



A SAFE PLACE TO BE

Crisis Stabilization Services and Other Supports for Children and Youth

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A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth

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Abstract:

The developmental, social, and clinical needs of youth are different from those of adults. A robust crisis continuum of care is needed that specifically can meet the needs of youth and families in their homes and communities whenever possible. The essential elements of a community-based crisis service array are *someone to contact* (crisis call lines), *someone to respond* (mobile response teams), and a *safe place to be* (this includes a system to support the youth and family including home- and community-based stabilization services as well as acute care such as inpatient care). Although ideally a youth can be cared for at home, the important element is that they have a *safe place to be*, and this might include a crisis stabilization location or inpatient care. Still, stabilization services at home should not be considered an alternative to a robust continuum of care (including acute care) but rather are critically necessary services nested within a service array. While mobile response can and should be designed to *respond* to an immediate incident, de-escalate the situation, and begin the process of stabilization, states and localities must ensure they also have sufficient capacity to refer for and deliver stabilization services. Stabilization components must be provided to the youth and family as soon as practicable and may continue for up to six to eight weeks, depending on youth and/or family preferences, and clinical and functional needs of the family system. This paper reviews the need for and components of crisis stabilization services for children, youth, young adults, and their families.

Highlights:

- Amending or attempting to retrofit an adult crisis response system to serve the needs of youth and families is insufficient.
- 988 provides the opportunity to streamline the process for youth and families experiencing a crisis to obtain timely, necessary services and supports, reduce unnecessary use of emergency departments and police response, and provide equitable response and access for diverse populations.
- Crisis stabilization services include an array of services and supports for youth and families focused on de-escalation and stabilization within the home and community.
- Stabilization services are grounded in Systems of Care values and principles.

Recommendations for Policy Makers, Practitioners and Thought Leaders:

1. Ensure that child- and family-serving system partners, including youth and families with lived experience, are included in 988 and crisis system design and implementation efforts.
2. Use data to inform the development of a children's crisis continuum that addresses historic use of emergency rooms and police response as well the needs of diverse populations.
3. Develop capacity within a robust crisis continuum to provide stabilization services in homes and communities for up to six to eight weeks to meet the needs of youth and families who require ongoing stabilization after initial mobile response.
4. Consider funding and system design mechanisms to allow youth and families to access appropriate crisis service interventions regardless of where they enter the system of care, their ability to pay, or their diagnostic condition.

When children, youth, and young adults (hereinafter “youth”) experience a behavioral health crisis, they and their caregivers often have had limited options apart from calling 911 or going to the emergency department (ED), where they can face extended waits for care. A robust crisis service array is needed specifically to meet the needs of youth and families in their homes and communities. The essential elements of this community-based crisis continuum are **someone to call** (crisis call lines, which include text and chat options), **someone to respond** (mobile response teams), and a **safe place to be** within a system to support youth (home- and community-based stabilization services, as well as acute care services including inpatient care). This customized crisis continuum serves youth and families and offers 24/7 interventions to de-escalate, treat, and stabilize behavioral health needs while improving functional and clinical outcomes. Such services are instrumental in averting unnecessary ED visits in which youth are likely to be “boarded” – the practice of caring for people, including youth, in the ED for a prolonged length of stay after a determination that the person needs inpatient care but until an inpatient bed becomes available (which can take hours, weeks or more than a month at times).^{1,2} A continuum of services is also critical to minimize out-of-home placement, and placement disruption - while reducing overall costs.

“Someone to call” means that there is an easily identifiable, single point of access contact line available 24/7, regardless of previous or current system involvement or payer source, available to address crises as defined by the caller. “Someone to respond” indicates that 24/7 mobile response teams are ready to respond in the home or community and are staffed by appropriately licensed, certified, trained, and/or credentialed providers with expertise and experience in child and adolescent behavioral health and family systems.

Adult systems are evolving to facilitate de-escalation and response that can be managed in a natural setting, yet there is also a focus for adults to have “somewhere to go” as a default for a crisis intervention. For youth dealing with a behavioral health crisis, recognizing the importance of security and stability for their development, every effort is made to maintain them in their current living environment and in a family-based setting, ideally with active engagement from family members and other natural supports. The frame of reference is therefore labeled a “safe place to be,” which emphasizes safety, and infers making available an array of supports within a system of care that are delivered as home- and community-based services following the initial crisis response. These can include home-based stabilization services when needed for up to six to eight weeks in some instances. Ideally the youth’s crisis supports can be met through these services offered in the youth’s natural environment but can include services youth would receive when needed within crisis stabilization units or even inpatient psychiatric units in some instances. Ongoing supports can include a range of interventions, such as stabilization services provided in the home, substance use treatment, access to a child psychiatrist or other clinical approaches.³

As noted, the developmental, social, and clinical needs of youth are different from those of adults. Amending or attempting to retrofit an existing adult crisis response system to serve the needs of youth and families is insufficient. A dedicated, customized response system, including mobile response, *a safe place to be* including the availability of in-home stabilization services, is therefore necessary to fully meet the needs of youth and families. These crisis services should be well coordinated with other adult-, family- and youth-serving system partners, including those that serve youth of transition age.⁴ Youth experiencing behavioral health crises often are involved with multiple entities (e.g., primary care physicians, medical homes, schools, behavioral health providers, child welfare organizations, juvenile justice, law enforcement, community-based organizations, etc.). Existing and new system partners must work together to maximize the availability and accessibility of services – particularly when fiscal

resources and human capital are scarce – and minimize re-traumatization and unnecessary duplication of assessments, plans of care, and direct service provision.

Recognizing the importance of fostering “a safe place to be”, this paper focuses on one aspect of the third element of a robust crisis continuum, the system needed to support the youth, and the customizations required to best serve youth and families. As with other elements, stabilization services must be trauma-responsive, developmentally appropriate, culturally humble, and focused on de-escalating and preventing future crises in the least restrictive setting required to appropriately meet the needs of the youth and family.

Framing the Crisis Continuum

Front Door: 988 and Crisis lines

As noted in *From Crisis to Care*,⁵ Congress recently enacted laws⁶ to establish 988, a three-digit number analogous to 911, designed to assist individuals in crisis. Beginning in July 2022, 988 will operate 24/7. In April 2022, the U.S. Department of Health and Human Services awarded \$105 million to states and territories to “improve response rates, increase capacity to meet future demand, and ensure calls initiated in their states or territories are first routed to local, regional, or state crisis call centers...[R]ecipients may also use the funds to build the workforce necessary for enhancing local text and chat response.”⁷

The federal enabling legislation permitted states to impose a fee to administer their respective 988 hotlines. By April 1, 2022, 14 states (Colorado, Connecticut, Illinois, Indiana, Maryland, Mississippi, Nebraska, Nevada, New York, Oregon, Utah, Virginia, Washington, and West Virginia) enacted legislation to begin implementing 988, of which four states (Colorado, Nevada, Virginia, and Washington) had authorized or imposed a fee. Of the original 14 states, four (Connecticut, Nevada, Oregon, and Washington) had one or more child- or youth-specific implementation planning provisions included in the enacted legislation.^{8,9,10,11}

Creating a single point of access, as is intended with 988, streamlines the process and removes barriers to obtaining timely, necessary services and supports for youth and families experiencing a behavioral health crisis. An easy-to-remember single phone number available to the community and family- and youth-serving partners (e.g., child welfare, juvenile justice, schools, medical providers, etc.) to contact with a “no wrong door” approach simplifies what has historically been a time-consuming, complex, and sometimes dispiriting process.¹² “No wrong door” is an approach that provides all youth and families with access to appropriate service interventions regardless of where they enter the system of care, their ability to pay, or their diagnostic condition.

Mobile Response

According to the Substance Abuse and Mental Health Services Administration and the Center for Medicaid and CHIP [Children’s Health Insurance Program] Services (CMCS), mobile response and stabilization services are “instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalization.”¹³ Mobile response is a child-, youth-, and family-specific crisis intervention model for home- and community-based response. It is designed to meet a youth and caregiver’s sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis.¹⁴ Caregivers are involved intricately in children’s crisis situations due to the nature of the caregiver-child relationship.

Mobile response teams provide needed assistance to youth and families in de-escalation; perform brief, initial safety assessments and assess immediate basic needs such as food, housing, and medical care; develop and begin implementing a crisis care plan; facilitate the youth and family's connection to natural supports; and engage the youth and family in care planning to identify triggers to prevent future crises, and avert and divert from restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice.¹⁵

Although mobile response responds to immediate needs, states and localities must ensure there is sufficient capacity to provide ongoing stabilization services when these are warranted. When additional supports are indicated, they may be provided by the same or a different team. Such services should be provided to the youth and family as soon as practicable and may continue for several weeks, depending on preferences, clinical and functional needs, and the specific delivery model.

Components of Stabilization Services

- Parent/caregiver education
- Positive youth development and recreational programs
- Family and youth peer support
- In-home services
- Systems navigation, including identification of formal and natural supports
- Linkages to home-, school- and community-based services
- Linkages to psychiatric or primary care services for medication management or evaluations
- Clinical treatment
- Respite care
- Care coordination with other family and youth-serving systems, such as education, child welfare, housing, and economic supports, as applicable

The Need for Youth-Focused Crisis Services

Behavioral health challenges are common: approximately 1 in every 11 children ages 3-17 has diagnoses of attention-deficit/hyperactivity disorder and anxiety, and 20% of youth ages 12-17 have experienced a major depressive disorder.¹⁶ From 2009-2019, the number of high school students reporting persistent feelings of sadness or hopelessness increased to 1 in 3, a 40 percent increase from 2009.¹⁷ Although female suicide rates have generally declined recently, they increased for female youth and young adults between the ages of 10 and 24. Suicide rates for males between the ages of 15 and 24 have remained stable from 2017 through 2020 after a significant increase from 2007-2017; there has been a significant increase in the rate of suicides for males ages 10-14, although the suicide rate for this population remains the lowest of all age groups.¹⁸ Although more female youth attempt suicide than male youth, male youth have a “considerably higher risk” of dying by suicide, which may be explained by their use of more lethal means, particularly firearms.¹⁹ These statistics highlight the importance of healthy emotional development for youth, including the ability to “perceive, assess, and manage emotions.”²⁰ From 2007 to 2016, the utilization rates of pediatric psychiatric ED increased for children ages 5-17.²¹ During the COVID-19 pandemic, these rates increased even further.^{22,23} Related data demonstrate that some racial and ethnic groups are disproportionately represented among youth who attempt or die by suicide. For example, suicide attempts among Black youth are rising faster than among any other racial or ethnic group.²⁴ The suicide rate for Black children and youth increased from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017.²⁵ Although the rate of deaths by suicide for children under 13 is smaller,

Black youth under 13 years are twice as likely to die by suicide as their White peers; Black males, five to 11 years old, are significantly more likely to die by suicide compared to their White peers.²⁶ In 2019, 40% of Hispanic high school students reported experiencing persistent feelings of sadness or hopelessness during the past year.²⁷

Youth with intellectual and developmental disabilities (IDD), from underserved and historically marginalized populations; with diverse sexual orientation, gender identity, and gender expression; in rural areas; in immigrant households; and involved with juvenile justice or child welfare agencies faced higher risks of behavioral health challenges during the pandemic due to racism and discrimination;²⁸ intergenerational and communal trauma;²⁹ economic,³⁰ educational,³¹ and social disruption;³² accessibility and access to care;³³ and language barriers.³⁴

Addressing Crisis Needs in Diverse Populations

As noted in the 2020 NASMHPD Technical Assistance Collaborative series and throughout SAMHSA's guidelines, it is important that crisis services are built to address the needs of diverse populations.³⁵ Yet, racism continues to be a factor that must be considered in developing properly adept crisis services. Racism is an organized system by which the dominant group "devalues, disempowers, and differentially allocates desirable societal opportunities and resources to racial groups categorized as inferior."³⁶ Youth of color are aware of at least some of these biases and may experience racism as chronic stressors that affect their mental health. A comprehensive review of over 100 studies examined the association between discrimination and health and well-being of youth finding that "[e]xposure to discrimination predicted worse mental health (e.g., anxiety and depression symptoms) in 76 percent of the 127 associations examined. Similarly, discrimination was inversely associated with positive mental health (e.g., resilience, self-worth, self-esteem) in 62 percent of the 108 associations examined."³⁷ In addition, several studies found an association between parental racial discrimination and childhood anxiety and depression.³⁸

The racial disparities in mental health care reflect ongoing and pervasive racism. An important indicator of acute and chronic unmet behavioral health needs are ED psychiatric visits for youth 6 to 24 years. These visits are increasing across the United States with the greatest increases occurring among Black and Hispanic youth even after adjusting for insurance status.³⁹

Disparities in Response

A recent study found that even when Black youth access care in the ED, they are more likely to be physically restrained. In a sample of over 551,000 visits of patients 0 to 16 years old, in which physical restraints were used, Black youth were 1.8 times more likely to receive a physical restraint than White youth. Boys were more likely than girls to be restrained.⁴⁰

In addition, Black youth are perceived as less "childlike" than their White peers and more likely to be the targets of police involvement. Such involvement is worrisome given that Black children are 18 times more likely than White children to be sentenced as adults and who represent 58 percent of children sentenced to adult facilities.⁴¹

Indigenous communities have striking higher suicide rates when compared to the U.S. as a whole. The Indian Health Service (IHS) Trends in Indian Health Report, which provides data on American Indians and Alaska Natives residing in IHS service areas identified suicide as the second leading cause of death for

children and youth aged 5 to 24.⁴² In May 2022, agencies across the U.S. Department of Health and Human Services issued a joint letter urging states, tribes, and jurisdictions to prioritize and maximize efforts to strengthen children’s mental health and well-being:

“mental health challenges were a leading cause of disability and poor life outcomes in young people even before the COVID-19 pandemic. The COVID-19 pandemic exacerbated the unprecedented stressors young people already faced, as they have navigated pandemic-related deaths of family and friends, illness, economic instability, and fear and loneliness. At the same time, children and youth are remarkably resilient...It is imperative that we work together to implement meaningful and equitable approaches to identify and address mental health needs among children and expand access to high quality pediatric mental health care.”⁴³

One in four youth in the U.S. resides in a family with at least one immigrant. Youth- and family-serving systems must be cognizant of the needs of immigrants, including mixed status families. Mixed status refers to a family with both citizen and non-citizen members, with any combination of legal status (asylees, refugees, lawful resident, and those who are undocumented). A common situation is one in which the youth was born in the U.S. and is a citizen with at least one non-citizen parent or caregiver. Immigrant youth and families are heterogeneous and have diverse strengths and needs that affect their behavioral health needs, as well as their access to care.⁴⁴

Immigrants and refugees may experience harm as they depart from their country of origin or secondary location and travel to the U.S. Such harm might include “exposure to sexual assault, human trafficking, and other forms of violence, and from the ongoing stress from starting a new life away from family and culture, as well as prejudice and discrimination received from those in the United States.”⁴⁵ In addition, some youth may be traveling alone. Unaccompanied minors arrive in the U.S. or at its border without an adult caregiver or parent. These youth may be “may be exploited, abandoned, or abused on more than one occasion, from pre-migration throughout the journey.... The accumulation of traumatic stressors can extend to their postmigration lives here, where they may face substandard living conditions, social isolation, discrimination, and complicated unification with family members who are known to them only virtually.”⁴⁶

Furthermore, providers of crisis response and stabilization services —especially those providing out-of-home services (e.g., 23-hour crisis stabilization units, respite care, treatment foster care), must ensure that they are utilizing best practices in serving youth who identify as transgender, non-binary, or have other diverse sexual orientation and gender identity and expression. This includes the adoption of non-discrimination policies, processes, and procedures; staff training; and use of preferred names and pronouns. A 2018 study found a strong relationship between mental health symptoms, suicidality, and insecure housing amongst youth who identify as lesbian, gay, bisexual, and transgender (LGBTQ+).⁴⁷ A recent survey of youth who identify as LGBTQ+ found that “42 percent...including more than half 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 desired.”⁴⁸ A 2020 survey by The Trevor Project found that LGBTQ+ youth face significant barriers to care due to inability to afford care, lack of confidentiality, fear of conversion therapy, and identity-related barriers stemming from a workforce unequipped to provide them the care they needed.⁴⁹ Such youth need LGBTQ+-affirming care at the point of crisis, and community crisis centers should consider developing LGBTQ+ resources⁵⁰ and forming partnerships with homeless prevention partners to protect these youth from housing instability if they must leave family home in the post-crisis stabilization⁵¹ as youth who identify as LGBTQ+ are at increased risk of homelessness compared to their peers.⁵² Parental or caregiver support for transgender youth, including the youth’s mental health concerns, is also important; transgender youth are at increased risk for mental health problems and suicide.⁵³

Crisis systems should be designed in concert with youth and families with lived experience. The exact design should reflect the specific needs of the community to be served. As entities consider developing youth crisis systems, they should explore the [National Culturally and Linguistically Appropriate Standards \(CLAS\) Checklist and embrace cultural humility](#). Cultural humility is the recognition of power imbalances and implicit bias to avoid authoritative communication and treatment in favor of an open, youth- and family-centered approach that validates their respective lived experience. Like cultural responsiveness, cultural humility notes the importance of providers gaining familiarity with the populations they are likely to serve and emphasizes critical self-awareness and self-reflection to avoid making assumptions about youth and families. Instead, providers become immersed in learning from the youth's and families' perspectives.⁵⁴

States and localities must utilize all available tools to ensure that all youth and families—including those who are LGBTQ+—feel safe and able to access quality services. This requires adoption of non-discrimination policies, development of processes and procedures for the physical safety of participants, workforce training and coaching, and using youth and family members' self-identified names and pronouns.

Beyond Beds

Historically, the crisis response approach for youth has been limited largely to evaluation in a hospital ED. Numerous studies have documented the challenges associated with emergency psychiatric care, including lengthy “boarding” where children and youth remain in the ED – often for several days (or longer)⁵⁵ – until a suitable inpatient treatment setting can be located. Generally, ED staff

“are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis... [D]espite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises. So behavioral health crises routed to the ED more often result in subsequent ED visits, more testing, longer stays, and boarding for hours to days until transfer from the ED to a suitable placement can occur.”⁵⁶

Some youth are placed in psychiatric residential treatment facilities, residential treatment centers, and group living environments. However, residential facilities are used all too often as a default, when they should only be used when it is the least restrictive setting available to provide the necessary intensity, clinical care and intervention, and supervision required by the child.^{57,58,59} Additionally, improvement during a residential placement does not predict future functioning or the ability to sustain clinical and functional improvements after a youth is discharged^{60, 61, 62} The most salient factors that sustain positive outcomes following discharge are family involvement and the availability of an array of home- and community-based services (HCBS).⁶³

Rather than considering increasing ED and inpatient care as a single solution, NASMHPD has called on states and communities to develop additional HCBS. * When such services and supports are available and accessible to youth and families, they reduce the need for inpatient and residential treatment beds. The U.S. Surgeon General urged states and localities to address the social drivers of health for youth and families and expand access to behavioral health services by:

“strengthening public and private insurance coverage...ensuring adequate payment for pediatric mental health services, investing in innovative payment models for integrated and team-based

* For additional information, please see NASMHPD's [Beyond Beds: A Series of Working Papers](#)

care, increasing the participation of mental health professionals in insurance networks, and ensuring compliance with mental health parity laws.”⁶⁴

as well as integrating screening and treatment with pediatric primary care and expanding telehealth, and school-based and crisis services.

The recommendation for additional HCBS is drawn, in part, from an evaluation of the Psychiatric Residential Treatment Facilities (PRTF) federal demonstration program. Nine states were awarded grants to develop and implement HCBS. The evaluation followed over 5,000 children for five years, finding that the HCBS in the demonstration resulted in improved clinical and functional outcomes, reduced suicide attempts, decreased contact with law enforcement, improved school attendance, and led to higher youth and familial satisfaction.⁶⁵

What is Crisis Stabilization?

Youth-centered crisis response incorporates the recognition that a youth needs a *safe place to be*. Where possible, this would be in the youth’s home setting. Thus, it is important for crisis stabilization to include and prioritize a treatment pathway that leads to a *system* of HCBS and supports. Stabilization services are not an alternative to a robust continuum of care (including acute care in settings such as crisis stabilization units, inpatient care or even residential care if needed) but rather **stabilization services are critically necessary services nested within such a continuum**.

While mobile response can and should be designed to *respond* to an immediate incident, de-escalate the situation, and begin the process of stabilization, states and localities must ensure they also have sufficient capacity to refer for and deliver stabilization services. Depending on the model, these stabilization components may be provided by the mobile response team or by a separate but well-coordinated crisis stabilization provider. No matter the model, stabilization components must be provided to the youth and family as soon as practicable and may continue beyond the immediate crisis needs, with some states providing them for up to six to eight weeks, depending on youth and/or family preferences, and clinical and functional needs of the family system.

A mobile response itself can take time and is often considered active even up to 72 hours to de-escalate a situation. After the immediate intervention, not every youth or family who requests mobile response will require stabilization services, depending on the nature of the crisis, existing relationships with service providers, the availability of natural supports, and the presence of other stressors on the family. Yet, stabilization services must be available to those families who need them as a transition following the mobile response that they received.

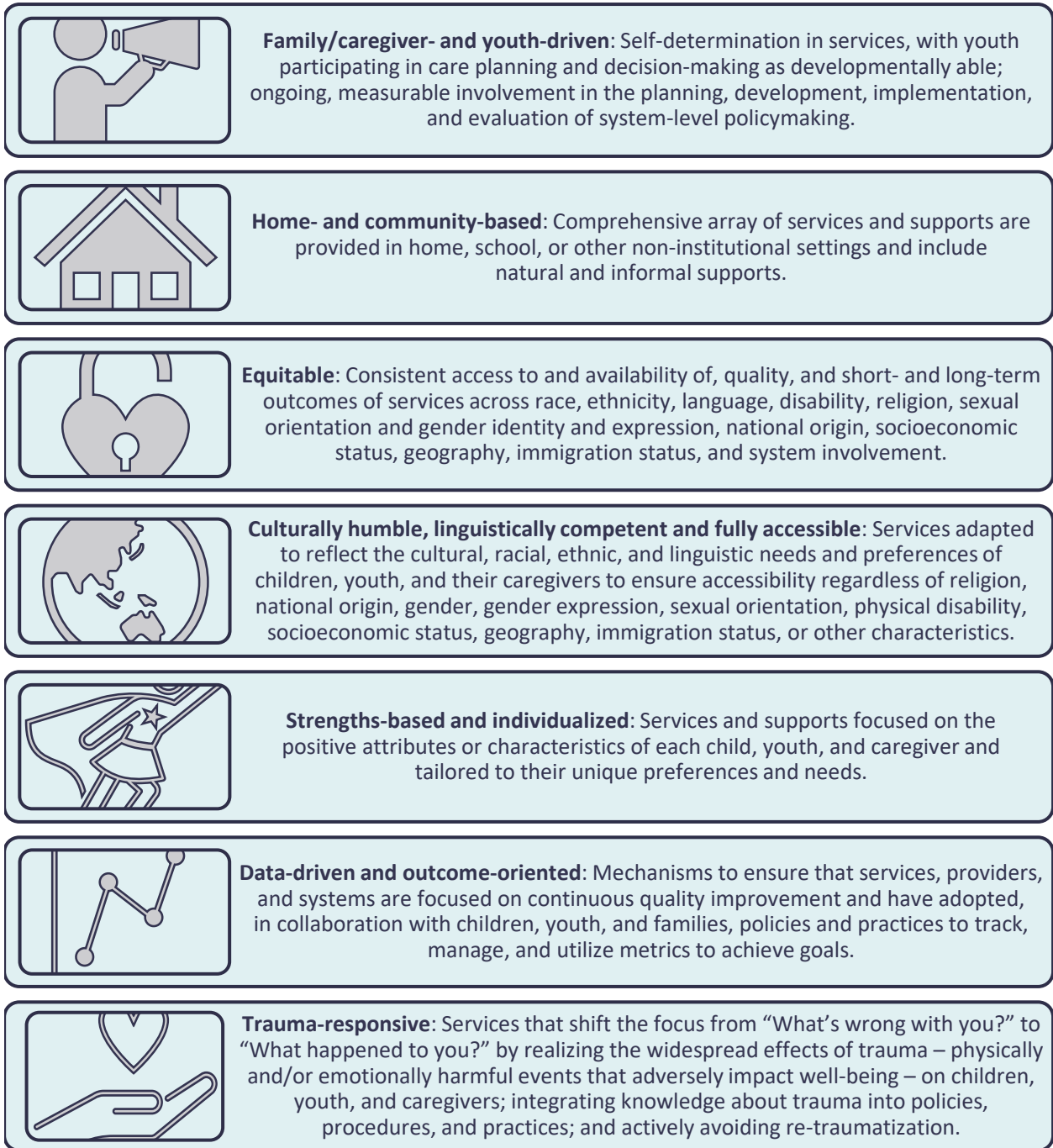
During the initial mobile response, the youth should receive a trauma-responsive, individualized assessment. Many states are incorporating the use of a validated, standardized tool (e.g., the [Crisis Assessment Tool](#)),⁶⁶ which is used to support the development of an Individualized Crisis Plan (ICP); both the assessment and the ICP are then able to be reviewed during the stabilization period, with the ICP updated to reflect goals and strategies to further address needs. Providers incorporating these steps are well-positioned to engage in a strengths discovery to ensure that strengths are incorporated into the ICP and should actively engage and empower youth and families as active partners in care planning and service delivery. One state, Oklahoma, for example, requires the development of a crisis safety plan in conjunction with the youth and family. The plan must be proactive; written in the youth’s own words; define appropriate and inappropriate behaviors; describe safety steps and supportive services to prevent or manage behavioral triggers; and include methods to manage “negative reactions to the

behavior or situation from authorities, peers, and members of the community that could cause further harm or shame to the youth or young adult.”⁶⁷ While it is difficult to attribute positive outcomes to any particular intervention, including mobile response, from January 2019 through January 2021, 79 percent of youth who received mobile crisis and crisis planning in Oklahoma were diverted from a change in placement.⁶⁸ Similar successes have been reported in Connecticut, with a reduction in ED use,⁶⁹ and New Jersey with placement stability.⁷⁰

In systems that have leveraged these more rigorous and standardized models of mobile crisis response the youth, family, and stabilization service provider can work together to develop goals that are integrated into the ICP to address the factors contributing to or maintaining the presenting crisis or situation. Engaging and empowering youth and families often involves identifying unmet needs, communication challenges, and underlying concerns such as familial or other interpersonal conflict; behavioral problems; academic challenges, including special education needs; unmanaged anxiety, depression, or other mental health disorders; symptoms related to trauma exposure; social or peer problems; delayed skills acquisition; and/or housing or financial instability.^{71,72}

The ICP typically includes the formal and informal or natural services that will address the factors that contributed to or maintain crises and to prevent further recurrence. The ICP is a living document and must be updated in response to the acuity level, youth and family’s progress and preferences, strengths, and needs. Stabilization services are grounded in Systems of Care (SOC) values and principles (Figure 1).

Figure 1: Systems of Care Values in Service Planning and Provision. Adapted from Stroul, B.A., Blau, G.M., & Larsen, J. (2021). *The Evolution of the System of Care Approach*. Baltimore: The Institute for Innovation and Implementation.



Stabilization Supports and Services

The assessment process will help guide the provider, family, and youth to determine the type and volume of services that would be appropriate to address the identified goals. Examples of such services include parent/caregiver education; positive youth development and recreational programs; family and youth peer support; in-home services; systems navigation, including identification of formal, informal, and natural supports; linkage to home-, school- and community-based services; linkages to psychiatric or primary care services for medication management; psychological treatment; respite care; and care coordination with other family and youth-serving systems, such as education, child welfare, housing, and economic supports. Youth and families should have access to care coordination; parent, infant, and early childhood supports; peer support and natural supports; intensive in-home services; school-, community- and office-based services; and population-specific resources.

A percentage of families and youth will require continued support after the six- to eight-week period of stabilization services. For example, in 2021, 33% of the youth in Connecticut were referred to outpatient services, 8.3% to intensive in-home services, 1.3% to care coordination, and 0.6% to residential treatment.⁷³ For youth with moderate to complex behavioral health needs, states and localities will need to consider how to transition the roles and responsibilities from mobile response to stabilization providers to other HCBS providers, including other coordinating entities.

When considering, selecting, and referring a youth and family to services, including evidence-based practices[†], providers should consider the cultural humility and linguistic competency of programming and the fit of the intervention with the strengths, needs, and goals of the youth and family. State and localities are encouraged to adopt consistent training for all providers serving children, youth, and families. In addition to training on child and youth development, the adolescent brain, and trauma-responsive systems, communities can provide training on how data can inform continuous quality improvement; workforce development to eliminate the use of seclusion and restraint; how to establish a performance improvement team with non-tokenized roles for youth and families; and the importance of youth- and family-centered care, respect, and dignity. Family, youth, and other team members should be active participants in making decisions about the transition from stabilization services to ongoing services.



Figure 2: Key Components of Stabilization Service Array

[†] See the California Evidence-Based Clearinghouse for Child Welfare (<https://www.cebc4cw.org/>), the Washington State Institute for Public Policy (<http://www.wsipp.wa.gov/>), the Title IV-E Prevention Clearinghouse (<https://preventionservices.acf.hhs.gov/>), the Blueprints for Healthy Youth Development (<https://www.blueprintsprograms.org/>), and the What Works Clearinghouse (<https://ies.ed.gov/ncee/wwc/>) for more information evidence-based and evidence-informed interventions.

Care Coordination

During the stabilization service phase, providers may provide care coordination activities to assist youth and families in developing, implementing, and completing their care plan. Care coordination focused on initial and ongoing stabilization and youth and family resiliency includes, but is not limited to, attending school-based meetings, connecting or re-connecting to formal and informal services and supports, communicating with the medical home or primary care provider about follow-up plans, reviewing insurance and/or entitlement eligibility, and linking youth and families to resources in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. In addition, it is critical to engage community partners and peer supports in offering services that align with the cultural, social, and linguistic needs of youth and families. Providers may also refer youth and families to receive additional supports after stabilization services have ended.

This may include, as an example, Intensive Care Coordination (ICC) with Wraparound, a structured model utilizing a child and family team to develop, implement, and monitor an individualized plan of care.[‡] Some states, for example, have developed intensive care coordination (ICC) entities.⁷⁴ Though not all states have ICC entities, where they exist, the model includes “assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services....” The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports.”⁷⁵ Likewise, for youth and families enrolled in a service like ICC, prior to contacting a crisis line, mobile response should be coordinated and there should be a hand-off to the ICC provider for stabilization services.

Parent, Infant, & Early Childhood Services

Stabilization services are best designed to address children and families through the lifespan, including the early childhood period (generally considered to be infancy through ages 5-8). Children in this age range exhibit behaviors different than those of school-aged peers and specialized experience may be necessary to identify these behaviors as mental health concerns. Children can show characteristics of mental health disorders at a young age and young children process experiences and traumatic events differently than older children and adults.⁷⁶ Resources such as the updated *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3R)* supports clinicians to recognize mental health and developmental challenges in young children while understanding how relationships and environment impact health and development.⁷⁷ Nonetheless, “early interventions aimed at emotional and behavioral disturbances are more effective when done at preschool age rather than school age.”⁷⁸ Infant and early childhood mental health is “the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment and learn all in the context of family, community and culture.”⁷⁹

Stabilization service providers must have the knowledge and skills to support family engagement for young children. Such skills and competencies include understanding “a child’s physical environment, experience of attachment, social relationships, culture, life circumstances (e.g., poverty and domestic violence), temperament, and developmental capacities all impact behavior and social and emotional

[‡] See the National Wraparound Initiative (<https://nwi.pdx.edu/>) for more information.

well-being.”⁸⁰ This includes an appreciation of how parents/caregivers experience with trauma, separation, physical and/or behavioral health conditions, loss, socioeconomic status, and cognitive functioning, affect caregiving and coping skills.

Creating positive outcomes for young children requires a two-generation approach that supports the caregivers in the child’s life. Stabilization supports for young children and their families may take the form of parent coaching, postpartum behavioral health treatment, stress management, wellness education, and referral to family-run⁸¹ organizations. Families may benefit from evidence-based and promising practices, including home visiting approaches like Attachment and Biobehavioral Catch-up (ABC), Health Families America, Parents as Teachers, or Nurse-Family Partnership (NFP).⁸² There are also evidence-based and promising practices that support improved caregiver-child interactions and address socio-emotional and behavioral health needs. These include Child-Parent Psychotherapy (CPP)⁸³ and Parent-Child Interaction Therapy (PCIT).⁸⁴

If indicated through initial screening and assessments, stabilization providers should be prepared to refer families to receive Part C Infants & Toddlers Services for children under age 3 if the family and provider identify a possible developmental delay in the child. Part C is a section of the Individuals with Disabilities Education Act; it is a federal grant program that provides assistance to states for early intervention services.⁸⁵ Similarly, providers should be aware of infant and early childhood mental health consultation services that may be available to support young children and their caregivers, including in childcare settings, to support children’s social and emotional development;⁸⁶ address challenging behaviors in early learning and home environments; and reduce childcare or preschool suspensions and expulsions,⁸⁷ which was found to be triple the rate for school-aged peers.^{88,89}

Family and Youth Peer Support, Natural Supports, and Other Support Models

Natural supports are individuals who are connected to a youth or family and provide unpaid support. Natural supports include family members, friends, neighbors, after school programs, clergy, coaches, and others. In Wraparound,⁹⁰ natural supports “are integral team members” and, “when possible, strategies in the [individual care] plan are undertaken by natural supports within the youth’s and family’s community.”⁹¹ One recent study found that higher percentages of natural supports on child and family teams were associated with better outcomes. These outcomes included decreased youth problematic behavior and impairment and improved child functioning.⁹² Natural supports assist with building and maintaining family, friend, and community connections and can help to carry out and sustain interventions after formal services end.⁹³

In terms of others who may have important roles in crisis response, in late 2021, the Centers for Medicaid and Medicare Services (CMS) and CHIP [Children’s Health Insurance Program] provided guidance on the scope and payments for community-based mobile crisis services. In a State Health Official Letter, they reinforced the use of peers in crisis services: “Best practices include incorporating trained peers who have lived experience in recovery from mental illness and/or SUD [substance use disorder] and formal training within the mobile crisis team; responding without law enforcement accompaniment, unless special circumstances warrant inclusion, in order to support justice system diversion...”⁹⁴ Over thirty states⁹⁵ currently permit Medicaid reimbursement for family and/or youth peer support services.

Two states recently included coordination with walk-in or peer-run crisis stabilization in their recently enacted 988 legislations:

- Colorado’s SB 21-154, which requires the non-profit organization operating the 988 hotline to “coordinate access to crisis walk-in centers” which includes peer-run centers.⁹⁶
- Oregon’s HB 2417, which requires the crisis call center to triage calls and “link individuals to follow-up care [including] facilities offering short-term respite services, peer respite centers, and behavioral health urgent care walk-in centers.” The bill defines “peer respite center” as a “voluntary, nonclinical, short-term residential peer support” provided in a home-like setting by a peer-run organization, directed and delivered by individuals with lived experience.⁹⁷

Family peer support providers “...deliver peer support through face-to-face support groups, phone calls, or individual meetings. They bring expertise based on their own experience parenting children or youth with social, emotional, behavioral, or substance use challenges, as well as specialized training, to support other parents and caregivers.”⁹⁸ Youth peer support providers connect “...youth and young adults with mental health conditions or substance use disorders with young adults who have experienced similar challenges and completed specialized training to learn how to use their experience to support others. Like adult peer support, [youth peer support] encompasses a range of activities and interactions focused on promoting connection, inspiring hope, and supporting young people with mental or substance use disorders to set their own goals and take steps toward building fulfilling, self-determined lives for themselves.”⁹⁹ Youth peer support also may be helpful as young people navigate the transition between, often disconnected, child and adult-serving behavioral health systems.¹⁰⁰

One approach to supporting youth of transition age is the clubhouse model. This model was developed as a patient-led initiative in the late 1940s. Today, clubhouses are non-clinical peer communities of adults and youth of transition age (typically 14-26 years old). Activities are generally centered on employment (including supported employment), wellness, health promotion, and social/peer relationship building. A 2018 systematic review of clubhouses found that participation in clubhouse activities was associated with lower rates of ED use, re-hospitalization, and increased feelings of satisfaction and self-efficacy; however, the authors note these studies are of varying quality and generally have a small sample size.¹⁰¹ A 2017 study found that clubhouse members who attended three or more days per week had average one-year mental health care costs of \$5,697 compared to \$14,765 for those who attended less often.¹⁰²

A similar model, the living room model, includes clinical staff in addition to peers. The living room model aids in eradicating the stigma surrounding mental health and monitors the whole individual in assessing the hierarchy of basic needs alongside their crisis concerns. The living room is used as an alternative to the ED; they typically do not serve children but do offer services to youth of transition age. Individuals seeking services are referred to as “guests” and are assessed for safety, including danger to self or others, and basic health. Following the clinical assessments, individuals are paired with a peer to discuss the crisis, including any precipitating events, and to practice coping skills.^{103,104} The living room model can also be helping to serve a marginalized/underserved population by working with the whole person and having such a strong peer component.

The inclusion of both family and youth peer support and peer-based models that help emerging adults throughout the crisis continuum, as available stabilization services is critical. Peer support reduces isolation; assists youth and families in navigating child-serving systems, including the often-difficult transition to the adult behavioral health system for those youth who need continued care; promotes hope and resiliency; improves help-seeking behavior; and fosters trusting and supportive relationships among those with lived experience.^{105,106} Apart from individual or familial service provision, family and youth peers must be included in the planning, design, and implementation of stabilization services at a system level.

Intensive In-Home Services

Intensive in-home services beyond crisis response include behavioral health and therapeutic services provided to children and families in their homes to address clinical needs and improve functioning. In-home services may be provided through a combination of licensed mental health professionals and other trained or certified individuals.¹⁰⁷ Several states include intensive in-home services in their Medicaid behavioral health service array.

In Massachusetts, In-Home Therapy is provided by a qualified clinician with one or more qualified paraprofessionals; the service includes interventions to enhance the family's capacity to improve the youth's functioning by implementing focused interventions and behavioral techniques.¹⁰⁸ Connecticut's Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) has three treatment phases and provides four to five hours of clinical services over an average of six months in the home. This program demonstrated evidence that youth with serious behavioral health needs who received the service experienced improvements in psychosocial functioning.¹⁰⁹

There are several evidence-based practices (EBP) that can be utilized with intensive in-home services, including Family Centered Treatment (FCT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST).⁵

School-, Community-, and Office-Based Services

There are numerous effective services and supports that can be provided in community-based settings, including in traditional clinics, outpatient behavioral health treatment centers, and schools. Stabilization service providers may want to connect families to practitioners to receive individual, family, or group-based therapies or treatment to address needs identified throughout the assessment and stabilization process. Availability of services will vary by community; however, some of the EBPs that may be available in a community-based setting include Acceptance and Commitment Therapy (ACT); Aggression Replacement Training (ART); Brief Strategic Family Therapy (BSFT); Child-Parent Psychotherapy (CPP); Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Eye Movement Desensitization and Reprocessing (EMDR) for child trauma; Familias Unidas; Integrated Dual Disorder Treatment (IDDT); Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Program (MATCH-ADTC); Parent-Child Interaction Therapy (PCIT); Stop Now and Plan (SNAP); The Seven Challenges; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Triple P-Positive Parenting Program. **

Some communities use telehealth consultation and learning opportunities to buttress primary care and to extend access to care especially in the context of shortages of licensed providers and provide initial and ongoing psychiatric consultation as part of stabilization services. Examples of such services include:

- **Massachusetts Child Psychiatry Access Program (MCPAP)** is an example of one state's system of regional behavioral health consultation teams based at academic medical centers designed to provide additional resources to help primary care clinicians (PCC) and their practices to promote

^{5,**}: See the California Evidence-Based Clearinghouse for Child Welfare (<https://www.cebc4cw.org/>), the Washington State Institute for Public Policy (<http://www.wsipp.wa.gov/>), the Title IV-E Prevention Clearinghouse (<https://preventionservices.acf.hhs.gov/>), the Blueprints for Healthy Youth Development (<https://www.blueprintsprograms.org/>), and the What Works Clearinghouse (<https://ies.ed.gov/ncee/wwc/>) for more information evidence-based and evidence-informed interventions

and manage the behavioral health needs of youth. The MCPAP provides free collaborative support to all PCCs by implementing a system for the PCC to obtain (1) immediate informal telephonic consultation regarding the mental health needs of any child in the primary care setting within 30 minutes, (2) timely, as needed, provision of formal outpatient consultation for children referred by the PCC, (3) assistance in coordinating care for children who need community mental health services, and (4) continuing professional education regarding children's mental health designed specifically for PCCs.¹¹⁰ Similar lines and services exist in over 35 states, with more states developing similar models.¹¹¹

- **Project ECHO (Extension for Community Healthcare Outcomes)** is a hub-and-spoke model - the "hub" site offers services and acts as an anchor institution branching out through physically distant "spokes" – that assists a cohort of community providers in responding to challenging cases. Project ECHO has been rigorously evaluated as evidenced by dozens of peer-reviewed journal articles and found effective in delivering behavioral health care to historically underserved populations.¹¹² Several states, including Colorado, Montana, Nevada, New Mexico, and Oregon have used Project ECHO to facilitate multidisciplinary collaboration to improve behavioral health outcomes for youth and families.¹¹³

Many schools offer mental health services, including some EBPs, like CBT. As many as 70-80% of children who receive mental health services do so in schools and treatment can be particularly effective when integrated into the youth's academic setting.¹¹⁴ Schools may have psychologists, social workers, school counselors, or other professionals who can provide individual and group interventions. These services may be provided without a cost to the student, depending on the source of the funding (e.g., Medicaid, block grants, discretionary grants, state/local allocations, etc.).¹¹⁵

Caring for a youth's behavioral health condition places unique demands and stressors upon caregivers. Apart from the availability and accessibility of EBPs and other HCBS, respite can provide a safe and supportive environment on a short-term basis for youth with behavioral health needs when their families need relief.¹¹⁶ Respite is a service intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite may be offered to families (foster, kinship, adoptive, and birth) during emergencies or on a pre-planned basis to improve youth and family functioning and stability.¹¹⁷ Although the preference is to provide respite care in the home or community, some youth and families may have a need that is best met with short-term, facility-based care. While respite can play an essential role in reducing caregiver stress and improving quality of life,¹¹⁸ the benefits are not solely reserved to caregivers. Respite can allow siblings uninterrupted time with their caregiver and give them an opportunity to "recharge" from the stress of living with a sibling with a behavioral health challenge. For the youth, respite care can offer a safe and supportive environment, build life skills, and most importantly help them remain in their own home and community, preventing the need for an out of home placement.

Crisis Stabilization Units

As noted, the preference is to treat the youth in the home and community, yet some youth may need acute care services, including inpatient care, residential treatment, or short-term, facility-based crisis care, sometimes referred to as "23-hour units" (though states vary in the duration of these programs, with some running up to 72 hours, for example). These crisis stabilization units (CSU) should have the capacity to provide urgent diagnostic and functional assessments; crisis intervention, treatment, and support; and medical assessment, including for youth with co-occurring disorders. CSUs also may offer further diagnostic testing, withdrawal management, medication administration or management and

response monitoring, and linkages to home- and community-based services and social supports. CSUs provide an alternative to ED or inpatient hospitalization.¹¹⁹ As with other services in the continuum, it is essential that CSUs that serve youth incorporate SOC values and principles (Figure 1). CSUs that serve youth must be staffed by providers with appropriate pediatric and adolescent clinical expertise, experience working with family systems, and a commitment to teaming and collaboration. A few states have begun developing youth-specific CSUs:

- **New York** emphasizes that Children’s Crisis Residence (term used for their CSU services) “...are one component of a comprehensive continuum of crisis services, intended to help avert extended emergency room visits and inpatient hospitalizations. Community-based crisis services available within the continuum include crisis hotlines, mobile crisis intervention, and other crisis service components under Children and Family Treatment Supports and Services, as well as Comprehensive Psychiatric Emergency Programs. For children in crisis who are identified as needing a short-term higher level of care, the expanded benefit of a Children’s Crisis Residence [can now offer children and their families the greater level of service and support needed to help ensure a more successful return home.”^{120,121}
- **Oklahoma**, which has been a leader in developing mobile crisis services, has two children’s crisis stabilization units: the Counseling and Recovery Service Child and Adolescent Life Management (CALM) Center and Red Rock Behavioral Health Services Children’s Crisis Unit. Both units offer services for children and youth ages 10-17.¹²²
- **Virginia** began Medicaid reimbursement for several new crisis services in 2021, including MST, FFT, mobile crisis, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization units as part of Project BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes).¹²³

Additional community-based resources may include referrals to concrete services and supports, such as eviction prevention, security deposit funding, and other housing services; intimate partner/domestic violence services; support to access benefits, such as food/nutritional, energy, cash assistance, child care vouchers, mobility support and enrollment in Medicaid/CHIP; tutoring, job training, GED, or other educational and vocational supports; and connections to recreational and social organizations and activities, including camps, after school programming, mentoring, and faith-based entities.

Stabilization service providers should ensure that the physical well-being of the youth and family is addressed in the plan. Providers should check that the youth and family have an identified primary care provider and oral health care provider and receive routine health screens and immunizations. Children and family members with chronic medical conditions (e.g., diabetes, hypertension, asthma, heart disease, etc.) should be supported to access specialty treatment or resources, as needed.

As with all services, referrals should be consistent with the youth and family’s goals, strengths, and needs and should be respectful of their identities and preferences.

Population-Specific Services

All care plans should be customized to the individual strengths and needs of the youth and family and reflect their goals for themselves. Further, there are populations of youth who may benefit from additional population-specific interventions during and after stabilization services. These populations include children and youth with intellectual and developmental disabilities, youth experiencing foster care, and youth with prodromal symptoms of psychosis or early-onset psychosis.

Children and youth with intellectual disability/developmental disorder (ID/DD)

An estimated 1-3% of children and youth have an ID/IDD, with as many as 40% of those children experiencing a co-occurring mental health disorder.¹²⁴ However, only approximately 1 in 10 children with a co-occurring ID/IDD and mental health disorder receive specialized mental health services. Co-occurrence of mental illnesses are higher within other neurodevelopmental disorders as well.¹²⁵ These children and youth may benefit from receiving a more comprehensive approach to their needs, particularly since this population is heterogeneous with considerable variability in their capabilities, symptom expressions and available natural supports.¹²⁶ Some guidelines exist for mental health practitioners to better treat children and youth with a range of challenges from various neurodevelopmental disorders, including adapting psychotherapy approaches to the expressive and receptive language skills of the youth. Adaptations could include language used; length, frequency, and/or duration of therapy; modification of interventions; and engaging in a team approach.¹²⁷

Youth experiencing foster care

Youth experiencing foster care are more likely to experience behavioral health disorders than other children.^{128,129} This is due in part to their experiences of child maltreatment, trauma related to removal from the home, and instability while in out-of-home placement.^{130,131,132,133} Children in foster care also are more likely to receive behavioral health services in more costly and restrictive environments typically in a child welfare-based residential care system for youth.¹³⁴ Youth in foster care who experience a behavioral health crisis are commonly referred to EDs and are at increased risk of placement disruption. Mobile response teams can provide early intervention and support to youth experiencing foster care and to their caregivers to minimize the likelihood of future crises and placement disruptions, but such families often need additional supports and services to maintain stabilization.

Therapeutic foster care (TFC) is a community-based treatment option for youth with serious behavioral health needs. Models of TFC vary by state and community and there is no single approach or set of standards. However, the Family Focused Treatment Association, a membership organization of providers, states that TFC provides the “positive aspects of the nurturing and therapeutic family environment” with “active and structured treatment.”¹³⁵ Typically, TFC requires caregivers to complete initial and ongoing trainings, partner with the child’s treatment team and child welfare worker, engage with the child’s family (if appropriate), and support implementation of the child’s plan of care, including any behavioral interventions.

Two evidence-based TFC models are:

- **Treatment Foster Care Oregon** (TFCO; previously referred to as Multidimensional Treatment Foster Care) provides a consistent environment for the youth with daily structure, close supervision, and support to help the youth develop prosocial relationships. TFCO views the foster home as the primary clinical environment and provides daily contact with the foster parent while supporting skill development to address problematic behaviors. TFCO has a model for preschoolers, children, and adolescents.^{136,137}
- **Together Facing the Challenge** (TFTC) trains foster parents and agency staff and supervisors to utilize effective parenting techniques, build therapeutic relationships, and prepare youth for adulthood. TFTC utilizes a trauma-informed approach and promotes cultural sensitivity, problem-solving, and cooperation.¹³⁸

Youth with prodromal symptoms of psychosis or early-onset psychosis

Psychosis includes symptoms such as hallucinations, delusions, or confused thinking. Psychosis is most often associated with schizophrenia, which typically does not manifest fully until late adolescence or early adulthood. Some youth may experience what are known as prodromal or early signs of psychosis, which can include bizarre behavior, changes in thinking or speech, preoccupation with a particular topic, and social withdrawal.¹³⁹ Individuals experiencing their first episode of psychosis (FEP) benefit from timely linkage to evidence-based services and interventions, including supportive approaches, family work, and medications, as these are critical to reduce the risk of suicide and more intense or worsening symptoms.¹⁴⁰ A host of resources are also available that address the evidence-based practice of Coordinated Specialty Care (CSC) for individuals with FEP.¹⁴¹

Clinics and programs across the country are providing specialized treatment to youth and young adults experiencing prodromal symptoms or FEP. The NASMHPD Early Intervention in Psychosis virtual resource center¹⁴² includes information on effective interventions to support these individuals. The Early Psychosis Intervention Network (EPINET)¹⁴³ includes eight regional hubs and more than 100 early psychosis clinics across 17 states. Additionally, SAMHSA maintains a treatment locator for early serious mental illness, including psychosis.¹⁴⁴

Conclusion

The developmental, social, and clinical needs of youth are different from those of adults. A robust crisis continuum of care is needed specifically to meet the needs of youth and families in their homes and communities. Comprehensive crisis response systems geared for youth and family needs include mobile response as well as considerations for a safe place for the youth to be, which can include in-home stabilization services and linkages from mobile interventions to an array of other offerings. The provision of crisis stabilization services in homes and communities for up to six to eight weeks to meet the needs of youth and families who require ongoing stabilization after initial mobile response is a critical component of a continuum, as are appropriately designed settings for acute care. Attention to the needs of diverse populations is essential to ensure equity and access. The stabilization services provided after a crisis are important to ensure that all youth and families have the resources they need to implement crisis plans, improve functioning and well-being, maintain safety, and decrease the likelihood of future crises or other poor outcomes.

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