

Mobile Crisis Response Program Guide

Introduction

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 must be mobile crisis response (MCR) teams that can be rapidly deployed to the location of the crisis and provide crisis assessment and stabilization services to anyone, anywhere, and at any time.

Purpose

The purpose of this guide is to accompany the Health Care Authority's (HCA) Behavioral Health Administrative Service Organization (BH-ASO) crisis contract language and provide guidance to the contracted mobile crisis response providers in best practices. This will act as a living document that can be updated outside of the strict timelines of contract amendments, and it will change over time as necessary to meet the needs of Washingtonians.

Goal of Implementing New Models

HCA is committed to implementing nationwide best practices for crisis care in alignment with Substance Abuse Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit¹ and the National Association of State Mental Health Program Directors (NASMHPD) to include Mobile Response and Stabilization Services (MRSS) for youth. These best practices for mobile crisis response teams are intended to improve awareness of and utilization of crisis teams when people are in crisis rather than relying on emergency responders such as law enforcement, fire, and EMS. The vision from SAMHSA is to provide someone to talk to, someone to respond, and somewhere to go for a person in crisis and to be able to access support quickly with minimal barriers.

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 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
- Expand the definition of crisis to whatever the person experiencing in the situation defines it as to reduce barriers to potential solutions
- Address systemic barriers by addressing the needs of underserved populations

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

Background

The National Suicide Hotline Designation Act of 2020² established a national, 3-digit easy to remember number to call, 9-8-8, for people to connect directly to National Suicide Prevention Lifeline services. In response to this

¹ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

² <https://www.congress.gov/bill/116th-congress/senate-bill/2661>

legislation, the Washington legislature passed HB 1477 (E2SHB 1477³), the Crisis Call Center Hubs and Crisis Services Act, in 2021 to enhance and expand behavioral health crisis response and suicide prevention services for all people in Washington State. The E2SHB 1477 was signed into law on May 13, 2021. A key component of E2SHB 1477 is to invest in an enhanced crisis response system by developing and deploying mobile rapid response crisis teams that provide professional on-site, community-based interventions and follow-up support for individuals that are experiencing a behavioral health crisis.

Scope

Mobile crisis response (MCR) services offer voluntary community-based intervention 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 caller, 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 inclusion, to support true justice system diversion
- Reduce the use of emergency departments
- Assessing for risk and 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

Minimum requirements and mobile crisis team standards

Mobile crisis response services must be available to individuals experiencing a behavioral health crisis. Services should be provided in person for youth and to adults if they request an outreach. Trained staff should remain, in person or on the phone, with the individual in crisis to provide stabilization and support until the crisis is resolved or referral to another service is accomplished⁴.

Team Composition

A mobile crisis response team must provide coverage 24 hours per day, every day of the year with at least one team of two staff per shift. Overall team composition can be flexible based on regional need and staff availability. Teams must include, at a minimum two staff to outreach. This should include a Mental Health Professional (MHP) or a Mental Health Care Provider (MHCP) with approved DOH exemption⁵ and a certified peer counselor responding together to all crisis referrals. Each team shall have a mental health professional supervisor and an MHP will be available 24 hours per day for clinical consultation. The consulting MHP does not have to be the team supervisor. At the discretion of the provider, teams may also include other professional or paraprofessionals with expertise in developmentally appropriate behavioral health crisis intervention.

Location of Services

Mobile crisis response 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. Team will assess for risk and opportunities to resolve the crisis in the least restrictive setting.

Mobile crisis response services reduce the need for and the utilization of law enforcement, other first responders, and emergency departments. Enhanced Federal Medicaid Assistance Percentage (FMAP), the amount of federal dollars provided per state dollar, may not be available for MCR services provided in an emergency department. Services provided in an emergency department can still be billed and paid but will not qualify for the higher match.

³ <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20220914155211>

⁴ WAC 246-341-0900

⁵ WAC 246-341-0302

Best Practice: Teams will respond with a multi-disciplinary team of clinicians and a peer. This will give the person in crisis and the team multiple perspectives to problem solve.

Availability

Mobile crisis response services must be available 24 hours a day, every day of the year, and be able to respond to an emergent crisis within 2 hours of the referral for an emergent crisis and within 24 hours for an urgent crisis. Telephonic support will be provided until in-person response arrives⁶. This telephonic support can include the caller with a call back number, the NSPL or RCL staying on the line with them depending on need, or mobile response team cell phone numbers for callback.

Referral type	Definition
Emergent	An emergent crisis is an extreme 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 occur after crisis response services are provided.

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

To ensure safety for responders and clients, mobile crisis response team shift schedules shall 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 selfcare and stress reduction to improve workforce retention. Schedules can be adjusted according to outreach activities or peak times for calls, and rural vs. urban demand. Shifts in urban areas may be 8-hour shifts, or 12-hour shifts, while rural areas may consider employing fire schedules such as 24 on 48 off or any similar combination. This staffing pattern will ensure safety, improve critical decision making and rapport building with clients, support work life balance, and improve recruitment and retention efforts.

All members of the team must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Youth mobile crisis teams shall be trained in developmentally appropriate trauma informed care, de-escalation, harm reduction, and crisis and safety planning for youth and families. Additional recommended training for team members will continue to be developed and could include developmentally appropriate nonviolent crisis intervention, conflict resolution, interpersonal violence, motivational interviewing, 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

Due to 24/7 availability requirements and the unpredictability of community crisis needs, mobile response team staff shall not be expected to maintain a quota of direct contact hours. If teams are not responding to crisis referrals, they should be building relationships in the community through outreach and engagement. These efforts work to educate the public and providers on mobile crisis response and offer opportunities for upstream interventions. Working relationships with NSPLs, RCLs, emergency departments, schools, providers, primary care clinics, Indian Community Health Programs (IChP), Tribal Nations, 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 triage and stabilization facilities, substance use providers, foster care social workers, parents, caregivers and managed care organizations (MCOs) will encourage use of MCR teams over the ED and offer true justice system diversion. These efforts will increase the likelihood of a person in crisis receiving an appropriate response from a trained crisis team and establish mutual relationships with emergency response system providers.

Privacy and Confidentiality

Teams must maintain privacy and confidentiality of information consistent with federal and state requirements. Minors aged 13-17 may initiate and consent to evaluation and treatment for mental health, substance use disorder treatment, or withdrawal management without parental knowledge or consent.

⁶ WAC 246-341-0900

Documentation

Documentation of mobile crisis response must be completed by the on-scene clinician responding. This can be a MHP or MHCP (with approved DOH exemption) under the supervision of the MHP supervisor⁷. Peers can add additional note to the documentation, but it must also contain the clinician's notations and be signed by the clinician. Documentation must include the following⁸, 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 referral 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
- 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.

Teams should document 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. Documentation should be done in an EHR following employer guidelines and procedures and within confidentiality laws.

Staff roles and descriptions

Required Staff

Below is an outline of staffing expectations for mobile crisis teams. Teams are required to have a licensed or credentialed Mental Health Professional as a supervisor. Teams have flexibility in overall team composition. Outreach should occur via a team of at least two staff. Preferably with one clinician and one peer Teams need to have an MHP available 24/7 for support and clinical consultation. This does not have to be the supervisor if other MHPs are on staff.

Supervisor MHP

Provides clinical supervision and oversight of the mobile response teams. Is responsible to ensure the service provided by the team meets medical necessity, is clinically appropriate, and meets all necessary requirements. The person in crisis is assumed to need crisis intervention based on them reaching out for help. Further services will need to be made with clinical judgement on medical necessity.

Minimum position requirements

Must meet the requirements as a Mental Health Professional and meet all licensure or credentialing requirements from DOH to provide services. Recommended to have experience supervising and overseeing crisis services.

SPA definition

Mental Health Professional means:

- (A) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapter 71.05 and 71.34 RCW;
- (B) 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. Such person shall 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 a mental health professional.
- (C) A person who meets the waiver criteria of RCW 71.24.260 which was granted prior to 1986.
- (D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

⁷ WAC 246-341-0910.

⁸ WAC 246-341-0900 and WAC 246-341-0910

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265. This includes qualified individuals with an agency affiliated credential or associate license who qualify as an MHP.

Clinician

Provides crisis services and uses clinical judgement within the scope of their education and training to deescalate 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. This MHP does not need to be the supervisor of the team.

Minimum position requirements

Must have at least a BA/BS degree or higher in a behavioral health field and be licensed and/or credentialed by DOH to provide services.

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 rule from DOH using the process outlined in WAC 246-341-0302.

SPA definition

“Mental Health Care Provider” means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years of experience in the mental health or related fields.

Certified Peer Counselor (CPC)

Provides peer support to a person in crisis with the focus of building trust, rapport, and helping the person in crisis feel heard and understood while crisis services work to resolve the crisis or find the next steps to resolve the crisis.

Minimum position requirements

Must be a certified peer counselor and credentialed by DOH to provide services, typically as an Agency Affiliated Counselor. Peers will receive additional training on providing crisis peer services in the future to improve service delivery and resilience for the workforce. This training will not be required for the current workforce until it is available on a wider basis. CPCs can only provide services when accompanied by a licensed or credential staff or their supervisor. All services provided by CPC must be provided under the oversight of the MHP supervisor.

WAC definition

"Peer counselor" means a person recognized by Medicaid agency as a person who:

- (a) Is a self-identified consumer of behavioral health services who:
 - (i) Has applied for, is eligible for, or has received behavioral health services; or
 - (ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;
- (b) Is a counselor credentialed under chapter [18.19](#) RCW;
- (c) Has completed specialized training provided by or contracted through the Medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;
- (d) Has successfully passed an examination administered by the Medicaid agency or an authorized contractor; and
- (e) Has received a written notification letter from the Medicaid agency stating that the Medicaid agency recognizes the person as a "peer counselor."

Service Delivery and Modalities

Mobile crisis response 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/Screening

The initial step in providing mobile crisis response is to determine the level of risk present in the crisis and determine the most appropriate response. This screening process must include screening for suicide or self-harm and risk of harm to others. The triage and screening process may be completed by crisis call line staff, by the mobile crisis response team staff, or both. When the initial triage/screening is done by crisis call line staff they must share this information with the mobile crisis team. As part of the triage and screening 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 whether they have a history of dangerousness or potential dangerousness.

Best Practice: To support true justice system diversion, respond without law enforcement accompaniment unless special circumstances warrant inclusion

Scene Safety

Ensure that responding staff members have access to any available information regarding dangerousness or potential dangerousness of the individual experiencing the crisis. This information must be made available without unduly delaying the crisis response in compliance with WAC 246-341-0900.

When responding to non-secure locations, ensure that two staff members are present for safety and that team members have mobile devices that can be used to call for help if needed. Crisis response staff cannot be required by their employer to respond to a crisis without a second person. Best practice is to always respond to crisis calls with two staff members⁹.

Best Practice: Respond to all crisis referrals with a team of two staff members regardless of the location or risks identified.

When arriving to the location of the crisis, it is important to take a few moments to assess the location for safety for both staff members and individuals in crisis. Pay special attention to the location of exits, potentially dangerous implements or weapons, and signs of agitation or hostility from anyone in the vicinity.

Best Practice: Ensure other team members know the exact location you are responding to and when they should expect to get contact from you. GPS monitoring through mobile apps or cell phones is used in other states for safety.

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 event, any safety concerns for the individual or others, strengths, resources available to the person in crisis, recent inpatient hospitalizations and/or enrollment with mental 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 quicker 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 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 the 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 providing support. When engaging the individual in

⁹ [WAC 246-341-0900](#)

crisis, it is often most effective for the CPC to take the lead. Documentation for peers should be completed by the clinician noting the peer's presence and interactions with person in crisis.

Coordination

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

Transport

When working with individuals in crisis, they may need transportation to places that can help resolve their crisis. These places can be pharmacies, food banks, crisis stabilization or other facilities, or other locations relevant to their current challenges. MCR teams may arrange for transport or provide transportation to these places when safe¹⁰.

ITA Investigations

Individuals in crisis may present at 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 MCR team 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.

Best Practice: Whenever possible, MCR teams 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. Persons in crisis may respond best to a MCR intervention lacking the legal authority dynamic inherent to the DCR role.

Crisis Planning and Follow-up

As part of the mobile crisis response intervention, team members should initiate a crisis planning process that can help the individual prevent future crises. This process may include the development or modification of a safety plan. This is a good time to introduce Mental Health Advance Directives (MHAD), if the individual does not already have one, and support the individual in developing their MHAD. 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, telephonic, or in-person follow-ups should be provided to determine if any services the individual was referred to were provided and if they met their needs.

Peers can help a person start or complete a WRAP plan¹¹ with the individual to provide agency and insight for the person to manage their current crisis and prevent future crisis. Documentation for the development of a WRAP plan needs to be done by the clinician.

Mobile Response and Stabilization Services (MRSS) for Children, Youth and Families

Purpose

MRSS is a child and family specific crisis intervention model that recognizes the developmental needs of children, young adults, parents, and caregivers. Caregivers and children are interconnected in their relationship and thus, crisis situations for children impact the parent's ability to respond to the crisis and de-escalate the situation. Supporting the caregiver's response to the behavioral health crisis decreases the likelihood of child welfare and juvenile justice involvement.

A comprehensive crisis continuum acknowledges that youth can be screened upstream of a crisis event and stabilized and connected to resources and supports downstream. This reduces return to an acute crisis phase, improves

¹⁰ WAC 246-341-0900

¹¹ <https://www.wellnessrecoveryactionplan.com/what-is-wrap/>.

outcomes, and offers a cost-effective alternative to the re-traumatization and stress of costly out of home interventions.

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. Law enforcement should consider the team a reliable, consistent referral for any youth encounter, day, or night. States delivering youth crisis services under the MRSS model are reporting successful ED diversion by building relationships with local school districts.

Other outreach areas for consideration include pediatric primary care providers, emergency departments, inpatient adolescent units, juvenile justice, schools, Department of Children, Youth, and Families (DCYF), foster parents, after school programs, substance use, co-occurring disorder providers, and shelters.

Crisis Mobile Response (up to 72 hours)

The crisis response, or intervention phase, is the initial response and can last up to 72 hours. 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 including family voice.

Teams should intentionally include parents, caregivers, natural supports, and relevant treatment providers to stabilize the person in crisis. This should be in accordance with Washington state law when encountering youth ages 13-17, and within the limits of confidentiality.

The responding team can assess risk and safety needs, provide developmentally appropriate de-escalation, deliver peer support, help caregivers secure the home, or increase supervision depending on safety concerns. Safety planning is a collaborative process that includes the identified client, caregivers, natural supports, and existing providers. When creating or updating existing safety plans, teams will empower the family to recognize their needs, risk factors, triggers, and identify existing strengths that can inform coping skills moving forward. Teams should identify and connect families with existing systems of care and natural supports through warm handoffs, including to the stabilization phase.

This service should be billed using service encounter code H2011 - Crisis Intervention Services¹².

Crisis Response Goals:

- The crisis is defined by the youth, young adult, parent, or caregiver
- The team responds in person to the location of the person in crisis, home, school, or community within 2 hours and with telephone support available until arrival.
- Respond without law enforcement
- Work with the youth and caregivers to reduce unnecessary admissions to EDs, inpatient adolescent units, unnecessary contact with law enforcement, detention centers, residential treatment centers, or foster care transitions
- Initial response should include developmentally appropriate de-escalation, a children or youth risk assessment, safety planning, peer support, and skill-building
- Support and maintain youth in their living and community environment, reducing out of home placements
- Promote and support safe behavior in the home, schools, and community
- Ensure staff are trained in culturally responsive, developmentally appropriate trauma-informed care, de-escalation, safety planning for youth and families, and harm reduction

Stabilization

After families have experienced an initial mobile crisis response encounter, best practices in MRSS include an in-home stabilization phase, which is separate but must be connected to the mobile response phase. A stabilization phase provides *up to* 14 days of intensive in-home services. Funding for stabilization services is approved by the MCOs, fee for service, BH-ASO for uninsured, or commercial carriers. MCOs and commercial insurance carriers are

¹² <http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri>

required to cover this intervention as part of their network adequacy. In-home stabilization supports the child's ability to manage daily activities and establishes clear connections to treatment service and community supports to reduce the likelihood of returning to the acute crisis phase. Providers may need to support families in accessing and following through with ongoing care.

This phase can include identifying and addressing ongoing needs, reviewing safety plans, skill building, youth and/or family peer support, parent support and skill building, and care coordination to identify and connect families with community providers through family facing systems of care, and natural supports. Community connections are linked to inherent strengths and interests of the youth and provide opportunity for connection, relationships, skill building, and built-in community-based respite support. This may include extracurricular activities, after school programs, sports, arts, community events, church groups, 4-H, neighbors, and family members.

This service should be billed using service encounter code S9484 – Stabilization Services¹³.

Stabilization Goals

- Support and maintain youth in their current living situation and community
- Services are provided face to face in the youth's natural environment, home, school, and community
- Support youth and families with developmentally appropriate and culturally appropriate trauma-informed care
- Assist youth and families in identifying, accessing, and linking to community systems of care and refer to additional clinical services if needed
- Care coordination to assist youth and families in identifying and linking to ongoing natural and system supports to reduce return to the crisis phase. Include peer support for youth or caregivers as appropriate

Implementation

Shared understanding of the MRSS model with system partners will aid in implementation of MRSS best practices. Collaboration with community partner and stakeholders to understand care pathways and interruption points will provide early identification and prevention of more costly interventions. Working with the following systems and implementing a system of care language is essential to the success of MRSS.

- Behavioral Health Administrative Service Organizations
- Managed Care Organizations
- Juvenile Justice, Law Enforcement and Family Courts
- Schools and Universities
- Pediatric Primary Care Providers
- Department of Health
- Department of Children, Youth and Families
- Emergency Departments, Inpatient Adolescent Units, and Children's' Hospitals
- Community Mental Health Providers and Mental Health Agencies
- Community Organizations, Shelters
- Center for Parent Excellence (COPE), Family Youth System Partner Round Tables (FYSPRTs)

Looking Forward

This guide will evolve with the implementation of HB 1477. Future versions will incorporate tools developed through the technical and operational plan and best practices developed from it. This guide will continue to align further with

¹³ <http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri>

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practices toolkit and MRSS. As tools and trainings allow for implementation of other aspects, the plan will also evolve based on recommendations from the CRIS committee and sub-committees set up through HB 1477.

This guide will also evolve with feedback from MCR teams and BH-ASOs. These models we are introducing are based on successful models from other states, but we need to adapt it to work for all of Washington. Your feedback is important to ensure MCR can meet the needs of our people.

References

[SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#)

[Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services](#)

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2022 SAMHSA's *Children's Crisis Response and Stabilization* – (publication in process)

2018 NASHHPD [Making the Case for a Comprehensive Children's continuum of Care](#)

Crisis mental health services – General – [WAC 246-341-0900](#)

Crisis mental health services – Outreach services – [WAC 246-341-0910](#)

Agency licensure and certification—Exemptions and alternative means or methods – [WAC 246-341-0302](#)

[Behavioral Health Data Guide for Supplemental Data](#)

[Service Encounter Reporting Instructions](#)