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together

National Guidelines for Child and Youth Behavioral Health Crisis Care

SAMHSA
Substance Abuse and Mental Health Services Administration

National Guidelines for Child and Youth Behavioral Health Crisis Care

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Forward

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

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

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

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

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

This document captures recommendations from an expert children's crisis continuum workgroup, best practices identified in the research, and learnings from pioneering children's crisis response programs. It is not the final word—it is a beginning. With the implementation of 988, we will continue to learn better ways of engaging, serving, and supporting young people in crisis and their families. Together, we can build a crisis response system that both responds effectively to all youth in crisis *and* prevents emotional and behavioral health needs from escalating to crisis.

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

Executive Summary

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

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

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

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

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

SAMHSA strongly encourages youth crisis systems to:

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

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

1. Addressing Recovery Needs

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

Core Components of Child, Youth, and Family Crisis Response

SAMHSA recommends a broad conceptualization of crisis services as including three core components designed to meet the needs of a person in behavioral health crisis and include: 1. Someone to talk to; 2. Someone to respond onsite, if the situation cannot be resolved through the crisis call center; and 3. Somewhere to go if the situation is better addressed with facility-based staffing, security, and resources.

While this framework was developed for adults in crisis, SAMHSA envisions a similar three-component design for child- and family-serving crisis services:

Someone to Talk To: Crisis Call Centers. Operating 24/7/365, crisis call centers should offer developmentally appropriate assessment, sensitive de-escalation supports, and connections to ongoing care, when needed. Staff should include clinicians, family and youth peer support providers, and other team members with specialized training to respond to youth and families.

Someone to Respond: Mobile Response Teams. Mobile crisis teams go where they are needed to respond to crises—whether in children's homes, their schools, or their communities. They should provide immediate supports, safety planning, and follow-up with qualified crisis responders, including family and youth peer support providers. They should prioritize keeping youth in their homes if it is safe to do so.

A Safe Place to Be: Crisis Receiving and Stabilization Services. Stabilization supports for youth and families can include in-home services delivered over several weeks. When appropriate for the needs of the youth, supports can also include developmentally appropriate, trauma-informed care provided in crisis care facilities, emergency departments, and hospital settings.

Integrating Systems of Care Approach in Serving Children, Youth, and Families in Crisis

The youth crisis continuum should be rooted in the System of Care framework. Services should be family-driven, youth-guided, and culturally and linguistically responsive (Stroul et al., 2021). Agencies should coordinate and collaborate across systems to provide individualized care for youth and families, emphasizing services in the home or community. To achieve this, crisis response systems should partner with agencies across the continuum of care, including schools, family and peer support, community organizations, child welfare and foster care, juvenile justice, and pediatricians and other primary care providers.

Special Populations and Settings

All youth and families should have access to crisis care that meets their needs, and these needs vary across communities and groups. Crisis care providers should be trained to recognize and respond to the needs of a great diversity of youth. This group includes infants and young children; transition-age youth; racial and ethnic minority youth, including youth in Tribal communities; lesbian, gay, bisexual, transgender, queer,

intersex, and other sexual and gender minority (LGBTQI+) youth; youth who are immigrants or refugees; youth experiencing homelessness; and youth with intellectual or developmental disabilities, among other important service populations. All crisis response systems should engage diverse clinicians and peers who reflect the diverse communities they serve. Crisis care providers in communities with large non-English speaking populations will need to recruit multi-lingual and multi-cultural staff and have the appropriate policies and sensitivities that are relevant to the needs of youth who may be undocumented. Crisis care providers in rural areas will need to strategically engage natural supports in the community to create a crisis response workforce that can cover large geographic areas. Telehealth services may be used as a service and support alternative as appropriate.

Introduction

The transition to the 988 Suicide and Crisis Lifeline in July 2022 is an unprecedented opportunity to expand behavioral health crisis systems nationwide. In 2020, Congress enacted laws to establish 988, a universal three-digit number to help people who are in suicidal, mental health, or substance use crisis (Public Law, 2018). People who call or text 988 or chat via 988lifeline.org are connected to the Suicide and Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline), which currently consists of more than 200 crisis centers that operate 24 hours a day, seven days a week (Our Crisis Centers, n.d.).

The transition to 988 has already resulted in an increase in the number of calls that are routed through the Lifeline network. However, many states and communities do not have staffing or services in place to provide timely, appropriate crisis response for youth. This need is especially acute in rural and frontier regions. Even in more populated areas, youth in crisis may experience days or weeks of hospital boarding or be transported hundreds of miles away to an in-patient facility (Mental Health Oversight and Accountability Commission, 2016).

The *National Guidelines for Child and Youth Behavioral Health Crisis Care* provides a roadmap that can be used to truly make a positive impact in the lives of children, youth, young adults, and families in communities across America.

About this Document

The main purpose of the *National Guidelines for Child and Youth Behavioral Health Crisis Care* is to offer best practices, implementation strategies, and practical guidance. Although there is some discussion of research findings and statistics, this is not a research document. This document does include both research-based guidance and learnings shared by SAMHSA's Children's Crisis Continuum expert panel (2021).

This document is intended to be a starting point for building a 988 crisis system that supports youth and families effectively. It builds on previous SAMHSA guidance, including the following key publications, as well as recommendations from the expert panel. It **complements, not replaces,** SAMHSA's previous work.

- National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit, released in 2021 by SAMHSA
- Crisis Services: Meeting Needs, Saving Lives, released in 2021. Included SAMHSA's *Best Practice Toolkit* and articles by the National Association of State Mental Health Project Directors (NASMHPD)
- Ready to Respond: Mental Health Beyond Crisis and COVID-19, released in 2021. Collection of 10 crisis response briefs developed by NASMHPD in response to the pandemic

Language and Terminology

The language we use to talk about behavioral health shapes how we think about behavioral health. Some terms that are acceptable today may be considered stigmatizing in the future. Throughout this document, we have tried to use recovery-oriented language that promotes acceptance and person-centered support.

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

"Youth" and "young people" are used throughout this document to describe children, youth, and young adults of transition age who are still involved in youth-serving systems.

"Families" is meant inclusively. It refers to all individuals with caregiving responsibility for a young person, including parents, stepparents, guardians, foster families, grandfamilies or kinship families, or other caregivers (Generations United, n.d.). In some contexts, it refers to others in the home who may be impacted by a young person's crisis (such as siblings).

Youth Crisis in Context

In the past year, President Biden, U.S. Surgeon General Vivek Murthy, and a collective comprised of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association have all called attention to urgent youth mental health needs (Biden, 2022; Office of the Surgeon General, 2021; American Academy of Pediatrics, 2019).

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

Although the national rise is alarming on its own, some historically underserved youth populations are disproportionately burdened by behavioral health crisis. For example, non-Hispanic American Indian or Alaskan Native (AI/AN) children have the highest rate of suicide. LGBTQ high school students attempt suicide at a rate approximately four times greater than non-LGBTQ youth (Johns et al., 2020). Suicide attempts among Black youth are rising faster than among any other racial or ethnic group, and Black children under age 13 are twice as likely to die by suicide as their White peers (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Lindsey et al., 2019).

Traditional Youth Crisis Response System

In the past—and in most areas of the U.S. today—youth in crisis have often become involved in systems that may cause harm instead of providing appropriate support. **There is an urgent need to expand and promote a comprehensive, trauma-informed, customized crisis continuum for youth and families.**

Emergency Departments and Hospitalization

When youth are experiencing a behavioral health crisis, or when an adult believes them to be in crisis, the young person is often taken to an emergency department (ED). Nationwide, pediatric behavioral health ED visits have increased dramatically in recent years, particularly for youth with Medicaid or no health insurance (Bostic & Hoover, 2020; Lo et al., 2020).

After initial assessment, youth will typically stay in the ED or be transferred to an in-patient medical unit until a "bed" becomes available at an in-patient psychiatric facility. This process is referred to as "boarding," and it may last for hours, days, or (in extreme cases) weeks (Hazen & Prager, 2017; McEnany et al., 2020). Pediatric psychiatric ED boarding has been described as a national crisis, and it has worsened during the pandemic (Cutler et al., 2022).

There are many reasons why it is not ideal for youth to visit the ED or be boarded when they are in crisis. Examples include (Bostic & Hoover, 2020):

- Youth in the ED may experience seclusion; physical restraint; and environments that are crowded, loud, and potentially frightening.

- ED staff may not be trained to respond to youth crisis, and youth generally do not receive mental health treatment when boarded.
- Many youth are brought to the ED repeatedly for costly crisis visits, rather than transitioning to ongoing care and community-based alternatives.

There are also important racial and ethnic disparities related to ED boarding. Youth visits to the ED for psychiatric reasons are rising most quickly for Black and Hispanic or Latino youth (Kalb et al., 2019). In a study of more than half a million youth who were physically restrained in the ED, Black youth were almost twice as likely as White youth to be restrained (Nash et al., 2021).

Justice System

Youth in crisis also frequently interact with law enforcement officers, either because the officers are first responders for 911 calls or because they are where youth are (e.g., school resource officers). Although youth-focused Crisis Intervention Training (CIT) and similar programs for police are increasingly widespread, many law enforcement officers are not adequately trained or resourced to respond effectively to youth in behavioral health crisis (Bunts, 2021; Kubiak et al., 2018).

Police involvement in crisis situations can provoke fear, anxiety, and trauma response or re-traumatization, particularly among Black, Indigenous, and other People of Color (BIPOC) youth and families and those in low-income, segregated communities (Baker & Pillinger, 2019; Feldman et al., 2019). For example, Black and Hispanic or Latino communities are significantly more likely than Whites to experience police violence, police-involved deaths, and incarceration. Asian American or Pacific Islander and Hispanic or Latino youth are more likely than other young people to have undocumented legal status or to have family members with undocumented status. These youth and families may experience fear of or past trauma from arrest, incarceration, or deportation. (Snowden et al., 2008; Delva et al., 2013). Having these experiences, having loved ones with these experiences, or worrying about these experiences can create significant psychological distress (Graham et al., 2020).

LGBTQ individuals have also experienced discrimination, harassment, and profiling by law enforcement, which weakens community trust (Mallory et al., 2015). LGBTQ youth are overrepresented in the justice system, especially LGBTQ girls and LGBTQ youth of color (Wilson et al., 2017; Jones, 2021). They are more likely than non-LGBTQ youth to experience family rejection and homelessness, so they are disproportionately likely to be jailed for running away and they lack resources when they are released (Center for American Progress, 2016).

Police presence in schools has nearly doubled over the last two decades, and students experiencing mental health challenges (especially students of color) are disproportionately subjected to school discipline, arrest, and incarceration (Choi et al., 2021; Irvine, 2010). LGBTQ youth are overrepresented in the justice system, especially LGBTQ girls and LGBTQ youth of color (Wilson et al., 2017; Jones, 2021). In schools, the management of disruptive behavior in classrooms too often results in arrest of Black youth, compared to other strategies that are applied for non-Black youth. This contributes to early juvenile and eventual criminal justice system involvement due to an accumulation of justice system interactions, which exacerbates school-to-prison pipeline (Nance, 2016). Black youth are at higher risk of being detained or committed in juvenile facilities (Rovner, 2021). They are also at higher risk of being tried and sentenced as adults (Thomas, 2018). LGBTQ youth also experience a school-to-prison pipeline, receiving disproportionate punishments for activities such as violating gender norms (e.g., dress codes), engaging in

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

Core Youth Crisis Services

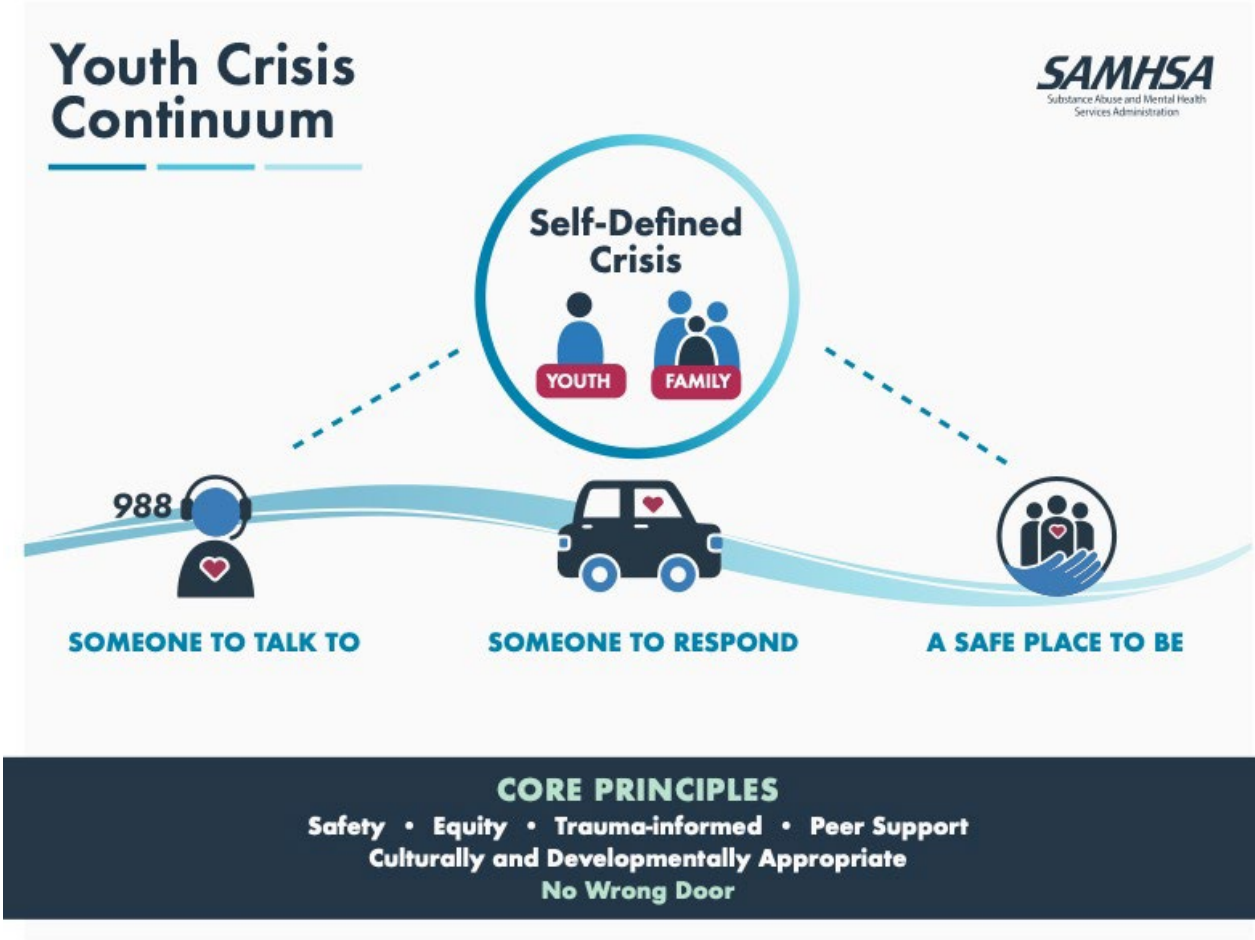
SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* described three core services as essential to a comprehensive crisis response system. This crisis response system should include having "someone to talk to" when a person is experiencing crisis; and if that does not resolve the crisis, having "someone to respond" in their home or community; and if that does not resolve the crisis, having "a safe place to be" for de-escalation and stabilization.

These three components comprise a **stepped care system** in which families receive the most effective, yet least restrictive and least resource-intensive, services they need. In other words, many calls, chats, and texts can be resolved simply by talking with the 988 call responders. Of those that remain, many can be resolved with the mobile crisis team.

1. ***Someone to Talk To*** **– Regional Crisis Call Center**: A toll-free, single-point-of-access line, operating 24/7 and staffed by individuals with child and adolescent behavioral health expertise. This includes the 988 Suicide and Crisis Lifeline network as well as other local and statewide crisis call centers.
2. ***Someone to Respond*** **– Crisis Mobile Team Response**: Mobile crisis teams that respond 24/7 to homes, schools, primary care settings, or any other location of the young person in crisis. Mobile crisis teams are made up of behavioral health practitioners, e.g., social workers, psychologists and psychiatrists, paraprofessional crisis stabilizers, and peer support providers.
3. ***A Safe Place to Be*** **– Crisis Receiving and Stabilization Services**: Facilities operating 24/7 to provide short-term de-escalation and care for youth who have crisis needs beyond what the mobile team can provide. Stabilization services may also include ongoing, in-home interventions that are delivered over a period of several weeks.

Crisis receiving services may also include emergency departments and inpatient hospitalization. However, in many situations, hospitals are not an ideal situation for youth in crisis, because of the reasons discussed above in Emergency Departments and Hospitalization. SAMHSA strongly advises that, unless safety is an immediate or imminent concern, crisis response systems be designed to provide safe and effective alternatives to hospitalization, and that emergency departments and hospitals only be used as a last resort.

Services will vary in each community. For example, some regions have a single mobile response team service that operates throughout the county or state, while more populated areas may have multiple teams in the same geographic area.



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

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

Someone to Talk To – Crisis Call Hub Services

In July 2022, the National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline, which includes call, text, and chat points of access through the more than 200 crisis call centers operated by the Lifeline nationwide. Creating a single point of access makes it easier for people to obtain behavioral health-focused crisis services (Manley et al., 2018).

Crisis call centers provide developmentally appropriate, brief screening and intervention via telephone call, text, and chat. Contact centers should be staffed by clinical and paraprofessional behavioral health staff that have specialized training to meet the needs of youth, including licensed behavioral health professionals and family and youth peers.

Expectations and Best Practices

The following are suggested strategies for ensuring that crisis center services are responsive to youth and families. This guidance includes best practices identified in the literature, learnings from communities that have implemented crisis response systems, and guidance from SAMHSA's Children's Crisis Continuum expert panel.

Essential Operations

- Operate every moment of every day (24/7/365). Be staffed to answer every contact from youth and families, as well as from agencies and organizations that serve these populations (e.g., schools). If resources are not available to support this, coordinate overflow coverage with another youth- and family-trained crisis center (SAMHSA, 2020a).
- Have protocols and resources in place to quickly access translation services, and TTY (teletypewriter) for those who are deaf or hard of hearing. Have sufficient capacity and oral fluency in languages that match the community need.
- Gather data on call volume, response time, user satisfaction, and outcomes to inform a continuous quality improvement process, which should include regular review of call data to identify and address disparities, identify service gaps, and determine training needs (Vincent & Viljoen, 2020).

Technology

- Incorporate Caller ID functioning (SAMHSA, 2020a).
- Implement GPS-enabled technology in collaboration with partner crisis mobile teams to dispatch care more efficiently (SAMHSA, 2020a).
- Build technological capacity to incorporate texting, chat, and video. Recent research has shown that telehealth might improve help-seeking behavior for youth, and some youth report texting is their preferred method of communication (Evans et al., 2013; Kauer et al., 2014).
- Utilize real-time regional bed registry technologies that integrate information about which facilities have openings for youth (SAMHSA, 2020a). (Recognize, however, that most users will not need inpatient services.)

Note about Bed Registries

Bed registries are online databases that show current availability at behavioral health inpatient settings. "Bed" is defined by the state or locality and can include "public and private psychiatric hospitals, psychiatric units in general hospitals, crisis stabilization units (short and long term), crisis respite centers, residential settings, social detox centers, and recovery homes." Bed registries reduce ED boarding and streamline referrals (Morrissette, 2021). Improving Access to Behavioral Health Crisis Services with

Electronic Bed Registries from NASMHPD provides useful examples of states that include information about youth-specific settings and services.

Staffing and Training

- Staff crisis call centers with an interdisciplinary team of child and adolescent behavioral health clinicians, family and youth peers, and other trained team members (SAMHSA, 2020a). As much as possible, hire staff whose racial, ethnic, linguistic, and sexual orientation or gender identities are representative of the communities served.
- Ensure all responders receive relevant training on developmentally appropriate supports and services available in the region or community. Other important training topics may include:
    - De-escalation strategies that are specific to youth and families, including how to navigate family systems and engage families as co-supporters (Bunts, 2021; Bostic & Hoover, 2020).
    - Mandatory reporting requirements in cases of child abuse and neglect, including how to respond to youth and families describing abuse or neglect, how to assess for the child's immediate safety, and when and how to make a report (Cash et al., 2020).
    - Typical developmental milestones, challenging behaviors, and youth-specific signs and symptoms of behavioral health challenges. Training should focus on how these issues may present during a crisis call specifically (see Table 1 in "Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm," Bostic & Hoover, 2020).
    - Conducting safety planning and strengths-based caller engagement with youth and families (Bostic & Hoover, 2020).
    - Promoting positive behavioral health, positive childhood experiences, and resiliency (Health Outcomes from Positive Experiences, n.d.).
    - Bias, racism, cultural responsiveness, and LGBTQI+ affirming care, especially on how these issues manifest in crisis management and response (e.g., use of preferred pronouns; addressing culturally relevant fears around the potential involvement of police, child protective services, or immigration services) (Bunts, 2021).
    - Stressors and concerns that are important to youth, such as issues related to school, peer rejection, romantic breakups, and bullying (Bostic & Hoover, 2020).
    - Adverse Childhood Experiences (ACEs); trauma and trauma-informed care; and the social drivers of health, also known as social determinants of health (Administration for Children and Families, n.d.; Bruner, 2017, Settipani, 2018).

Providing Services

- Assess for risk of self-harm or suicide in a manner that meets Lifeline Suicide Risk Assessment Standards and assess for risk of harm to others. Use developmentally appropriate tools and protocols (SAMHSA, 2020a).
- The *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* also directs Lifeline crisis center staff to adhere to the Lifeline's Imminent Risk of Suicide model (SAMHSA, 2020a).

- If needed, coordinate connections to mobile crisis response teams and crisis facilities that offer developmentally appropriate services. Provide warm hand-offs and coordinate transportation as needed (SAMHSA, 2020a).
- With the family's permission, schedule home- and community-based follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode, in collaboration with the mobile response team (SAMHSA, 2020a).

Youth Crisis Response Case Example: Sally, Age 7

Fictitious names and the vignette are adapted from Bostic, J., Hoover, S. (2020). Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm.

Sally has not gone to or stayed at school since the beginning of the school year, typically screaming and crying when approaching the school. Today, she screamed and bit at a teacher, and the school told Sally's parents they will have to report her as habitually truant if she is unable to attend school regularly. Sally's parent, John, texts 988.

The 988 responder begins by asking questions to assess Sally's imminent risk of harm to herself or others and to clarify Sally's safety in other ways (e.g., whether there are specific people at school whom Sally is frightened of). The 988 responder explores what John's reasons or goals are for calling now. John's fear is that the police or child protective services will be called if Sally is reported as truant, and that she and her siblings may all be taken from the home. The 988 responder offers de-escalation strategies (e.g., playing music to distract Sally while driving to school) and consultation with the mobile crisis team. The mobile crisis team has an initial phone call to allay John's fears of being reported to the police or child protective services. The mobile crisis team arrives at Sally's home and works with John to further de-escalate the crisis, find solutions, and create an action plan (e.g., having Sally enroll in virtual schooling temporarily, accessing community-based care if Sally continues to experience anxiety about leaving home).

Someone to Respond – Mobile Crisis Team Services

Mobile crisis teams or mobile response teams support families wherever the crisis is taking place in the community. Youth and families may request mobile crisis services themselves, although youth-serving systems (e.g., schools) frequently make these requests as well. Mobile response teams support de-escalation, assessment, education and coping skills, safety planning, identification of next steps, referrals to additional care (as needed), transitions to crisis stabilization or hospital settings (as needed), and follow-up.

988 is one route to access support from mobile crisis teams. Mobile response teams may also be dispatched after a call directly to the mobile service; a call to another local crisis contact line; or through coordination with 911, law enforcement, or hospital systems.

There are many mobile crisis response teams that do not currently have partnerships in place with Lifeline centers. As noted elsewhere, all 988 calls are routed to Lifeline centers. Establishing connections between mobile response teams and Lifeline centers is an important component of building a system to support 988 (McKeon, 2021).

Mobile response teams include professional and paraprofessional staff such as mental health counselors, crisis intervention specialists, social workers, nurses, trained youth or family peer support providers, and psychologists. Response from mobile response units is typically in teams of two; however, this may differ if the team is dispatched from a staffed facility or if, as in rural or frontier communities, telehealth services are utilized.

Important Note

Youth crisis services are centered on de-escalation and stabilization **within the home and community.** This is an important priority for all crisis services and is especially important for youth. If it is safe for the young person and their family, **every effort should be made to help them stay in their current living environment,** with family or other natural supporters actively participating in the young person's care and stabilization.

Expectations and Best Practices

Many states and localities have implemented successful mobile response teams for youth. This section integrates community-defined evidence as well as best practices from the literature.

Essential Operations

- Respond to crises on location in home- and community-based settings, including schools and post-secondary institutions, recreational centers, homeless shelters, and other community centers (SAMHSA, 2020a).
- Implement real-time GPS technology in partnership with the region's crisis center hub (SAMHSA, 2020a).
- Be available to respond quickly to crises. Arriving onsite within one hour of dispatch is the general standard most mobile crisis teams follow. For mobile response systems covering a large geographic area, there may need to be multiple provider teams at different locations. Considerations for rural and frontier communities are discussed in the Rural and Frontier Communities section.

Staffing and Training

- Have access to a licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with youth populations. The clinician may be onsite, or they may consult over the phone or through video (Bostic & Hoover, 2020; SAMHSA, 2020a).
- Incorporate youth and family peers within the response team (SAMHSA, 2020a).
- Respond without law enforcement accompaniment unless special circumstances warrant their inclusion. Safe reduction of unnecessary police involvement is critical for youth of color, who are more likely than their White peers to face harsh consequences like school exclusion and arrest (Bunts, 2021; Maryland State Department of Education, n.d.; McFadden, 2021; U.S. Commission

on Civil Rights, 2019). Additionally, avoiding unnecessary police engagement during a mental health crisis allows for more efficient use of scarce law enforcement resources.
- Provide staff training about how to describe mobile response services to youth, their caregivers, and other callers. The entire approach should be framed in terms of acceptance and help, never blaming youth or families. Situations which result in frequent calls for the same young person should be framed as special challenges that need to be addressed with action plans that support transition to community-based or wraparound services.

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

- Developmental tasks of childhood and adolescence
- Family relationships
- Child and youth engagement and motivation, including motivational interviewing
- Culturally responsive care
- Crisis intervention with LGBTQ youth
- Positive behavior support
- Crisis response protocol
- Assessing violence risk; using suicide assessment tools
- Crisis intervention for youth with developmental disabilities
- Child traumatic stress, trauma-informed care, Trauma Focused Cognitive Behavioral Therapy
- DSM 5 diagnostic categories (children and youth)
- Youth substance use
- Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT)
- Safety awareness considerations for working in the community
- Domestic violence and intimate partner violence
- Child abuse and reporting laws

Onsite Needs: Assessment Tools

Mobile response teams may use a standardized screening and assessment tool to help promote shared understanding across providers. Standardized tools are also intended to reduce the impacts of bias. Common tools include:

- Crisis Assessment Tool (CAT), a "decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis" (The John Praed Foundation, n.d.-a)
- Child and Adolescent Needs and Strengths (CANS), a tool developed for child-serving systems "to facilitate the linkage between the assessment process and the design of individualized service plans" (The John Praed Foundation, n.d.-b; Manley et al., 2018)
- The Child and Adolescent Service Intensity Instrument (CASII), "a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and his or her family" (American Academy of Child and Adolescent Psychiatry, n.d.; Manley et al., 2018)

- Columbia-Suicide Severity Rating Scale (C-SSRS) is an evidence-supported questionnaire used by numerous organizations to assess immediate risk of suicide, including by Lifeline centers.

Onsite Needs: De-escalation Strategies

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

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

Spotlight: Mobile Response and Stabilization Services (MRSS)

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

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

- The youth, family, or caregiver defines the crisis, and the MRSS responds 24/7 to meet their sense of urgency
- Single point of access and "no wrong door" approach
- The mobile response team is dispatched to provide services in person when available
- Responders support children and families in their natural environments
- Staffing does not rely on crisis responders from predominately adult-oriented systems
- MRSS partners with all child-serving systems
- Initial mobile response services may continue over a period of 72 hours, as needed
- Stabilization supports may continue for up to 8 weeks, as needed; e.g., in-home support, respite care, short-term care coordination

- Outcome data is tracked, reported, and used for quality improvement purposes

To learn more about MRSS, access Mobile Response & Stabilization (University of Maryland); Making The Case for a Comprehensive Children's Crisis Continuum of Care (Manley et al., 2018); or Ohio's Mobile Response Stabilization Service Tool Kit and Resource Guide V1.0.

Onsite Needs: Safety Planning

Creating a **crisis or suicide safety plan** is a key component of ensuring the young person's short-term safety and long-term stability. This should be a collaborative and strengths-based process that identifies and integrates their natural supports. SAMHSA describes safety planning in their *Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth* Evidence-based Resource Guide (SAMHSA, 2020b):

"Safety planning is a collaborative process in which an individual and provider work together to develop a personalized list of coping strategies the individual can use during times of increased suicide risk. Safety planning is brief, effective, and can be done by any health professional with training. **Safety planning should be universally available for youth at risk of suicide**." (p. 10)

"A safety plan is a prioritized list of coping strategies and sources of support that youth can use before or during a suicidal crisis and is often completed before starting treatment and/or during the first session. Safety plans are based on clear communication and a collaborative relationship between the client and provider…. Clinicians should collaborate with youth and their parents (if it is safe and appropriate to involve the family) at the beginning of a treatment program to develop a safety plan that is brief, in the youth's own words, and easy to read." (p. 34)

Examples include:

- The Stanley-Brown Safety Plan is a widely used, one-page, evidence-informed tool. There is also a series of brief training videos available that models each step in the plan, as well as an iOS-based Stanley-Brown Safety Plan mobile application ("app").
- The Parent/Professional Advocacy League (PPAL) and the Massachusetts Behavioral Health Partnership (MBHP) developed a set of three Crisis Planning tools to help families and youth prepare their essential information and preferences in advance of crisis.

Onsite and Post-Crisis Needs: Care Coordination and Follow-up

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

- Know the crisis and medical facilities in the region, and also the broader array of child and adolescent supports and services. These include local behavioral health providers, school-based supports, and other county and community resources (e.g., housing support) (Bostic & Hoover, 2020). Include resources and supports that are designed for specific communities, such as drop-in centers for LGBTQI+ youth.

- If needed for the young person's safety and stability, provide a warm hand-off to a crisis receiving and stabilization facility. In some instances, such as if the young person is in medical distress or in imminent risk of harming themselves or others, it may be necessary to transition to a hospital. In both cases, provide transportation as needed.
- Provide a warm hand-off for appointments with appropriate local providers for ongoing care after a crisis episode, if needed, with consent from the family.

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

Youth Crisis Response Case Example: Brandon, Age 15

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

Staff at a youth homeless shelter call the mobile crisis response team for 15-year-old Brandon, who has run away from home and has made comments that he does not care if he dies. Brandon has experienced recurring homelessness in the past with his mother, as well as abuse from men involved with his mother.

The mobile crisis worker works to build rapport by showing willingness to listen without interruption, empathizing, and providing opportunities for Brandon to take ownership of his decisions. Brandon shares that he would like to hurt his mother's boyfriend, but he is several states away and Brandon shows no interest in returning to where the boyfriend is, so the crisis worker considers Brandon to be at low risk of violence toward others. The crisis worker talks with Brandon to name and validate his feelings and to try to identify the precipitating event that provoked him to run away.

Together, the crisis worker and Brandon brainstorm possible solutions to his problem of not having a place to live (e.g., stay with an aunt), and develop a specific action plan with measurable and realistic steps (e.g., call the aunt). The final stage is follow-up. Brandon's aunt purchases a train ticket for him for the following day, and the crisis worker meets Brandon at the train station. They discuss Brandon's plans for the next 24 hours, and Brandon agrees that he will call or text the crisis worker when he arrives at his aunt's house or if there are problems when he arrives.

A Safe Place to Be – Crisis Receiving and Stabilization Services

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

Every community's emergency department should be equipped to address youth behavioral health in a developmentally appropriate, culturally responsive, and trauma-informed manner.

Crisis Receiving and Stabilization Service Types

Youth crisis services are centered on de-escalation and stabilization within the home and community. **This is an important priority for all crisis services, but it is especially important for youth.** Every effort should be made to maintain the young person in their current living environment, ideally with the active participation of family members and other natural supports.

However, there are times when the safest and best management of a situation involves inpatient care or out-of-home crisis stabilization. When young people receive out-of-home services, the priority should be to transition them back to home and to appropriate services in the community (as needed) as soon as it is safe to do so.

In this section, stabilization facilities are described first, because they are intended to support the young person's immediate safety in the initial hours or days after a crisis begins. This is followed by a description of in-home stabilization supports, which may be provided over a longer period of several weeks.

Crisis Receiving and Stabilization Facilities

There are several types of crisis facilities that can help youth when they have more intensive care and safety needs than can be met through home- and community-based services. Examples include crisis stabilization centers, 23-hour beds/observation units, respite care, walk-in services, and the Living Room Model (Saxon et al., 2018). Depending on the young person's needs, facilities can offer a safe environment and short-term care that effectively diverts youth from hospitalization, or they can function as a step-down service after hospitalization.

The shared goal of these services is to help youth return home and transition them to outpatient supports (if needed) as quickly as possible (SAMHSA, 2014a). Some residential settings, such as respite care facilities, are also intended to reduce strain on families and prevent longer-term out-of-home placements (Bruns & Burchard, 2000). Crisis stabilization facilities often have a small number of beds (e.g., 6-16), and they may operate in a residential, home-like setting (Saxon et al., 2018). They also typically have a maximum period of stay, ranging from less than a day (23-hour units) up to two or three weeks.

Sample services include assessment, rapid stabilization, observation, medication management, peer support, brief individual and family counseling, care coordination and service linkages, and discharge planning, among others. Facilities are often staffed by peer support providers and other crisis response paraprofessionals or professionals. Psychiatrists, psychiatric nurse practitioners, or physicians may provide supervision and medical consultation (Saxon et al., 2018).

In-Home Stabilization

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

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

Stabilization providers collaborate with the youth and family as active partners to develop goals that are integrated into a crisis plan of care. This involves identifying unmet needs, communication challenges, underlying concerns, individual strengths, and coping strategies. Importantly, services are provided to both the youth and their family. Too often, families have felt sidelined by service providers who focus exclusively on the young person, without sufficiently considering important family dynamics or the supports that family members need (Hepburn, 2022a).

Expectations and Best Practices

The following recommendations adapt and expand on the guidance provided in the *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit,* integrating best practices from the research literature, learnings from communities, and guidance from SAMHSA's Children's Crisis Continuum expert panel. Some of these guidelines are more relevant for facility-based crisis stabilization than in-home supports.

Essential Operations

- Accept all youth referrals, at least 90% of the time, with a "no rejection" policy for first responders. Offer walk-in and first responder drop-off options that accept youth (SAMHSA, 2020a).
- Offer developmentally appropriate services to address mental health and substance use crisis issues impacting youth.
- Do not require medical clearance prior to admission; instead, provide assessment and support for medical stability while in the program (SAMHSA, 2020a).
- Include beds within the real-time regional bed registry system, identifying how many beds are available for youth (see Note about Bed Registries).
- Collect data on crisis resolution, user satisfaction, and other outcomes, and review these data to develop quality improvement plans.

Staffing and Training

- Be staffed at all times with a multidisciplinary team with expertise in meeting the needs of youth, which may include: youth and family peer support providers; psychiatrists, psychiatric nurse practitioners, or physicians; social workers, counselors, and crisis specialists (SAMHSA, 2020a).
- Have staff who can assess physical health needs and deliver care for most minor physical health challenges. Have an identified pathway to transfer the young person to more medically staffed services, if needed (Bostic & Hoover, 2020).

- Ensure that staff have appropriate youth and family expertise and experience. For important training topics, see the sections on Crisis Call Center Staffing and Training, Mobile Response Staffing and Training, and Special Populations.
- Provide training to all staff on effective crisis management strategies that minimize the use of seclusion and restraint. Staff should also be trained in the safe, respectful, and appropriate use of seclusion and restraint. Such actions should only be used by trained personnel as a last resort and for brief periods of time (see Safety/Security for Staff and People in Crisis).

Facility Setting

- If the facility serves both youth and adults, have separate receiving and support areas. If the facility serves both younger children and adolescents, it is also ideal to have separate areas for them (Bostic & Hoover, 2020).
- Provide spaces that are trauma-informed in their design and that promote dignity as well as safety (e.g., open and airy design with inviting colors; no barriers, such as Plexiglass, that separate or isolate people in crisis) (SAMHSA, 2014c).
- Provide spaces that are calming and welcoming and that offer developmentally suitable supports for youth and families (e.g., privacy for adolescents, space for young children to play safely) (Bostic & Hoover, 2020).
- Provide confidential spaces for families to gather, with the young person and without, where they may receive clinical services and support (Bostic & Hoover, 2020).

Providing Services

- Screen for risk of self-harm, suicide, and risk for violence using tools that are designed or appropriate for youth. For examples, see Onsite Needs: Assessment Tools.
- If short-term individual and family therapies are provided, integrate community-defined evidence programs and cultural adaptations of evidence-based interventions, in addition to traditional evidence-based interventions (National Latino Behavioral Health Association, 2021).
- Provide warm hand-offs to home- and community-based, youth-serving care.
- Incorporate some form of intensive support beds, either within the facility's own child and youth services area or with a partner that also offers children- and youth-specific crisis services.

Youth Crisis Response Case Example: Nikki, Age 8

Vignette adapted from a case study presented in Singer, J. B. (2015). "Child and Adolescent Psychiatric Emergencies: Mobile Crisis Response." Crisis Intervention Handbook: Assessment, Treatment, and Research, Fourth Edition.

Repeated Access to Mobile Response Services and Follow-up

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

The crisis worker talks with Nikki and her mother separately in the school offices and identifies that Nikki has had suicidal ideation for years. Nikki's mother, Jamie, shares that she has been diagnosed with bipolar disorder, but does not currently take medication or receive therapy; she also conveys that she is angry with Nikki for the child's behavior.

The mobile team's on-call psychiatrist reviews Nikki's assessment and does not believe that she is at imminent risk of harm. The crisis worker develops a safety plan with Nikki and Jamie, but Nikki is not transferred to crisis receiving or stabilization services. Although the safety plan identifies that Jamie will resume taking her medication, as well as meet weekly with the mobile response team worker, neither of these things happen.

There is a second crisis incident in which Nikki cuts herself with a knife and the mobile response team is called out. The crisis worker (in consultation with the crisis team's on-call psychiatrist) recommends that Nikki stay with her grandmother temporarily, and Jamie agrees. During this time, the crisis worker meets weekly with Jamie to discuss the problems their family is experiencing and brainstorm solutions in a way that empowers Jamie. Together, they formulate an action plan to transition away from crisis services (e.g., to a community-based Family Preservation Program that will help Jamie avoid out-of-home placement for Nikki). Approximately two months after initial contact, Nikki and Jamie are fully transitioned to the community-based program, and Nikki is no longer a risk to herself or others.

Core Values and Principles

SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* established six core principles for crisis response systems. This section explores how each of the core principles can be specifically applied to children's and youth crisis care.

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

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

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

Addressing Recovery Needs

A ***recovery-oriented*** approach to crisis focuses on promoting recovery, resiliency, respect, and empowerment for people with lived experience. It is a person-centered approach that involves *working with* the person in crisis to reduce risk to themselves and others, instead of treating the person in crisis as if they are a risk.

This recovery-oriented approach is aligned with the core tenets of the System of Care (SOC) approach. The SOC approach affirms that youth experiencing behavioral health challenges and their families should be full partners in determining their care. The SOC approach also promotes well-coordinated services across systems (e.g., between schools and mental health providers) and emphasizes the need for community-based services (Stroul et al., 2021). SOC is described in detail in the Connecting to the System of Care section.

Addressing recovery needs involves actively engaging youth and families in a shared decision-making process that explores their preferences and priorities, providing them with information about the supports that are available, and helping them make care-related decisions that align with their priorities. Staff should also support youth in identifying their strengths and natural supports, both in immediate crisis planning and in follow-up care and stabilization. Natural supports may include cultural and faith communities, sports teams, mentoring, volunteer roles, or other extracurricular activities and relationships that support positive youth development and social engagement.

Summary of Implementation Strategies

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

Trauma-Informed Care

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (SAMHSA, 2014b). It is important to know that people can experience trauma because of things that happen directly to them, and also because of things that happen to their loved ones; experiences in their community; natural or person-made disasters; or historical and cultural events, such as forced family separations or genocide.

Unfortunately, there are many aspects of traditional crisis response systems that can be traumatizing or retraumatizing for youth and families, such as out-of-home placements, physical restraint, and experiences or fears of being harmed by law enforcement (Mental Health America, 2017; National Council for Behavioral Health, 2021).

A trauma-informed approach promotes a sense of safety, trustworthiness, and empowerment. SAMHSA defined the "four Rs" of a trauma-informed approach (SAMHSA, 2014b). In a crisis response system:

- All staff in the crisis response system ***realize*** that trauma is a major contributor to behavioral health crises. They also know that past trauma and community trauma impact how crisis services are perceived.
- Staff in the crisis response system can ***recognize*** the signs of trauma, including those that are specific to children and adolescents.
- The program, organization, and system ***respond*** to these realities by applying a trauma-informed approach into all aspects of services.
- Organizations seek to ***resist re-traumatization*** of both the people they serve and their own staff or volunteers. For example, they do not place a child who has been traumatized by familial neglect into a seclusion room.

While a trauma-informed approach is important for all crisis response services, it is especially crucial for working with youth, who are still developing the coping and resiliency skills they need to respond to events that may be traumatic.

Summary of Implementation Strategies

- Seek to employ staff that reflect the racial, ethnic, sexual orientation and gender identity, cultural, and linguistic diversity of the community to be served.
- Ensure that crisis call center, mobile response team, and crisis stabilization services staff receive training on trauma-informed care.
- Promote use of strengths-based approaches that support young people's resiliency and acknowledge that healing from trauma is possible.
- Provide training to key systems partners (e.g., schools, law enforcement) on trauma and trauma-informed crisis management approaches that limit the use of seclusion and restraint, including de-escalation training (Manley et al., 2018).
- Integrate trauma screening (e.g., Trauma Screening, Brief Intervention, and Referral to Treatment, also known as T-SBIRT). Ensure that staff are trained to implement trauma screenings in a sensitive and developmentally appropriate way (Wisconsin Department of Health Services, 2018).
- Provide training to staff and volunteers about secondary traumatic stress, including the unique stress of working with children who have been traumatized.

Significant Role for Peers

People with lived experience can provide support to others facing similar behavioral health challenges. People with lived experience who serve as peer support specialists receive specialized training in how to use their own experiences to help other people. They inspire hope, a sense of connection, and empowerment, which can help others move from crisis to recovery (Masselli et al., n.d.).

Crisis response programs have integrated peers within their crisis call centers, mobile response teams, crisis facilities, and follow-up stabilization supports. Peer support is discussed in more detail in the Core Services sections. Note that many states and organizations have age requirements for youth and young adult peer supporters, often starting between the ages of 14 and 18 and going up to ages 26 to 30.

Peer support providers serve as both on-the-ground staff and as leadership. In a crisis, they can help to quickly build trust and a sense of safety. After immediate crisis, peer specialists can also support families in navigating services (SAMHSA, 2017; Walker et al., 2018).

Summary of Implementation Strategies

- Hire youth and family peer support providers. As much as possible, peer supporters should reflect the communities served (e.g., BIPOC families, LGBTQI+ youth).
- Provide ongoing support, training, and developmentally appropriate supervision for peer support providers.
- Integrate peers within each of the core services (crisis call centers, each mobile response team, and at crisis receiving and stabilization facilities).
- Refer families and youth to peer support services in their local area.

Zero Suicide/Suicide Safer Care

Suicide prevention is a core responsibility of crisis intervention services. The Zero Suicide framework from the Educational Development Center (EDC) focuses on preventing suicide deaths in healthcare and

behavioral healthcare settings by promoting safer suicide care at the systems and organizational levels. The following are the seven core elements of the Zero Suicide model (Education Development Center, n.d.-a):

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

For children and youth, EDC specifies:

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

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

Summary of Implementation Strategies

- **Lead:** commit to a goal of Zero Suicide for children and youth as a crisis response system.
- **Train** staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk.
- **Identify** youth at risk of suicide using evidence-based assessment tools. Examples include the Ask Suicide-Screening Questions (ASQ) tool, designed for screening youth ages 10-24 in medical settings (see ASQ Toolkit), or the Columbia-Suicide Severity Rating Scale (C-SSRS), which offers resources for implementing the C-SSRS in various settings.
- **Engage** youth using developmentally appropriate suicide safety planning tools. For more information, see the Onsite Needs: Safety Planning section of this guide.
- **Treat**: youth at risk of suicide should receive appropriate care that directly addresses their suicide risk and behavioral health crisis, rather than being subjected to police detainment, seclusion, long periods of ED boarding, or similar practices.
- After the immediate crisis response and stabilization, **transition** young people to appropriate, community-based services that address long-term suicide risk and behavioral health needs.
- **Improve** policies and practices: collect and regularly review data related to youth and families who call in for suicide-related concerns, youth who screen positively for suicide risk, and their outcomes (e.g., follow-up supports).

Safety/Security for Staff and People in Crisis

Ensuring the safety of youth in crisis and the people around them is foundational to crisis care. One safety issue of special concern to the youth crisis system is seclusion and restraint. Seclusion refers to confining a

young person to a space or isolated area (e.g., a locked room). Restraint includes both physical means of restricting movement and chemical means (e.g., sedatives).

Physical restraint and seclusion are used on youth in residential treatment settings at higher rates than on adults in care. These practices can be traumatizing for both youth and families, and they are associated with frequent injuries to youth, deaths, and injuries to staff (Bystrynski, 2021). **SAMHSA is committed to reducing and ultimately eliminating the use of seclusion and restraint, with the goal of creating care environments that are free of coercion and violence** (SAMHSA, 2022).

Summary of Implementation Strategies

- Commit to a "no force first" policy to minimize the use of seclusion and restraint (SAMHSA, 2020a).
- Provide comprehensive staff training on the experiences of youth placed in restraint or seclusion; trauma-informed approaches; and effective, person-centered alternatives to restraint and seclusion (Craig & Sanders, 2018). Including youth and families to talk about their experiences with seclusion and restraint is an effective part of training (Bryson et al., 2017).
- If seclusion or restraint occur, both the staff and the young person should be debriefed, together or separately depending on the needs of the young person. (Craig & Sanders, 2018; Reddy et al., 2017).
- Employ prevention strategies to limit situations that may result in seclusion or restraint, such as individual assessments for risk of violence and active safety planning (Reddy et al., 2017).
- Create spaces that feel safe, comfortable/comforting, and nonconfining (Reddy et al., 2017). Provide youth-specific areas so that they are not exposed to adults in crisis.
- When promoting 988 or other crisis response services, use images and messaging that communicate a sense of physical and emotional safety.

Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS)

It is essential for the behavioral health crisis response system—including 988 crisis contact centers—to build partnerships with traditional first responders. In many regions, police and 911 are still the primary response system for crises of any kind, for both youth and adults.

Many localities have implemented "co-responder" models in which a law enforcement officer or EMS provider and a mobile crisis team are trained and resourced to respond to behavioral health crises together (sometimes via telehealth). Some researchers and organizations have argued that this practice harms communities of color and contributes to fear of contacting mobile response teams (Bunts, 2022). SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* encourages crisis teams to safely reduce unnecessary criminal justice system involvement unless the encounter merits law enforcement intervention. There are many co-responder models, and these programs should be adapted for local contexts, cultural responsiveness within the community, and developmental appropriateness (when involving youth) (Balfour et al., 2020; Krider et al., 2020).

Summary of Implementation Strategies

- Provide Crisis Intervention Team for Youth (CIT-Y) trainings or similar curricula to law enforcement, including school resource officers and other law enforcement officers embedded in youth-serving agencies.
- Establish clear policies and protocols for 911 dispatch to divert calls to the crisis response system, when appropriate to do so.
- If they are not co-responders, train crisis response staff on when to contact law enforcement or emergency medical services.
- If possible, co-locate crisis call center responders and/or mobile crisis teams with 911 services (Hepburn, 2021b).
- Have local crisis responders, including youth and family peer supporters as feasible, participate in trainings with law enforcement on topics related to the partnership.
- Incorporate regular meetings between crisis response and first responders to identify and address challenges. Discussion topics should include strategies to better respond to youth, families, and youth-serving agencies like schools (SAMHSA, 2020a). Use these as opportunities to create shared language as well.
- When appropriate, adopt a "no refusal" policy for first responders and law enforcement bringing youth to crisis receiving facilities and expedite the process in lieu of justice settings (Hepburn, 2021b).
- Provide training specific to responding to youth with disabilities (see Youth with Intellectual and Developmental Disabilities (IDDs)).
- Share aggregate data regarding youth- and family-related calls to crisis call centers and 911 to identify opportunities for outreach, awareness building, and diversion.

Connecting to the System of Care

For youth and families, a strong crisis response system needs to be more than just resources and services. It will require policies and practices that are aligned with the System of Care (SOC) values of being family driven, youth guided, trauma informed, and culturally and linguistically responsive (Stroul et al., 2021).

The crisis response system is one component of a constellation of services for youth with behavioral health needs. SOC is an essential framework for understanding how families receive services, and why it is important to coordinate among youth-serving systems (e.g., children's mental health, child welfare, juvenile justice, primary care, and schools). First developed to serve children and youth with serious emotional disorders and their families, the SOC approach has since expanded into a concept that may be applied to any population that receives services and supports from multiple agencies or providers (Stroul et al., 2015).

The System of Care framework comprises three components (Stroul et al., 2021):

1. **Philosophy**: services should be family-driven, youth-guided, developmentally appropriate, strengths-based, trauma-informed, community-based, and culturally and linguistically responsive. The SOC philosophy also emphasizes care coordination, interagency collaboration, least-restrictive settings, and interventions that are evidence-based or based on community-defined evidence (National Latino Behavioral Health Association, 2021).
2. **Infrastructure**: an infrastructure is needed to develop policies and procedures that reflect a SOC approach. Examples of infrastructure components include, but are not limited to, provider partnership and collaboration agreements; data-sharing agreements; financing approaches; and partnerships across systems, across agencies, and with youth- and family-run organizations.
3. **Services and Supports**: the SOC approach recognizes that individual therapy, medication, and inpatient or residential treatment are part of a broader array of important supports. The SOC model emphasizes community-based services and supports that help keep children and youth in their homes.

SAMHSA encourages youth and family crisis response systems to adopt and integrate the SOC philosophy. A crucial component of this is to emphasize supports that keep youth in their own homes, schools, and communities. Other strategies for aligning with the SOC philosophy are discussed throughout this document.

Note that youth and family crisis services are not intended to take the place of a local SOC. The SOC approach is a best-practice model for supporting the ***long-term*** recovery, functioning, and wellness of children, youth, and young adults with behavioral health needs. Crisis services, on the other hand, focus on the young person's safety and stability ***during*** crisis and in the ***immediate*** aftermath (potentially up to several weeks).

Spotlight: Wraparound Model

Families and youth that repeatedly use crisis services may have needs that are not easily met through a warm hand-off to a community-based service. Youth with complex service needs, including youth who are involved in multiple systems, may be eligible for intensive care coordination. Many states and

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

In some areas, Wraparound care coordination and mobile crisis services are provided by the same entity. For example, Wraparound Milwaukee contracts with community agencies to provide care coordination and also offers the Children's Mobile Crisis Team (formerly known as the Mobile Urgent Treatment Team, or MUTT). Crisis response service providers can also refer eligible youth and families to local Wraparound programs.

Key System of Care Partners

Crisis response agencies should develop informal relationships and formal partnerships with local youth-serving agencies. Crisis services staff should be trained and equipped to provide referrals and warm hand-offs to home- and community-based services and supports across the SOC.

The following are examples of how crisis response systems may effectively coordinate and collaborate with service providers in the broader SOC.

Schools

Schools are critical partners for youth and family crisis services (Centers for Medicare & Medicaid Services, 2021). Most children interact with the education system far more than any other youth-serving system. Schools are also the second-most common place where children receive behavioral health services (closely following specialty mental health settings) (Center for Behavioral Health Statistics and Quality, 2020). Unfortunately, as described elsewhere in this document (Traditional Youth Crisis System), students experiencing crisis—particularly BIPOC and LGBTQI+ students—have frequently experienced policing and harsh discipline rather than appropriate care. Crisis response services can divert students from these outcomes, with the goal of returning students to their classroom and their normal school activities as quickly as possible (Manley, 2021).

When a student is experiencing behavioral health crisis in school, appropriate personnel (e.g., school-based mental health providers) should engage the student in de-escalation activities before contacting crisis services and while waiting for the mobile response team to arrive (if needed) (Zenn & Moore, 2021). There are many de-escalation trainings that schools can access; one example is the Crisis Prevention Institute's Nonviolent Crisis Intervention. Certified or licensed school personnel or a telehealth provider may also complete a risk assessment with the young person. Mobile responders and school-based mental health professionals should receive training on using the same risk assessment protocols (e.g., Columbia-Suicide Severity Rating Scale) (Moore et al., 2021).

The University of South Florida created an infographic that shows sample steps for schools in their Best Practices Response Protocol for Schools to Use Mobile Response Teams document.

Crisis system leaders and school partners can offer cross-training on topics that are important in their own communities (e.g., support for students experiencing homelessness, how parents can access support for children with Autism) (Gasperini, 2021). Crisis responders should be knowledgeable about school-specific concerns and procedures, such as parental consent and confidentiality requirements. Regular meetings can

include mobile response team members and key partners such as school personnel, law enforcement, and other key partners at both the community and state levels. These meetings can be a place for discussing current challenges and identifying useful trainings (Moore et al., 2021).

Establishing formal partnerships, such as Memoranda of Agreement (MOA), can facilitate effective mobile response for students in crisis in schools. Connecticut's Emergency Mobile Psychiatric Services (EMPS) program has posted its current MOA with Schools to its website. These may serve as a model, although MOA should be customized to align with state and local laws, regulations, and resources. Sample MOA components include:

- Purposes of the MOA: maintaining student safety, improving care coordination, reducing juvenile justice system involvement and hospitalizations, etc.
- Roles and responsibilities of the mobile response team, such as hours of availability, timeframe for arriving after dispatch, services provided, and communication expectations.
- Roles and responsibilities of the school or district, such as using a mobile response telehealth platform, contacting caregiver(s), and providing onsite space for consultation.
- Mutual responsibilities that are shared by the school and mobile crisis response teams.
- Signatures from the crisis response service provider and a responsible authority in the school or district.

Community Organizations

The crisis response system should complement, not replace, community-based services for youth and families. There are several key connecting points for crisis response agencies and community partners.

Before a crisis, it is helpful to engage in dedicated outreach to community partners to raise awareness around the new 988 number, help them understand what crisis services are available, and explain when and how to access crisis support. Crisis response approaches may also involve training community and faith partners.

During a crisis, responders can help youth and their families identify their natural supports in the community. This may include afterschool and recreational programs, faith-based communities, and cultural organizations, for example. Involving family and youth peer supporters is another way that crisis response systems can build connections between individuals in crisis and their broader community.

In the follow-up to a crisis, responders may provide a warm hand-off to community-based services for longer-term stabilization and care (Bostic & Hoover, 2020). Examples of these kinds of services include in-home treatment interventions, family resource centers (FRCs), peer support programs, positive youth development programs, and caregiver education programs (Kurtz et al., 2020). Crisis responders may also refer families to community service agencies that help families meet their basic needs (e.g., food, housing, utilities, clothing). It is important for crisis responders to have strong understanding of the regional and local community-based services available to families.

Child Welfare and Foster Care

Youth involved in the child welfare and foster care systems are at higher risk for experiencing complex trauma and trauma-related behaviors. As many as 90 percent of youth in foster care have been exposed to

trauma, including personal experiences of abuse and neglect (Dorsey et al., 2012). Up to 80 percent of youth in foster care have a significant mental health need (Szilagyi et al., 2015).

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

Strong partnerships between child welfare agencies and crisis response providers can help ensure that foster parents know when to contact crisis services and what to expect (Children's Behavioral Health Initiative, 2015). Some programs have established crisis response services to support youth who have just experienced out-of-home placement. New Jersey's MRSS, for example, automatically dispatches a team member to meet with the young person at their foster placement or relative's home within the first 72 hours of their removal from home. This program has helped to improve placement stability for young people (Casey Family Programs, 2018b).

Juvenile Justice

Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder (Bostic & Hoover, 2020). An important role of crisis response is to divert young people from the justice system when appropriate. See the section on Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS) for more information.

Crisis response service providers are strongly encouraged to form partnerships with juvenile justice agencies (Optum, n.d.). At the state level, some agencies that are responsible for implementing 988 have formed cross-system partnerships with groups like Crisis Intervention Team steering committees, criminal justice planning councils, or police-mental health collaborations (Council of State Governments Justice Center, 2022). At the regional or local level, partnership activities may include regular meetings, cross-education and training, data-sharing agreements, sharing of screening tools, and development of protocols for when and how to contact crisis services (Wasserman et al., 2021).

Juvenile justice systems involve multiple agencies whose roles vary across states and localities (e.g., probation, juvenile court, centralized intake centers). Crisis response systems should be available to provide supports at multiple points in the process, including reentry (Manaugh et al., 2020).

Pediatricians and Other Primary Care Providers

Many families talk to their child's primary care provider about behavioral health concerns. Primary care providers can be especially helpful partners in raising awareness of 988 among families (Bostic & Hoover, 2020). At the state level, state Medicaid agencies are charged with ensuring that mobile crisis teams maintain relationships with relevant community partners, included primary care providers such as pediatricians (Centers for Medicare & Medicaid Services, 2021). At the local level, crisis follow-up and

stabilization supports can include referring families to primary care providers or coordinating with the young person's provider (NASMHPD, 2022).

Primary care providers should have strong understanding of when and how to contact crisis services, including what to expect. Additionally, crisis response services (such as mobile teams) may provide training to primary care partners on de-escalation strategies that they can use with youth and/or share with families.

Spotlight: Child Psychiatry Access Programs (CPAPs)

Most states, and several U.S. territories and Tribal communities, have established or been funded to establish Child Psychiatry Access Programs (CPAPs). The Massachusetts CPAP launched in the mid-2000s to provide primary care providers and pediatricians consultation with specialty care child psychiatrists, and the program has since been replicated widely (National Network of Child Psychiatric Access Programs, n.d.). These services are not a replacement for an integrated crisis response system. However, they can be an important tool for outreach and partnership with rural primary care providers, and they can support primary care providers in identifying when additional crisis supports are needed (Bostic & Hoover, 2020).

Homeless Shelters and Transitional Housing Programs

A significant minority of children, youth, and young adults experience homelessness. In 2019, 27% of people experiencing homelessness were under age 24, and 19% were under age 18 (U.S. Department of Housing and Urban Development, 2019). Some young people are at greater risk for experiencing homelessness, including youth and young adults who are Black, Hispanic or Latino, LGBTQI+, or parents (Morton et al., 2017). There are many different ways a young person can experience homelessness: they may be unaccompanied or with their family; they may be unhoused for a short period of time, a long period, or across multiple periods; and they may be unsheltered, in a shelter, or in another unhoused living situation. It is crucial to ensure that the young person has safe and stable housing, but safety is unique to the young person's needs (living with immediate family, living with extended family, living in low-barrier independent housing, etc.) (Morton et al., 2017).

There should be strong partnerships between crisis response services and the homeless shelters and transitional housing programs that support youth and families. These partnerships help crisis responders connect unhoused youth and families to community services, including emergency housing when needed (Committee on Psychiatry, 2021). Collaboration also helps homeless providers understand when to contact the crisis response service and promote it in the community (Usher et al., 2019). Cross-training between these services enables everyone to better identify and respond to the needs of youth and families experiencing homelessness.

Special Populations

Children and youth have unique needs, strengths, and service experiences that vary across different groups and populations. This section identifies some of the youth populations that have special service needs. This section is not comprehensive. As youth crisis response systems continue to grow nationwide, SAMHSA's intention is to provide more guidance about serving these populations and other youth populations with high needs, unmet needs, or unique needs.

Early Childhood

Crisis response often focuses on adolescents and adults, although infants and very young children also have mental and developmental health needs. In addition, the behavioral health of a young child's caregiver may need to be addressed. Behavioral health crisis teams must be able to respond to children across the lifespan and to the caregivers of young children.

Infants, toddlers, and young children have different signs of distress than school-age children. Examples may include excessive fussiness, intense separation anxiety, violent tantrums, and feeding or sleeping issues. Specialized experience may be necessary to assess whether young children's behaviors are typical or concerning. For example, a crisis response team may have a psychiatrist with early childhood expertise available for telephone or video consultation, or counselors who are trained in infant and early childhood mental health consultation.

All staff should receive training around family relationships and family engagement, which includes understanding how caregiver mental health can impact children (SAMHSA, n.d.). Parents of infants have unique mental health risks. An estimated 15-20% of women and 10% of men experience perinatal mood and anxiety disorders during pregnancy or in the year after childbirth (Lomonaco-Haycraft et al., 2018). For example, research has also found important disparities in postpartum care: Black women, Latina women, and women with Medicaid insurance are less likely than other women to receive postpartum mental health screening or treatment (Sidebottom et al., 2021).

As with older children and youth, SAMHSA strongly emphasizes the importance of avoiding out-of-placements for young children, except as necessary to ensure safety. When assessing safety, it is important to know that young children are especially vulnerable to abuse and neglect. Nationwide, more than one-quarter of children who are maltreated are in the age range of birth through two years old. Seventy percent of children who die from maltreatment are under age three (U.S. Department of Health & Human Services, 2021).

Mobile response and stabilization providers must collaborate with families. This must include respectful, ongoing engagement to understand familial perspectives, lived experiences, strengths, and needs (SAMHSA, n.d.). Family stabilization services and supports may take the form of parent coaching, postpartum behavioral health treatment, stress management, wellness education, or referrals to family-run centers (FRCs), for example.

To help ensure that early childhood crisis services are reimbursable through Medicaid, the *DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* should be adopted (Clark, 2018). *DC:0-5* provides developmentally specific diagnostic criteria that are unique to infants, toddlers, and young children. States may formally integrate the *DC:0-5* into their

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

Summary of Implementation Strategies

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

Transition-Age Youth (TAY) and Young Adults

TAY generally refers to young people at the developmental stage of transitioning from childhood to adulthood. It is used differently in different contexts, but generally refers to adolescence through approximately age 25.

There are several unique needs and challenges involved in providing crisis response services to TAY. The majority of mental health challenges emerge in adolescence through young adulthood (Jones, 2013; Solmi et al., 2022). Serious mental illnesses are more prevalent during the transition age than at any other period (SAMHSA, 2018; Zajac et al., 2013).

Young adulthood also involves the transition from child-serving systems (foster care, juvenile justice, special education, pediatric care, etc.) to adult-serving systems. Children's services typically have age requirements that vary from system to system, and often do not consider individual needs. Rather than a streamlined system of care, many youth and young adults experience a series of transition tunnels and cliffs (Babajide et al., 2020). This can make it challenging for youth with behavioral health needs to access new services or continue existing services.

TAY are also in a developmental period that is often characterized by a need for independence alongside a continued need for familial supports. For youth under 18 years old, parental consent to receive crisis services may or may not be required, depending on state law (SchoolHouse Connection, 2021; Tawa & Westbay, 2020). Even if parental consent is not required, some youth may elect to involve their family or other natural supports in developing their plan of care. SAMHSA strongly encourages respect for the autonomy of the youth, and the inclusion of family and other supports, wherever possible, in addressing crisis and crisis resolution. Providers and policies should encourage the young person to engage their families in crisis care planning while recognizing that family relationships, treatment history, and previous

experiences of removal/out-of-home placement may affect the young person's willingness to do so (Children's Behavioral Health Initiative, 2015).

Crisis response services must have policies in place addressing when and how a young person's health information can be shared with family members and/or other service providers if they are 18 or older. In general, the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal Regulations Part 2, and the Federal Education Rights and Privacy Act (FERPA) permit providers to disclose protected health information when the health or safety of an individual or the public is at imminent risk *and* the information is being shared with someone who can reduce or eliminate that risk. State laws may also impose additional privacy protections on sharing this type of information (Draper et al., 2015).

Summary of Implementation Strategies

- TAY with lived experience should have authentic, non-tokenized roles in planning, implementing, and evaluating crisis response systems that serve youth.
- Offer TAY-specific crisis stabilization facilities.
- Engage youth and young adults as peer support providers. Provide developmentally appropriate training, supervision, and supports.
- Provide training and clear policies around obtaining caregiver consent for services and sharing health information with families.
- Be prepared to refer TAY to county and community services that address a range of transition needs, including supports for life skills development, secondary education transitions, and employment.
- Form strong partnerships with foster care agencies: youth transitioning out of foster care are at higher risk for experiencing homelessness and other crises.

Youth with Intellectual and Developmental Disabilities (IDDs)

People with IDD have often been left out of the planning of mental health and crisis response services, even though they are at higher risk for co-occurring mental health conditions. Children and youth with IDD have a risk of developing mental health challenges that is three to four times higher than that of other young people (Munir, 2016; Pinals et al., 2017).

Police officers may have limited or no training on de-escalation with people who have IDD, which can lead to excessive force or deaths (Criminal Justice, 2021; Hepburn, 2022b). Similar challenges impact young people in schools. In 2014, students with disabilities represented 12% of students overall, but were 58% of the students placed in seclusion or confinement and 75% of the students who were physically restrained (U.S. Department of Education Office for Civil Rights, 2014).

Many of the same crisis response practices apply for youth with IDD as for other youth: focus on safety, assess for risk, engage in de-escalation, and create a plan for next steps and continued safety. As with all youth, out-of-home placement should be avoided unless necessary for safety. It is important to note that youth with IDD "are more likely to be neglected, sexually abused, emotionally abused, and physically abused than children without such disabilities" (Pinals et al., 2017).

Youth with IDD are typically more dependent on family members than youth without disabilities, and family members are often their primary natural supports (Primm, 2021). Because of this, families are much

more likely to be very involved in crisis management and stabilization supports or therapies (Trauma and Intellectual/Developmental Disability Collaborative Group, 2020). Lack of access to disability-competent, culturally responsive care is a significant challenge for many families (Hepburn, 2022b). For example, youth with IDD often face difficulty when transitioning to adult-serving systems, with some continuing to see pediatric clinicians well into adulthood (Bloom, 2012).

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

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

Summary of Implementation Strategies

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

LGBTQI+ Youth

A trauma-informed, culturally, and linguistically responsive system must include attention to the needs of LGBTQI+ people in crisis. A recent survey of youth who identify as LGBTQI+ 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" (The Trevor Project, 2021).

Youth who identify as LGBTQI+ are also at increased risk of homelessness compared to their peers (see Homeless Shelters and Transitional Housing Programs). One study found that nearly one-third of youth contacting a national LGBTQ crisis hotline had experienced homelessness in their lifetime, and that their risk was higher if they had disclosed their identity to their parents or experienced parental rejection (Rhoades et al., 2018). Training related to LGBTQI+ youth should include discussion of family dynamics, the family acceptance model (SAMHSA, 2014d), and special considerations for preventing LGBTQI+ youth homelessness.

The National Suicide Hotline Designation Act of 2020 (S.2661), otherwise known as the 988 bill, recognizes that LGBTQI+ youth are at higher risk of suicide than their heterosexual and cisgender peers. The 988 bill encourages a strategy for call responders to receive LGBTQI+ cultural competency training and for callers to have access to LGBTQI+ specific services.

One component of person-centered care is understanding that LGBTQI+ youth may be especially reluctant or afraid to engage with law enforcement, medical or mental health professionals, shelter staff, and others because of past experiences of discrimination (National Resource Center on LGBTQ+ Aging, n.d.). Gender-diverse youth can also experience discrimination and barriers to crisis care, especially facility-based care. Some crisis stabilization facilities, short-term residential programs, youth shelters, and similar settings are specific to "boys" or "girls," without making accommodations for transgender boys and girls or nonbinary youth (Shelton, 2015).

Summary of Implementation Strategies

- Provide training for all staff on affirming, responsive, and appropriate supports for LGBTQI+ youth, including the use of pronouns and preferred names (True Colors United, 2019; Bostic & Hoover, 2020).
- At the local or regional level, maintain lists of LGBTQI+ affirming organizations and providers in the community for successfully transitioning LGBTQI+ youth to community services they will actually use (National Resource Center on LGBTQ+ Aging, n.d.).
- Engage in outreach efforts to LGBTQI+ youth and LGBTQI+ youth-serving organizations. Clearly present crisis services as inclusive and LGBTQI+ affirming.
- Recruit diverse peer support providers, including LGBTQI+ youth and young adults (Wisconsin Department of Health Services, 2018).
- Adopt non-discrimination policies, processes, and procedures that prioritize the physical and emotional safety of LGBTQI+ program participants. LGBTQI+ people with lived experience should be involved in the development of policies (Shelton, 2015).
- Build strong partnerships with homeless prevention organizations and shelters to help protect LGBTQI+ youth from housing instability (Rhoades et al., 2018).

Rural and Frontier Communities

Youth in rural counties have poorer access to behavioral health services than those in urban or suburban counties. Much of the U.S. includes a rural county or health professional shortage area. While roughly two-thirds of all U.S. counties had at least one mental health facility serving youth, fewer than one-third of all highly rural counties had such a facility (Graves et al., 2020).

Rural and frontier communities face significant barriers in developing and implementing behavioral health crisis services. Large geographic areas, combined with a limited workforce, can make it difficult to deliver services in a timely manner. Some rural residents may not be able to afford the cost of health insurance or the cost of out-of-pocket care if they lack health insurance, which is more common in rural areas than urban areas (National Conference of State Legislatures, 2020).

Three recent, SAMHSA-funded publications provide detailed discussion of the challenges and innovative solutions to implementing crisis response systems in rural, frontier, and Tribal regions:

- *Mental Health System Development in Rural and Remote Areas during COVID-19* (NASMHPD, 2021)
- *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.* (NASMHPD, 2020)
- *Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities* (SAMHSA, 2019)
- *Cultural Elements of Native Mental Health with a Focus on Rural Issues* (Northwest Mental Health Technology Transfer Center [MHTTC], 2022)

To avoid duplication with existing documents, this section focuses on rural crisis response considerations that are specific to youth and families.

Many rural regions are working to supplement their workforce with non-traditional mental health providers. For example, Behavioral Health Aide program in Alaska and the Community Health Aide Program from Indian Health Services train individuals (who do not have formal backgrounds in mental health) to respond to behavioral health crisis and provide therapeutic services in rural and Tribal communities. Community- and faith-based organizations and events can be another way to embed mental health awareness into non-traditional, comfortable settings (e.g., conference for young ranchers) (Neylon, 2020).

Family and youth peers can also help grow the regional crisis response workforce and serve an essential role in breaking down stigma around mental health services in rural areas. SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* recommends that the police should not be dispatched to crisis situations unless it is appropriate to the specific crisis, or other behavioral health responders are not available. However, in rural and frontier areas, there may not be other options. Partnering a peer co-responder with law enforcement can help to de-escalate crisis situations where law enforcement are the only available responders.

Long transportation times between where a mobile response team is located, where the crisis is happening, and where there is an available crisis facility (for those who need it) pose a major challenge in rural areas. One strategy is to implement a statewide electronic bed registry system that includes information about beds available to children and youth (see Note about Bed Registries) (Neylon, 2020).

In rural regions, where there is less access to specialized services in general, it is often important to find ways to build on established programs rather than developing new programs. This can include providing new tools and resources to existing staff and providing specialized, youth-specific training to responders who address a broad range of crises. For example, in urban areas, only a portion of law enforcement officers may receive Crisis Intervention Training (CIT). Conversely, in a rural area with a smaller staff and larger

geographic area, it may be necessary to train all officers in CIT (including the CIT for Youth add-on or similar curriculum) (SAMHSA, 2019b).

Telehealth is a crucial strategy for addressing the challenges of rural and frontier workforce shortages and delivering services over a wide geographic area. Sharing technologies can help to streamline connections between first responders and crisis response teams. For example, Nevada's rural schools, hospitals, and juvenile detention centers are equipped with the same telehealth program that the Rural Mobile Crisis Response Team uses, which facilitates faster response times (Rural Children's Mental Health Consortium, 2018). Law enforcement or emergency medical services (EMS) providers can use mobile tablets to connect with mobile response teams or telehealth providers who deliver assessment and counseling directly to people in crisis (Neylon, 2020; SAMHSA, 2019b).

Summary of Implementation Strategies

- Expand the workforce of family and youth peers, community health workers, and others who are not mental health clinicians, but who receive specialized crisis response training and who have ties to their communities.
- Raise awareness and improve literacy around youth mental health communities through programs such as Youth Mental Health First Aid (Y/MHFA) and partnerships with community and faith organizations.
- For primary care providers (PCPs), participate in virtual learning models such as Project ECHO (Extension for Community Healthcare Outcomes) in which specialists train PCPs to recognize and respond to youth behavioral health challenges.
- Establish partnerships with rural health clinics and rural hospitals so that the mobile response team is called when youth come in for mental health crisis. Partner with rural clinic case managers for coordinating follow-up and stabilization supports (Rural Children's Mental Health Consortium, 2018).
- Share technology resources and telehealth applications with key systems partners.
- Integrate information about youth-specific services into electronic bed registries.

Conclusion

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

This document shares learnings from decades of work by thousands of dedicated individuals striving to create state and local systems that meet the unique developmental needs of young people and honor the important role of families. These innovative programs are successfully linking youth and families to much needed supports in the community, from the Emergency Mobile Psychiatric Services (EMPS) in Connecticut to the Children's Crisis Outreach Response System (CCORS) in King County, Washington, and in a growing number of states and localities in between. Together, we can work to create a trauma-informed, equity-driven, developmentally appropriate crisis system that is truly responsive to the needs of youth and families in every community.

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Appendix I: Summary of Implementation Strategies

The following table provides easy reference to strategies discussed throughout the National Guidelines for Child and Youth Behavioral Health Crisis Care.

CORE CRISIS PRINCIPLES

Adapted from SAMHSA's National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
ADDRESSING RECOVERY NEEDS	• Meaningfully integrate the SOC values of *family-driven, youth-guided, and culturally and linguistically responsive* at every level of service. Respect the preferences of youth and families as much as possible while ensuring safety. • Create engaging environments that do not use barriers to separate or isolate people in crisis (SAMHSA, 2020a). • Engage youth and families in shared decision-making. • Support youth in identifying their strengths and natural supports that will aid their recovery. Ensure that multilingual staff or translation supports are available so that youth and families accurately understand the choices available to them.
TRAUMA-INFORMED CARE	• Seek to employ staff that reflect the racial, ethnic, sexual orientation and gender identity, cultural, and linguistic diversity of the community to be served. • Ensure that crisis call center, mobile response team, and crisis stabilization services staff receive training on trauma-informed care. • Promote use of strengths-based approaches that support young people's resiliency and acknowledge that healing from trauma is possible. • Provide training to key systems partners (e.g., schools, law enforcement), including de-escalation training, on trauma and trauma-informed crisis management approaches that limit the use of seclusion and restraint when appropriate (Manley et al., 2018). • Integrate trauma screening (e.g., Trauma Screening, Brief Intervention, and Referral to Treatment, also known as T-SBIRT). Ensure that staff are trained to implement trauma screenings in a sensitive and developmentally appropriate way (Wisconsin Department of Health Services, 2018).

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	Provide training to staff and volunteers about secondary traumatic stress, including the unique stress of working with children who have been traumatized.
SIGNIFICANT ROLE FOR PEERS	• Hire youth and family peer support providers. As much as possible, peer supporters should reflect the communities served (e.g., BIPOC families, LGBTQI+ youth). • Provide ongoing support, training, and developmentally appropriate supervision for peer support providers. • Integrate peers within each of the core services (crisis call centers, each mobile response team, and at crisis receiving and stabilization facilities). Refer families and youth to peer support services in their local area.
ZERO SUICIDE/SAFER SUICIDE CARE	• **Lead:** commit to a goal of Zero Suicide for children and youth as a crisis response system. • **Train** staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk. • **Identify** youth at risk of suicide using evidence-based assessment tools. Examples include the Ask Suicide-Screening Questions (ASQ) tool, designed for screening youth ages 10-24 in medical settings (see ASQ Toolkit), or the Columbia-Suicide Severity Rating Scale (C-SSRS), which offers resources for implementing the C-SSRS in various settings. • **Engage** youth using developmentally appropriate suicide safety planning tools. For more information, see the Onsite Needs: Safety Planning section of this guide. • **Treat**: youth at risk of suicide should receive appropriate care that directly addresses their suicide risk and behavioral health crisis, rather than being subjected to police detainment, seclusion, long periods of ED boarding, or similar practices. • After the immediate crisis response and stabilization, **transition** young people to appropriate, community-based services that address long-term suicide risk and behavioral health needs. **Improve** policies and practices: collect and regularly review data related to youth and families who call in for suicide-related concerns, youth who screen positively for suicide risk, and their outcomes (e.g., follow-up supports).

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
SAFETY/SECURITY FOR STAFF AND PEOPLE IN CRISIS	• Adopt a "no force first" policy to minimize the use of seclusion and restraint when appropriate(SAMHSA, 2020a). • Provide comprehensive staff training on the experiences of youth placed in restraint or seclusion; trauma-informed approaches; and effective, person-centered alternatives to restraint and seclusion when appropriate(Craig & Sanders, 2018). Including youth and families to talk about their experiences with seclusion and restraint is an effective part of training (Bryson et al., 2017). • If seclusion or restraint occur, both the staff and the young person should be debriefed, together or separately depending on the needs of the young person. (Craig & Sanders, 2018; Reddy et al., 2017). • Employ prevention strategies to limit situations that may result in seclusion or restraint, such as individual assessments for risk of violence and active safety planning (Reddy et al., 2017). • Create spaces that feel safe, comfortable/comforting, and nonconfining (Reddy et al., 2017). Provide youth-specific areas so that they are not exposed to adults in crisis. When promoting 988 or other crisis response services, use images and messaging that communicate a sense of physical and emotional safety.
CRISIS RESPONSE PARTNERSHIPS WITH LAW ENFORCEMENT, DISPATCH, AND EMERGENCY MEDICAL SERVICES (EMS)	• Provide Crisis Intervention Team for Youth (CIT-Y) trainings or similar curricula to law enforcement, such as de-escalation training, including school resource officers and other law enforcement officers embedded in youth-serving agencies. • Establish clear policies and protocols for 911 dispatch to divert calls to the crisis response system, when appropriate to do so. • If they are not co-responders, train crisis response staff on when to contact law enforcement or emergency medical services. • If possible, co-locate crisis call center responders and/or mobile crisis teams with 911 services (Hepburn, 2021b). • Have local crisis responders, including youth and family peer supporters as feasible, participate in trainings with law enforcement on topics related to the partnership. • Incorporate regular meetings between crisis response and first responders to identify and address challenges. Discussion topics should include strategies to better respond to youth, families, and youth-serving agencies like schools (SAMHSA, 2020a). Use these as opportunities to create shared language as well. • Adopt a "no refusal" policy for first responders and law enforcement bringing youth to crisis receiving facilities and expedite the process in lieu of justice settings when appropriate(Hepburn, 2021b). • Provide training specific to responding to youth with disabilities (see Youth with Intellectual and Developmental Disabilities (IDDs)).

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	Share aggregate data regarding youth- and family-related calls to crisis call centers and 911 to identify opportunities for outreach, awareness building, and diversion.

SPECIAL POPULATIONS AND COMMUNITIES

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
EARLY CHILDHOOD	• Equip staff to refer families to the local and regional resources that are available to caregivers of young children, including young children who may have developmental delays. This should include basic needs resources (e.g., Women, Infants, and Children [WIC] food benefits). • Train staff in how to identify signs of abuse or neglect in infants and young children, how to respond, and when and how to report. • Crisis call center and mobile response team staff have access to clinicians with expertise in the mental health and development of infants, toddlers, and young children, including the use of evidence-based screening and assessment. • Early childhood care providers and educators are included in outreach related to 988 and accessing crisis services (e.g., pediatricians, Head Start and Early Head Start programs, home visiting programs). Integrate *DC:0-5* diagnoses into state policy and local practice.
TRANSITION-AGE YOUTH (TAY) AND YOUNG ADULTS	• TAY with lived experience should have authentic, non-tokenized roles in planning, implementing, and evaluating crisis response systems that serve youth. • Offer TAY-specific crisis stabilization facilities. • Engage youth and young adults as peer support providers. Provide developmentally appropriate training, supervision, and supports. • Provide training and clear policies around obtaining caregiver consent for services and sharing health information with families. • Be prepared to refer TAY to county and community services that address a range of transition needs, including supports for life skills development, secondary education transitions, and employment. Form strong partnerships with foster care agencies: youth transitioning out of foster care are at higher risk for experiencing homelessness and other crises.
YOUTH WITH INTELLECTUAL AND	• As with all youth, provide trauma-informed, person-centered, and strengths-based crisis support.

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
DEVELOPMENTAL DISABILITIES (IDDs)	• At the state and local level partner with agencies that have IDD specialization, such as Councils on Developmental Disability, Centers for Independent Living, and University Centers for Excellence in Developmental Disabilities (Hepburn, 2022b). • Provide staff trainings on important topics such as: effective communication (e.g., being aware of sensory challenges, not talking about people with IDD as if they are not there, using short sentences); incorporating family into de-escalation strategies; safety planning (Primm, 2021). • Train staff to assess for abuse and neglect of youth with disabilities, including IDD. • Have access to providers with IDD-related expertise, whether in person or through telehealth. • Be prepared to refer families to specialized IDD supports in the community, such as early intervention services, functional behavioral assessment, applied behavior analysis, function-based treatment, and caregiver education (Kurtz et al., 2020). Engage families in a way that is appropriate to the young person's needs and be prepared to adapt strategies to include family members.
LGBTQI+ YOUTH	• Provide training for all staff on affirming, responsive, and appropriate supports for LGBTQI+ youth, including the use of pronouns and preferred names (True Colors United, 2019; Bostic & Hoover, 2020). • At the local or regional level, maintain lists of LGBTQI+ affirming organizations and providers in the community for successfully transitioning LGBTQI+ youth to community services they will actually use (National Resource Center on LGBTQ+ Aging, n.d.). • Engage in outreach efforts to LGBTQI+ youth and LGBTQI+ youth-serving organizations. Clearly present crisis services as inclusive and LGBTQI+ affirming. • Recruit diverse peer support providers, including LGBTQI+ youth and young adults (Wisconsin Department of Health Services, 2018). • Adopt non-discrimination policies, processes, and procedures that prioritize the physical and emotional safety of LGBTQI+ program participants. LGBTQI+ people with lived experience should be involved in the development of policies (Shelton, 2015). Build strong partnerships with homeless prevention organizations and shelters to help protect LGBTQI+ youth from housing instability (Rhoades et al., 2018).
RURAL AND FRONTIER COMMUNITIES	• Expand the workforce of family and youth peers, community health workers, and others who are not mental health clinicians, but who receive specialized crisis response training and who have ties to their communities.

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	• Raise awareness and improve literacy around youth mental health communities through programs such as Youth Mental Health First Aid (Y/MHFA) and partnerships with community and faith organizations. • For primary care providers (PCPs), participate in virtual learning models such as Project ECHO (Extension for Community Healthcare Outcomes) in which specialists train PCPs to recognize and respond to youth behavioral health challenges. • Establish partnerships with rural health clinics and rural hospitals so that the mobile response team is called when youth come in for mental health crisis. Partner with rural clinic case managers for coordinating follow-up and stabilization supports (Rural Children's Mental Health Consortium, 2018). • Share technology resources and telehealth applications with key systems partners. Integrate information about youth-specific services into electronic bed registries.

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Applying Principles from Safety Science to Improve Child Protection

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Child Protective Services Agencies (CPSAs) share many characteristics with other organizations operating in high-risk, high-profile industries. Over the past 50 years, industries as diverse as aviation, nuclear power, and healthcare have applied principles from safety science to improve practice. The current paper describes the rationale, characteristics, and challenges of applying concepts from the safety culture literature to CPSAs. Preliminary efforts to apply key principles aimed at improving child safety and well-being in two states are also presented.

Organizations in high-risk and high-profile industries such as aviation (Merritt & Helmreich, 1996), nuclear power (Terence & Harrison, 2000), and healthcare (Vogus, Sutcliffe, & Weick, 2010) have begun applying principles and concepts from safety science to improve practice and reduce the incidence of error leading to tragic outcomes (Weick & Sutcliffe, 2007).[1] State-level child protective services agencies (CPSAs) share many features in common with these and other high-risk, high-profile organizations. Although the task of ensuring the safety and well-being of children alleged to have been abused or neglected is very different from flying planes, producing electricity, or providing healthcare services, the results of error in the system are no less catastrophic. About 1,600 children die each year in the United States because of maltreatment (U.S. Department of Health and Human Services [DHHS], 2012).

The current paper applies principles and concepts from the safety culture literature to three aspects of CPSA practice that impact child welfare outcomes (e.g., sociopolitical context, organizational culture, and traditional social work practice perspective) and proposes a framework for advancing safety culture in CPSAs. A safety culture is one in which values, attitudes and behaviors support a safe, engaged workforce and reliable, error-free operations (Vogus, Sutcliffe & Weick, 2010). Safety cultures strive to balance individual accountability with system accountability and value open communication, feedback, and continuous learning and improvement (Chassin & Loeb, 2012). Early experiences from two states will be reviewed to highlight issues of implementation and sustainability.

Sociopolitical Context

All organizations work within a sociopolitical context that informs their goals, values, and operations (Hatch & Cunliffe, 1997). Because mistakes in high-risk industries such as aviation, nuclear

1 For purposes of this article, errors include mistakes in gathering or assessing available information, mistakes in planning, unintended failures of execution, and rule violations (Reason, 1990). Actions of sabotage—that is, violations with malicious intent—are excluded from our definition.

power, or healthcare often have high-profile consequences, a tension exists between hesitance to report errors to avoid media and other scrutiny and open, transparent reporting in the pursuit of "safer" practice (Morath & Turnbull, 2005). Studies of hospital nursing staff have found a positive association between organizational cultures characterized by reluctance to report errors and acknowledge mistakes and the frequency with which medical errors occur (Hofmann & Mark, 2006; Naveh, Katz-Navon, & Stern, 2005). Thus, organizational cultures that promote open, transparent, reporting have been shown to be safer.

A similar dynamic exists in CPSA practice. CPSAs' responsibility to protect vulnerable children has resulted in service systems shaped not only by genuine, well-placed interest in serving these youth but also by media attention, public outrage, and attempts at court-ordered reform (Geen & Tumlin, 1999). The social and political pressures of high-profile cases have been shown to affect both front-line workers and policy-level decisionmaking (Geen & Tumlin, 1999) and may, in certain circumstances, compel CPSAs to react defensively and to shift policy and practice to fend off the most recent crises created by the most recent high-profile case (Orr, 1999).

High-profile cases often fuel public perception that CPSAs have either failed in their duty to protect or have overstepped their authority (Gainsborough, 2009). On one end of the continuum are cases in which a maltreated child previously known to the system is not protected from subsequent abuse. On the other end of the continuum are cases in which CPSAs remove a child from his or her family and home prematurely or without good cause. Both scenarios can lead to intense media scrutiny and attention from policymakers and other key stakeholders. Although it is certainly the case that this scrutiny and attention is an inherent and potentially helpful part of the sociopolitical context within which CPSAs operate (Rainey, 2008), it is also the case that it can impede progress by discouraging, rather than encouraging, transparency in actions and reporting (Edmondson, 1999; Lachman & Bernard, 2006).

Organizational Culture

In addition to the open, transparent reporting required by the sociopolitical context within which organizations in high-risk, high-profile industries operate, specific organizational characteristics have been shown to be important for child welfare and other human services agencies (Cyphers, 2001). Over-emphasis on formal structure, regulations, and reporting relationships are less likely to result in innovative organizations that can sustain improvement (Kenny & Reedy, 2006; Poskiene, 2006). Conversely, organizations with cultures that value affiliation, trust, and support are characterized by work unit behaviors that promote teamwork, shared decisionmaking, and open communication (Hartnell, Ou, & Kinicki, 2011). Within child welfare agencies, better casework has been associated with organizational cultures that promote practice improvements (Glisson & Green, 2011).

An organization's culture also affects the perceptions of its workforce (Sparrowe, 1995). Cultures that prioritize efficiency, formal structure, and productivity over more team-supporting behaviors often develop a workforce with negative perceptions of organizational leadership, mission, and commitment to developing the workforce (Edmondson, 1999). Existing research has shown that in some CPSAs, organizational culture is characterized by poor communication and workload demands that caseworkers believe are unreasonable and present obstacles to keeping children safe (Yamatani, Engel, & Spejeldnes, 2009).

Traditional Child Protection Practice Perspective

CPSAs employ and prepare a workforce with a unique mission and set of personal and professional challenges. Child protection work involves making potentially life altering decisions affecting children and their families. The work is fraught with uncertainties and ambiguities, while requiring staff to make determinations of child safety and predict future harm. Despite playing a crucial role in protecting vulnerable children, front line positions are often filled by persons

who may have college degrees, but not necessarily in social work or related disciplines (Barth, Lloyd, Christ et al., 2008). Turnover is typically high in these positions, with approximately 30%–40% turnover within two years (U. S. General Accounting Office, 2003).

Basic training in child protection is likely to focus on agency policies and procedures, with the unintended consequence of implicitly encouraging staff to selectively attend to certain case information at the potential expense of other case-idiosyncratic and complex information requiring a novel response or more time to unravel (Munro, 2008). In short, the regulatory demands of jobs in child protection may discourage critical thinking about case complexities.

Traditional child protection work draws on social work approaches that place a great deal of emphasis on establishing rapport in order to successfully engage children and families. Because the nature of the relationship between caseworkers and children and families is inherently coercive, with an explicit or implied threat that children may be removed from the home, there can be tension between establishing rapport and protecting children and families (Rooney, 2000). This is further complicated by the fact that front line CPSA workers must often make quick decisions, often under difficult circumstances and with incomplete or insufficient information (Munro, 2008). Errors in judgment of child safety can lead to placing a child in out-of-home care unnecessarily or failing to remove a child from the home who is later harmed. Both types of error (e.g., false positives and false negatives) can have devastating consequences to the child, the family, and the credibility of the CPSA.

Safety Culture in the Context of Child Protection

The complexity of CPSA practice requires an integrated, systems-focused solution that—at all organizational levels—prioritizes the safety and well-being of children (Weigmann, 2002; Wiegmann, Zhang, Von Thaden, Sharma, & Gibbons, 2004). Other high-risk, high-profile fields such as the nuclear power industry (Terence & Harrison, 2000), aviation industry (Merritt & Helmreich, 1996) and

healthcare (Vogus, Sutcliffe, & Weick, 2010) have begun to focus on advancing a safety culture in their organizations. As described earlier, there is general agreement that safety culture have a shared belief in the value of safety and a commitment to the following principles (Halligan & Zecevic, 2011):

(1) Leadership commitment to safety;
(2) Prioritizing teamwork and open communication based on trust;
(3) Developing and enforcing a non-punitive approach to event reporting and analysis; and
(4) Committing to becoming a learning organization.

Principle 1: Leadership is Committed to Safety

Successfully enabling a safety culture means that leadership will make safety a priority and establish a context that fosters open communication in the public agency (Vogus, Sutcliffe, & Wick, 2010). To enable a safety culture, effective leaders must advocate on behalf of their staff and their advocacy must emerge from understanding what is required to conduct high-quality child protection investigations and issues faced by staff at the ground level. The perspectives of front-line staff and supervisors should be well-understood and inform advocacy efforts. Effective leaders demonstrate their commitment and support to their staff through words and actions, not only training. This might include relying upon veteran highly competent investigators to serve as mentors to junior staff, and allowing opportunities for new staff to shadow skilled investigators (E. Munro, personal communication, June 29, 2012). Organizational leadership must trust their staff in order for their staff to trust them and shape the context in which a safety culture can develop and thrive.

In child protection, given the large number of investigations of maltreatment, a child death is a relatively rare event. Complacency regarding the quality of investigations may only be disrupted when a tragic outcome occurs. An organization with leadership committed to safety keeps potential failures in the foreground, and maintains continuous vigilance for organizational weaknesses that may

contribute to future adverse events (Weick & Sutcliffe, 2007). This means encouraging the free flow of information, including listening to staff concerns and providing responsive feedback on actions taken by agency leadership.

Principle 2: Prioritize Teamwork and Open Communication

Transparent and open communication both vertically and laterally is essential to the development of a less defensive organizational culture in which difficulties in practice can be discussed candidly. Safety efforts must focus not only on correcting errors in practice, but also anticipating and preventing future errors that could lead to a tragic case outcome. Critical thinking, particularly in the context of a team or workgroup, reinforces appreciation of case complexities, including conflicting views and interests of various family members and other stakeholders. Group discussion has the potential to uncover individual biases that can interfere with sound decisionmaking (Munro, 2008). In addition, valuable expertise is often found among experienced peers, not necessarily in the organization's hierarchy (Weick & Sutcliffe, 2007).

The high-risk, high-profile organizations referenced earlier in this paper have already identified the value of teamwork. In healthcare, teamwork has been associated with better patient outcomes, higher staff and patient satisfaction and a higher perception of overall quality (Singer & Vogus, 2013). These findings have led to an increased emphasis on team-based care and the broad dissemination evidence-based teamwork training programs.

Principle 3: Develop and Enforce Non-Punitive Approaches to Event Reporting and Analysis

Processes identified in other high-risk, high-profile organizations that foster more competent practice include the development of strategies for identifying, reporting, and managing practice errors. Also included are clear rules that distinguish reportable, non-punishable errors from missteps that are subject to penalties, and clear guidelines for reporting near misses (Reason, 1997; Weick & Sutcliffe, 2007).

Policymakers have the ability to direct resources and develop policy to support an organization's move away from "shame and blame" and toward processes that balance system and individual accountability (Dekker, 2007). The current approach to remediation and punishment limits opportunity for learning and improvement. Aviation and healthcare now understand this dynamic and have invested in confidential reporting systems and peer review processes (Larson & Nance, 2011). However, it is important to note that both industries also have federal legislation protecting the inquiry process. Pilots and clinical providers have a level of protection when they report their mistakes. Healthcare providers have additional layers of protection provided by their medical malpractice insurer and the hospital's risk mitigation processes. Unlike CPSA staff, healthcare providers are often shielded from at least some personal risk and public scrutiny (Larson & Nance, 2011).

Further, traditional reliance on serious incident reporting must be augmented by a blameless, confidential, reporting system (Gambrill & Shlonsky, 2001). Confidential, but not anonymous, reporting of error allows a system to uncover latent threats to safety. Systems from the highest levels will need to ensure confidentiality to maximize reporting. Confidential reporting should be an option for caseworkers and all other stakeholders who engage in direct practice, including private providers, foster parents and families of origin.

Principle 4: Become a Learning Organization

Caseworkers need to be able to learn from their mistakes and have access to expertise and state of the art knowledge in the field. Defensive cultures do not support the open discussion of issues faced in the field, mistakes made by staff, or potential solutions. Learning from mistakes is especially important to new staff to develop the skills necessary to do their jobs well, to understand that job performance is rarely error-free, and that not all errors are fatal. Without the ability to learn from mistakes, subpar practice habits are likely to develop if not caught and corrected. Well-intentioned personnel can become desensitized to deviations from standards which are

reinforced informally by supervisors or peers who may reward the wrong kind of excellence (such as routinely closing case investigations more quickly than policy requires, regardless of case complexity). This can lead to the evolution of an informal chain of decisionmaking that operates outside the organization's/agency's policies and procedures (Rzepnicki et al., 2012).

The ability, time, and encouragement to think critically are essential to the establishment of a learning environment. Relevant competencies include challenging assumptions, identifying and reflecting on anomalies, and considering potential adverse consequences of possible courses of actions. All employees, from line staff to top-level administrators are watchful for conditions or activities that can have a negative impact on agency operations, the conduct of investigations, or the well-being of children. Agency managers and supervisors acknowledge that there are times when the flexible application of agency procedural rules is appropriate in novel or highly complex circumstances.

Finally, CPSAs share responsibility for involving policymakers, stakeholders and the media in the system's development. Success and failures must be openly discussed, and to involve full stakeholder participation in the development of solutions. This is a process that involves a commitment to reflection and feedback, and is more than just learning, it is "a continuing effort to pinpoint subtle details, (and to) uncover capabilities that had gone uncovered" (Vogus, Sutcliffe, & Weick, 2010).

Paying continuous attention to key process indicators in order to catch problems early before serious problems arise is essential to the creation of and sustainability of a learning organization. However, no matter how good or careful our child welfare programs are, we will never be able to totally eliminate child fatalities (Perrow, 1984). Our best hope is to reduce serious injuries and deaths of children, and to learn from negative events when they occur. Below are few examples from Illinois and Tennessee where elements of safety science are beginning to be implemented.

Current Applications

The Illinois Experience

In an effort to move closer to becoming a safety culture where the potential for tragic case outcomes, including child deaths, is diminished, the Office of Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS) has been working to improve child protection decisionmaking.

State leadership expressed a *commitment to safety* through legislation that created the OIG in 1993. A statutory amendment added in 2008 requires the OIG to remedy patterns of error or problematic practices that compromise child safety as identified in death and serious injury investigations (20 ILCS 505/35.5, 35.6. 35.7). Each year, OIG staff conduct approximately 90 investigations of child fatalities in families known to DCFS (Office of Inspector General, DCFS, 2013). Based on investigation results, the office has the authority to make recommendations for change to the DCFS director, as well as pursue pilot projects, training, and supportive consultation to improve practice. The Inspector General is well-suited to lead such efforts, with a master's and doctorate in social work, many years of experience in a range of child welfare positions, and qualified personnel who include many social workers and former child protection staff. She and her investigators maintain frequent and regular communication with regional DCFS staff through phone and on-site visits. They are sympathetic to the complexities of practice and have been able to earn the confidence of many regional managers and supervisors upon whom they must rely to ensure that practice improvements are implemented.

Teamwork and open communication between the OIG, DCFS staff and administrators have been is emphasized in the error reduction initiative. For example, an in-depth, mixed-methods study of child maltreatment investigations was initiated when it was recognized that many child homicides had had previous contact with DCFS involving allegations of cuts, welts, and bruises in infants and very young children (Office of Inspector General, DCFS, 2013). Results of data analyses were communicated to each regional office in writing and

through in-person meetings with OIG staff. Discussions with regional administrators and managers addressed findings related to local practice strengths and weaknesses. Following the discussions, on-site training of all child protection personnel conducted by the OIG focused on critical thinking, the use of a brief checklist to guide interviews with medical professionals, and the application of empirical knowledge to practice. Periodic feedback was provided to the teams as new performance data were collected, followed by tailored consultation to promote further improvement (Office of Inspector General, DCFS, 2012, 2013). In addition, a periodic FAQ newsletter was made available to child protection units across the state to clarify common areas of misunderstanding (a description of this investigation can be found in Office of Inspector General, DCFS, 2007, 2009, 2012, 2013; Rzepnicki et al., 2012). Problem-based learning was encouraged within the teams through the use of redacted cases that prompted critical discussion and group problem solving. This work represented some initial steps to becoming a *learning organization*. Key to the effort was an emphasis on helping staff understand that mistakes are inevitable, that there is value in using them as opportunities for learning, and that critical reflection on the sources of error can inform improvements not only in their own decisionmaking, but also at multiple points within the CPSA (Munro, 2008).

The error reduction initiative focusing on decreasing child fatalities continues with projects aimed at improving outcomes for pregnant and parenting teen wards and cases where mental health issues play a big role (Office of Inspector General, DCFS, 2013). It is evident that steps toward a fully functioning safety culture involve a protracted and incremental process. Much more work needed, since the results of efforts to date have resulted in uneven performance across the state. Attention has not yet been devoted to *developing a nonpunitive approach to event reporting* and further development of strategies to better support supervisors and front line investigators are essential. Without these organizational improvements, changes in individual behavior are not likely to persist.

The Tennessee Experience

Tennessee, like many states, is challenged to ensure the quality and safety of its child protection services. Frustration and concern have led to various initiatives, plans, advisory panels, oversight groups and reporting requirements. In spite of these efforts over many years, Tennessee's partners in child protection—medical practitioners, members of law enforcement, and educators—have expressed limited confidence in the system's ability to keep children safe. Media reports on child deaths have led to a legal challenge to open the Tennessee Department of Children's Services (DCS) case records to the press in cases of fatality or near fatality, in the belief that public pressure will bring about needed changes.

In 2011, demonstrating leadership's *commitment to safety*, DCS partnered with Vanderbilt University's Center of Excellence for Children in State Custody to introduce safety science concepts to DCS, with learning activities structured on the Institute for Healthcare Improvement's Collaborative Model for Breakthrough Improvement.

To support this departmental initiative, DCS hired Master's degree-level staff licensed as mental health practitioners in 2011. Beginning in the summer of 2012, these staff started conducting root cause/event analyses in child fatality cases with direct involvement from responsible front-line staff and supervisors. These *non-punitive* analyses and are being used to develop action plans and identify trends in order to facilitate *organizational learning* and increase the likelihood that future injuries or deaths can be prevented. For example, root cause/event analyses of infant deaths led to the identification of a number of interrelated factors creating barriers to identification and mitigation of environmental hazards. These factors directly informed the development of a new "safe sleep" initiative to prevent sleep-related infant deaths.

The department is also working with its university partners to adapt a previously validated safety climate survey for the child welfare system (Vogus & Sutcliffe, 2007). The information generated by this survey will assist the Department in its efforts to identify and

prioritize organizational changes needed to produce "collective mindfulness" among agency staff. Surveys of this kind are now widely used in other industries to measure staff perceptions. Like all measurement, assessments of organizational culture exist to facilitate communication (Lyons, Epstein, & Jordan, 2010). Results from this survey will help establish a language for driving culture change.

Conclusion

The quality of child protection work depends to a large extent on characteristics of the work environment and workforce, especially the critical thinking skills of caseworkers and supervisors. Defensive practice may develop within CPSAs as a response to social, political and media pressures to avoid tragedies. Defensiveness can create environments in which "shame and blame" displaces learning from mistakes. While mistakes are inevitable, CPSAs must begin to incorporate principles from safety science known to promote organizational cultures in which individuals acknowledge mistakes, learn from their peers and improve their critical thinking skills. In an increasingly complex world, it is essential to adopt a systems approach to understand how errors and breakdowns in organizational communication and quality control occur and how to support sound decisionmaking. CPSA leaders must move the organization beyond a culture of blame to embrace transparent, and open communications, build inclusive partnerships among stakeholders in child protection, and to set aside differences to make progress on the common goal of ensuring child safety.

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THE STUDY & ADVANCEMENT OF JUSTICE EFFECTIVENESS

Report of a Research to Practice Partnership to Develop the Youth Housing Stability Model for Juvenile Courts

Accelerating Progress in the Justice System

JULY 2018

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Executive Summary

Homeless youth experience elevated risks for a variety of maladaptive social, health, and legal outcomes. Among these are higher rates of physical and sexual victimization, drug use exposure, mental health need, and justice-system contact. More than 75% of homeless youth will have contact with police, with more than 50% experiencing arrest. Because of the high proportion of homeless youth who experience justice-system contact, there is currently significant interest in developing policies and programs to minimize this contact while providing youth with the necessary supports and services to remain housed.

The development team used a participatory approach with two juvenile courts to develop a court-based strategy for preventing youth homelessness: The Youth Housing Stability (YHS) model for juvenile courts. The team used Intervention Mapping with local, interdisciplinary workgroups to assess needs and develop outcome targets, map the existing research literature to these needs, and used local data to estimate feasibility and impact.

Key findings from these activities were synthesized into a final model. These findings included the following:

- Homelessness services across counties are variable and fragmented, with availability and scope largely dictated by funding, licensure, and the geographic placement of service providers. An effective prevention model will need to address these system challenges in addition to supporting specific programs for youth and families.
- Very few evidence-based programs are designed to address youth homelessness. However, existing programs which address risk factors for youth homelessness (e.g., home conflict) are likely to work well with this population. Only one such program (Functional Family Therapy) is available to court-involved youth and eligibility is driven by criminal history and not housing risk. Courts will need to develop service maps of right-sized prevention programs already available in the community and advocate to implement additional programs, as needed, to meet these needs.
- Identifying and referring youth to housing and housing prevention services falls outside of the current routine and expected duties of juvenile court staff, including probation counselors. Relying on a probation-led model would present challenges in buy-in,

quality monitoring, and capturing the expected number of youth. Identification should be simple, standardized, and required, but more intensive assessment and case management should be provided by a dedicated staff person who does not have other duties within the court.

The resulting YHS model is intended to address both system and program level needs for the prevention of housing instability for an estimated 100-150 youth within each court, annually. The model has the additional aim of building community capacity for effective prevention through the implementation of services accessible to youth referred from non-court agencies as well. The model articulates 5 key components:

1) Regular, court-wide awareness trainings on risk factors and identifiers for youth homelessness
2) An identification and referral system using routine data flags
3) A dedicated housing stability coordinator to receive referrals, conduct housing stability assessments, and connect with community providers
4) A stepped care model of prevention services to provide the right dose of intervention based on youth and family need
5) Coordinated housing services for youth already experiencing homelessness

The model presented in this report attempts to articulate a standardized, practical role for the juvenile courts to play in addressing youth homelessness. The development process included a consideration of the potential risks of building services only accessible to court-involved youth as well as the feasibility of shifting current probation and court practice in the short vs. long term. The resulting model is expected to be feasible to implement at the current time given the general practices of court and probation staff while providing a conceptual model of assessment, referral, and stepped care that is expected to be applicable to courts and other youth service systems as systems evolve.

Introduction

This report summarizes the development of a juvenile court-based model of youth homelessness prevention and intervention funded by the Raikes and Block-Leavitt Foundation by a grant to the Center for the Study and Advancement of Justice Effectiveness (SAJE). The project adopted a participatory research approach with two juvenile courts in Washington State (Kitsap and Snohomish Counties). This approach was used to develop an innovative model given the lack of existing system-level interventions focused on the intersection of housing instability and justice involvement. This report is the first phase in a project that will also examine quantitative predictors of housing instability for youth who are court-involved.

Background

Housing instability and homelessness present significant risks to youth health and well-being. Youth who are homeless over an extended period of time will be exposed to violent victimization and drug use at higher levels than stably housed youth (Ferguson et al., 2011; Kaufman & Widom, 1999; Stein et al., 2009; Yoder et al., 2014). Nearly two thirds of youth will be victimized while homeless, including physical or sexual assault (33%), being threatened with a weapon (41%) or robbed (41%; Administration on Children, Youth, and Families [ACYF], 2016; Kipke et al., 1997; Rotheram-Borus et al., 1991). A little over one fourth of youth report "being sexual" in exchange for a place to spend the night (ACYF, 2016). Runaway and homeless youth are at a greater risk of depression, substance use, and conduct problems compared to housed youth (Chen et al., 2006).

Homelessness also puts youth at increased risk for arrest. Over three quarters of homeless youth will have contact with the police and more than half will be arrested (ACYF, 2016). While these contacts may result in a youth receiving services, the collateral consequences of justice involvement may also act as a barrier to future stable housing (Quirouette et al., 2016). For youth transitioning out of incarceration, the legal status of having a criminal record can limit opportunities for securing independent housing (Mears & Travis, 2004) or moving back with families living in subsidized housing (Snyder, 2004). Incarceration of

more than a year may also disrupt preexisting social networks, leaving youth with fewer supports upon release. These youth rely heavily on public systems to provide basic housing and needed resources for successful transition back to the community and are less likely to stay in stable placements (Tam et al., 2016).

A number of recent reports include policy and practice suggestions for improving justice responses to youth homelessness (Columbia Legal Services, 2015; Morton et al., 2017; Britton & Pilnik, 2018; Pilnik et al., 2017). For example, the Coalition for Juvenile Justice's Ten Principles for Change is designed to support communities to improve housing stability for justice-involved youth (Pilnik et al., 2017). These principles focus on reducing or minimizing future justice-system contact for youth entering the justice system and on accessing stable housing for youth exiting the justice system. The report recommends not charging youth for survival behaviors, repealing such laws, and eliminating court fines. The report also recommends strategies to reduce the likelihood youth will be released from justice settings into homelessness (Pilnik et al., 2017). These recommendations include more expansive transition planning, coordinated school reenrollment efforts, and maintaining open child welfare cases through justice placement. A different report from the National Council of Juvenile and Family Court Judges proposes strategies courts can take to prevent youth homelessness, including coordinated reentry planning and prevention through dependency proceedings (Britton & Pilnik, 2018).

Currently housed youth may also be arrested for behaviors that signal risk for imminent homelessness. Home conflict, for example, is one of the most common precipitants of youth homelessness (ACFY, 2016). At least 50% of youth homelessness appears to be directly preceded by a family conflict resulting in the youth running away or being kicked out of the home (ACYF, 2016). Courts process a high volume of referrals for adolescent family violence cases and it is likely that a substantial number of these cases include youth who will experience homelessness in the near term. Consequently, the justice system may be well placed to assist in identifying and preventing homelessness as well as minimizing the legal consequences that may arise from being unhoused.

An analysis conducted by our team using state data for this project found that just under 40% of youth screened for court services had a history of housing instability through

runaway, and 2% were not under the supervision of an adult at the time of assessment (although this may be skewed by youth who were under the court's guardianship at the time of assessment; Walker et al., in press). This is important to understand because justice systems have a number of competing mandates and performance goals. Implementing the systemic changes recommended by the previous policy reports are likely to be more successful to the degree that homelessness is identified as a significant issue for justice-involved youth or can be aligned with other initiatives addressing similar needs.

The current study is supported by a research-practice partnership with two juvenile courts in Washington State to develop and evaluate court-based models to improve the identification and service referral process for youth at risk of homelessness. We applied principles of community-based participatory research (Israel et al., 1998; Bess, 2009), ensuring that the developed model reflected the values and system operations of the local setting.

Development of Community Plans

Sites

Snohomish County Juvenile Court is a midsized, geographically diverse jurisdiction covering semi-urban, suburban, and rural areas. The population of adolescents ages 12 – 17 within the county was estimated at 59,225 in 2017 (Washington State Office of Financial Management [WAOFM], 2017). The largest proportion of these youth were White (75.3%), with Hispanic (13.71%), Asian (9.81%), and Multiracial (9.08%) youth also making up a large percentage of the subpopulation. Black (3.25%), American Indian / Alaskan Native (1.19%), and Native Hawaiian / Pacific Islander (0.68%) youth made up the smallest proportion of youth in the county. Snohomish Juvenile Court has participated in the Juvenile Detention Alternatives Initiative since 2012, having implemented numerous policies and practices oriented towards reducing youth detention for lower-level offenses. The court recorded the second lowest rate of detained youth in the state for 2014 (9.1 detentions per 1,000 youth ages 10 -17) and the fourth lowest rate of criminal offense filings (11.1 filings per 1,000 youth ages 10 - 17; Gilman,

2016). In 2017, Snohomish filed 882 criminal offense cases, at a rate of approximately 14.9 case filings per 1,000 youth ages 12 – 17.

Kitsap County Juvenile Court is a small sized, rural jurisdiction with a 2017 estimated population of 17,950 youth between the ages of 12 – 17 (WAOFM, 2017). Similar to Snohomish, Kitsap's youth population was primarily White (74.9%), with Multiracial (13.12%) and Hispanic (10.7%) youth comprising a large proportion of the non-white population. Asian (5.3%), Black (3.0%), American Indian / Alaskan Native (2.2%), and Native Hawaiian / Pacific Islander (1.5%) made up a smaller proportion of the youth population. Kitsap County does not participate in the JDAI initiative but in 2014 recorded a detention rate comparable to Snohomish of 15.3 per 1,000 youth ages 10 – 17 and a case filing rate of 12.7 per 1,000 youth ages 10 – 17 (Gilman, 2016).

Development Workgroups

In order to produce a collaborative model that responded to local needs, we convened workgroups within each county to steer the development of their respective youth homelessness models, and then found common themes across sites to produce a model that could be generalizable to other courts.

Kitsap County

Kitsap County already had an established workgroup dedicated to addressing issues of homelessness, operated through its Human Services department. When presenting this opportunity to work on a court model of reducing youth homelessness, the county decided to integrate this focus into the existing county work. Accordingly, we worked with the coordinator of this larger workgroup to bring together members with the interest and capacity in specifically addressing youth homelessness and its intersection with the juvenile justice system. The resultant "youth homelessness development workgroup" for Kitsap County was comprised of members from a variety of service providers and public agencies (Table 1). This workgroup was facilitated by both the homelessness program coordinator and the juvenile court administrator, focusing primarily on producing an intervention model for court-involved

homeless youth. Our team had dedicated time on the agenda to solicit information and report back to the group.

Snohomish County

At the start of this project, there were no workgroups or formal interagency collaborations in Snohomish County with the goal of addressing youth homelessness and the justice system. However, the county did have a longstanding group focused on reducing youth substance use through system coordination (Reclaiming Futures). We approached the probation manager of the Juvenile Court to convene a preliminary workgroup meeting with relevant service providers and community agencies. A focus of this preliminary meeting was to present the overview of our project and identify community partners to form a youth homelessness workgroup (Table 1). After this preliminary meeting, we reached out to all identified partners to convene a subsequent workgroup meeting, which was comprised of representatives from juvenile probation, juvenile detention, the school district, the primary homeless youth services provider in the county, and a county-funded advocate working with commercially sexually exploited youth. As the development workgroup continued to convene, members were encouraged to invite additional stakeholders as new areas of need emerged through discussion. Similar to Kitsap County, the members of the Snohomish Workgroup steered the development and ultimate design of their youth homelessness intervention model. However, unlike Kitsap County, the Snohomish workgroup was convened for the express purpose of this project, was facilitated by the University of Washington, and the content of the workgroups were solely focused on the production of an intervention model.

Table 1: County Workgroup Participants[1]

Kitsap County		Snohomish County	
Agency	**Participants**	**Agency**	**Participants**
Juvenile Court	Court Administrator	**Juvenile Court**	Program Manager, Probation Supervisor, Probation Counselor, Assistant Court Administrator, Juvenile Justice Fellow

Kitsap County Human Services	Housing & Homelessness Program Coordinator	**Department of Social and Human Services**	ART Quality Assurance Specialist
Children's Administration	Missing-from-Care Locator	**Everett School District**	McKinney Vento facilitator
Partnering for Youth Achievement	Outreach Coordinator	**Cocoon House**	Director of Outreach Services
Kitsap County Commission on Children and Youth	Human Services Planner	**North West Educational School District**	Juvenile Detention Teacher
Kitsap Strong	ACEs & Resiliency Project Director, Project Manager	**Sexual Exploitation Intervention Network**	CSEC Specialist
Olympic Educational Services District	Youth Services Director	**Providence**	Mental Health Specialist
Coffee Oasis	Outreach Services Director		
Scarlet Road	Director of Outreach		

[1]Walker, Valencia, Bishop, Irons, & Gertseva (in press)

Workgroup Process

To support the local workgroups in developing their plans, our team used the Intervention Mapping model (Bartholomew, Parcel, & Kok, 1998) to highlight areas of strengths and need, and to recommend intervention approaches. First developed for creating health education programs, Intervention Mapping is a process for developing new programs and models for specific populations using existing theory and research. It consists of five steps: 1) create a matrix of program objectives; 2) select theory based methods and strategies; 3) design and organize a program; 4) specify adoption and implementation plans; and 5) generate program evaluation plans. In developing the county intervention models, we relied on Social Development Theory (Hawkins & Weis, 1998) and on the principles delineated by Pilnek et al. (2017) to collaboratively produce models which comprehensively address micro and macro youth homelessness factors across areas of homelessness identification, resource/service availability and adequacy, methods of service engagement, and policies governing service provision. Additionally, we incorporated the prevention-to-intervention framework (Tolan, Guerra, & Kendall, 1995) into our facilitation as we presented the workgroups with research-

based programs and models with demonstrated success in addressing risk factors for youth homelessness. A detailed review of the process in Snohomish County is highlighted in an upcoming paper (Walker et al., in press).

Team Meetings

In both counties, the development workgroup convened bimonthly over 8 months (for a total of 4 workgroup meetings). The purpose of the first meeting was to gather as much information as possible from the workgroup participants about existing processes, policies, programs, and resources that could inform the development of a model. The discussion was facilitated by the Principal Investigator of the project and included a series of prompting and clarifying questions about court policies, court staff knowledge and motivation to address homelessness, existing programs in the court and community, community expertise and resources, and areas of perceived significant need. For both counties, suggestions emerged from the discussion about areas of additional information and data gathering needs. The project team followed up and then brought this information back to the second workgroup. In the second workgroup, the teams worked on developing the matrix of objectives identified from the first meeting and through data gathering. In both counties, these discussions produced cross-agency themes around the need for new methods of identifying risk of homelessness in court settings, dedicated staff for assessment and referral, and increased programming options for prevention. Other themes related to the inadequacy of existing housing options and barriers to accessing housing were also identified. The third meeting focused on specific program triage and content for prevention and intervention services. The fourth meeting reviewed the draft model and refined details of the model.

Data Collection

To understand the service context for preventing and intervening with youth homelessness, our team conducted key informant interviews in both counties and captured local data estimating the number of youth who might be identified and referred for assessment in a developed program model. For the key informant interviews, we spoke to a program manager at a youth services organization in Snohomish County that provides shelter, housing,

and services for homeless youth (Cocoon House). In Kitsap County, we conducted interviews with a program manager at a youth services organization that provides services and housing referrals for homeless youth (Coffee Oasis) as well as a youth locator from the regional Child Welfare department. The discussion content of each interview was captured via audio recordings and hand written notes taken by team members. We used directed content analysis (Hsieh & Shannon, 2005) to code the data using pre-selected themes that matched the areas of interest highlighted by the workgroup process (availability of services, content of services, youth satisfaction). As the workgroups progressed, the qualitative data captured were analyzed within the thematic framework produced in the first meetings to build out and reaffirm these initial themes, and subsequently shape the resultant intervention models. This method of triangulation served to facilitate trustworthiness among the workgroup members, and confidence in the credibility of its outcomes (Miles, Huberman, & Saldana, 2014).

In Snohomish County, local data on indicators of housing instability risk were examined to provide estimates of how many youth per month could be expected to be flagged as at risk for housing instability. This included all cases (which could include duplicates) receiving the PACT prescreen between February 2016 through February 2017, n = 555. The prevalence of local data items presumed to indicate risk for housing instability were also compared to the state findings as a check on generalizability of the developed model for other jurisdictions. These indicators include previous runaway incidents, previous out-of-home placement, and level of conflict in the home. In Kitsap County, the workgroup identified address mobility as a marker for housing need among youth accessing detention. This was recorded as the number of unique home addresses provided by youth upon detention within one year. To estimate the number of youth this data marker would identify in one year, data was requested from January through December, 2017 (n = 716).

Key Informant Interviews

Snohomish County. The service agency for Snohomish County provides housing services, independent living skills building, general family preservation/reunification support services, and limited mental health services. Among the housing services provided are short-term and long-term shelter services for minors (12 – 17), with limited short-term and long-term

housing for youth 18 and older who are signed into extended foster care. Additionally, the agency operates a drop-in center for youth that provides ad hoc access to general agency services, as well as laundry and showering services, and a designated activity space. The Snohomish agency identifies itself as utilizing a trauma-informed approach to its work and attempts to scaffold positive youth development through the use of incentive-based participation in agency activities and through employing youth who utilize the agency as peer mentors for other young people navigating homelessness.

Kitsap County. The Kitsap County service agency provides emergency shelter services for youth between the ages of 16 – 24, though for minors under the age of 18, the agency is obligated to connect with a minor's parents within 72 hours of checking into emergency shelter services before they are able to move forward with any additional housing services. The agency also operates a variety of transitional homes for youth ages 18 – 25 (one specifically to serve commercially and sexually exploited youth, CSEC) which maintain their own case management services for residents. Additionally, the county agency has begun to utilize Host Homes as a long-term housing solution for youth as young as 13 years old. The Kitsap agency also provides an array of support services for youth at risk for homelessness and outreach services to identify youth already experiencing homelessness. Notably, the Kitsap agency articulates the structure of its programs as targeting youth engagement with housing, education, employment, and their families.

Findings

In this section we review 1) findings from the key informant interviews, 2) local data indicating the number of estimated monthly referrals, and 3) a literature search for programs designed for a homeless or at-risk-for-homelessness youth population.

Review of County Programs

The content analysis of the key informant interviews with youth homelessness service providers and locators resulted in the following findings: 1) housing options for youth are

fragmented and vary by county, 2) licensing and workforce turnover adds burden to overtaxed agencies, 3) services can be too structured or unresponsive to the needs of chronically homeless youth, and 4) existing social services have infrastructure but insufficient resources to effectively provide the degree of prevention services needed.

Fragmented Housing Options for Youth

Snohomish County noted that it had few long-term housing options for youth over the age of 18 who were not involved in foster care. It expressed that it would be exploring the option of Host Homes for these youth. Additionally, the Snohomish agency felt that its long-term housing options for minors were not always suitable for youth ages 12-15 (due to the independent-living nature of its programming).

> *"12 to 15 [year olds]… they are not well suited for [our] type of program. We will take those younger kids, and we have, because if they don't have any options obviously we're going to house them…[but] they tend not to do well in that setting."*

Snohomish also noted the lack of family shelter options within the county, which results in youth being separated from families in order to access housing.

Conversely, while the Kitsap agency has demonstrated success in long-term housing options for youth 18 and older (and preliminary success in utilizing host homes for youth as young as 13), there was a dearth of emergency shelter options for youth under the age of 16. Further, there exist no specific housing opportunities for commercially sexually exploited children, who present a unique set of needs.

Workforce and Licensing Challenges

The workforce for shelter agencies are typically made up of young adults who stay one to two years. Turnover is high due the heavy nature of the work and the demands of licensing (such as having shelter staff available 24/7 and in ratio to the number of youth sheltered). Background checks also take a long time to process, making rehiring difficult and putting a strain on existing staff. Both agencies acknowledged the importance of licensing and

regulations to ensure the safety of youth but noted that the rigidity of licensing (and funding) requirements can contribute to the development of gaps in service provision.

> *"It's just, you know, licensing is a good thing to keep youth protected, but at the same time it is, it has its challenges."*

For example, per licensing requirements, youth shelters can only support youth under the age of 18. Youth who rely on shelter services due to persistent, systemic barriers are moved to adult housing upon turning 18 while not being fully prepared for independent living.

Challenges Serving Chronically Homeless Youth

The Snohomish agency observed that chronically homeless youth engage with housing services in particular patterns. For those youth who utilize short-term shelters, the agency frequently observes youth "shelter-hopping" between sites in Snohomish and neighboring King Counties. Additionally, the Snohomish agency operates shelters with very structured programming, and finds that it can be difficult for youth to acculturate to this structure once they've accessed services, causing them to leave. This difficulty in adjusting to the structure of housing programs contributes to what both county agencies observe as self-elected homelessness, where housing and shelter services are available for youth (indeed, in some cases where youth are currently accessing housing or shelter services) but youth ultimately abstain from taking advantage of resources. In such cases, the county agencies are sometimes able to engage these youth in other support services, and always communicate to youth that shelter/housing services are available if and when they would like to access them.

> *"I think about understanding that [youth] are going to mess up and they're going to go on [to runaway] and maybe use drugs. And when they come back, we welcome them and we let them know that… we're glad you're back."*

Youth who take advantage of the county agency housing resources have often experienced homelessness with their family as a young child. Youth will frequently utilize shelter services during family episodes of homelessness, return to their families when housing

is found, and subsequently return to patterns of shelter use when housing is lost. Both agencies serve foster care and adopted youth who leave stable housing situations and seek out shelter/transitional housing services as preferred placement. The Kitsap agency observed that foster and adopted youth in particular engage in patterns of self-elected homelessness in spite of having, what they viewed, as ideal housing situations.

> *"One thing that [we've] noticed, that really kind of strikes a nerve…is that a lot of [our] youth who [we] work with who are adopted, who have loving, caring adoptive parents…choose homelessness over those homes."*

The Snohomish agency noted that in situations where youth of color are placed with White guardians, the White guardians often lack the ability to support these youth in their racial identity, leading to conflict. They further suggested that the interplay between trauma and adolescent development results in behaviors that foster/adoptive parents are not prepared to manage.

> *"As you know, teenage brains are so volatile, [it's] kind of a thing that the adoptive parents, it's too much for them to take on and the youth suddenly breaks apart from their adoptive parents and we see those kids in our shelter."*

Infrastructure Present for Delivering Prevention Services

Both the Kitsap and Snohomish agencies provide homelessness prevention resources for youth and families, though they also acknowledge the limitations of these services and the general lack of prevention services within their respective counties. The Kitsap agency offers case management services for youth which adopt family preservation/reunification principles and prioritize reengaging youth with their families. Additionally, the agency provides prevention resources under the mantel of outreach and support services, notably, operating skill-building classes within district schools, providing education (re)engagement services, conducting employment training programs, overseeing a mentoring program, and operating a crisis-intervention text-line. The Snohomish agency's prevention services are primarily oriented towards parents struggling with their youth, and families in general. For parents with lower-

level needs, the agency offers brief parenting phone consultations with a licensed therapist (offered both in English and Spanish), as well as a short parenting workshop series. The agency also offers more family case management for families with higher-level need.

Quantitative Findings

Kitsap County

Data from detention admissions indicated that 96 youth listed two or more address changes within calendar year 2017, while 26 youth listed three or more address changes. Utilizing this data marker alone as a flag for referral into Kitsap's intervention system, a housing coordinator could expect approximately 8 youth referrals per month. Kitsap County also collects data regarding family conflict, history of abuse, mental health, substance use issues, and a youth's housing situation. Kitsap is currently in the process of reviewing these data to obtain a more accurate estimate of referrals into their intervention model. Presuming Kitsap utilizes data markers for two or more address changes, any ARY/CHINS/Truancy petitions, youth with any indicated non-parental living arrangements, and youth with a history of abuse, aggression/violence, or family conflict, a current estimate of the Kitsap Model is approximately 10 to 13 youth per month to be screened for prevention and/or housing services.

Snohomish County

From prescreen data on youth referred to court services, a minority of the youth (about 10%) had at least one previous out of home placement in foster care, a mental health treatment facility, or a state justice facility. The percent of youth with an assessed runaway history was also relatively low compared to the total assessed group: 22% had at least one previous runaway episode and 7% had more than five previous runaway episodes. Youth displaying consistently hostile behaviors at home, presumed to be a risk factor for being kicked out by parents, reached 11% of the assessed sample.

While the presence of these indicators was relatively low in the overall population, the number of youth with at least one of the above indicators reached 175 youth a year when runaway history was set to at least two prior episodes (not accounting for possible duplicates). Divided by 12 months, the court could expect about 14 referrals a month if these items were

considered “flags” for potential housing instability or risk. If the indicator for consistent youth hostility in the home was added as a flag, this could add another 60 youth a year, for an estimated 19-20 “flagged” youth per month from court-referred youth alone. The court also processes about 20 ARY cases a year, increasing the estimated monthly expected referrals to 22-24 cases. The workgroup was not able to access detention data for the planning phase, but estimated another 5 referrals monthly from detention and diversion/non PACT screened youth. This led the workgroup to estimate approximately 30 referrals per month for a housing coordinator to assess, triage, develop case plans, and coordinate follow-up with indicated services.

Review of Programs

Our team conducted a literature program search in order to inform the developing models about available or researched services. This included a literature search focused on programs developed for homeless youth or youth at risk of homelessness as well as a review of family-based services designed to reduce adolescent family conflict.

Search Strategy and Program Selection

To gather relevant programs, the following databases were searched in June of 2018: NIJ’s Crime Solutions; SAMHSA’s NREPP; Blueprints for Healthy Youth Development; and CEBC for Child Welfare. In each of these databases, the following search terms were utilized: “homeless,” “homelessness,” “street youth,” “runaways,” and “throwaways.” All programs that resulted from those searches were examined in detail and programs whose aim was to prevent or reduce youth homelessness, runaways, or throwaways and/or were intended to improve outcomes for these populations were selected.

A total of 26 programs were selected using the above parameters (see Appendix A for a full list of programs). These programs were sorted into five categories using the intended population and expected outcome, including: 1) currently homeless youth as an intended population; 2) youth at risk of homelessness as an intended population; 3) previously homeless

youth as an intended population; 4) housing stability as an intended outcome; and 5) programs that did not include housing stability as an intended outcome.

Programs for Currently Homeless Youth

We identified 15 programs developed to serve currently homeless youth. These included programs whose target population was homeless youth as well as programs adapted or extended to include homeless youth. Programs targeting homeless youth varied widely in program features. They included programs aimed at general functioning; programs that focus on substance use disorder, trauma, or other mental health issues; programs for those aging out of other support systems; education programs; housing programs; family-based programs; and programs aimed at organizational change. Of the 15 programs targeting homeless youth, only 2 were rated as having a substantial evidence base, 6 of the 15 programs were rated as promising, and 7 were not rated for evidence. Programs with a strong evidence base with homeless youth as an intended population included Adolescent Community Reinforcement Approach (A-CRA) and Parent Management Training, Oregon Model.

Programs for Youth at Risk for Homelessness

We identified 10 programs whose intended population only included those at risk of homelessness. Program features targeting those at risk of homelessness also varied widely. They included programs aimed at general functioning; mentor/case management programs; programs for current or recently released juvenile offenders; programs for those aging out of other support systems; family-based programs; education programs; and a program for those at high risk of involvement in sex trafficking. Of the 10 programs targeting only youth at risk of homelessness, none were rated as having substantial evidence base, only 1 was rated as promising, 3 were rated as having no effect, and 6 were not rated for evidence.

Programs for Previously Homeless Youth

We identified one program whose intended population only included those who were previously homeless (FamilyLive).This program is a family-based intervention focused on youth with histories of trauma (including homelessness). This program was not rated for evidence.

Programs with Housing Stability as an Intended Outcome

We identified 15 programs intended to improve housing stability for youth. These included programs whose only aim was to improve housing stability, programs that include housing stability among a number of intended outcomes, and programs that directly provide housing as part of their program. Programs intended to improve housing stability varied widely. They included programs aimed at general functioning; programs that focus on substance use disorder or other mental health issues; mentor/case management programs; programs for newly released juvenile offenders; programs for those transitioning out of other support systems; family-based programs; education programs; and a program for those at high risk of sex trafficking. Of the 15 programs aimed at improving housing stability, 1 was rated as having a substantial evidence base (A-CRA), 3 were rated as promising, two were rated as having no effect, and 8 were not rated for evidence.

Programs without Housing Stability as an Intended Outcome

11 of the 26 programs we identified did not include improving housing stability as an intended outcome. These programs varied widely and included programs aimed at general functioning; programs that focus on mental health issues; programs aimed at improving family relations; programs aimed at reducing recidivism; and a program aimed at affecting organizational change. Of the 11 programs that did not include improving housing stability as an intended outcome, only one was rated as having a substantial evidence base (Parent Management Training for reduced adolescent aggression), 4 were rated as promising, one was rated as having no effect, and 6 were not rated for evidence.

Review of Programs Shown to Improve Family Conflict for Adolescents

Overall, we found the program literature focused on intervening or preventing homelessness for youth to be sparse with limited research. Accordingly, we also undertook a review of programs shown to improve family conflict for adolescents. We reasoned that these programs would be good candidates for preventing homelessness for youth whose housing instability was precipitated by conflict in the home. Using the same inventory and database sources as the previous search, we searched for programs with the key words of “adolescent

family violence," "adolescent domestic violence," "family conflict," and "family climate." The result of this review is shown in Table 2. Our search found that there are a number of well-tested and evidence-supported programs shown to improve family climate, reduce family conflict, and reduce adolescent aggression. These results were also presented to the county workgroups.

Table 2: Program Review for Effective Family-Based Prevention Programs for Adolescents

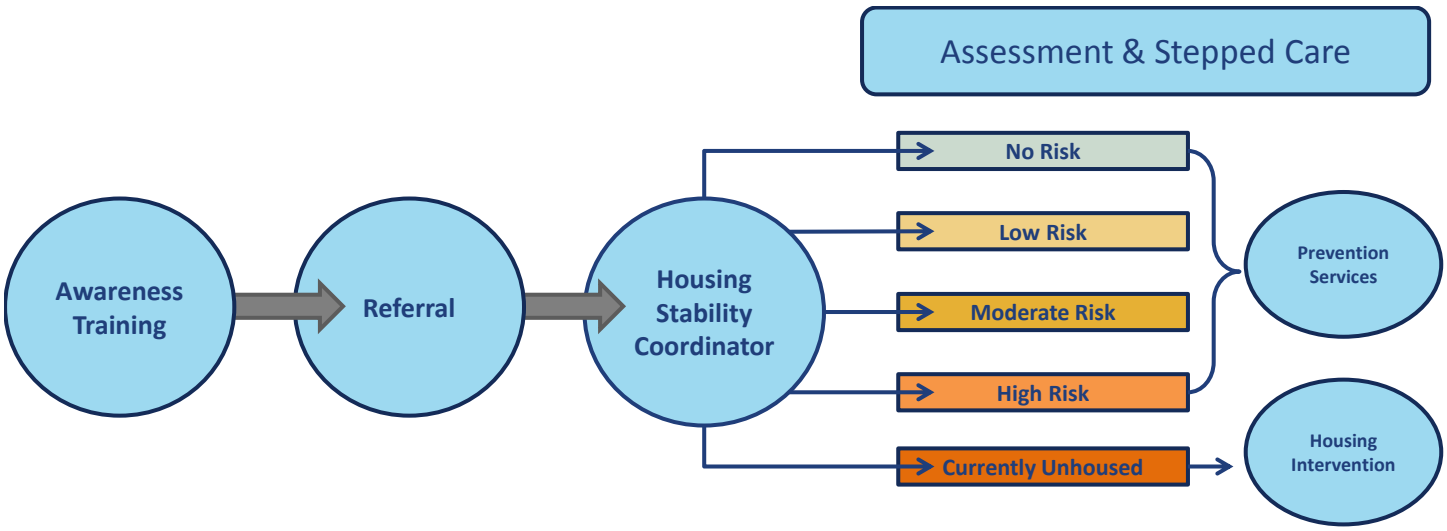
Program	Target Population	Outcome		
		Rating	Prevention Level	Research
Brief Strategic Family Therapy	8 to 18 years	Blueprints: Promising NREPP: OJJDP/Crime solutions: Effective	Indicated Prevention, Intervention	Aggression, Substance use, Family functioning
Creating Lasting Family Connections	9 to 17	NREPP: 3.0-3.5 Blueprints: Promising OJJDP/Crime Solutions: Effective	Universal, Selective	Substance use, Family functioning
Functional Family Therapy	12 to 17 years	Blueprints: Model. Crime Solutions: Effective OJJDP: Effective	Indicated Prevention; Intervention	Aggression, Family functioning, Substance use
Guiding Good Choices	12 to 14 years	Blueprints: Promising Crime Solutions: Effective SAMHSA: 2.6-3.1 out of 5	Universal Prevention	Substance use, Family functioning
MultiSystemic Therapy	12 to 17 years	Blueprints: Model Plus. Crime Solutions: Effective OJJDP: Effective SAMSHA: 2.90-3.2	Indicated Prevention. Intervention	Aggression, Out of home placement, Delinquency
Parent Management Training	3 to 12 years	Model Program	Selective Prevention Indicated Prevention	Aggression, Internalizing
Raising Healthy Children	5 to 18 years (different modules for childhood, early and late adolescence)	Blueprints: Promising Crime Solutions: Promising	Universal Prevention	Substance use, Educational outcomes
Staying Connected with Your Teen	12 to 14 years	OJJDP: Promising	Universal	Aggression
Step Up	12 to 17 years	None (unpublished studies show promising effects in reducing arrests for youth on probation)	Indicated Prevention, Intervention	Recidivism
Strengthening families (ages 10-14)	10 to 14 years	Blueprints: Promising Crime Solutions: Effective SAMHSA: 2.8-3.3 out of 5	Universal Prevention	Substance use, Aggression, Delinquency

Strengthening Multi-Ethnic Families and Communities	Birth to 18 years. No specific teen version.	Rated as promising in a 1999 matrix from OJJDP/SAMHSA *But has a Washington Evaluation	Universal Prevention	Family functioning
Strong African American Families	Adolescent	Blueprints: Promising Crime Solutions: Effective OJJDP: Effective NREPP: 3.6-3.8	Universal Prevention	Delinquency

Youth Housing Stability (YHS) Model for Juvenile Courts

Data from the qualitative and quantitative analyses were reviewed along with the principles identified from the Intervention Mapping exercise and the prevention services literature to develop the Youth Housing Stability (YHS) model for juvenile courts. The workgroup members reviewed the major gaps and resources identified from the previous meeting and the prevalence data to develop a working model to improve identification, system coordination, and services to reduce youth homelessness through prevention and intervention services. The results specified the need for five major components: 1) agency wide awareness training; 2) screening and mandatory referrals using routine data across multiple court divisions; 3) a dedicated housing coordinator position; 4) stepped care prevention services; and 5) coordinated housing services.

Figure 1: County Model for Youth Homelessness Prevention and Intervention



Training

The workgroups identified agency wide training as a needed component of the model in order to address the challenge of inconsistent awareness and perceived responsibility to address homelessness among current court and probation staff. As identified by the workgroup, the training would need to be offered to all probation and diversion staff and focus on flags for homelessness not available in the existing assessment tools, the benefits of addressing homelessness for reducing youth recidivism, and any new procedures the court adopts to assist with system coordination. Following best practice from the literature, the training should be conducted by an individual with significant experience working directly with homeless youth (Havlik et al., 2016). Content would likely follow some of the trainings currently offered online through the National Center for Homeless Education on signs of homelessness, understanding "doubled up," and preventing drop out. This might include training court staff to look for signs of lack of continuity in education (lack of personal records, attendance at many schools), poor health (hoarding food, significant fatigue), transportation problems (erratic attendance), poor hygiene, and significant social/behavioral concerns (unwilling to form relationships, need for immediate gratification; "Potential Warning Signs of Homelessness," n.d.).

Data Flags Using Routine Data

Given the challenges of instituting an entirely new screening tool on top of existing paperwork and responsibilities, the workgroup focused on how to use existing indicators to flag youth for referral to a central coordinator for further assessment. The workgroup identified the indicators on the prescreen assessment as noted above, as well as indicators from detention (McKinney Vento data), the at-risk youth court (ARY, noncriminal court), and for youth on warrant for failing to appear to court. For court-referred youth, this included all youth with two or more instances of running away, current or past foster care status, and the highest score possible (3) on an item measuring levels of home conflict. For ARY youth, the workgroup recommended that all be referred to the program for assessment. For detained youth, all youth with an active McKinney Vento indicator, all youth detained for an assault, and all youth with more than one runaway episode would be referred. Because of various screening practices for

youth on diversion, the recommendations varied. For diverted youth receiving the PACT screen, the same indicators would apply as for youth referred to court. For youth not receiving the PACT screen, the diversion staff would be trained on common indicators of family stress and housing risk to facilitate referrals to a housing coordinator.

The value of identifying routine data is twofold. First, routine data does not add any additional burden to court staff. Because screening is intended to yield false positives and identify youth who do not have significant housing needs, screening data do not need to be direct measures of housing instability or risk. Routine data collected in the current courts were judged to be a good indicator of likely need and risk and future planned analyses will assist in developing even more precise decision rules using this information. Second, using routine data for screening and setting an expectation around referrals provides a path for quality control that is not present when court staff are asked to make referrals from their judgement alone. The use of routine data takes some of this discretion and risk of bias out of the hands of court staff, and allows for potential checks on whether referrals are being made as expected.

Dedicated Housing Coordinator

The workgroup felt a dedicated job position was necessary to avoid underserving youth who could benefit from further assessment if the responsibility to provide comprehensive housing and services coordination otherwise fell to the probation counselors. This is also supported by findings that educational liaisons for preventing youth homelessness (e.g., McKinney-Vento advocates) who take this role on in addition to administrative or teaching positions (school counselor, vice-principal) are often too stretched to meet the needs of homeless youth (Havlik et al., 2016). Further, this would ensure that referral would not be limited to only youth on probation and eligibility could be opened up as needed. The workgroup also felt that the coordinator should come from a community agency rather than the court so that the youth could continue to have contact with the individual past the point of justice contact, if necessary. The coordinator's job would be to locate youth referred by court staff, conduct a housing assessment, and develop a support plan to include leveraging available resources and services to keep youth in the most stable, home-like situation available. This could include connecting the family with effective family support services, coordinating short

and long term housing, providing or arranging for transport, coordinating with schools to preserve enrollment, or advocating for the youth in relevant social service systems. The coordination would prioritize transitioning the youth and family to longer term case management services and would not be expected to last more than two to three months per case.

Table 3: Components, Objectives, and Content for a Youth Housing Stability Program for Juvenile Courts[1]

Component	Target Population	Objective	Content
Awareness Training	All court divisions (diversion, probation, ARY, detention)	• Engage court staff in supporting a new direction in practice • Set expectations about referring youth based on routine data flags • Educate staff about common signs of housing instability for discretionary referrals • Engage court staff in sexual exploitation response training oriented towards homelessness prevention	• Definitions of youth homelessness • Overview of existing services • Signs and risks for homelessness • Existing screening items requiring referral • *Sexual Exploitation Identification and Response*
Referral	All court divisions (diversion, probation, ARY, detention)	• Identify youth across the continuum of court involvement • Create court wide expectations for referring youth	• PACT prescreen items: ≥2 times runaway; any out-of-home placement; highest level of hostility at home • At Risk Youth (ARY): all petitions • Detention: ≥2 times runaway; all DV assault holds; current McKinney Vento
Housing Stability Coordinator	All court referred youth and families	• Centralized coordination of services • Brings expertise on housing and family-based prevention to court operations • Works flexibly with court staff to support housing as one component of a case plan	• Conducts agency wide awareness trainings • Follows up on court referrals to conduct a housing stability assessment • Develops case plans • Monitors case plans through completion of services (for prevention) or after confirming contact with community-based case management (for unstably housed youth)
Prevention Services	Youth assessed as low to high risk for instability but currently housed under adult supervision in a family that is currently housed	• Provide a continuum of care for families based on need • Save costs and time with a stepped care model • Build resiliency in youth and families to promote youth development	• Low need: brief family support through telehealth, phone coaching, education, and information about community resources • Moderate need: selective family-based prevention services, 5-7 weeks of curriculum, practice, and coaching • High need: in home support using intensive family intervention, e.g., wraparound, family systems therapy models
Housing Intervention	Youth unhoused at the time of assessment	• Provide youth with immediate shelter • Plan for long term housing • Build youth resiliency and life skills	• Court Housing Coordinator refers to existing community case management to support long term housing stability

[1]Walker, Valencia, Bishop, Irons, & Gertseva (in press)

Stepped Care Prevention Services

Finally, the model indicates the need for a stepped care approach to family-based services to prevent youth from being kicked out or running away when reunification or prevention is an option. The workgroup discussed needing to "right-size" the family program to the level of the family's need in order to address the original concern that some families need more services than are currently provided or offered. The program model, therefore, aimed to build a feasible system-level intervention for coordinating communication and referrals across service systems while articulating the program principles necessary for effectively preventing and intervening to improve youth housing stability. This resulted in a "stepped care" model of intervention. In this model, youth are assessed and triaged into one of five paths: no need, low need, moderate need, high need, and currently unhoused. Each path specifies a set of appropriate services given the level of need and theory-driven approaches to reduce risk and support long term housing stability and youth development. These include, at the low need level, brief family stabilizing interventions including information about community resources and parent phone coaching. At the moderate level of need, families would be referred to in person group sessions based on evidence-based principles of family-based prevention science. These models (e.g., Strengthening Families, Guiding Good Choices) build communication skills and positive relationships between parents and adolescents. At the high level of need, families would be referred to more intensive in-home supports including Functional Family Therapy (Sexton & Turner, 2011) or Wraparound services (Bruns et al., 2010). At each level of care, families would be assessed for whether more intervention services are needed, with families moving up the hierarchy of intensity as indicated.

Coordinated Housing Services

The housing coordinator is expected to receive referrals, follow up to conduct an assessment of needs, refer to services, and provide brief case management for prevention cases. For currently homeless youth, the housing coordinator would be expected to refer the youth to existing community services focused on providing intensive case management and housing services and then discontinue active case management. As noted in the findings, counties will vary in the supports available to youth who need housing. However, all school

districts will have, at a minimum, a staff member identified to manage the housing needs of students through McKinney-Vento. The court-based housing coordinator would be expected to coordinate with the educational liaison as well as other available resources to hand the youth over to services following the identification of need within the court.

Conclusion

This project was focused on developing a system level intervention for reducing the prevalence of homelessness among youth. Given the high rates of justice contact in this population, others have rightly called for policy and practice shifts to reduce arrest and the collateral consequence of justice involvement. However, many homeless youth are likely to continue to come to the attention of law enforcement and the courts. In addition, many youth are arrested for behaviors that may indicate high risk for imminent housing instability, particularly behaviors related to family conflict. This positions the juvenile court as a potential resource for identifying and referring youth to services that will mitigate this risk. As no previous systemic intervention existed for reducing homelessness for justice involved youth, we undertook a research-practice partnership with two juvenile courts in Washington State to develop a court-based model. This involved gathering data from workgroup members, key informants, local data systems, and literature reviews. The resulting model recommends five steps for policy and program implementation and is anticipated to be feasible to implement across diverse contexts.

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Appendices

Appendix A: Program Search Results Summary

Name	Search Website	Summary	Target Populations	Intended Outcome(s)	Overall Evidence Rating
Adolescent Community Reinforcement Approach (A-CRA)	Crime Solutions & NREPP	Outpatient program/behavioral intervention that aims to replace structures supportive of drug and alcohol use with ones that promote a clean and healthy lifestyle. Overall goals are to reduce substance use and dependence, increase social stability, improve physical and mental health, and improve life satisfaction. Includes sessions with adolescents, parents/caregivers, and both together during the course of treatment. It has also been adapted for use with Assertive Continuing Care, which provides home visits to youth following residential treatment for alcohol and/or substance dependence, and for use in a drop-in center for street-living, homeless youth.	Currently homeless youth	Global functioning with emphasis on substance use (social stability outcome measured by % of days working, receiving education, **in a home or shelter**, or receiving medical care)	Effective - more than 1 study
Promotor Pathway Program	Crime Solutions	A community-based program that uses a caring adult, called a Promotor, to provide case management, mentoring, and advocacy for youths with multiple risk factors. The goals of the program are to improve education and employment outcomes, boost life skills, and prevent delinquency and unhealthy behaviors among at-risk or disconnected youths.	Youth at risk of homelessness	Global functioning (including % of youth sleeping in a shelter)	No Effect - one study
Serious and Violent Offender Reentry Initiative (SVORI)	Crime Solutions	A collaborative Federal effort concentrated on improving criminal justice, employment, education, health, and housing outcomes of adult and juvenile offenders upon their release from incarceration. In total, 69 State and community agencies received funding through SVORI to facilitate the reentry and reintegration of offenders.	Youth at risk of homelessness	Global functioning (including housing)	No Effect - one study
Aggression Replacement Training (ART) for Adolescents in a Runaway Shelter	Crime Solutions	A program that targets adolescents who live in a short-term facility (a runaway shelter) and exhibit signs of antisocial behavior problems (ASB). The program combines anger-control training, social skills training, and moral reasoning education. The goal of the program is to reduce aggression and violence among youth by providing them with opportunities to learn prosocial skills, control angry impulses, and appreciate the perspectives of others.	Currently homeless youth	Reduction in aggression and violence	Promising - one study
Ecologically Based Family Therapy (EBFT) for Substance-Abusing Runaway Adolescents	Crime Solutions & CEBC	A home-based, family preservation model that focuses on families who are in crisis because a youth has run away from home. EBFT was developed based on the HOMEBUILDERS family preservation model in which services are initiated when there is a family crisis, such as a child's removal or departure from the home. The goal of EBFT is to improve family functioning and reduce youths' substance use.	Currently homeless youth	Family functioning and youth substance use and mental health	Promising - one study
California's Repeat Offender Prevention Program (ROPP)	Crime Solutions	An intensive multimodal early intervention program targeting young offenders at high risk of becoming chronic delinquents using intensive supervision and wraparound services to address school behavior, substance use, and high-risk behaviors. The collaborative partners offer an array of enhanced services such as individual and group counseling, mental health services, tutoring, transportation, and vocational training.	Youth at risk of homelessness	Recidivism and education	No Effects - more than one study
Interventions Targeting Street-Connected Youth	Crime Solutions	Interventions targeting street-connected youths generally focus on inclusion, reintegration, and harm-reduction strategies that serve children and young people while they are living on, or closely connected to the streets. The overall goals are to 1) reduce the risks that coincide with living and working on the street, such as early sexual activity and substance misuse; 2) promote inclusion and reintegration into society; 3) increase literacy and numeracy; 4) promote access to education, training, and employment opportunities; and 5) promote a healthier lifestyle, including mental health and self-esteem. These types of interventions are often single projects, drop-in centers, or peer education interventions.	Currently homeless youth	Global functioning	n/a

Name	Search Website	Summary	Target Populations	Intended Outcome(s)	Overall Evidence Rating
Youth Villages YVLifeset	Blueprint	Formerly known as Transitional Living, it is an independent living program for youth in need (e.g., transitioning from foster care or juvenile justice custody). The program lasts 9 months for most youth who successfully complete the program and involves intensive, individualized, and clinically focused case management, support, and counseling. At entrance, each person receives an assessment and individualized treatment plan. The bulk of the services are then provided during hour-long, weekly sessions with a case manager.	Youth at risk of homelessness	Global functioning (including housing stability)	Promising
Parent Management Training - Oregon Model (PMTO)	Blueprint & NREPP	A group of parent training interventions that aims to teach effective family management skills in order to reduce antisocial and problematic behavior in children who range in age from 3 through 16 years. It is delivered in group and individual family formats, in diverse settings (e.g., clinics, homes, schools, community centers, homeless shelters), over varied lengths of time depending on families' needs. It coaches parents in the use of effective parenting strategies, namely skill encouragement, setting limits or effective discipline, monitoring, problem solving, positive involvement, identifying and regulating emotions, enhancing communication, giving clear directions, and tracking behavior.	Currently homeless youth	Global functioning and parenting practices	Model Program
Partners with Families & Children: Spokane	NREPP	A service model that provides intensive, sustained services to families with children who are referred by child protective services, law enforcement, or other public health agencies as a result of persistent child neglect and who are unlikely to respond to briefer interventions. Partners is a strengths-based, family-centered practice based on wraparound-service principles and attachment theory. The Partners model wraps a team of professionals, friends, and extended family members around each family affected by chronic neglect to create an individualized service plan. The treatment services include onsite, gender-specific, integrated substance use and mental health treatment for parents, and interventions to strengthen the parent–child relationship and aims to link parents to needed resources such as housing, employment, and transportation.	Youth at risk of homelessness	Global functioning (including housing stability)	n/a
Say it Straight (SIS)	NREPP	A communication training program designed to help students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility. In turn, the program aims to reduce risky or destructive behaviors such as substance use, eating disorders, bullying, violence, precocious sexual behavior, and behaviors that can result in HIV infection. Its application has been expanded to include students in detention and treatment, student mentors and mentees, parents, high-risk communities, adults in treatment, college students, and the homeless. SIS is based in social learning and positive psychology, emphasizing values such as resiliency, courage, compassion, and integrity.	Currently homeless youth	Global functioning, communication skills, risky behavior	n/a
Attachment, Regulation, and Competency (ARC)	CEBC	A core components framework designed to support individual/familial/dyadic intervention with youth and families who have experienced complex trauma within a wide range of systems. The framework is organized around the core domains of attachment (e.g., building safe caregiving systems), regulation (e.g., supporting youth regulation across domains), and developmental competency (e.g., supporting factors associated with resilient outcomes).	Currently homeless youth	Global and family functioning	Not able to be rated
Case Management, Outreach, Referral, and Education (CORE)	CEBC	Targets families with children (ages 0-19 years) in transition such as those who are living in homeless shelters, temporary or doubled-up housing situations, or in foster care situations. The purpose is to improve the stability and well-being for children and families by providing a wide range of wrap-around services to improve conditions that place them at social, psychological, and safety concerns. It helps families with: coordination of medical care for their children; identification of resources that will facilitate family function and stability including counseling; support with recovery from substance abuse; and referral and assistance with completing housing applications.	Currently homeless youth	Family functioning and stability	Not able to be rated

Name	Search Website	Summary	Target Populations	Intended Outcome(s)	Overall Evidence Rating
FamilyLive	CEBC	A strengths-based caregiver-focused family therapy intervention that helps caregivers with unresolved trauma histories and significant present day stress improve parenting skills and respond to their children's trauma-affected moods and behaviors. The model places emphasis on specialized engagement strategies that highlight competencies and encourage caregivers to become active participants in the treatment process. The model was developed in response to the needs of families and children exposed to significant adversities including racial and economic marginalization, community violence and traumatic family histories including parental incarceration, domestic violence, and homelessness.	Previously homeless youth	Parenting skills	Not able to be rated
Fostering Success Coach Model	CEBC	The model focuses on providing holistic support for youth and young adults while they pursue and/or enroll in postsecondary education settings. It takes into account the unique challenges of living through adversity and the foster care system. Skills are designed to enhance a child welfare or higher education professional's ability to partner with youth assessing strengths and challenges in targeted seven life domains–education, employment, housing, health, relationships, identity and life skills--by prioritizing level of need and intervening by teaching life skills that strengthen youths' healthy habits as they transition to the emerging adult years.	Currently homeless youth	Global functioning (including housing)	Not able to be rated
Independent Living Program - Lighthouse	CEBC	Designed to provide referrals and case management support to enable older youth to complete their education, gain employment, obtain housing, participate in life-skills training, get mental health counseling and other support services, and move toward becoming responsible and productive members of the community. These youth could be aging out of the child welfare or juvenile justice systems, at risk of homelessness, or unable to return to biological families.	Youth at risk of homelessness	Global functioning (including housing)	Not able to be rated
Massachusetts Adolescent Outreach Program for Youths in Intensive Foster Care (MA Outreach)	CEBC	Assists teenage intensive foster care youths in preparing to live independently and to achieve permanency after exiting care. The goals of the program are to help youths earn high school diplomas, continue education, avoid nonmarital childbirth, avoid high-risk behaviors, avoid incarceration, gain employment, attain self-sufficiency, and avoid homelessness. Other goals include supporting youths' participation in higher education, achieving permanency through a connection to a caring adult, and identifying a support network.	Youth at risk of homelessness	Global functioning (including avoiding homelessness)	Not able to be rated
My First Place	CEBC	Supports youth in their transition from foster care to successful adulthood by promoting choices and strengthening individual and community resources. Consists of a supportive housing program, an academic enrichment program, counseling, youth community center, and collaboration with other organizations.	Currently homeless youth	Global functioning (including housing assistance)	Not able to be rated
Project Connect	CEBC	Works with high-risk families who are affected by parental substance abuse and are involved in the child welfare system. The program works to connect families with, and help them to manage, the larger systems in their lives (i.e., schools; courts; child welfare systems; treatment programs for substance abuse, mental health issues, medical problems, and domestic violence; homeless shelters; Social Security; AFDC etc.). Offers home-based counseling, substance abuse monitoring, nursing, and referrals for other services. Also offers home-based parent education, parenting groups, and an ongoing support group for mothers in recovery.	Currently homeless youth	Global parental functioning (including housing permanency)	Promising
Sanctuary Model	CEBC	A blueprint for clinical and organizational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek services, but equally on the people and systems who provide those services. Sanctuary has been used in organizations that provide residential treatment for youth, juvenile justice programs, homeless and domestic violence shelters as well as a range of community-based, school-based and mental health programs.	Currently homeless youth	Global functioning with emphasis on mental health	Promising

Name	Search Website	Summary	Target Populations	Intended Outcome(s)	Overall Evidence Rating
Threshold Mothers Project Transitional Living Program (TLP)	CEBC	Provides comprehensive services for 17-23 year-old pregnant/parenting young women with mental health challenges referred by child welfare, juvenile justice, or homelessness. Includes 24-hour staffed residences where young mothers and their children live together, and receive support and guidance. Additionally, residents receive case management, individual and group therapy, Dialectical Behavior Therapy (DBT) skills training, psychiatry, parent education, supported employment and education services, and access to the early learning center.	Currently homeless youth	Global functioning (including housing)	Not able to be rated
Transition to Independence Process (TIP) Model	CEBC	Developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to: a) engage them in their own futures planning process; b) provide them with developmentally appropriate, nonstigmatizing, culturally competent, trauma-informed, and appealing services and supports; and c) involve the young people, their families, and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals. Helps with transition domains, such as: employment/career, educational opportunities, living situation, personal effectiveness/well-being, and community-life functioning.	Currently homeless youth	Global functioning (including living situation)	Promising
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)	CEBC	An educational and therapeutic intervention designed to prevent and treat traumatic stress disorders (including PTSD, severe anxiety disorders, depression, and dissociative disorders), co-occurring addictive, personality, or psychotic disorders, and adjustment disorders related to other types of stressors. Teaches a seven-step sequence of skills, the FREEDOM Steps, designed to enable participants to recognize, understand, and gain control of stress reactions by enhancing their strengths/abilities for mental focusing, mindfulness, emotion regulation, executive function, and interpersonal engagement/interaction.	Currently homeless youth	Global functioning with emphasis on mental health	Promising
Larkin Extended Aftercare for Supported Emancipation (LEASE)	CEBC	A scattered-site residential program for youth ages 18-24 who have emancipated from the foster care system. Youth are housed in apartments and receive a range of supportive services including counseling, employment training, education counseling, and case management. Most participants attend college on a part-time or full-time basis. Youth work with their Case Manager to develop an individual plan to meet their unique needs. For all participants, an emphasis is placed on developing the life skills needed for independent living such as household organization and money management.	Youth at risk of homelessness	Global functioning	Not able to be rated
Let's Talk: Runaway Prevention Curriculum	CEBC	14-module life skill curriculum. The curriculum can be used in its entirety or as individual 45-minute modules. It includes the companion film, 1-800-RUNAWAY. Goals of the program are to build life skills, increase knowledge about runaway resources and prevention, educate about alternatives to running away, and to encourage youth to access and seek help from trusted community members.	Youth at risk of homelessness	Global functioning with emphasis on knowledge of runaway resources, runaway prevention	Not able to be rated
youthSpark Voices	CEBC	A direct service program that partners with the local juvenile court to provide critical intervention services to youth deemed high-risk for trafficking involvement or who do not self-identify as a trafficking victims even though exploitation is present. At a high level, the program works to increase their school attendance, decrease runaway attempts and risky behaviors, and, more importantly, build important skills that put the girls on a positive track of personal growth and self-sufficiency.	Youth at risk of homelessness	Global functioning with emphasis on **runaway prevention**, school attendance, risky behaviors	Not able to be rated

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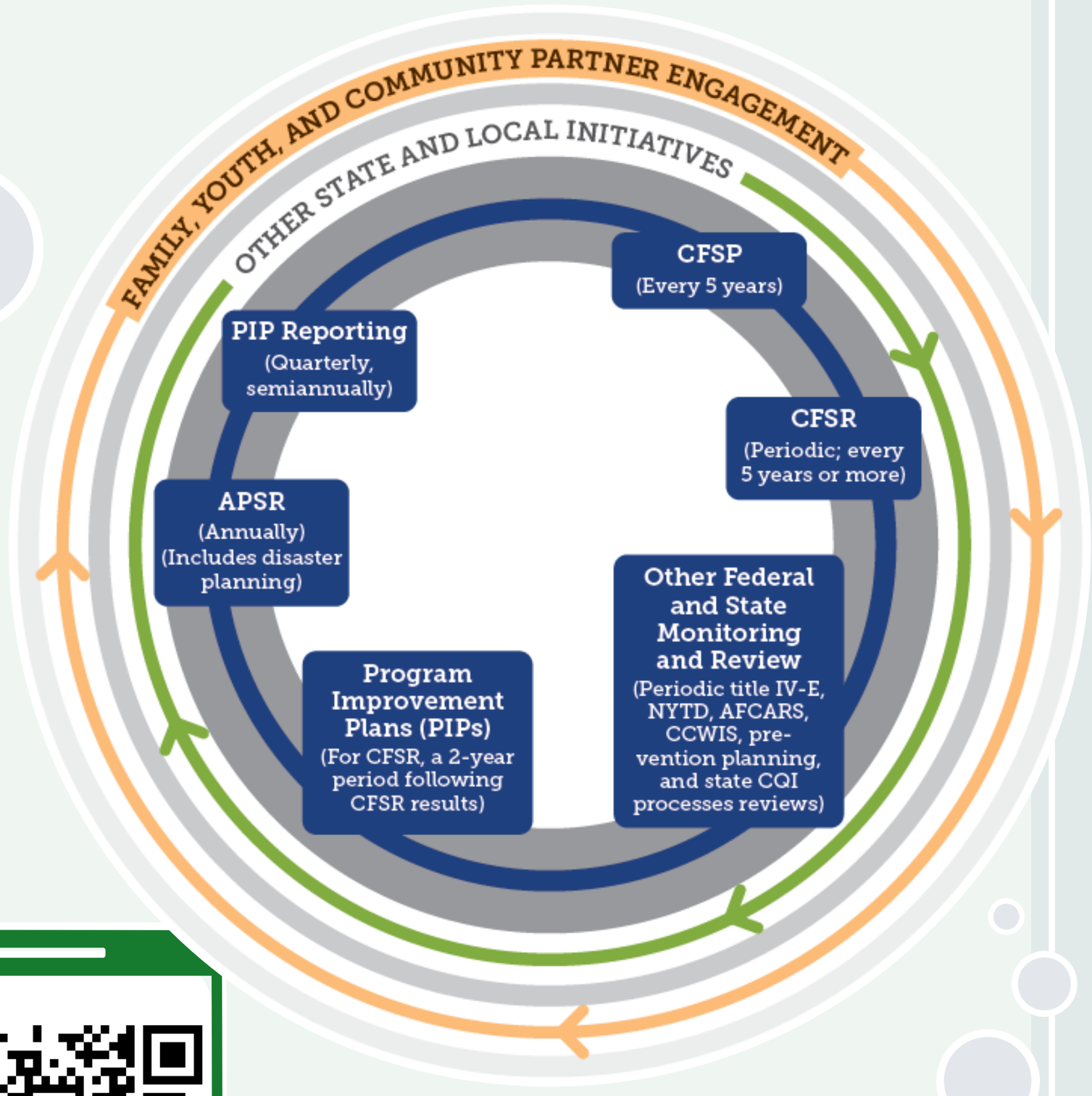

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The U.S. Surgeon General's Framework for

Workplace Mental Health & Well-Being

2022

This Framework is dedicated to all workers who lost their lives during the pandemic and to their families. May this serve as a call to action to lift up the voices of workers, particularly those most vulnerable, and to protect their health and well-being.

Table of Contents

Introduction Letter from Dr. Murthy

Growing up in Miami, I often spent my after-school hours and weekends in the small clinic that my father and mother ran. As I watched my immigrant parents work, I could see that their jobs provided them with not only a paycheck, but also purpose, dignity, and community. The connection between their work and their mental health and well-being was clear. And they knew it. For all the financial hardships and social struggles they faced during those years, their work allowed them to support their family, connect with others, and find meaning. Their work helped them thrive.

The COVID-19 pandemic has changed the nature of work, and the relationship many workers have with their jobs. The link between our work and our health has become even more evident.

Today, more and more workers are worried about making ends meet, dealing with chronic stress, and struggling to balance the demands of both work and personal lives. The toll on their mental health is growing. The pandemic also sparked a reckoning among many workers who no longer feel that sacrificing their health, family, and communities for work is an acceptable trade-off. Organizations are also increasingly aware of another trade-off: when the mental health of workers suffers, so does workplace productivity, creativity, and retention.

The pandemic has presented us with an opportunity to rethink how we work. We have the power to make workplaces engines for mental health and well-being. Doing so will require organizations to rethink how they protect workers from harm, foster a sense of connection among workers, show them that they matter, make space for their lives outside work, and support their long-term professional growth. This may not be easy. But it will be worth it, because the benefits will accrue to both workers and organizations. A healthy workforce is the foundation for thriving organizations and a healthy community.

My parents, like so many others, were drawn to this country by the opportunities it offered: to work, learn, and grow; to be happy and healthy; to belong and to matter. Workplaces have the power to provide such opportunities, and when they do, everyone is better off. Revitalizing our workplaces to support mental health and well-being is how we can turn a moment of crisis into a moment of progress. The Surgeon General's Framework for Workplace Mental Health & Well-Being shows us how to begin that journey.

Vivek H. Murthy, M.D., M.B.A.
Vice Admiral, U.S. Public Health Service
Surgeon General of the United States

Workplaces Can Be Engines of Mental Health and Well-Being

There are more than 160 million people who are a part of the U.S. workforce today.[1] Work is one of the most vital parts of life, powerfully shaping our health, wealth, and well-being.[2] At its best, work provides us the ability to support ourselves and our loved ones, and can also provide us with a sense of meaning, opportunities for growth, and a community. When people thrive at work, they are more likely to feel physically and mentally healthy overall, and to contribute positively to their workplace.[3] This creates both a responsibility and unique opportunity for leaders to create workplace environments that support the health and well-being of workers.

Although the COVID-19 pandemic may have accelerated the evolution of work and the conversation around workplace mental health and well-being, broad recognition and appreciation for the relationship between the work environment, culture, community, and our health preceded the pandemic.[4, 5, 6, 7] While many challenges outside the workplace may impact well-being—from economic inequality, food insecurity, and housing insecurity to household, educational, and medical debt—there are still many ways that organizations can function as engines for mental health and well-being.[8, 9] Organizational leaders, managers, supervisors, and workers alike have an unprecedented opportunity to examine the role of work in our lives and explore ways to better enable all workers to thrive within the workplace and beyond.

The Case for Workplace Mental Health and Well-Being

> *"Mental health in the workplace: It's not a nice-to-have, it's a must-have."*
>
> Human Resources Leader and Business Consultant

Workplace mental health and well-being is a critical priority for public health. It has numerous and cascading impacts for the health of individual workers and their families, organizational productivity, the bottom-line for businesses, and the U.S. economy. The U.S. has a long history of labor organizing that has, over the years, established protections for workers through federal and state laws. The U.S. Department of Labor (DOL) was established "to foster, promote and develop the welfare of working people, to improve their working conditions, and to enhance their opportunities for profitable employment."[10] Since then, laws including the Fair Labor Standards Act, the Civil Rights Act, and the Americans with Disabilities Act have all established crucial worker protections including the minimum wage, overtime regulations, standards for youth employment, and protections from discrimination, across government and private organizations.[11, 12, 13, 14] While Federal and state laws represent a minimum floor of protections for workers, organizations and employers can do more.[15] Consensus scientific bodies and professional societies like the National Academy of Medicine and the American Psychological Association, along with U.S. government agencies such as the Department of Veterans Affairs, the Occupational Safety and Health Administration (OSHA) at DOL, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC) National Institutes of Occupational Safety and Health (NIOSH), have called national attention to the effects of the workplace on health.[7, 16, 17, 18, 19, 20, 21]

Workers manage daily stress that affects their health and organizational performance. These stressors arise from heavy workloads, long commutes, unpredictable schedules, limited autonomy, long work hours, multiple jobs, low wages, and a variety of other work-related challenges on top of responsibilities outside of the workplace.[22, 23] Some workers may face other challenges in the workplace, such as hostile or dangerous working conditions, harassment, and discrimination.[24] Research suggests that five workplace attributes are most predictive of whether workers refer to their organization's culture as "toxic": disrespectful, non-inclusive, unethical, cutthroat, and abusive.[24]

Chronic stress leads to overactivation of the "fight or flight" response, among other responses, and can have negative effects on numerous organ systems in the body.[25] Elevated stress hormones disrupt sleep, increase muscle tension, and impair metabolic function.[26] Stress can increase one's vulnerability to infection, the risk for diabetes, and the risk for other chronic health conditions.[27] In fact, chronic stress has also been linked to a higher risk of developing diseases such as high blood

pressure, high cholesterol, heart disease, obesity, cancer, and autoimmune diseases.[25] Such stress can also contribute to mental and behavioral health challenges, including depression, anxiety, suicidal ideation, and substance misuse, and can have negative impacts on the mental health of the children and families of workers.[27, 28, 29, 30, 31]

Competing work and personal demands can also negatively impact the health and well-being of workers in a variety of ways. These role conflicts can magnify psychological stress, increase the risk for health behaviors such as smoking, unhealthy dietary habits, alcohol and substance use, and medication overuse, and cause disruptions to relationships both at work and at home.[32, 33]

The COVID-19 pandemic brought the relationship between work and well-being into clearer focus.[5] Workers across the world reported feeling more stressed in 2021 than they were in 2020.[34] In a separate 2021 survey of 1,500 U.S. adult workers across for-profit, nonprofit and government sectors, 76% of respondents reported at least one symptom of a mental health condition, an increase of 17 percentage points in just two years.[35] Furthermore, 84% of respondents reported at least one workplace factor (e.g., emotionally draining work, challenges with work-life balance, or lack of recognition) that had a negative impact on their mental health. In a survey of more than 2,000 workers conducted by the American Psychological Association by 2022, low salaries, long hours, and the lack of opportunity for advancement were commonly reported as key workplace stressors.[36] Among these same workers, however, **seven in ten reported that their employer is more concerned about the mental health of workers than before.**

76% of respondents reported at least one symptom of a mental health condition, an increase of 17 percentage points in just two years.

While the pandemic did not create these work conditions, it worsened many of them. Rates of anxiety, depression, social isolation, job burnout, and insecurity related to food, housing, and income rose between March 2020 and mid-2022.[5, 37, 38] The Kaiser Family Foundation found that 62% of health workers surveyed reported that pandemic-related worry and stress negatively affected their mental health, while 49% of health workers reported the pandemic negatively impacted their physical health, including sleep issues and frequent headaches.[39] In a 2022 survey, the CDC found that nearly half of the 26,069 U.S. public health workers they surveyed experienced at least one symptom of a mental health condition during the COVID-19 pandemic, including anxiety, PTSD, and depression, and one in twelve experienced suicidal thoughts.[40] *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce,* released in May 2022, further highlights this crisis that has been exacerbated in the setting of the COVID-19 pandemic.[38]

Workers are still finding it challenging to address these burgeoning negative impacts on their mental health and well-being. Mental Health America assessed the perceptions of over 11,000 workers across 17 industries in the United States in 2021.[33] They found that nearly 80% of workers surveyed report that their workplace stress affects their relationships with friends, family, and coworkers, and only 38% of those who know about their organization's mental health services would feel comfortable using them. Organizational leaders must prioritize mental health in the workplace by addressing structural barriers to seeking help and decreasing stigma around accessing mental health support in the workplace.

It is important to note that workers face different challenges based on their occupation, setting, organizational structures, and personal characteristics such as race, sex (including pregnancy, gender identity, and sexual orientation), immigration status, national origin, age, disability, or genetic information. Workforce demographics in the U.S. are shifting, with increases in racial and ethnic minority workers, including foreign-born workers.[41] This population is highly concentrated in non-standard work arrangements (including day-labor, seasonal workers, etc.) which pose unique occupational health safety risks. As the workforce changes, it is imperative that workplaces be intentional in preventing institutionalized bias due to organizational design, work arrangements, technologies, or global climate change.

In addition to the many impacts on the health and well-being of workers themselves, **workplace well-being can affect productivity and organizational performance.** When people feel anxious or depressed, the quality, pace, and performance of their work tends to decline.[42] Workforce shortages are also exacerbated due to early exit from the workforce or missed workdays due to health concerns, work-life conflicts, or burnout.[38, 43] All of these challenges have been magnified by many factors over the years, including the rise in chronic diseases, growing mental health concerns, and more recently Long COVID, a post-COVID-19 infection syndrome that can affect multiple organ systems, leading to persistent shortness of breath, fatigue, and impaired concentration.[44, 45, 46, 47]

In addition to the many impacts on the health and well-being of workers themselves, workplace well-being can affect productivity and organizational performance.

All workers are part of larger communities, and their well-being is also impacted by external socio-economic, political, and cultural factors that may be outside of an organization's control. These include what is known as the "U.S. health disadvantage": poorer health, shorter lifespans, higher health care costs, and less access to health care compared with other wealthy countries.[48, 49]

Even so, organizational efforts to invest in workplace well-being, as well as in local organizations and community development, can in turn support the development of a happier, healthier, more productive workforce and contribute to the success and economic well-being of an organization.[37, 50, 51, 52, 53, 54]

Chronic diseases and injuries in the U.S. workforce costs employers more than half a trillion dollars in lost productivity each year.[55] Decades of research have also shown that prioritizing and investing in efforts that address workplace well-being can have significant returns impacting the bottom line. Workplace well-being efforts have notable effects on organizational costs—for example, those associated with reductions in absenteeism and annual health care claims. Organizations that focused on worker well-being have also reported higher productivity and retention rates.

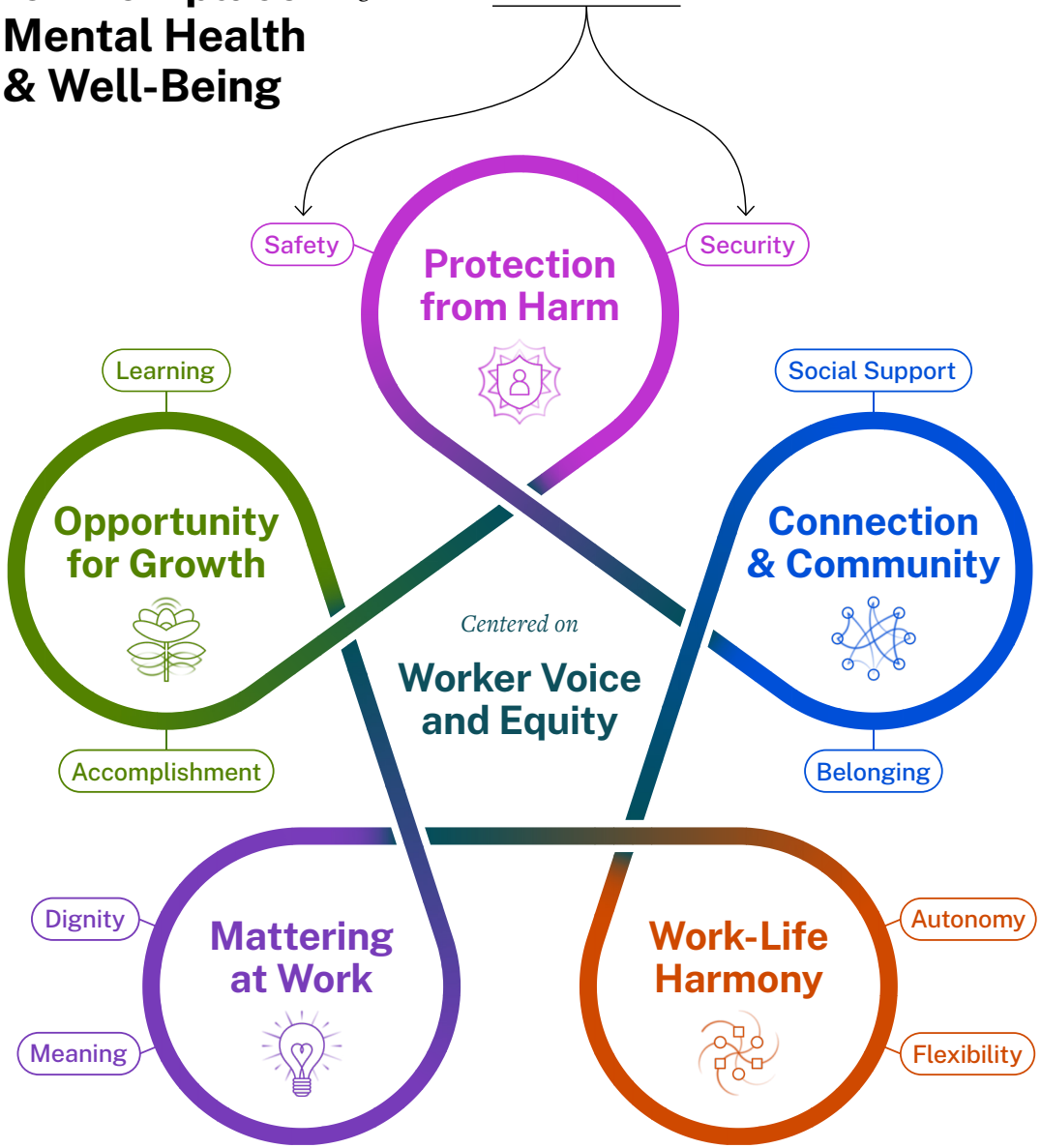
Work is an important social determinant of worker health. Improving the work environment to support workplace mental health and well-being calls for workers at the table. The U.S. labor movement has improved worker well-being by advocating for health care and occupational health and safety regulations and protections, especially in eliminating workplace hazards and preventing accidents.[56] Many components in this Framework have been successfully fought for and won in workplaces across the U.S. by workers themselves, including paid sick and family leave, living wages, and social support at work.[57, 58] Creating an environment where workers' voices are supported without fear of job loss or retaliation is an essential component of healthy organizations.[59, 60]

Creating an environment where workers' voices are supported without fear of job loss or retaliation is an essential component of healthy organizations.

The Surgeon General's Framework for Workplace Mental Health & Well-Being is intended to spark organizational dialogue and change in the workplace. It can also catalyze areas for further research, strategic investment, and broader policy advancement. Centered around the foundational principles of equity and the voices of all workers, it includes five Essentials and necessary components for addressing workplace mental health and well-being based on human needs (see Figure on following page). Organizations can use this Framework to support their workplaces as engines of mental health and well-being.

Five Essentials for Workplace Mental Health & Well-Being

Centered on the worker voice and equity, these five Essentials support workplaces as engines of well-being. Each Essential is grounded in two human needs, shared across industries and roles.



Components

Creating a plan with all workers to enact these components can help reimagine workplaces as engines of well-being.

Protection from Harm

- Prioritize workplace physical and psychological safety
- Enable adequate rest
- Normalize and support mental health
- Operationalize DEIA* norms, policies, and programs

Connection & Community

- Create cultures of inclusion and belonging
- Cultivate trusted relationships
- Foster collaboration and teamwork

Work-Life Harmony

- Provide more autonomy over how work is done
- Make schedules as flexible and predictable as possible
- Increase access to paid leave
- Respect boundaries between work and non-work time

Mattering at Work

- Provide a living wage
- Engage workers in workplace decisions
- Build a culture of gratitude and recognition
- Connect individual work with organizational mission

Opportunity for Growth

- Offer quality training, education, and mentoring
- Foster clear, equitable pathways for career advancement
- Ensure relevant, reciprocal feedback

**Diversity, Equity, Inclusion & Accessibility*

Office *of the* **U.S. Surgeon General**

Framework Development and Application

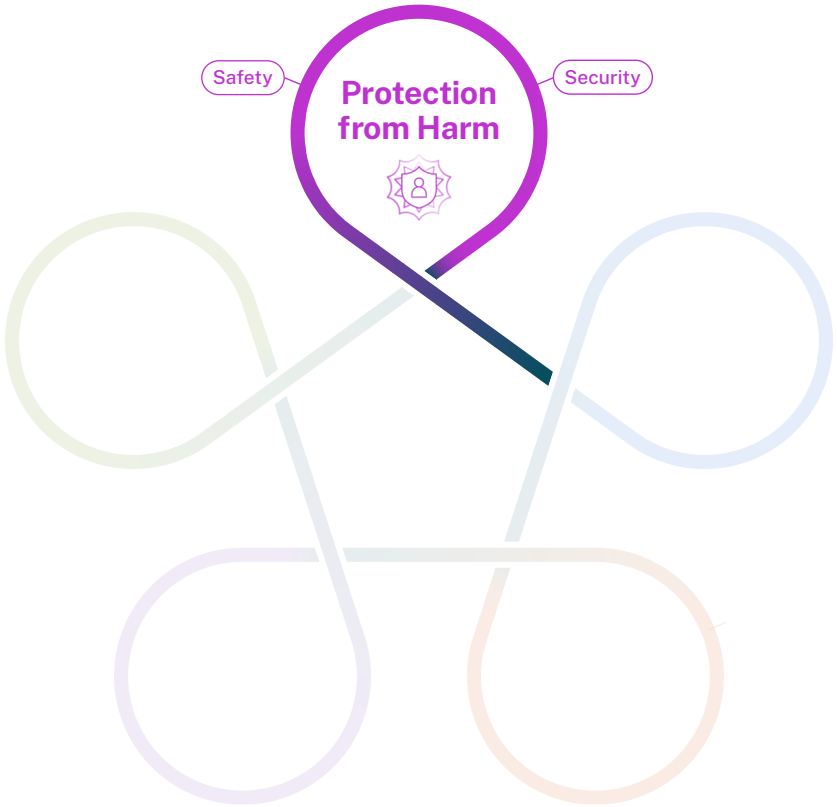
This Framework contributes to decades of public health, economic, sociological, and organizational psychology research. It is informed by the voices of many workers and unions based in a variety of occupations and sectors, including retail, childcare, education, hospitality and travel, agriculture, construction, manufacturing, grocery, technology, finance, utilities, government, and health care. It is also informed by conversations with workplace leaders, as well as academic and industry experts. While not an exhaustive literature review of the evidence base, the Framework was developed based on desk research as well as numerous conversations and expert roundtables.
The framework includes Five Essentials for Workplace Mental Health & Well-Being:

The Framework can be viewed as a starting point for organizations in updating and institutionalizing policies, processes, and practices to best support the mental health and well-being of workers. Ensuring workplace well-being requires an intentional, ongoing effort by employers and leaders across all levels, with the voices of workers and equity (i.e., a more equitable policy and practice environment) at the center.[61]
The Five Essentials can guide leaders, managers, and supervisors, as well as empower workers, to identify and communicate about priority organizational changes needed. Workplace leaders and supervisors across all industries can have a powerful impact on worker well-being by setting organizational culture, shaping the day-to-day experiences of workers, and prioritizing workforce engagement. The most effective leaders express compassion, empathy, and generosity; communicate openly, often, and clearly; and practice human- and wellness-centered leadership by recognizing the connection between individual strengths, growth, and organizational change.[62, 63, 64]

The Five Essentials can be adapted across different workplaces with the recognition that some components may be adapted more extensively for organizations with access to greater resources. Organizations should build in systems for accountability, review existing worker engagement survey data to better understand the needs among disproportionately impacted groups, utilize validated tools for measuring worker well-being, and ensure processes for continuous quality improvement.[65, 66, 67] These systems are critical to sustain workplace structures and practices that advance rather than harm the health and well-being of all workers long-term.[68, 69, 70, 71]

Essential 1:
Protection from Harm

> *"The leaders of a company set the tone, and if they're willing to talk about mental health, that trickles all the way down."*
>
> Workplace Wellness Leader, Technology Sector



The first Essential of this Framework is **Protection from Harm**. This Essential rests on two human needs: **safety** and **security**. More than two-in-five workers surveyed by the American Psychological Association in 2022 reported that health and safety concerns negatively affect their stress level at work.[72]

Workplace safety means all workers are in a safe and healthful work environment, protected from physical harm, injury, illness, and death.[73] This is done through continued efforts to minimize occupational hazards and physical workplace violence, as well as psychological harm such as bias, discrimination, emotional hostility, bullying, and harassment.[74, 75] Security builds on safety to include financial, and job security, given the negative effects that layoffs and job loss can have on the workers and their families.[76] (Discussed further in Essential 4).

Protection from Harm
Components

- Prioritize workplace physical and psychological safety
- Enable adequate rest
- Normalize and support mental health
- Operationalize Diversity, Equity, Inclusion, and Accessibility (DEIA) norms, policies, and programs

Prioritize workplace physical and psychological safety

The first component of this Essential is to *prioritize workplace physical and psychological health and safety.* People cannot perform well at work if they feel physically or psychologically unsafe.[77, 78, 79] When workers feel psychologically safe, they speak up without the risk of being punished, retaliated against or humiliated, and without fear of these risks. Racial and ethnic minority workers are at higher risk for workplace injuries, which has led to an increased frequency and prevalence of work-related disabilities for non-Hispanic Black and foreign-born Hispanic workers.[80] Workers such as migrant and seasonal agricultural workers, who are often foreign-born Hispanic workers, may also be disproportionately affected by climate change and subjected to extreme heat stress.[81] They may also face discriminatory practices such as living in fear of potential deportation or losing their job if they report injuries.

To fully address workplace violence, organizations must take all steps to comply with regulations and regularly improve related policies and programs.[79, 82, 83] Workplace violence is disproportionately experienced by women, whether it comes from a customer, a coworker, or partner who threatens or harms them at work.[84] Between fiscal years 2018 and 2021, the U.S. Equal Employment Opportunity Commission received a total of 98,411 charges alleging harassment (e.g., race, national origin) under any basis and 27,291 charges alleging sexual harassment.[85] Of these, 43% were concurrently filed with a retaliation charge. 62% of all harassment charges were filed by women, and 78% of the sexual harassment charges were filed by women. Of the 1,945 sexual harassment charges filed concurrently with a race charge, 71% were filed by Black/African women. Importantly, the majority of individuals who say they experience harassment never take formal action. Organizational leaders can do more to encourage reporting by protecting workers from harassment and potential retaliation.[85] Certain industries are also at greater risk for workplace violence, including health care, law enforcement and correctional officers, education, and service providers, with taxi drivers being more than 20 times more likely to be murdered on the job than other workers.[86, 87, 88]

Mitigating harmful impacts in the work environment begins with a review by employers of all existing occupational health and safety legal requirements, and their own workplace policies and conditions to ensure standards and regular compliance.[89] There are numerous resources and validated tools from the CDC and OSHA that organizations can use to guide these efforts (see resources on page 16). Organizations can request technical

assistance, education, and training from OSHA for information on legal requirements, and periodic guidance on and monitoring of implementation of policies and measures to protect worker health and well-being.

Leaders at all organizational levels can collaborate with workers to examine and eliminate workplace hazards, then design, implement, and regularly evaluate programs for workplace safety.[62] Efforts can include, but are not limited to, workstation redesign to prevent injury, including work-related access to lethal means (a risk factor for suicide among workers); ensuring policies for infection prevention and control, and prevention of heat-related illnesses. In addition to specific efforts to prevent physical injury, leaders can collaborate with workers to promote total worker safety. Efforts can include, but are not limited to, increasing access to workplace training and job tools in multiple languages, examining workload and adequacy of resources to meet job demands (e.g. staffing, coverage), reducing long working hours, and eliminating policies and productivity metrics that cause harm (e.g. limiting worker rest or bathroom breaks).[8, 90, 91, 92, 93]

Enable adequate rest

The second component is to *enable adequate rest.* Insufficient rest, whether lack of sleep or lack of quality rest, or from long work hours, night shift work, stress, anxiety, pain, health conditions, medications, caffeine, alcohol, or possibly from lack of refresh breaks or working multiple jobs, can impair the physical, emotional, and mental health of workers.[94] One meta-analysis found that workers who did not get adequate sleep were 1.62 times as likely to have a workplace injury than those who did.[95] Long work hours have been shown to raise workers' risk for exhaustion, anxiety, and depression.[96] Fatigue diminishes productivity as the risk of burnout soars.[97, 98] When workers have adequate rest at work, they are less vulnerable to workplace mistakes and injuries.[96, 99] Workplace leaders can consider the length of working hours, overtime shifts, and opportunities for offline rest and refresh time.

Normalize and support mental health

Third, organizations can further *normalize and support mental health* while decreasing stigma at work by validating challenges, communicating mental health and well-being as priorities, and offering both support and prevention services. Leaders and managers throughout an organization must be supported to create a culture of inclusivity and to normalize mental health care. This culture includes modeling, communicating, regularly promoting, and supporting workers' access to services throughout all channels of worker engagement. This should also include training and support for supervisors at all levels with resources, including on-call services such as workplace Employee Assistance Programs (EAP) which remain significantly underutilized.[100, 101] Organizations can regularly evaluate EAP utilization, and strive to promote, improve, and supplement them based on worker needs. Employers should review benefits packages and provide comprehensive health care coverage that includes access to mental health and substance use care and treatment. Organizations can further make mental health care more easily accessible while ensuring confidentiality by facilitating access

to both on-site and off-site after-hours care, encouraging time off for mental health care, and supporting access to quality and affordable mental health care services, including telehealth. Workplace leaders can further normalize mental health by supporting organizational and local efforts to address stigma, such as by signing on to the National Alliance for Mental Illness StigmaFree Company Pledge.[102]

Operationalize Diversity, Equity, Inclusion, and Accessibility (DEIA) norms, policies, and programs

The fourth and final component is to *operationalize DEIA norms, policies, and programs.* Prioritizing DEIA norms means operationalizing relevant policies and programs in ways that ensure safety. This includes confronting structural racism, microaggressions, ableism, and implicit bias.[103, 104] In inclusive workplace cultures, all workers, including those with disabilities and from diverse racial and socioeconomic backgrounds, feel safe to be authentic and express their feelings because they trust that their coworkers welcome and value their unique perspectives.[33, 105] When diversity is celebrated as a source of strength, workers experience less stress and anxiety as bias and prejudice is not tolerated.[106, 107] Inclusive leadership is vital for fostering diversity among teams and is required to support a work environment where all team members feel valued and represented.[33, 108]

DEIA also includes considerations for people with disabilities to ensure equitable access to employment, as well as workplace participation, accommodations, and modifications. People with disabilities face discrimination and steep employment disparities. As of 2021 U.S. data, only 19% of persons with a disability were employed, compared to 63% of persons without a disability.[109] Employers are required to provide reasonable accommodations to qualified individuals with disabilities. Job Accommodation Network (JAN) and Administration for Community Living's Americans with Disabilities Act National Network provide free training and resources for employees, employers, and job applicants.[110] The White House Executive Order 14035 on DEIA, the U.S. Equal Employment Opportunity Commission, and the U.S. Department of Labor Office of Disability Employment Policy also offer additional resources in these areas.[111, 112, 113]

Box 1

Protection from Harm
Resources

Manuals, Guidebooks, Training

- Americans with Disabilities Act National Network
- Fundamentals of Total Worker Health® Approaches Centers for Disease Control and Prevention (CDC) / National Institute for Occupational Safety and Health (NIOSH)
- "What is a Safety Climate?" CDC/NIOSH Webinar
- Sleep: An Important Health and Safety Concern at Work CDC Workplace Health Resource Center
- Workforce GPS Guide: Beyond the Record, a Justice-oriented Approach to Background Checks John Jay College Institute for Justice and Opportunity
- Resources and Technical Assistance DOL Office of Disability Employment Policy (ODEP)
- Workplace Violence Program Resources DOL
- Training Resources for Employers to Protect Workers DOL / Occupational Safety and Health Administration (OSHA)
- Spanish-Language Compliance Assistance Resources DOL/OSHA
- Safety & Health Improvement Program Oregon Healthy Workforce Center
- Mental Health Toolkit Employer Assistance and Resource Network on Disability Inclusion (EARN)

Mental Health and Substance Use Recovery Support

- Workplace Supported Recovery CDC/NIOSH
- CDC Mental Health Resources
- Recovery for Every Worker, Every Employer DOL
- What can YOU do?: The "Mental Health at Work: What Can I Do" PSA Campaign DOL
- Drug-Free Workplace Resources Substance Abuse and Mental Health Services Administration (SAMHSA)

Suicide Prevention

If you or someone you know is experiencing emotional distress or thoughts of suicide, help is available. Call the Suicide Prevention Lifeline 24/7 at 988. Or in a crisis, text 741741 for 24/7, confidential, free crisis counseling. Or call the National Alliance for Mental Illness (NAMI) Helpline at 1-800-950-6264, Monday-Friday, 10 a.m. to 10 p.m., ET.

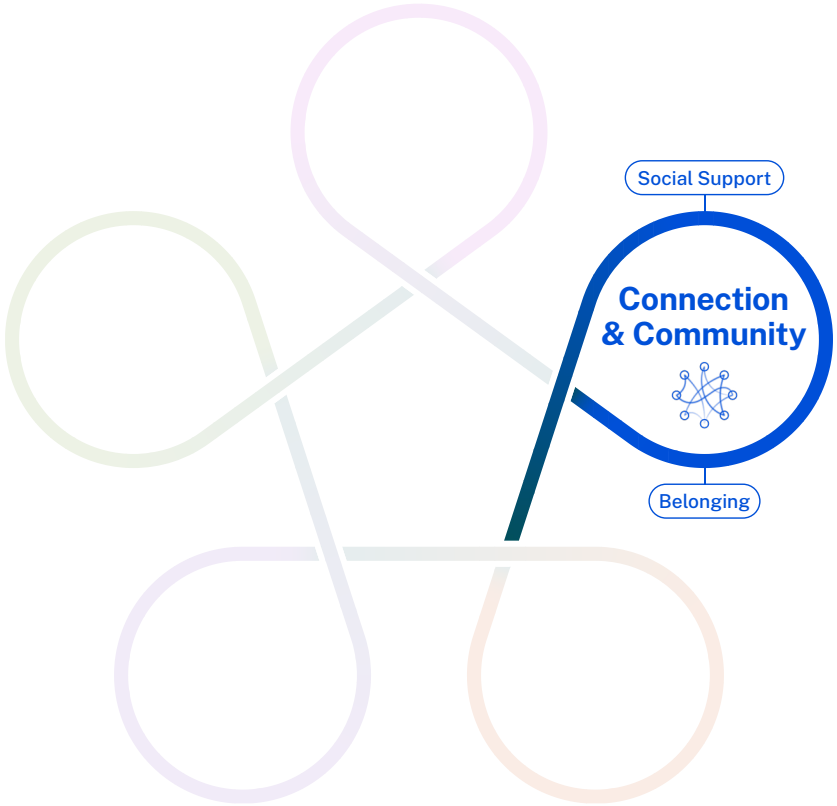
- Preventing Suicide: A Technical Package of Policy, Programs, and Practices CDC
- Comprehensive Blueprint for Workplace Suicide Prevention National Action Alliance for Suicide Prevention
- National Suicide Prevention Lifeline: 988

Other

- Helping Small Businesses DOL/OSHA
- On-Site Consultation DOL/OSHA
- Stigma-Free Company National Alliance for Mental Illness (NAMI)
- Resources for Prioritizing Staff Wellness Office of Head Start
- Wellbeing In The Workplace Guidebook U.S. Chamber of Commerce
- Advancing Health Equity The Community Guide
- Guidelines on Mental Health at Work World Health Organization (WHO)

Essential 2:
Connection and Community

> *"I don't want to just feel like I know how to perform to belong. I want to feel like I can be exactly who I am and still belong... that's very different."*
>
> Mid-career Mental Health Worker



The second Essential is **Connection and Community**. Organizations that create opportunities for social connection and community can also help improve health and well-being.[8, 114] This Essential rests on two human needs: **social support** and **belonging**.

Human beings have an innate need for social connection and the COVID-19 pandemic exacerbated the health and well-being impacts of isolation.[115, 116] The need for social connection extends to the workplace, as supportive relationships are not limited to intimate networks of close family or friends.[114, 117] Given the amount of time people spend in the workplace, the relationships and connections we build there can have a variety of impacts. Having social support, or relationships and networks that can offer physical and psychological help, such as emotional support, informational support, and advice, can mitigate feelings of loneliness and isolation.[118] Belonging is the feeling of being an accepted member of a group, or of connectedness given one's interpersonal relationships.[48] Fostering a sense of belonging and connection within the broader communities they are a part of has the potential to improve the health and well-being of workers and communities, and the prosperity of organizations themselves.[48]

Connection and Community
Components

- Create cultures of inclusion and belonging
- Cultivate trusted relationships
- Foster collaboration and teamwork

Create cultures of inclusion and belonging

The first component of Connection and Community is to *create cultures of inclusion and belonging.* Organizations can begin to build social connections and community at work by encouraging what scientists call prosocial behavior, while guarding against practices, policies, or behaviors that may be barriers to social connection.[119] Prosocial behavior promotes positive social relationships through welcoming, helping, and reassuring others. Organizational cultures that promote belonging can also foster a powerful protective force against bias, discrimination, and exclusion in the workplace.[8, 120, 121, 122] Organizational leaders should cultivate environments and cultures where connection is encouraged, and workers of all backgrounds are included. This may also include support, without fear of retaliation, for workers to have their voices and concerns heard for local policy and program change, such as through associations, cooperatives, and unions.

Cultivate trusted relationships

The second component of this Essential is *cultivating trusted relationships.*[119] Leaders can create structure and opportunities for workers to build trust and better understand one another as whole people and not just as skill sets.[123, 124] This mitigates loneliness and helps workers across all levels value and empathize with each other, while helping each other cope with stress and uncertainty.[122, 125] Having supportive work relationships can improve performance and is associated with worker engagement and innovation.[115] Many workplace relationships can positively affect worker health and well-being, including those between leaders and workers, among workers collaborating on teams, and between workers and their consumers and customers.[8, 126]

Having clear and consistent communication between workers and leaders is foundational in building trust.[127] Trust can be difficult to foster if workers feel disconnected from their leaders and organizations.[123] Promoting trust among leaders and workers begins with listening to worker concerns and explaining why key decisions are made within an organization.[128] Leaders can build trust through small, everyday interactions such as modeling and inviting others to share important moments of their daily lives with each other.

Foster collaboration and teamwork

The third component is to *foster collaboration and teamwork.* The future of work includes both remote and hybrid work, in a variety of full-time and part-time arrangements, so there is even more need to be intentional about how to build teams, communicate, and collaborate.[129, 130, 131] Organizational leaders, supervisors, and project managers can communicate the importance of teamwork, encourage regular communication, model authenticity, provide teams with effective collaboration tools, and include time for non-work connection such as community service.[132] Across organizations and within their communities, leaders can also consider community liaisons or Asset-Based Community Development to address issues like racial injustice, LGBTQ+ inequities, and other social determinants of health to support worker well-being and foster connection in the broader community, while improving the bottom line of businesses.[48, 133, 134]

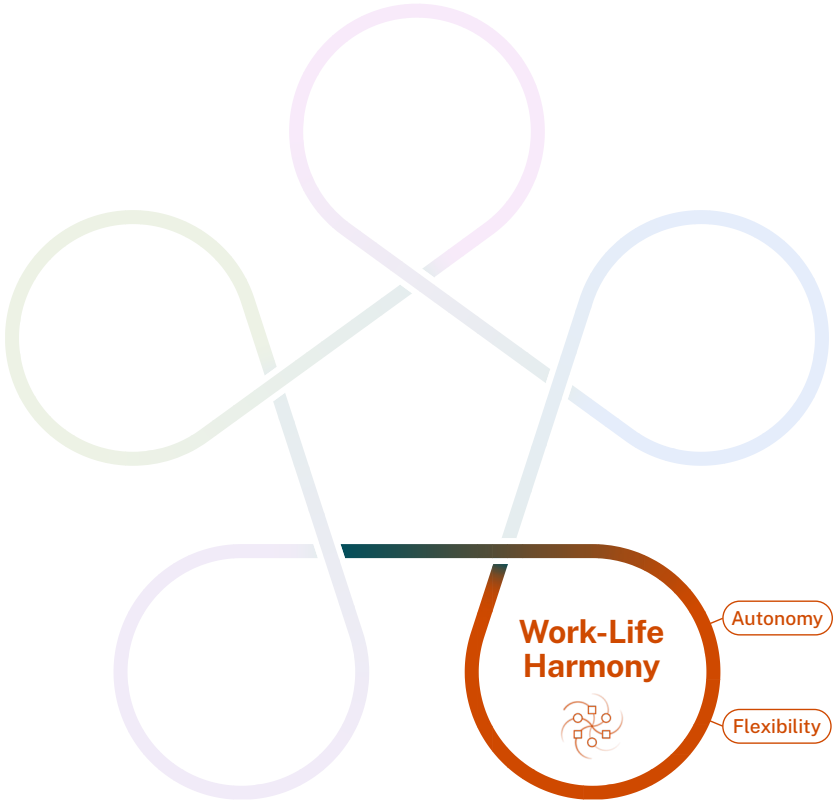
Box 2

Connection and Community
Resources

- Worker Resource and Organizing Center U.S. Department of Labor (DOL)
- Disability Inclusion in the Workplace: Why It Matters Employer Assistance and Resource Network (EARN)
- Empower Work Text Line
- Work Design Principle #3: Improve Social Relationships in the Workplace The Work and Well-Being Initiative (Harvard T.H. Chan School of Public Health / MIT Sloan School of Management)
- A to Z of Disabilities and Accommodations Job Accommodation Network
- Center for Peer Support Mental Health America
- Find Local Assistance and Network of Partners U.S. Small Business Administration (SBA)

Essential 3:
Work-Life Harmony

> *"I felt powerless in the position. I felt like there was never any freedom to choose things or make decisions [for myself]."*
>
> Mid-career worker, currently unemployed, with numerous prior low-wage service sector jobs



The third Essential is **Work-Life Harmony**. Professional and personal roles and responsibilities can together create work and non-work conflicts.[8, 135] The ability to integrate work and non-work demands rests on the human needs of **autonomy** and **flexibility**.[136] Organizations that increase worker autonomy, or how much control one has over how they do their work, and whose workplaces provide greater flexibility, or the ability to work when and where is best for them, see workers who are more likely to succeed and retain staff for longer.[8] The expansion of remote and hybrid work opportunities, driven by the needs of the COVID-19 pandemic and enabled by advances in technology, has a number of impacts on worker mental health and well-being that merit additional research. While some reporting has shown the positive impacts of remote and hybrid work on flexibility, others have indicated negative impacts of blurred work-life boundaries.[137, 138]

Organizations must see workers not only for their work roles, but as whole people. They may have many needs, roles, and responsibilities outside of work, whether it is time needed for routine physical and mental health care, an unexpected family issue that requires urgent attention, or for regular time and space for rest, exercise, educational pursuits, and hobbies. Workers who are experiencing, or who care for family members who are experiencing, acute or chronic illness, mental health challenges,

or a disability may also need additional time to manage their conditions, responsibilities as a caregiver, and care for themselves. This may include having the flexibility to attend multiple regular or unplanned appointments. Many workers may also have caregiving responsibilities for children, older parents, or other dependents.[139, 140, 141, 142] Notably, these responsibilities disproportionately fall on women.[143]

The overload and interference that can arise between work and life roles have been linked to negative health outcomes, including an increased risk of cardiovascular disease, digestive issues, poor sleep quality, and substance use.[144, 145, 146] On the other hand, workers who feel they can better harmonize their professional and personal needs report greater satisfaction with their work and life and experience fewer symptoms of depression and anxiety.[147, 148] In a recent survey by the Society for Human Resource Management, many human resource professionals reported that they recognize the importance of workplace mental health and well-being, but some feel they lack the resources to meet the needs of workers, and others are unsure of which benefits to provide.[149]

Young workers today represent more than one-third of the U.S. workforce and play an important role in shifting societal attitudes and perceptions around work-life harmony.[150] According to a 2022 Deloitte survey among 23,220 Gen Z and Millennial workers (born between 1996-2010 and 1980-1995, respectively) across 46 countries globally, low compensation was the number one cited reason for leaving their jobs in the last two years, and 44% of Gen Zs and 43% of Millennials say many people have recently left their organization due to workload pressure.[151, 152] When asked about their priorities in choosing an employer, workers ranked "good work-life balance and learning and development opportunities" highest; workers also wanted more flexibility in where they worked, with 75% preferring hybrid or remote work options.[152] Another group to consider are older adults (aged 65 years and up), for whom organizations can examine work environments and policies to enable them to remain in the workforce longer, while promoting their healthy longevity and well-being.[153]

Work-Life Harmony

Components

- Provide more autonomy over how work is done
- Make schedules as flexible and predictable as possible
- Increase access to paid leave
- Respect boundaries between work and non-work time

Provide more autonomy over how work is done

The first component of work-life harmony is to *provide more autonomy over how work is done.* Organizations that increase opportunities for worker control over how, when, and where work is done can mitigate work and life conflicts, engender more trust in workplaces and coworkers, and improve health.[8, 154, 155, 156]

When possible, increased worker control over scope of work, process for accomplishing projects, and scheduling and location (e.g. condensed hours or work weeks and remote or hybrid work arrangements), can help reduce turnover as workers report greater productivity and increased satisfaction with work.[8, 157, 158, 159] Employers must clearly and frequently communicate with workers to address tensions between the flexibility that staff may want and need, alongside organizational needs.

Make schedules as flexible and predictable as possible

The second component of Work-Life Harmony is to *make schedules as flexible and predictable as possible.* Many workers are subject to variable and unpredictable work hours and scheduling demands.[160] A Brookings Institute analysis found that, in the leisure and hospitality industry, three-quarters of all workers receive their schedules less than one-month in advance, with most receiving notice less than two weeks in advance.[161] In the construction industry, nearly 40% of workers report receiving their schedules less than one week in advance. Unstable and unpredictable scheduling is linked to increased income volatility and an increased risk of economic hardship, which can degrade physical and mental health.[162] For example, while it may not always be possible to predict job needs and schedules, unstable schedules can make it difficult to obtain childcare and transportation. Workers with disabilities who need accommodations for transportation or personal care at the workplace may not have access to those accommodations on demand, and this instability fuels psychological distress and burnout.[163, 164, 165]

Workers subject to irregular schedules are more likely to report a higher likelihood of psychological distress and poor sleep quality, which is linked to a host of negative health outcomes.[166] Schedule irregularity among workers can also lead to work-life conflicts that adversely affect relationships both in and out of the workplace, including behavioral and mental health challenges in children of working parents.[163, 164, 167, 168] Employers can implement family-friendly policies such as flexible start and end times to work days, and not penalizing workers with lost wages when personal, family needs, or emergencies arise.

Increase access to paid leave

Third, organizations should *increase access to paid leave*—paid sick leave; paid family and medical leave, including paid parental leave for pregnancy and post-partum care; and paid time off for vacation.[169, 170] The U.S. remains the only advanced economy in the Organization for Economic Co-Operation and Development that does not require paid medical and family leave be provided to its workforce.[171] While paid sick leave was available to 79% of U.S. civilian workers in March 2021, there are significant disparities among wage categories. 95% of workers whose average hourly wage placed them in the top 10% of civilian workers had access to paid sick leave, compared to only 35% of those in the bottom 10% of all civilian workers, disproportionately impacting Black and Hispanic workers. Paid family leave remains the least accessible paid leave benefit, available to 23% of civilian workers overall but only 7% of workers in the bottom 10% wage category.[156, 172] Unequal and limited access to paid sick, family, and medical leave, can contribute to a higher percentage of individuals working while

sick (or "presenteeism") and the spread of infection at work, as well as decreased productivity, burnout, and labor shortages.[173, 174, 175, 176, 177, 178] Increasing access to paid sick and other types of leave (e.g., family, medical, school) can reduce the likelihood of lost wages by 30%, positively affect the physical and mental health of workers and their children, improve retention, and reduce the costs associated with turnover.[135, 156, 179, 180]

Respect boundaries between work and non-work time

The fourth component of work-life harmony is to *respect boundaries between work and non-work time.* When leaders and supervisors set, respect, and model clear boundaries between time on and off the job, without penalizing workers for this flexibility needed, workers report a greater sense of well-being.[181] This also helps workers have the critical time needed for rest to optimize their health, productivity, and creativity, while alleviating anxiety or fears of missing work demands. One study among 2,000 faculty and staff across 40 public universities in Australia from June to November 2020 found that staff who had supervisors that expected them to respond to messages after work reported higher levels of psychological distress and emotional exhaustion, including headaches and back pain, than groups whose supervisors did not.[182] Workplace leaders and supervisors across all organizational units can establish policies to limit digital communication outside of work hours, such as after a specific evening hour and on weekends.[183]

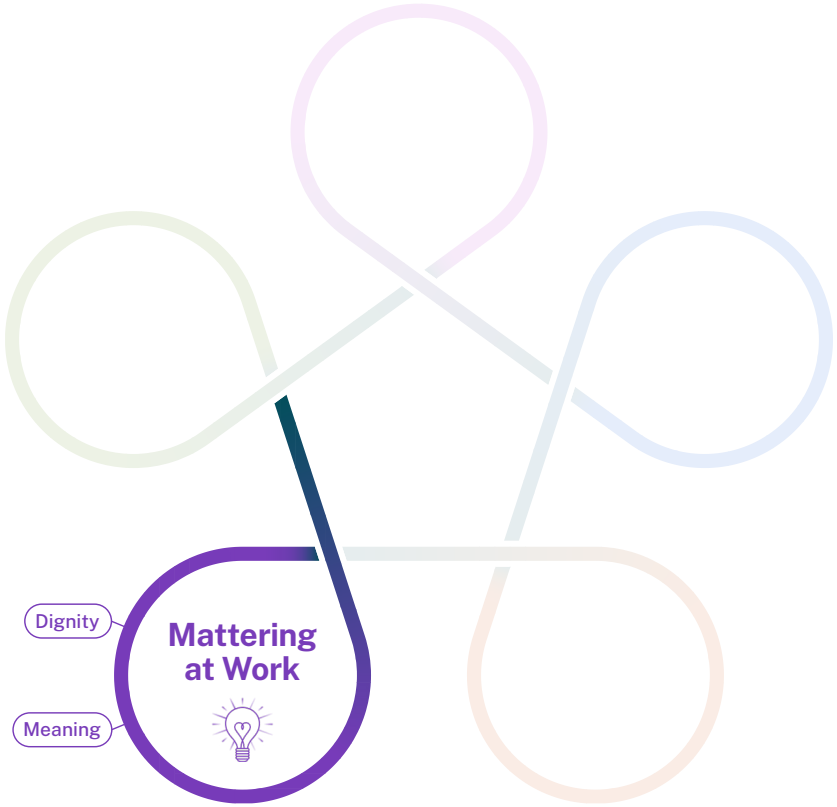
Box 3

Work-Life Harmony
Resources

- Work Design Principle #1: Give Employees More Control Over Their Work The Work and Well-Being Initiative (Harvard T.H. Chan School of Public Health / MIT Sloan School of Management)
- Work and Life: A Behavioral Approach to Solving Work-Life Conflict Ideas42
- How Can We Grant Employees More Flexibility in Their Job Positions Mental Health America
- Five Ways Leaders Can Support Remote Work MIT Sloan Management Review
- National Business Group on Health
- Paid Leave National Partnership for Women & Families

Essential 4:
Mattering at Work

> *"We are real people. We go home, we have real issues... workers need to know that their employers don't see them as robots."*
>
> Mid-career Emergency Medical Technician



People want to know that they matter to those around them, and that their work makes a difference in the lives of others. Knowing you matter has been shown to lower stress, while feeling like you do not can raise the risk for depression.[184, 185]

The fourth Essential is **Mattering at Work**. It rests on the human needs of **dignity** and **meaning**. Dignity is the sense of being respected and valued.[186] When the dignity of workers is affirmed and supported in the workplace, it enhances well-being. Conversely, being made to feel disrespected or not valued may lead to an increase in stress and feelings of anger, cynicism, hostility, and withdrawal.[187] Meaning in the workplace can refer to the sense of broader purpose and significance of one's work. Studies have shown that having meaning and purpose reduces the risk for health complications such as heart attacks and stroke, and when connected to work, can lead to improved productivity and innovation.[186, 188, 189, 190]

Mattering at Work
Components

- Provide a living wage
- Engage workers in workplace decisions
- Build a culture of gratitude and recognition
- Connect individual work with organizational mission

Provide a living wage

The first component of this Essential is to *provide a living wage.* Nearly one-third of U.S. workers earn less than $15 an hour, which is broadly recognized as insufficient to meet the cost of living in many parts of the country.[191] Work and income are critical social determinants of health and well-being.[192] The American Psychological Association's 2022 Work and Well-Being Survey found that workers who worried about their compensation not keeping pace with inflation were more likely to report work as having negative impacts on their mental health.[36] Another recent survey conducted by PricewaterhouseCoopers of 3,000 workers across several industries found that more than half of respondents (56%) reported feeling stressed about their finances, and among "financially-stressed" workers, 49% said that money worries had a severe or major impact on their mental health in the past year.[193] Organizations should review all work resources to meet job demands, including compensation, to offer workers a living wage as well as access to benefits that further promote and protect their health and well-being. This should include mental health supports and, where feasible, retirement plans, workers' compensation, financial and legal services, and caregiving supports (e.g., childcare).

A recent study funded by the National Institute on Minority Health and Health Disparities found that every $1 increase in the minimum wage of U.S. states could reduce the suicide rate among people with a high school education or less by nearly 6%.[194] Increases in the minimum wage across a range of sectors in the U.S. have been shown to improve parent-reported health among young children and reduce racial and ethnic disparities in income.[195, 196] Performing uncompensated work, unpaid overtime, or routinely making self-sacrifices for organizations may affect worker health and well-being.[197] Aligned with the Good Jobs Principles outlined by DOL and the U.S. Department of Commerce, organizations must ensure that all workers are paid an equitable, stable, and predictable living wage before overtime, tips, and commission, and that these wages increase as worker skills increase.[93]

Engage workers in workplace decisions

The second component of Mattering at Work is to *engage workers in workplace decisions.* Employers must ensure that they are equitably engaging and empowering all workers to improve workplaces.[198] Employee or worker engagement is the extent to which organizational leaders and supervisors involve workers in developing organizational mission statements, values, goals, and objectives, as well as the level of enthusiasm and commitment

that workers have in their work and workplace.[65] A 2022 Gallup State of the Global Workforce Survey found that worker engagement in the U.S. and Canada is low at 33%, yet it is among the highest globally.[34] To identify and respond to their workers' priority well-being needs, leaders can utilize existing engagement surveys, add measures to executive dashboards, and use other validated tools to regularly measure well-being.

Build a culture of gratitude and recognition

Third, in addition to recognizing workers through compensation, workplace leaders can *build a culture of gratitude and recognition* where workers feel seen, respected, needed, and valued. Supervisors hold a powerful role in shaping organizational culture and worker well-being. Regardless of their position, when people feel appreciated, recognized, and engaged by their supervisors and coworkers, their sense of value and meaning increases, as well as their capacity to manage stress.[199, 200] Researchers have also found that staff who received frequent appreciation at work from colleagues and supervisors were more likely to recognize and appreciate others, and that this culture had positive effects on their sense of feeling valued, as well as on team performance.

Connect individual work with organizational mission

The fourth component is to *connect individual work with organizational mission* and the impact of their work. Shared purpose, or a collective sense of working toward a common goal, assigns further meaning to work, generates pride, and fuels motivation, all while reducing stress.[186] Organizations can help workers see the connection between their day-to-day work and the organizational purpose and mission. Leaders can also reinforce these connections by acknowledging the different roles of individuals, teams, and departments in achieving organizational goals.[201]

Box 4

Mattering at Work

Resources

Manuals, Guidebooks, Toolkits

- Job Quality Toolkit U.S. Department of Commerce
- Tool for Conducting a Pay Analysis to Understand Whether Full-time Hourly Employees Earn Enough Money to Support Their Household Good Jobs Institute
- The Power of Four Words: "What Matters to You?" Institute for Healthcare Improvement
- Addressing Burnout in the Behavioral Health Workforce through Organizational Strategies, Chapter 3- Planning Processes Substance Abuse and Mental Health Services Administration (SAMHSA)
- Healthy Workplace Participatory Program Toolkit University of Massachusetts Lowell
- "Who is Engaged at Work?" Article (2019), American College of Occupational and Environmental Medicine
- "6 Job Quality Metrics Every Company Should Know" Article (2021), Brookings

Measurement Tools

- NIOSH Worker Well-Being Questionnaire Centers for Disease Control and Prevention (CDC) / National Institute for Occupational Safety and Health (NIOSH)
- Workplace Health Promotion CDC
- Valid and Reliable Survey Instruments to Measure Burnout, Well-Being, and Other Work-Related Dimensions National Academy of Medicine (NAM)

Essential 5:
Opportunity for Growth

> *"What makes work hard is when I don't see or sense that the people who are right directly above me, like my boss, advocate for my growth. They don't even have a sense of what's next for me."*
>
> Entry-level Worker, Non-profit Sector

The fifth and final Essential is **Opportunity for Growth**. This Essential rests on the human needs of **learning** and **accomplishment**. Learning is the process of acquiring new knowledge and skills in the workplace, which provides opportunities for individual intellectual, social, professional, and emotional growth.[202] Learning helps workers meet deadlines and reach goals at work, while promoting healthy social interactions.[203, 204] Without learning or working towards shared goals, workers can start to feel stagnant, frustrated, and ineffective.[202] While learning is the process of growth, accomplishment is the outcome of meeting goals and having an impact.[205] Accomplishment confers a sense of competence that reduces stress, anxiety, and self-doubt.[206] When organizations create more opportunities for learning, accomplishment, and growth, workers become more optimistic about their abilities and more enthusiastic about contributing to the organization.[207]

Opportunity for Growth
Components

- Offer quality training, education, and mentoring
- Foster clear, equitable pathways for career advancement
- Ensure relevant, reciprocal feedback

Offer quality training, education, and mentoring

The first component of Opportunity for Growth is to *offer quality training, education, and mentoring.* A recent survey of executives at 129 large and midsize U.S. companies found that only 59% of companies surveyed have prioritized worker learning and growth over the past three years.[208] Training to increase skills may also be coupled with opportunities for education outside of work to build knowledge in their own work, or in other areas of interest. Employers can informally promote growth opportunities by showing genuine interest in workers through personal encouragement, coaching, and mentorship.[209, 210]

Foster clear, equitable pathways for career advancement

The second component is to *foster clear, equitable pathways for career advancement.* When organizations provide transparent career pathways and advancement opportunities for all workers, this also fosters inclusion and diversity in the workplace. This should include resources and tools that can better support workers over time and address systematic barriers in the workplace. Opportunities might include accessible professional training programs, career navigation support, tuition reimbursement for classes outside of the workplace, English language courses, and promotion opportunities. For other workers this may take the form of rotations through other departments or organizations, sabbaticals, or being offered new types of responsibilities or assignments that give them an opportunity to stretch their skills or learn new ones. It is critical to ensure an equitable and fair distribution of opportunities and eliminate barriers for advancement among workers of color. With more remote and hybrid work, organizations must also ensure that these work arrangements do not limit access to growth or other career advancement opportunities.[211]

Ensure relevant, reciprocal feedback

The final component is to *ensure relevant, reciprocal feedback.* Leaders and managers can provide an appropriate level of guidance to help workers by considering their strengths and growth opportunities.[33] Organizations can create more opportunities for genuinely engaging with their workers, especially in a way that is positive, collaborative, and outcome-oriented. This should include equipping all leaders, especially new or mid-level supervisors and managers, with the supportive training, tools, and resources they need to engage, manage, lead, and coach others.[65]

Box 5

Opportunity for Growth
Resources

- Resource Leveraging & Service Coordination to Increase Competitive Integrated Employment for Individuals with Disabilities Federal Joint Communication to State and Local Governments
- Toolkits to Achieve Workplace Change Harvard University Work, Family & Health Network
- Bridging the Advancement Gap: What Frontline Employees Want—and What Employees Think They Want McKinsey & Company
- What Professional Development Opportunities Can We Offer? Mental Health America
- 4 Tools to Help Managers Connect With Remote Teams MIT Sloan School of Management
- President's Executive Order on Diversity Equity Inclusion and Accessibility in the Federal Workforce
- 7 Tips for Making the Most of Your Check-Ins The Management Center
- Learning at Work and Wellbeing What Works Centre for Wellbeing

Conclusion

As we recover from the pandemic and rebuild our economy, leaders across organizations, together with workers, have an opportunity to reinvest in the mental health and well-being of our nation's workforce. We can build workplaces that are engines of well-being—showing workers that they matter, that their work matters, and that they have the support necessary to flourish. In doing so, we will foster more resilient, productive, and successful organizations and communities.

This Surgeon General's Framework for Workplace Mental Health & Well-Being underscores the inextricable connection between the well-being of workers and the health of organizations. It offers a foundation and resources that can be used by workplaces of any size, across any industry.

Ultimately, sustainable change must be driven by committed leaders in continuous collaboration with the valued workers who power each workplace. The most important asset in any organization is its people. By choosing to center their voices, we can ensure that everyone has a platform to thrive.

To learn more about this framework and to find shareable resources, visit our webpage at **surgeongeneral.gov/workplace**

*Practice Examples**

*This list is not comprehensive, nor does including an example indicate endorsement. Rather, these examples are intended to serve as a starting point for organizations and organizational leaders as they apply the Framework in their workplaces.

Kent State University[212]

Kent State University (KSU) is a public, higher-education institution with approximately 6,000 employees across eight locations in Ohio and New York. In 2012, KSU leadership committed to addressing employee well-being, work-life balance, and mental health. After surveying staff, holding focus groups, and creating an inventory of campus resources, KSU administration confirmed that mental health and work-life balance were top employee concerns and developed a Workplace Mental Health and Wellness Initiative.

In addition to efforts to build trust and workshops to help supervisors identify and respond to signs of depression among staff, the team at KSU focused on normalizing mental health by minimizing stigma around accessing support services. This included improvements to and communication around their comprehensive EAP program, with online and telephone options, and support with stress, anxiety, depression, child and older adult caregiver needs, as well as assistance with financial, legal or identify theft. The EAP is available to all staff, household members, and dependents of staff. They also focused on increasing time and opportunities for connection, including 'walk and talks' which gave workers an opportunity to be together, be physically active, and find peer support.

In the first six months following the launch of the campaign, KSU found a notable increase in EAP utilization and increased web traffic to their EAP website on mental health issues. For the 12-month period after the launch of the campaign in 2012, KSU saw a reduction in claims dollars spent for covered employees diagnosed with depression of $4,861.93 per employee per year, resulting in more than $1 million in savings. Following the implementation of the program, positive responses to employee surveys asking if workers believed their organization cared about their health and well-being more than tripled. Their continued efforts to cultivate a positive working environment for employees has led KSU to be recognized as one of the "Great Colleges to Work For" among 212 institutions for the 11th time since the implementation of the initiative.[213] This has included recognition for their efforts in the following areas: Compensation and Benefits; Confidence in Senior Leadership; Shared Governance; Faculty Experience; and Diversity, Inclusion and Belonging.

Gap, Inc[214]

Many retail workers will not know their schedules until a few days in advance of work, or are "on-call", forcing them to be available without any guarantee of a paid shift. Gap, Inc, a global clothing-retail company, participated in an intervention in 2015-2016 to study the effects of stable schedules on their workforce and business. Initiatives to stabilize working schedules included posting workers' schedules two weeks in advance and eliminating "on-call" shifts. Alongside these baseline initiatives, some managers at different stores implemented additional interventions, such as:

- Instituting standard start and end times for shifts
- Allocating extra staff during times when there is expected to be a sales increase
- Guaranteeing a minimum of 20 hours of work each week for workers
- Allowing associates to swap shifts with other associates without managerial approval

This example shows that making schedules as predictable as possible, while ensuring adequate staff resources to meet high work volume, can reap benefits for the worker and organizations alike. Twenty-eight Gap stores implemented stable scheduling initiatives, which impacted the schedules of nearly 1,500 workers. The total costs of these interventions were low—approximately $31,200. In the stores that implemented stable scheduling initiatives during the 35-week measurement period, Gap saw a 5% increase in worker productivity and a 7% increase in sales. An analysis of the intervention estimated that these stores saw $2.9 million in increased revenue due to the stable scheduling practices.[215] Individual-level impacts included sleep quality improving by 6–8% on average among staff surveyed.

9-1-1 Dispatchers[216, 217]

9-1-1 dispatchers experience a high rate of burnout due to the inherently stressful and traumatic nature of their job as first responders. For example, more than 40% of surveyed emergency dispatchers operating within the Los Angeles Police Department, the third largest police force in the U.S., reported high levels of burnout. Researchers at the University of California, Berkeley hypothesized that burnout and turnover among emergency dispatchers can be decreased by fostering a sense of belonging, support, and positive professional identity.

To test this hypothesis, a group of more than 500 dispatchers across nine U.S. cities received a weekly email for six weeks that featured a story of a dispatcher's work experience. These emails also included a prompt to encourage workers to reflect on their experiences, in hopes that they would share positive stories their coworkers might resonate with. The stories were collected and stored in an easily accessible online database for future emails. For example, one email featured the story of a dispatcher who saved the life of a woman experiencing intimate partner violence in the community. The email concluded with a prompt asking dispatchers to share similar stories about peers and name who would be great mentors and why. Responses were then featured in the following week's email.

By sharing stories, dispatchers were able to highlight the challenges of the job and find commonality while supporting their peers. This fostered a greater sense of belonging as more dispatchers were able to empathize with the stories and challenges shared by colleagues. Approximately two-thirds of participants asked that the weekly emails continue. Moreover, dispatchers who received these emails reported a decrease in burnout. One model suggested this intervention can reduce turnover by 50%, resulting in cost savings for organizations. For instance, according to the model, a city with 100 emergency dispatchers could save more than $400,000 in recruitment and training costs from turnover. These findings suggest that low-cost interventions for building social connections, helping workers feel valued, and creating a platform for trusted work relationships can mitigate burnout and contribute to worker well-being.

U.S. Army Corps of Engineers, Sacramento, CA[218]

The U.S. Army Corps of Engineers is a major Army command with approximately 37,000 civilian and military personnel, one of the world's largest public engineering, design and construction management agencies. The district of Sacramento has over 900 workers who manage some of the largest and most complex construction projects in the United States. Their leadership has emphasized the need for a robust and positive workplace safety culture, one that includes physical and psychological health and well-being. Their motto, "Building strong AND Taking care of people" reflects this.

There is a clear commitment from leadership across all levels to prioritize physical and psychological safety at work. The agency meets staff to support their well-being wherever they are, from office settings to government vehicles to construction sites. They utilize engagement surveys and awards so workers feel empowered to prevent and stop unsafe acts, while fostering a sense of ownership over their safety program and culture. Leadership provides early and ongoing communication and improvement opportunities, from new staff orientations to openly and publicly discussing workplace mental health and well-being. These communications also include safety expectation setting through district-wide letters to all staff, a quarterly council to highlight successes on workplace safety, and a district-wide employee council for troubleshooting challenges.

Panels with workers on workplace well-being through the pandemic and training on "Mental Health First Aid" for staff have also helped to normalize struggles and address stigma, while increasing access to mental health care and support. When it comes to workplace mental health and well-being, with this supportive safety culture, one worker reported feeling "more open to sharing my own challenges" with peers and "more supported to address them by my supervisor," especially alongside other disabilities for which he also needs support. The benefits of this program appeared to spill into the community as well, as at least one worker responded to efforts at work by taking on additional speaking engagements in their community to continue confronting stigma, including joining a city stigma association and sharing their story with local high schools, colleges, and teachers. One more worker shared, "Speaking out has helped others to also speak out and know they won't be punished… Having flexibility was (also) a life-saver for me—being able to make my doctor's appointments, adding flexibility to scheduling meetings—it's made a huge difference in my work life."

DTE Energy[219]

In response to survey results indicating low performance and creativity among their workforce, leadership at DTE Energy, a Detroit-based energy company, were eager for solutions. They were inspired after visiting a local call center where, contrary to expectations, they noted "positive, fully engaged employees collaborate and go the extra mile for customers." The secret: "connecting the people to their purpose."

One of DTE's first related initiatives was to film a video articulating the importance of each worker. They highlighted truck drivers, plant operators, corporate leaders, and many others to recognize the impact of their work in the company and on the community. Workers reported being moved by the videos because their work had never before been framed as a meaningful contribution. This newfound meaning was ingrained in the organizational culture itself, as the company adopted a new statement of purpose: "We serve with our energy, the lifeblood of communities and the engine of progress." This statement was woven into company leadership activities, onboarding and training programs, corporate meetings, and teambuilding efforts.

This example demonstrates one way to make an explicit connection between individual's work and the functioning of an organization and its surrounding community. After centering the importance of mattering in the workplace, DTE Energy received a Gallup Great Workplace Award five years in a row.

For more practice examples:

- Center for Workplace Mental Health American Psychiatric Association
- Total Worker Health® Case Studies Oregon Healthy Workforce Center
- Job Quality Case Studies U.S. Department of Commerce

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Health Resources and Services Administration (HRSA)
Centers for Disease Control and Prevention (CDC)
- Office of the Director
- National Institute for Occupational Safety and Health (NIOSH)

National Institutes of Health (NIH)
Office of the Assistant Secretary for Health (OASH)
Office for Civil Rights (OCR)
Office of the General Counsel (OGC)
Office of the Secretary (OS)
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Employee Benefits Security Administration (EBSA)
- Office of Disability Employment Policy (ODEP)
- Occupational Safety and Health Administration (OSHA)
- Women's Bureau (WB)

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