tasks of childhood and adolescence

- Crisis Assessment Tool ~ d•U ^]•]}v •µ‰‰}Œš v }uuµv] š]}v š}}o š} v }v•]•š vš }uuµv] š]}v }(šZ v • }(Z] (The John Praed ‰ Œ] v]vP Foundation, n.d.-a)
- Child and Adolescent Needs and Strengths (CANS), a tool developed for child-serving systems ^š} ( ]o]š š šZ o]vI P šÁ v šZ • • •µ of individualized • • v šZ • • ŒÀ] (The John Praed Foundation, n.d.-b; Manley et al., 2018)
- The Child and Adolescent Service Intensity Instrument ~ ^//•U ^ •š v Œ]Ì • • •u vš that provides a determination of the appropriate level of service intensity needed by a child or }o • vš v Z]• } Œ (American Academy of Child and Adolescent Psychiatry, n.d.; Manley et al., 2018)
- Columbia-Suicide Severity Rating Scale (C-SSRS) is an evidence-supported questionnaire used by numerous organizations to assess immediate risk of suicide, including by Lifeline centers.

Onsite Needs: De-escalation Strategies

De-escalation strategies are intended to increase safety while decreasing emotional distress. Sometimes this requires helping family members to recognize their own behavior in that moment, because it can be difficult for a young person to be calm if their family member is at a heightened emotional state (Shepler, 2021). Examples of de-escalation strategies include (Bostic & Hoover, 2020; Shepler, 2021; National Alliance on Mental Illness Minnesota, 2018):

- Establishing safety in the immediate environment
- Projecting a calm, empathetic demeanor, with a soothing voice and slow movements
- Engaging in active and reflective listening, not trying to reason or argue with the person in crisis, and avoiding judgment
- Respecting šZ Ç}µvP ‰ Œ•}v[• physical space
- Decreasing stimulation; alternatively, providing a distraction, such as listening to music
- Taking a movement break
- Deep breathing and grounding exercises
- Journaling or creating art
- Sensory soothing (e.g., blankets, soothing smells, feel of warm water)

Spotlight: Mobile Response and Stabilization Services (MRSS)

Mobile Response and Stabilization Services (MRSS) is a youth- and family-specific crisis intervention model that recognizes the developmental needs of children, the role of families or caregivers, and the importance of avoiding out-of-home placements or the removal of youth from their school and community. MRSS models have been implemented in numerous states and localities (Manley et al., 2021).

MRSS is rooted in System of Care principles, which promote youth-guided, family-driven, community-based, and culturally and linguistically responsive services (Davis, 2018). Key components of MRSS include (Manley et al., 2021):

- The youth, family, or caregiver defines the crisis, and the MRSS responds 24/7 to meet their sense of urgency
- Single point of access and ^ v } Á Œ } v P } } Œ _ ‰ ‰ Œ } Z
- The mobile response team is dispatched to provide services in person when available
- Responders support children and families in their natural environments
- Staffing does not rely on crisis responders from predominately adult-oriented systems
- MRSS partners with all child-serving systems
- Initial mobile response services may continue over a period of 72 hours, as needed
- Stabilization supports may continue for up to 8 weeks, as needed; e.g., in-home support, respite care, short-term care coordination
- Outcome data is tracked, reported, and used for quality improvement purposes

To learn more about MRSS, access Mobile Response & Stabilization (University of Maryland); Making

Mobile response teams may coordinate a transition to community-based mental health services, crisis receiving and stabilization services (described in the next section), or a hospital setting.

- Know the crisis and medical facilities in the region, and also the broader array of child and adolescent supports and services. These include local behavioral health providers, school-based supports, and other county and community resources (e.g., housing support) (Bostic & Hoover, 2020). Include resources and supports that are designed for specific communities, such as drop-in centers for LGBTQI+ youth.
- / (v (} Œ š Z Ç } µ v P ‰ Œ • } v [• • (š Ç v -off to a crisis Ç U ‰ Œ } À] receiving and stabilization facility. In some instances, such as if the young person is in medical distress or in imminent risk of harming themselves or others, it may be necessary to transition to a hospital. In both cases, provide transportation as needed.
- Provide a warm hand-off for appointments with appropriate local providers for ongoing care after a crisis episode, if needed, with consent from the family.

Mobile response teams typically provide some level of follow-up. For example, MRSS teams provide up to eight weeks of follow-up stabilization services. In other models, follow-up may be limited to check-ins over the first one to two weeks to ensure that youth and families transitioned to further services, if needed.

Youth Crisis Response Case Example: Brandon, Age 15

Vignette adapted and shortened from a case study presented in Singer, J. B. (2015). Intervention Handbook: Assessment, Treatment, and Research, Fourth Edition.

Staff at a youth homeless shelter call the mobile crisis response team for 15-year-old Brandon, who has run away from home and has made comments that he does not care if he dies. Brandon has

A Safe Place to Be: Crisis Receiving and Stabilization Services

Crisis receiving and stabilization services are essential for youth who require additional crisis support beyond what mobile response teams can provide, but who do not need hospitalization. There are several kinds of crisis receiving and stabilization services, including both in-home supports and facilities. SAMHSA strongly prioritizes home-based de-escalation and stabilization supports for youth.

Every community

planning, among others. Facilities are often staffed by peer support providers and other crisis response paraprofessionals or professionals. Psychiatrists, psychiatric nurse practitioners, or physicians may provide supervision and medical consultation (Saxon et al., 2018).

In-Home Stabilization

In-home stabilization services may serve as a bridge that helps youth transition from immediate crisis services (e.g., mobile response, crisis facilities) to ongoing care in the community. In-home stabilization components are provided as soon as practicable and may continue for several weeks. For example, in the MRSS model, in-home stabilization services are provided for up to eight weeks, while other models range from 6-16 weeks (Hepburn, 2021a).

Services may be provided by a therapist or clinician in partnership with a paraprofessional, who can help youth and families implement the plan that they identify with their therapist (Hepburn, 2021a; Williams, 2018). Sample in-home services include assessment, parent education programs, peer support, coping and conflict management skill-building, behavior management training, and warm hand-offs to other resources and services. Stabilization can also involve evidence-based therapies for the young person and their family, such as Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multidimensional Family Therapy, or Multisystemic Therapy (The Institute for or

- Provide warm hand-offs to home- and community-based, youth-serving care.
- Incorporate some form of intensive suppoŒš •U]šZ Œ Á]šZ]v šZ ( ]o]šÇ[• }Á youth services area or with a partner that also offers children- and youth-specific crisis services.

[Youth Crisis Response Case Example: Nikki, Age 8]()

s]Pv šš ‰š (Œ}u • •šµ Ç ‰Œ • vš]v ^]vP ŒU :X u ŒP v] •W D}]o ŒÇ]•] •‰}v• W Crisis Intervention Handbook: Assessment, Treatment, and Research, Fourth Edition.

Repeated Access to Mobile Response Services and Follow-up

A school counselor contacts the mobile crisis unit to request a suicide assessment for Nikki, an 8-year-old girl, who has drawn pictures of herself with knives cutting her body. Nikki has previously had fights with other children and frequent outbursts, including self-injurious behavior (e.g., biting her arms).

The crisis worker talks with Nikki and her mother separately in the school offices and identifies that E]ll] Z • Z •µ]] o] š]}v (}Œ, Jamie, shares that she has been diagnosed with bipolar disorder, but does not currently take medication or receive therapy; she also conveys that she]• vPŒÇ Á]šZ E]ll] (}Œ šZ Z]o [• Z À]}ŒX

dZ u}]o š on-call[•

^ D , ^ [National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit established six core principles for crisis response systems. This section explores how each of the core principles can be specifically ‰ ‰ o] š } Z] o Œ v [• v Ç } µ š Z Œ] •] • Œ X

1. Addressing Recovery Needs
2. Trauma-Informed Care
3. Significant Role for Peers
4. Zero Suicide/Suicide Safer Care
5. Safety/Security for Staff and People in Crisis
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services

In addition to these foundational principles for the broader crisis continuum, SAMHSA strongly emphasizes these values for the youth crisis continuum:

- Keeping youth within their homes and communities, when safe and appropriate to do so, is of paramount importance. Out-of-home placement should be avoided unless necessary for the safety and wellbeing of the young person and their family.
- Services must be developmentally appropriate and must treat youth as youth, not as small adults.
- People with lived experience, including family and youth peer supporters, must be integrated into service planning, implementation, and evaluation.
- Services must promote behavioral health equity. They should be culturally and linguistically responsive and designed to meet the needs of diverse youth and families (including racially, ethnically, linguistically, and sexual orientation and gender diversity).

Addressing

- Meaningfully integrate the SOC values of family-driven, youth-guided, and culturally and linguistically responsive at every level of service. Respect the preferences of youth and families as much as possible while ensuring safety.
- Create engaging environments that do not use barriers to separate or isolate people in crisis (SAMHSA, 2020a).
- Engage youth and families in shared decision-making.
- Support youth in identifying their strengths and natural supports that will aid their recovery.
- Ensure that multilingual staff or translation supports are available so that youth and families accurately understand the choices available to them.

Trauma-Informed Care

- Seek to employ staff that reflect the racial, ethnic,

behavioral health and/or substance use disorder systems and organizational levels.

The following are the seven core elements of the Zero Suicide model (Education Development Center, n.d.-a):

- **Lead** system-wide culture change committed to reducing suicides.
- **Train** a competent, confident, and caring workforce.
- **Identify** individuals with suicide risk via comprehensive screening and assessment.
- **Engage** all individuals at-risk of suicide using a suicide care management plan.
- **Treat** suicidal thoughts and behaviors directly using evidence-based treatments.
- **Transition** individuals through care with warm hand-offs and supportive contacts.
- **Improve** policies and procedures through continuous quality improvement.

For children and youth, EDC specifies:

> "Suicide prevention and treatment for youth must be developmentally appropriate, attend to critical social determinants of health, assess the presence of adverse childhood events (ACEs) and trauma, incorporate parental or guardian support, and address consent considerations." (Education Development Center, n.d.-b)

"[National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit] notes that the Zero Suicide model is also strongly aligned with Lifeline protocols for risk assessment, engagement, and follow-up (SAMHSA, 2020a).

- **Lead:** commit to a goal of Zero Suicide for children and youth as a crisis response system.
- **Train** staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk.
- **Identify** youth at risk of suicide using evidence-based assessment tools. Examples include the Ask Suicide-Screening Questions (ASQ) tool, designed for screening youth ages 10-24 in medical settings (see ASQ Toolkit), or the Columbia-Suicide Severity Rating Scale (C-SSRS), which offers resources for implementing the C-SSRS in various settings.
- **Engage** youth using developmen

Safety/Security for Staff and People in Crisis

Ensuring the safety of youth in crisis and the people around them is foundational to crisis care. One

and localities have adopted the Wraparound model of intensive care coordination. Wraparound is a structured model in which a care coordinator convenes a team that includes the young person, family, clinicians, and natural supports. The team works collaboratively to develop, implement, and monitor an individualized plan of care based on identified strengths, needs, and goals (SAMHSA, 2019a).

In some areas, Wraparound care coordination and mobile crisis services are provided by the same entity. For example, Wraparound Milwaukee contracts with community agencies to provide care coordi v š] } v v o • } }((Œ • š Z Z] o Œ v [• D }] o Œ] •] • d u ~

me theeesi8(go)-19(me)6me

housing, utilities, clothing). It is important for crisis responders to have strong understanding of the regional and local community-based services available to families.

Youth involved in the child welfare and foster care systems are at higher risk for experiencing complex trauma and trauma-related behaviors. As many as 90 percent of youth in foster care have been exposed to trauma, including personal experiences of abuse and neglect (Dorsey et al., 2012). Up to 80 percent of youth in foster care have a significant mental health need (Szilagyi et al., 2015).

Crisis response systems are encouraged to formalize partnerships with child welfare and foster care agencies to establish clear roles and agreements (Centers for Medicare & Medicaid Services, 2021). For example, in Milwaukee, the child welfare agency and the mobile crisis team established a unique MOA and funding for a dedicated crisis team for children in the foster care system. This partnership resulted in 90 percent of youth being stabilized in their current foster home (Karmadt & Morano, 2018). For all youth, the priority is to avoid removing youth from their current home unless necessary for their safety, including foster homes. Crisis response programs have been effective in reducing foster care placement disruptions (Casey Family Programs, 2018a; Shannahan & Fields, 2016).

Strong partnerships between child welfare agencies and crisis response providers can help ensure that foster parents know when to contact crisis services and what to expect ~ Z] o Œ v [• Z À] } Œ o , o š Initiative, 2015). Some programs have established crisis response services to support youth who have just experienced out-of- Z } u ‰ o u v š X E Á : Œ • Ç [• D Z ^ ^ U (} Œ Æ u ‰ o U µ š } š u u u Œ š } u š Á] š Z š Z Ç } µ v P ‰ Œ • } v š š Z] Œ (} • š Œ ‰ o u v š first 72 hours of their removal from home. This program has helped to improve placement stability for young people

unique to infants, toddlers, and young children. States may formally integrate the DC:0-5 into their Medicaid policy and require that providers use it for early childhood diagnosis. In regions where the DC:0-5 is not formally recognized, providers may use national or state-specific crosswalks that align DC:0-5 diagnoses with billable diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Statistical Classification of Diseases and Related Health Problems (ICD) (Szekeley et al., 2018).

- Equip staff to refer families to the local and regional resources that are available to caregivers of young children, including young children who may have developmental delays. This should include basic needs resources (e.g., Women, Infants, and Children [WIC] food benefits).
- Train staff in how to identify signs of abuse or neglect in infants and young children, how to respond, and when and how to report.
- Ensure that crisis call center and mobile response team staff have access to clinicians with expertise in the mental health and development of infants, toddlers, and young children, including the use of evidence-based screening and assessment.
- Include early childhood care providers and educators in outreach activities related to 988 and accessing crisis services (e.g., pediatricians, Head Start and Early Head Start programs, home visiting programs).
- Integrate DC:0-5 diagnoses into state policy and local practice.

Transition-Age Youth (TAY) and Young Adults

TAY generally refers to young people at the developmental stage of transitioning from childhood to adulthood. It is used differently in different contex g0 8(a)6(9 0.588 RG[(and)-5651.58 Tm0 g0 G[( )] TJETQq0.00000912 0

that youth with IDD ^ Œ u } Œ o] l o Ç š } v P o šmotionally Abused and Ç µ • U ‰ Z Ç •] o o Ç µ • š Z v Z] o Œ v Á] š Z } u š, 2017). Z] •] o] š] • _

Youth with IDD are typically more dependent on family members than youth without disabilities, and family members are often their primary natural supports (Primm, 2021). Because of this, families are much more likely to be very involved in crisis management and stabilization supports or therapies (Trauma and Intellectual/Developmental Disability Collaborative Group, 2020). Lack of access to disability-competent, culturally responsive care is a significant challenge for many families (Hepburn, 2022b). For example, youth with IDD often face difficulty when transitioning to adult-serving systems, with some continuing to see pediatric clinicians well into adulthood (Bloom, 2012).

There are several interventions and statewide models that incorporate training specific to crisis response and IDD. Examples include:

- The National Center for START (Systemic, Therapeutic, Assessment, Resources, and Treatment) Services, which offers a series of trainings on this evidence-informed model to provide community-based crisis intervention for individuals with IDD and mental health needs. Twelve states have certified START programs in place.
- Pathways to Justice is a community-based model to support justice partnership and reform for people with disabilities. Pathways participants receive support to create a local, multi-disciplinary Disability Response Team as well as training for local responders.
- The Mental Health and Developmental Disabilities National Training Center offers no-cost trainings, webinars, and resources, including some that are specific to crisis response.
- REACH (Regional Educational Assessment Crisis Services Habilitation) is from the Virginia Department of Behavioral Health and Developmental Services, which provides crisis response services statewide to individuals with IDD. Among other supports, they offer a Youth REACH Crisis Therapeutic Home for young people with IDD in need of brief residential crisis support.

- As with all youth, provide trauma-informed, person-centered, and strengths-based crisis support.
- At the state and local level partner with agencies that have IDD specialization, such as Councils on Developmental Disability, Centers for Independent Living, and University Centers for Excellence in Developmental Disabilities (Hepburn, 2022b).
- Provide staff trainings on important topics such as: effective communication (e.g., being aware of sensory challenges, not talking about people with IDD as if they are not there, using short sentences); incorporating family into de-escalation strategies; safety planning (Primm, 2021).
- Train staff to assess for abuse and neglect of youth with disabilities, including IDD.
- Have access to providers with IDD-related expertise, whether in person or through telehealth.
- Be prepared to refer families to specialized IDD supports in the community, such as early intervention services, functional behavioral assessment, applied behavior analysis, function-based treatment, and caregiver education (Kurtz et al., 2020).
- v P P (u] o] •] v Á Ç š Z š] • ‰ ‰ Œ } ‰ Œ] šbe prepared toÇ } µ v P ‰ Œ • adapt strategies to include family members.

LGBTQI+ Youth

A trauma-informed, culturally, and linguistically responsive system must include attention to the needs of LGBTQI+ people in crisis. A recent survey of youth who identify as LGBTQI = (} µ v š Z š ^ ð î ‰ Œ v š Y] v o µ] v P of transgender and nonbinary youth, seriously considered attempting suicide in the past year. Nearly half of respondents could not access the mental health care they •] Œ (The Trevor Project, 2021).

Youth who identify as LGBTQI+ are also at increased risk of homelessness compared to their peers (see Homeless Shelters and Transitional Housing Programs). One stu

With the transition to 988 in July 2022, communities nationwide are seeking to build, expand, and improve their behavioral health crisis response systems. It is essential that we recognize the crisis needs of youth and families and amplify their voices in designing these systems.

This document shares learnings from decades of work by thousands of dedicated individuals striving to create state and local systems that meet the unique developmental needs of young people and honor the important role of families. These innovative programs are successfully linking youth and families to much needed supports in the community, from the Emergency Mobile Psychiatric Services (EMPS) in }vv š] µšš}šZ Z]o Œ v[• Œ]•]• KQCSRE in King County, Washington, and in a growing number of states and localities in between. Together, we can work to create a trauma-informed, equity-driven, developmentally appropriate crisis system that is truly responsive to the needs of youth and families in every community.

TOPIC

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	x Integrate information about youth-specific services into electronic bed registries.

Administration for Children and Families, U.S. Department of Health and Human Services. (n.d.). Adverse childhood experiences https://nhttac.acf.hhs.gov/soar/eguide/stop/adverse_childhood_experiences

child maltreatment disclosures. Child Abuse & Neglect, 102. https://doi.org/10.1016/j.chiabu.2020.104414

Center for Behavioral Health Statistics and Quality. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National survey on drug use and health. SAMHSA. (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm

Centers for Disease Control and Prevention. (2020). Youth Risk Behavior Surveillance Data Summary & Trends Report: 2009-2019. https://www.cdc.gov/nchhstp/dear_colleague/2020/dcl-102320-YRBS-2009-2019-report.html

Centers for Medicare & Medicaid Services (CMS). (2021, December 28). SHO # 21-008. RE: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services. Department of Health and Human Services. Baltimore, MD.

Z] o Œ v [• Z À] } Œ o , o š Z / v] š] š] À ~ , / • X ~ î ì í ñ U : v µ Œ Ç • X u Œ P Crisis Intervention Practice Guidelines. https://www.mass.gov/doc/mobile-

e20182192. https://pediatrics.aappublications.org/content/pediatrics/143/4/e20182192.full.pdf

Kamradt, B., Morano, C. (2018, October). The Milwaukee Model of Mobile Response and Stabilization Services. https://wraparoundohio.org/wp -content/uploads/2018/10/MUTT-Presentation.pptx

Kauer, S. D., Mangan C., & Sanci, L. (2014). Do online mental health services improve help-seeking for young people? A systematic review. Journal of Medical Internet Research, 16(3). http://www.jmir.org/2014/3/e66/

https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf
Manley, E. (2021, S ‰ š u Œ î î • X ^ š š u v š u µ Œ] v P Z] o Œ v [• Œ] •] • } v š] Meeting. Substance Abuse and Mental Health Services Administration. Rockville, MD.
Manley, E., Schober, M., Sulzbach, D., & Zabel, M. (2021). Mobile Response and Stabilization Best Practices. [Fact Sheet]. http://www.theinstitute.umaryland.edu
Manley, E., Davis, D., Williams, S., & Vanderploeg, J. (2022, May 10-11). System of Care Strategy Virtual Summit 2022 t A Journey Together: Redefining Our Approach to a System of Care. National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC).
Maryland State Department of Education. (n.d.). Student arrest data collection (Sys 2015-2019). http://marylandpublicschools.org/about/Pages/DSFSS/SSSP/StudentArrest/index.aspx
Masseli, B., Bergan, J., Gold, V., Thorp, K., & Olson, B. (n.d.). Peer supporting youth and young adult recovery Youth Move International. https://c4innovates.com/brsstacs/Value-of-Peers_YYA-Peer-Supports.pdf
Mayne, S. L., Hannan, C., Davis, M., Young, J. F., Kelly, M. K., Powell, M., Dalembert, G., McPeak, K.E., Jenssen, B.P., & Fiks, A.G., (2021). COVID-19 and adolescent depression and suicide risk screening outcomes. Pediatrics, 148(3), e2021051507. https://publications.aap.org/pediatrics/article/148/3/e2021051507/179708/COVID-19-and-Adolescent-Depression-and-Suicide
McEnany, F. B., Ojugbele, O., Doherty, J. R., McLaren, J. L., Leyenaar, J. K. (2020, October). Pediatric Mental Health Boarding. Pediatrics, 146(4): e20201174. 10.1542/peds.2020-1174
McFadden, R. (2021). Juvenile detention declined, yet black children detained at high rate. Maryland Matters. Capital News Service.

NASMHPD. (2022). 988 Convening Playbook: Mental Health and Substance Use Disorder Providers. https://www.nasmhpd.org/sites/default/files/988_Convening_Playbook_Mental_Health_and_Substance_Use_Disorder_Providers.pdf

National Alliance on Mental Illness (NAMI) Minnesota. (2018, March). Mental Health Crisis Planning for Z] o Œ v W > Œ v š } Z } P v] Ì U D v P U W Œ À v š U v W o v (} Œ z https://namimn.org/wp-content/uploads/sites/188/2018/03/NAMI-MHCrisisPlanforChildrenFeb2016.pdf

National Conference of State Legislatures. (2020, June 23). Improving Rural Health: State Policy Options for Increasing Access to Care. https://www.ncsl.org/research/health/improving-rural-health-state-policy-options-for-increasingaccessto-care.aspx

National Council for Behavioral Health. (2021, March). Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.

National Network of Child Psychiatry Access Programs. (n.d.). About Us. Boston, MA. https://www.nncpap.org/about-us

National Resource Center on LGBTQ+ Aging. Working with LGBTQ+ Individuals: A Factsheet for Crisis Hotline Responders. https://www.lgbtagingcenter.org/resources/pdfs/FullFactSheetLGBTQHotlines.pdf

Neylon, K.A. (2020). Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S. https://nasmhpd.org/sites/default/files/2020paper10.pdf

K (( ] } (š Z ^ µ Œ P } v ' v Œ o X ~ î ì î í • X W Œ } š š] v P z } µ š Z D v š o , o š Z Advisory. U.S. Department of Health and Human Services. Washington, DC.

Optum. Mobile Crisis Intervention (MCI). https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/welcomeNtwk/ma/allwaysperfs/2022/3855LL.pdf

Our Crisis Centers. (n.d.). 988 and Suicide Crisis Lifeline. https://988lifeline.org/our-crisis-centers/

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., Hedden, S. L., Crosby, A. E., Visser, S. N., Schieve, L. A., Parks, S. E., Hall, J. E., Brody, D., Simile, C. M., Thompson, W. W., Baio, J., Avenevoli, S., Kogan, M. D., Huang, L. N., & Centers for Disease Control and Prevention (CDC) (2013). Mental health surveillance among children--United States, 2005-2011. MMWR. Morbidity and Mortality Weekly Report Supplements, 62(2), 1 t35.

Pinals, D. A., Hovermale, L., Mauch, D., & Anaker, L. (2017). The vital role of specialized approaches: Persons with intellectual and developmental disabilities in the mental health system. National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.7.IDD_.Final_.pdf

Podmostko, M. (2007). Tunnels and cliffs: A guide for workforce development practitioners and policymakers serving youth with mental health needs. Washington, DC: National Collaborative on Workforce and Disability for Youth, Institute for Educational Leadership.

Primm, S. (2021, September 16). Living Through Mental Health Crises with an Intellectual/Developmental Disability: Advice for Crisis Responders. Wisconsin Crisis Intervention Conference. https://www3.uwsp.edu/conted/Documents/Crisis/2021%20Power%20Points/Living%20Through%20Mental%20Health%20Crises%20with%20an%20Intellectual%20Developmental%20Disability%20-%20Primm.pdf

https://www.psychiatrictimes.com/view/strategies-reduce-and-prevent-restraint-and-seclusion-pediatric-populations

Rhoades, H., Rusow, J. A., Bond, D. Lanteigne, A., Fulginiti, A., & Goldbach, J. T. (2018). Homelessness, mental health and suicidality among LGBTQ youth accessing crisis services. Child Psychiatry & Human Development, 49, 643 to 651. https://doi.org/10.1007/s10578-018-0780-1

Z µ Œ o Z] o Œ v [• D v š o , o š Z } v • } Œ š] µ u X ~ î ì í Year Strategic Plan: W Œ } P Œ • • 2018 Status Update. https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/CMH/SOC/RuralChildrensM

Walker, J. S., Baird, C., & Welch, M-B. (2018). Peer support for youth and young adults who experience serious mental health conditions: State of the science. Research and Training Center for Pathways to Positive Futures, Portland State University. https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1232&context=socwork_fac

Wasserman, G. A., Elkington, K. S., Robson, G., & Taxman, F. (2021). Bridging juvenile justice and behavioral health systems: development of a clinical pathways approach to connect youth at risk for suicidal behavior to care. Health and Justice, 9(36). https://doi.org/10.1186/s40352-021-00164-4

Welsh, J. W., Mataczynski, M., Sarvey, D. B., & Zoltani, J. E. (2020). Management of complex co-occurring psychiatric disorders and high-risk behaviors in adolescence. Focus: The Journal of Lifelong Learning in Psychiatry, 18(2), 139-149.

SéŽ¾¬•,ä¬ËÅ BËZ S So o o o

õõõZÝ,Ä©Ý,Z¤Ëô