Service Standards

Crisis Response and Information Services

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Definition

Crisis Response and Information Services are immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual. Services may be provided via phone, video call, text, chat, or in person. Crisis Response and Information Services establish and maintain collaborative relationships with other members of the community's crisis response system to better meet the needs of individuals and families and increase access to crisis services.

Crisis Call Services establish immediate communication links and provide supportive interventions for individuals and families in critical or emergency situations.

Mobile Crisis Response Services respond to individuals and families in crisis wherever they are and offer on-site assessment, intervention, de-escalation, stabilization, safety planning, and referrals. Services are provided in the least restrictive, community setting possible and can be designed to serve children, youth, and families or adults. Mobile crisis response services typically operate 24 hours a day, 7 days a week; however, hours may be limited in some communities based on funding, staffing, or other challenges.

Crisis Receiving and Stabilization Services provide a safe space for extended observation, de-escalation, and crisis intervention and serve as an alternative to hospitalization for individuals experiencing a behavioral health crisis. Length of stay may vary from several hours to several days. Crisis receiving and stabilization services may be provided within a community mental health clinic, general urgent care office, hospital, or as a stand-alone facility within the community and may be referred to as a crisis stabilization center, crisis observation unit, walk-in crisis clinic, community crisis center, or crisis hub.

Interpretation: *Stabilization is a combination of methods used to return the service recipient to his or her pre-crisis level of functioning, including:*

1. *identifying the precipitating event;*
2. *mobilizing support and resources;*
3. *identifying coping skills; and*
4. *developing plans to ensure safety.*

Interpretation: *The level of family involvement in the crisis response process may vary based on the population served, the program model/design, and the expressed wishes of individuals.*

Note: *Crisis intervention services reviewed under CRI are distinct from fully peer-delivered crisis services, which provide non-clinical types of counseling that offer guidance, coaching, community support, and skill building to individuals, families, and groups and are separately reviewed under Coaching, Support, and Education Services (CSE).*

Note: *An organization that provides only Crisis Call Services will complete CRI 1, CRI 2, CRI 3, CRI 4, CRI 5, and CRI 9.*

An organization that provides only Mobile Crisis Response Services will complete CRI 1, CRI 2, CRI 3, CRI 4, CRI 6, and CRI 9.

An organization that provides only Crisis Receiving and Stabilization Services will complete CRI 1, CRI 2, CRI 3, CRI 4, CRI 7, CRI 8, and CRI 9.

Note: *Please see CRI Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see the CRI Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Crisis Response and Information Services

CRI 1: Person-Centered Logic Model

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Note: *Please see the Logic Model Template for additional guidance on this standard.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one desired outcome has been identified for all of its programs.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

*	• Program logic model that includes a list of outcomes being measured	

- See program description completed during intake

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel

CRI 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to:*

1. *needs assessments;*
2. *risk assessments; and*
3. *the best available evidence of service effectiveness.*

CRI 1.02

The logic model identifies outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. connection to formal and informal support systems;
d. health, welfare, and safety;
e. achievement of individual service goals;
f. community awareness of services provided or topics relevant to the service population; and
g. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Interpretation: *COA Accreditation recognizes that it may be difficult to track individual outcomes given the nature and duration of some CRI service models. If individual outcomes are not being tracked, the organization must be prepared to demonstrate how program-level outputs are being used to build capacity, improve programs, and have a positive impact on persons served. Additionally, the organization may speak to how it uses community-wide outcomes data collected by outside entities to make data-informed decisions within its program when appropriate.*

Crisis Response and Information Services

CRI 2: Personnel

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Program personnel have the competency and support needed to provide services and meet the needs of persons served.
Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications and, as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Table of Evidence

Self Study Evidence

* • List of program personnel that includes:
  • Title
  • Name
  • Employee, volunteer, or independent contractor
  • Degree or other qualifications
  • Time in current position
• See organizational chart submitted during application	

* • Procedures for accessing supervisory support	
* • Table of contents of training curricula	
* • Debriefing procedures	
* • Procedures or other documentation specific to peer support workers, if applicable	

Site Visit Evidence

* • Sample job descriptions from across relevant job categories • Formal agreements with necessary professionals, as applicable • Documentation tracking staff completion of required trainings and/or competencies • Training curricula • Coverage schedules for providing supervisory support for the past six months, if applicable

On-Site Activities

* • Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

CRI 2.01

Direct service providers are selected for their ability to handle stressful situations and for qualities such as maturity, judgment, empathy, respect for others, and their own personal lived experience.

CRI 2.02

Direct service providers work under the supervision of trained professionals who meet the applicable legal requirements for practice within their professions.

CRI 2.03

At all times when the program is in operation:

a. an individual with an advanced degree in human services and appropriate certification and/or licensure by the designated authority in their state is available to provide clinical supervisory guidance to direct service personnel;
b. personnel conducting clinical assessments have immediate access to clinical supervision, when applicable; and
c. procedures outline how to access this clinical support.

Interpretation: *This support may be available on staff, through on-call consultation, or through a formal arrangement with a social service organization.*

CRI 2.04

When staff with lived experience provide peer support to individuals and families, the organization:

a. clearly defines their roles and responsibilities;
b. includes peer support workers as equal partners on the team;
c. helps other program personnel understand the position and its purpose at the program;
d. establishes guidelines for recruitment and selection;
e. ensures peer support workers are trained to perform their roles and responsibilities;
f. provides ongoing support and supervision to address any issues that occur, including helping peer support workers manage personal triggers that may arise on the job;
g. facilitates opportunities for peer support workers to connect and consult with others performing similar roles; and
h. ensures peer support workers are offered opportunities for professional development, career advancement, and program planning activities.

NA: The organization does not hire peer support workers.

Examples: *Peer support workers can play an important role in welcoming, engaging, empowering, supporting, and advocating for individuals and families. Peer support workers often experience challenges in their employment including stigma from co-workers, inappropriate expectations from non-peer staff, role confusion, triggers from past trauma, and lack of opportunities for support and advancement. When they are viewed and included as full partners who have input into program decisions and given appropriate support, peer support workers can help organizations ensure their culture and practices prioritize the experience and involvement of persons served and their families.*

Examples: *Organizations may use other terms to describe peer support workers, such as peer support specialists, peer/family/youth partners, peer/family/youth advocates, peer recovery coaches, family mentors, and/or family liaisons. The inclusion of peer support specialists can lead to increased engagement with the individuals served and can supplement the mental health workforce.*

CRI 2.05 (FP)

There is at least one person on duty at each service delivery location any time persons served are present who has received first aid and age-appropriate CPR training in the previous two years that included an in-person, hands-on CPR skills assessment conducted by a certified CPR instructor.

NA: The organization provides technology-based services only and staff never interact with persons served in any physical space.

CRI 2.06

Prior to coming in contact with the service population, direct service personnel are trained on, or demonstrate competency in:

a. the principles and practices of person-centered care;
b. implementing a range of practices that promote a supportive and noncoercive environment;
c. assessing for and responding to suicide risk;
d. procedures for making referrals to, or providing information on, community resources;
e. interview techniques;
f. skills and strategies for engaging, partnering with, and supporting family members, when appropriate;
g. handling emergencies including assessing needs in crisis situations, de-escalation techniques, and situations that may require consultation with supervising or cooperating professionals or the police;
h. understanding the definitions of human trafficking (both labor and sex trafficking) and sexual exploitation, and identifying potential victims; and
i. specialized skills related to chosen interventions.

Interpretation: *Regarding element (i), specialized training should include techniques and best practices when utilizing text and chat functions, if applicable.*

CRI 2.07

Supervisors are trained on, or demonstrate competency in:

a. helping direct service personnel process and debrief following a crisis or traumatic event;
b. building and maintaining morale;
c. providing constructive ways for direct service personnel to approach difficult situations with service recipients;
d. providing effective supervision for peer support staff, if applicable; and
e. facilitating a structure for ongoing communication and collaboration among personnel.

CRI 2.08

Personnel providing services in a group setting are trained on, or demonstrate competency in:

a. establishing a supportive, nonjudgmental environment that promotes respectful interactions;
b. engaging and motivating group members;
c. helping participants develop skills and/or understanding relevant to the group's area of focus;
d. understanding group dynamics;
e. leading discussions; and
f. facilitating group activities.

NA: The organization does not provide services in a group setting.

CRI 2.09

The organization counteracts the development of compassion fatigue by:

a. helping personnel understand how they can be impacted by stress, distress, and trauma;
b. helping personnel develop the skills and behaviors needed to manage and cope with work-related stressors;
c. encouraging respectful collaboration and support among co-workers;
d. examining how the organization's culture and policies can prevent the development of compassion fatigue;
e. providing reflective supervision; and
f. informing personnel about treatment services, as needed.

Examples: *Regarding element (b), organizations can help personnel develop the skills and behaviors that will enable them to: (1) engage in positive thinking; (2) increase their self-awareness; (3) know their limits and needs; (4) practice self-compassion; (5) establish healthy boundaries; (6) effectively communicate about unrealistic and unspoken expectations; (7) identify and manage emotional triggers; (8) have difficult conversations with co-workers and supervisors; (9) practice brain-aware activities to stay regulated; and (10) take time for self-care.*

Regarding element (d), areas to consider include, but are not limited to: (1) supervision; (2) caseload assignment; (3) scheduling; (4) trainings; (5) crisis response; (6) psychological safety; and (7) healthy and realistic staff expectations and boundaries.

CRI 2.10

Employee workloads support the achievement of positive outcomes and are regularly reviewed.

Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of personnel including level of supervision needed;*
2. *the work and time required to accomplish assigned tasks and job responsibilities; and*
3. *service volume, accounting for assessed level of needs of persons served.*

CRI 3: Intake and Assessment

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

The organization assesses individuals promptly and responsively to efficiently determine urgency of need and ensure access to needed services.

Interpretation: *As noted in PRG 1, case record documentation in some CRI programs, such as rape crisis or victim services, will typically be limited to essential information. Peer reviewers should take this into account when reviewing records and may rely more heavily on other evidence (e.g., policies, procedures, and/or interviews) when assigning standards ratings.*

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment procedures	
*	• Copy of assessment tool(s)	

Site Visit Evidence

*	• Outreach and informational materials • Community resource and referral list

On-Site Activities

*	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

CRI 3.01

The organization provides the community with information about:

a. what services the organization offers;
b. hours of operation;
c. how to access the organization's services; and
d. whether crisis services have a particular focus (e.g. mental health or rape crisis intervention).

CRI 3.02

The organization provides services with little to no exclusionary criteria to remove barriers to accessing crisis care.

Interpretation: *The organization's screening and intake procedures should not wholly exclude individuals who are under the influence of substances, agitated, and/or otherwise difficult to engage.*

Interpretation: *The organization should not universally require all individuals to receive a medical clearance from a hospital emergency department before receiving services or automatically turn away first responders who are attempting to drop off individuals in crisis who have not been medically cleared.*

CRI 3.03 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. appropriately triage urgent needs and emergency situations; and

c. support timely initiation of services or an appropriate referral when individuals cannot be served or cannot be served promptly.

Interpretation: *Regarding element (a), supplementary information may be obtained from the referral source, collaborating providers, family members, and/or others involved with the individual and family, in addition to the individual in need of services, when appropriate.*

Interpretation: *If an organization is unable to adequately meet the needs of an individual requesting services due to the program model design, the organization has a clear policy on how to properly refer the individual to appropriate services and how to respond or intervene in an emergency.*

CRI 3.04 (FP)

Crisis intervention personnel conduct an individualized, trauma-informed, culturally and linguistically responsive assessment to determine:

a. if the individual needs an immediate intervention for a medical need, suicide in progress, or other dangerous situation;
b. potential lethality including harm to one's self or others;
c. the individual's psychosocial needs and crisis precipitants;
d. the individual's strengths, available coping mechanisms, and supports;
e. if the individual has co-occurring diagnoses or impairments; and
f. if the individual has current and/or previous involvement with the behavioral health system.

Interpretation: *Crisis call services may be unable to complete a full assessment of an individual in crisis; however, these services should make every effort to obtain the above information to make informed decisions regarding the appropriate level of care or referral options for the individual. Mobile crisis response services and crisis receiving and stabilization services should conduct a more thorough psychosocial assessment when the treatment provided is more extensive, including the prescribing of medication by a physician.*

Interpretation: *Regarding element (a), crisis call services should confirm the individual's physical safety at the beginning of the call or text to determine if immediate intervention is needed before continuing the conversation.?The intervention may or may not involve an involuntary emergency service intervention for a suicide in progress or other life-threatening event, which is only considered as a last resort.*

Interpretation: *Some crisis intervention programs, such as rape crisis and victim services, may conduct assessments with less emphasis on the individual's mental health. In these cases, personnel should, at a minimum, understand how to recognize and intervene in a behavioral health emergency as required by TS 2.04 .*

Interpretation: *Personnel that conduct assessments should be aware of the indicators of a potential trafficking victim, including, but not limited to: evidence of mental, physical, or sexual abuse;?physical exhaustion;?working long hours;?living with employer or many people in a confined area;?unclear family relationships;?heightened sense of fear or distrust of authority;?presence of older significant other or pimp;?loyalty or positive feelings toward an abuser;?inability or fear of making eye contact;?chronic running away or homelessness;?possession of excess amounts of cash or hotel keys;?and inability to provide a local address or information about parents.?Several tools are available to help identify a potential victim of trafficking and determine the next steps toward an appropriate course of treatment.?Examples of these tools include, but are not limited to, the Rapid Screening Tool for Child Trafficking and the Comprehensive Screening and Safety Tool for Child Trafficking.*

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA Accreditation's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

CRI 3.05 (FP)

The organization completes a comprehensive safety assessment when an individual expresses suicidal ideation using a combination of an assessment tool, the crisis intervention personnel's professional judgment, and the individual's own input and active involvement, paying specific attention to their:

a. suicidal desire;
b. intent to die and any identified method and plan;
c. suicidal capability, including history of attempts and available means; and
d. buffers/protective factors.

Interpretation: *Suicide risk assessment should be an engaging, collaborative process between the crisis intervention personnel and the individual that retains the individual's autonomy and choice to the greatest extent possible. Over-reliance on a single, standardized suicide assessment tool to predict future suicidal behavior and risk level may not provide an accurate assessment of an individual's suicide risk. Individuals do not always accurately report suicidal ideation when asked, and suicidal desire and intent may vary widely at any given moment.*

Crisis Response and Information Services

CRI 4: Crisis Intervention Service Elements

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

The organization responds immediately and appropriately to individuals or families in crisis situations.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Crisis response operating procedures	
*	• Supervisory review procedures	

Site Visit Evidence

*

- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Review case records

CRI 4.01

Crisis intervention personnel respond immediately and work with the individual and/or family to:

a. provide stabilization using de-escalation techniques;
b. create an action plan; and
c. develop or revise a safety plan, as needed, that does not include "no-suicide contracts" or "no-harm contracts."

Interpretation: *A safety plan includes a prioritized written list of coping strategies and sources of support for individuals navigating a suicidal crisis. Individuals can implement these strategies before or during a suicidal crisis to prevent a suicide attempt or possibly death. Components of a safety plan can include recognition of warning signs, internal coping strategies, socialization strategies for distraction and support, family and social contacts for assistance, professional and agency contacts, and lethal means restriction.*

Interpretation: *No-suicide contracts are based on a verbal or written agreement by the service recipient to not engage in self-harm or suicidal acts during a specific timeframe. Research does not support this practice or show that these agreements are effective at preventing suicides, nor have they been found to protect against malpractice lawsuits.*

CRI 4.02 (FP)

Written procedures address the provision of treatment and referral when individuals are at risk of imminent harm including situations involving suicide, medical crises, substance overdoses or withdrawals, violence, and other emergencies.

Interpretation: *When an individual calling a crisis call service is considered to be at imminent risk for suicide, staff should have a written procedure directing them to (1) practice “active engagement” to promote the caller’s collaboration in securing their safety, (2) use the least invasive intervention and consider involuntary emergency interventions as a last resort, and (3) initiate “active rescue” (i.e., immediately dispatching emergency rescue interventions with or without the caller's consent) if the caller remains unwilling and/or unable to act on their own behalf.*

CRI 4.03

The organization provides individuals, and their families when appropriate, with referrals to appropriate resources and, when the need for a higher level of care is identified, directly connects individuals to the correct level of care through collaboration with community providers.

CRI 4.04

Survivors who wish to report sexual assault, exploitation, or other criminal acts are provided with the resources and support they need to do so.

NA: The organization does not provide rape crisis intervention or other victim advocacy services.

CRI 4.05

The organization works with survivors of sexual assault, exploitation, or other criminal acts to manage any legal needs they may have by:

a. connecting them to appropriate legal resources;
b. ensuring they are informed about their legal rights and options; and
c. providing appropriate support as they navigate the legal system if they choose to do so.

NA: The organization does not provide rape crisis intervention or other victim advocacy services.

Interpretation: *The organization should be careful to ensure that the help it provides would not be classified as "legal advice" unless the personnel providing services are qualified legal professionals.*

Examples: *Support related to legal needs may include, for example: (1) facilitating communication between the individual and the courts and/or law enforcement, (2), providing accompaniment to investigation procedures and court proceedings, and (3) assisting with filing for crime victim compensation.*

CRI 4.06

The organization works with survivors of sexual assault, exploitation, or other criminal acts to manage any medical needs they request assistance with by:

a. ensuring they are informed about their options within the medical system;
b. offering accompaniment and emotional support during forensic exams and/or other medical appointments; and
c. advocating on their behalf with medical personnel and other service providers and ensuring their rights are upheld.

NA: The organization does not provide rape crisis intervention or other victim advocacy services.

CRI 4.07

When services are provided in a group setting, the organization:

a. involves participants in establishing agreed-upon guidelines and expectations, including expectations for confidentiality, at the outset;
b. provides opportunities for participants to ask questions, share their thoughts and experiences, and learn from the thoughts and experiences of others;
c. enables participants to build connections and develop relationships with others in the group;
d. responds flexibly to the changing needs of group members; and
e. schedules services with participants' time commitments in mind, to the extent possible and appropriate.

NA: The organization does not provide services in a group setting.

Examples: *Guidelines and expectations can be designed to foster a non-judgmental environment that promotes trust, respect, and group cohesion.*

CRI 4.08

Crisis intervention personnel provide appropriate follow-up within 24 hours, when appropriate and in accordance with organizational policy, to confirm that individuals were able to connect with the correct level of care.

Interpretation: *In cases of individuals at risk for suicide, every effort should be made to follow up within 24 hours after the initial contact.*

Interpretation: *Some crisis intervention models, such as mobile crisis response services, may provide post-crisis stabilization services and additional follow-up for an extended period.*

Examples: *Follow-up can be by telephone, non-identifiable postcards, emails, or text messages. Contacts can be brief, tailored to the individual's needs and preferences, and focused on continued assessment of risk.*

CRI 4.09

Supervisory personnel review service interventions within 24 hours.

CRI 5: Crisis Call Services

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Crisis call services provide immediate telephonic crisis intervention services to all callers via phone, video call, text, and/or chat capabilities and coordinate connections to additional support and resources based on the individual's needs and preferences.

NA: The organization does not provide crisis call services.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Crisis call services operating procedures	

Site Visit Evidence

*

- Coverage schedules for the previous six months

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
- Observe call service operations including the backup answering and dispatch system and documentation system

CRI 5.01 (FP)

Crisis call services operate 24 hours a day, seven days a week, 365 days a year.

CRI 5.02 (FP)

A live back-up answering service, or equivalent mechanism, is used when all incoming lines are busy.

CRI 5.03 (FP)

When individuals need emergency response services, the organization:

a. requests emergency response services without disconnecting callers;
b. takes steps to ensure contact was made; and
c. has procedures outlining what to do when emergency services are unable to contact the individual and how to document when personnel are unable to confirm if contact was made.

Examples: *Steps to ensure contact was made may include: (1) remaining on the line with the individual until help arrives; (2) contacting emergency service providers or mobile crisis staff; or (3) contacting the individual's formal or informal supports when possible and appropriate.*

CRI 5.04 (FP)

When a third party contacts a crisis call service to report that another individual is at imminent risk of suicide, crisis intervention personnel:

a. request information on the individual's risk status, the third party's relationship to the individual, and how to contact both the caller and the individual;
b. offer to facilitate a three-way contact with the caller and the individual to attempt to intervene with the individual directly when appropriate; and
c. assist the third party in taking action to reduce risk.

Examples: *Regarding element (c), methods to reduce risk can include removing access to lethal means and/or remaining with the individual until they can receive assistance.*

Crisis Response and Information Services

CRI 6: Mobile Crisis Response Services

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Qualified mobile crisis response teams provide immediate family- or person-centered interventions in the homes and communities of persons served during and following a crisis.

NA: The organization does not provide mobile crisis response services.

Rating Indicators:

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

• Procedures for delivering mobile crisis response services	

Site Visit Evidence

- Response time data for the previous 6 months
- Copies of agreements with cooperating service providers, as applicable
- Community resource and referral list

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant staff
    3. Persons served
- Review case records

CRI 6.01 (FP)

Mobile crisis response services provide a timely, in-person response to the location of the crisis, typically within one hour from the time of the request.

Interpretation: *COA Accreditation recognizes that there may be instances where response times exceed one hour, particularly in rural and frontier communities. Additionally, while an immediate, in-person response is considered best practice, some organizations may utilize telehealth and other technologies in collaboration with law enforcement to deliver faster responses to individuals in crisis until the mobile crisis response team can arrive.*

At the request of the person(s) served, the mobile crisis response team may schedule a response within 1-24 hours for needs the person identifies as non-emergent.

CRI 6.02 (FP)

Mobile crisis response teams:

a. respond in person in teams of two; and

b. include a clinician who is qualified by license or training in accordance with law and regulation to conduct clinical assessments, either on the in-person response team or immediately available via a telehealth platform.

Interpretation: *The mobile crisis response team may be comprised of two individuals with lived experience responding in person.*

Examples: *Working in teams of two helps ensure the safety of the team members and individuals served, reduces the chances of law enforcement involvement, and is less likely to overwhelm individuals in crisis. Mobile crisis response teams can be comprised of clinical mental health professionals such as social workers, licensed professional counselors, nurses, and psychiatrists, as well as individuals with lived experience.*

CRI 6.03

Mobile crisis response services provide specialized services for children, youth, young adults, and families by:

a. responding to a crisis as defined by the parent, caregiver, or youth;
b. establishing partnerships with schools, child welfare agencies, legal systems, and other child-serving services;
c. employing individuals who have specific training, credentials, and/or lived experience related to child and adolescent behavioral health;
d. providing or connecting to ongoing stabilization services, if needed; and
e. making a concerted effort to ensure that youth remain in their home when safe and appropriate, and only recommend or coordinate out-of-home placement or hospitalization when necessary to ensure the safety and well-being of the youth and their family.

NA: The organization does not provide mobile crisis response services to children and youth.

Examples: *Regarding element (d), some models, such as the MRSS model, provide in-home stabilization services for youth and families for up to eight weeks. In-home stabilization services may include components such as safety monitoring, caregiver education programs, family therapy, peer support, systems navigation, care coordination, and communication, conflict management, and coping skill-building. In-home stabilization services for children are considered the ideal, least restrictive intervention that offers services to both youth and caretakers without disrupting the youth's placement; however, clinical personnel may determine that stabilization in a facility-based setting is in the youth's best interest.*

CRI 6.04

Mobile crisis response services arrange for appropriate post-intervention support and follow-up provided directly and/or by referral.

Examples: *Mobile crisis response services may provide post-intervention support and follow-up in several ways, including but not limited to (1) reviewing options for continued behavioral health support and social service resources including those designed for specific populations as appropriate, such as veterans and LGBTQ individuals; (2) providing continued, short-term clinical interventions in the individual's home or community; (3) coordinating warm-handoffs to ongoing facility-based care within the least restrictive setting as determined by a professional, clinical assessment; and (4) offering brief, telephonic or in-person check-ins to ensure that the individual has successfully transitioned to the appropriate level of care.*

Crisis Response and Information Services

CRI 7: Crisis Receiving and Stabilization Services

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Crisis receiving and stabilization services offer immediate access to crisis observation, monitoring, and short-term counseling delivered by a qualified team in a facility-based setting.

NA: The organization does not operate a crisis receiving and stabilization service.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Procedures for delivering crisis stabilization services	
*	• Scheduling criteria	

Site Visit Evidence

*

- Coverage schedules for the previous 6 months

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant staff
    3. Persons served
- Review case records
- Observe Facility

CRI 7.01 (FP)

Individuals in crisis are accepted on a 24-hour basis without undue delays or barriers.

CRI 7.02

A collaborative, multidisciplinary team with expertise related to the populations served is available 24 hours a day, seven days a week, and includes:

a. a prescribing practitioner who provides medication management;
b. clinicians qualified by license or training in accordance with law and regulation to conduct clinical assessments;
c. a qualified medical practitioner readily available to conduct an initial health screening; and
d. staff with lived experience to provide peer support.

Interpretation: *Prescribing practitioners could include psychiatrists, psychiatric nurse practitioners, or physician assistants and may provide services as an employee, contractor, or through another formal arrangement either in-person or using telehealth platforms. There may be more than one psychiatrist providing coverage.*

Interpretation: *Qualified medical practitioner refers to a licensed physician, registered nurse, nurse practitioner, physician's assistant, or other healthcare professional who is permitted by law and the organization to provide medical care and services without direction or supervision.*

If the organization does not have a qualified medical practitioner on staff, it should research community resources and consider creating a formal arrangement or a memorandum of understanding (MOU) with a local physicians group, local health department, federally-qualified health center, urgent care clinic, community-based health clinic, or telehealth providers.

Interpretation: *When providing services for children and youth, personnel should have appropriate pediatric and adolescent clinical expertise.*

CRI 7.03

The organization ensures access to needed healthcare services by:

a. conducting an initial health screening for all individuals upon intake to identify the need for immediate medical care and assess for communicable diseases;
b. providing continued monitoring and medication management;

c. providing or arranging for specialized health services to meet the needs of the service population, as appropriate; and
d. transferring individuals to a hospital or another appropriate setting if their needs cannot be met.

Interpretation: *The crisis stabilization unit is responsible for transferring individuals to a higher level of care when there is a medical need identified and does not shift the responsibility back to the referral source, such as law enforcement or a mobile crisis unit, if applicable.*

Examples: *Conditions that require immediate or prompt medical attention include but are not limited to (1) signs of abuse or neglect; (2) serious or accidental injury; (3) signs of infection or communicable diseases; (4) hygiene or nutritional problems; (5) pregnancy; and (6) significant developmental or mental health disturbances.*

Examples: *Specialized health services may be needed by older adults, pregnant and parenting individuals, individuals with eating disorders, individuals with substance-use-related conditions, or children with autism and pervasive developmental disorders. These services may include, for example: (1) tobacco cessation programs; (2) fetal alcohol syndrome screening; (3) speech, language, and occupational therapy; (4) prenatal care, well-baby care, and help accessing child and infant health insurance programs; (5) gender identity counseling; and (6) screening for the onset or existence of common cancers.*

CRI 7.04 (FP)

The organization ensures appropriate care and supervision by providing:

a. ratios of direct care workers to persons served for daytime and overnight hours that are appropriate to the program model, length of treatment, and risks and needs of persons served;
b. enough additional personnel on-site that are qualified to meet special needs during busy/stressful periods, respond to emergencies, and carry out the organization's emergency response plan; and
c. rotating after-hours and holiday coverage when needed.

Interpretation: *The organization must demonstrate that based on their program model and the population served, their staffing ratios for daytime and overnight coverage are sufficient to maintain safety, address potential risks, and meet the clinical, developmental, and age-related needs of persons served.*

CRI 7.05

To the extent possible and appropriate, families are provided with opportunities to:

a. be involved in the care and treatment of the person served; and
b. receive information, support services, and/or psychoeducation.

Examples: *In addition to formal involvement in admission, assessment, service planning, service delivery, and aftercare planning, families can be actively involved in day-to-day issues and decision-making. For example, families of children and youth can: (1) provide input regarding what strategies may or may not work with their child; and (2) be kept up to date on their child's daily appointments and activities.*

Examples: *The organization can minimize barriers to family involvement by (1) providing written information regarding the family's role in services and the organization's procedures regarding family contact; (2) allowing participation by phone or video conference; (3) assisting with arranging transportation, as needed and to the extent possible; and (4) providing or arranging services for family members in the family's home and community, as needed and to the extent possible.*

CRI 7.06

The organization describes:

a. personal items individuals may keep with them, consistent with a safe, therapeutic setting;

b. items that are discouraged or prohibited; and
c. any safety procedures the program follows, or consequences that can result, when prohibited items are brought to the program site.

CRI 7.07

The organization establishes a daily routine that:

a. provides predictability, stability, and structure;
b. is clearly communicated to persons served, including advanced posting of schedules for structured and supervised activities; and
c. offers flexibility to support the individualized program and needs of each person served.

NA: The organization provides services for 23 hours or less.

CRI 7.08

Therapeutic and educational interventions or activities are designed to address the individual's immediate behavioral health needs including:

a. managing social, emotional, and behavioral challenges;
b. developing and utilizing healthy and effective coping and self-regulation strategies;
c. improving functioning; and
d. promoting healing and well-being.

Interpretation: *The specific areas targeted, and skills developed, will vary based on the needs of the population served.*

Examples: *Opportunities to participate in activities that promote healing and well-being may include (1) physical exercise; (2) mindfulness activities; (3) creative arts activities; (4) cultural enrichment activities, (5) time outdoors, or (6) religious observances in a faith or spirituality of choice.*

CRI 7.09

When individuals have experienced trauma, they are engaged in crisis stabilization services that are designed to help them:

a. maximize their sense of safety;
b. understand the connection between past experiences and current functioning; and
c. identify, anticipate, and manage their responses to trauma reminders.

CRI 7.10

The organization ensures an orderly, thorough discharge process by:

a. preparing for discharge upon intake;
b. involving all relevant members of the multidisciplinary team, persons served, and others, as appropriate to the needs and preferences of the individual;
c. providing individuals and families with a comprehensive discharge plan; and
d. notifying any collaborating service providers, as appropriate.

Interpretation: *Discharge plans should include, at a minimum: (1) pertinent contact information for service providers; (2) emergency contact numbers; (3) safety plans; (4) details of any follow-up appointments, and (5) a comprehensive list of currently prescribed medications.*

Crisis Response and Information Services

CRI 8: Crisis Receiving and Stabilization Facilities

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

Crisis receiving and stabilization facilities contribute to a physically and psychologically safe, healthy, homelike, non-institutional, therapeutic, and trauma-informed environment.

NA: The organization does not operate a crisis receiving and stabilization service.

Rating Indicators:

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

No Self Study Evidence

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served

- Observe facilities and outdoor area/grounds

CRI 8.01

Facilities meet individuals' needs by providing the space, supplies, and equipment needed to accommodate:

a. provision of on-site services, including therapeutic, educational, and medical services as needed;
b. separate spaces for serving families with children if applicable;
c. private telephone conversations with families and friends;
d. recreational and enrichment activities that support well-being;
e. quiet activities, including space specifically designed to encourage comfort, self-soothing, self-reflection, and emotional self-management; and
f. access to the outdoors.

CRI 8.02

Crisis receiving and stabilization facilities provide:

a. adequate space, supplies, and equipment for food preparation, housekeeping, laundry, maintenance, storage, and administrative support;
b. access to a telephone, computer, and the internet, as permitted, for use by personnel and persons served;
c. attractively furnished areas with a separate bed for each individual, including a clean, comfortable, covered mattress, pillow, sufficient linens, and blankets when stays last longer than 24 hours;
d. a safe place such as a locker to keep personal belongings and valuables;
e. at least one room suitably furnished for the use of on-duty personnel;?and
f. private sleeping accommodations for personnel who sleep at the facility, if applicable.

Interpretation: *In regards to element (c), programs that limit stays to 23 hours or less may utilize chairs or recliners instead of beds to create a more home-like environment as well as provide increased capacity.*

CRI 8.03

The organization creates a calming and healing physical environment by:

a. ensuring the program setting is clean, organized, and maintained in good condition;
b. using furniture, artwork, lighting, and acoustics to make living areas inviting, comfortable, calming, and reflective of the interests and diversity of persons served;?and
c. designing the program space to minimize disruption to the extent possible.

Examples: *Organizations can minimize disruption by, for example: (1) decreasing the use of overhead paging systems and (2) establishing routes that minimize unnecessary traffic through resting areas.*

Crisis Response and Information Services

CRI 9: Community Connections and Coordination

Purpose

Crisis Response and Information Services operate as part of the community's crisis response system to provide prompt responses and reliable information to promote safety and stability for individuals and families in crisis and avoid unnecessary emergency department visits, psychiatric hospitalizations, law enforcement involvement, and out-of-home placements.

The organization establishes formal agreements with members of the community's crisis response system, and procedures for service coordination in crisis situations.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

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- Documentation is routinely incomplete and/or missing.

Table of Evidence

Self Study Evidence

*	• Service coordination procedures	
*	• Procedures for evaluating referral resources	
*	• Procedures for collecting, summarizing, and responding to community needs	

Site Visit Evidence

*

- Written service agreements
- List of non-clinical community partners
- Community resource and referral list
- Most recent summary of community needs with plans for corrective action identified, if applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
    4. Community partners

CRI 9.01

To ensure rapid and efficient access, the organization establishes procedures for working with emergency responders including:

a. law enforcement and fire departments;
b. hospital emergency rooms;
c. mental and physical health crisis teams; and
d. child and adult protective services.

CRI 9.02

Procedures for working with law enforcement ensure that:

a. crisis responses occur without law enforcement involvement unless a specific, immediate safety concern is identified such as violence, threats of violence, or possession of a weapon;
b. officers with Crisis Intervention Team (CIT) or other specialized behavioral health training are requested and dispatched whenever possible;
c. law enforcement officials understand how to contact crisis services for assistance; and
d. organizational leadership and law enforcement partners communicate regularly to monitor role clarity and quality improvement efforts.

NA: The organization utilizes a police co-responder intervention model embedded in a police department.

Examples: *The organization may offer a dedicated first responder drop-off area within their facility to build trust with, and ease the burden on, law enforcement or responders who may otherwise choose to transport an individual experiencing a crisis to a more restrictive setting such as a hospital or jail.*

CRI 9.03

The organization has formal arrangements with local social service, mental health, and medical resources to facilitate referrals and service coordination and ensure rapid or priority access to services.

Examples: *The organization may collaborate with other service providers through (1) agency relationships; (2) Memorandums of Understanding (MOUs); (3) data sharing; (4) shared GPS-enabled communication systems; and/or (5) electronic bed registries.*

CRI 9.04

The organization seeks, develops, or maintains partnerships with non-clinical, supportive resources such as community organizations, social clubs, and faith communities to:

a. educate the public on how to access the organization's crisis services;

b. reduce stigma surrounding behavioral health treatment;
c. engage communities who have been historically underserved, mistreated, and/or harmed by emergency service providers; and
d. provide opportunities for continued support in addition to, or in place of, traditional mental health services.

CRI 9.05

The organization maintains, or has access to, a comprehensive and up-to-date list of community resources that includes:

a. name, location, and telephone number;
b. contact person;
c. services offered;
d. languages offered;
e. fee structure; and
f. eligibility requirements.

Interpretation: *The organization ensures the community resource list remains up-to-date by evaluating referral resources on an ongoing basis to assess the safety, quality, and availability of services provided.*

CRI 9.06

The organization collects and periodically summarizes data on community needs and available resources and makes summaries available to community partners or the public upon request.