

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ADULT MENTAL HEALTH SERVICES
MENTAL HEALTH CRISIS SERVICES STANDARDS
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Mental Health Crisis Services Standards

	<u>Page</u>
A. Introduction	1
1. Background	
2. Definitions	
3. Overview of Crisis Services	
B. Crisis Services Staff	3
1. Crisis Team	
2. Qualifications	
3. Consultation	
4. Supervision	
5. Training	
C. Types of Crisis Services	4
1. Crisis Assessments	
2. Crisis Telephone Services	
3. Walk-In Services	
4. Mobile Outreach Services	
5. Crisis Stabilization Units	
6. Psychiatric Consultation Services	
D. Crisis Plan	9
1. Plan Whenever Possible	
2. Roles and Responsibilities	
E. Administrative Requirements	10
1. Policies and Procedures	
2. Documentation	
3. Quality Assurance	
4. Critical Incidents	
F. Relationships with the Public and Others	12
1. Community Outreach	
2. Relationships with Hospital Emergency Departments	
3. Relationships with Law Enforcement Agencies/County Jails	
4. Coordination and Collaboration with Others	

A. Introduction

1. **Background.** These standards are the result of substantial work of the Emergency/Crisis Services Subcommittee of the Hospital and Crisis Services Initiative Group and the subsequent review by the Quality Improvement Council, the Consumer Advisory Group, CLASS and Hospital Initiatives, and the MAPSRC. Many of their suggestions have been incorporated in addition to the requirements as outlined in the October 13, 2006 Consent Decree Plan.
2. **Definitions.** As used in this document, the following terms have the following meanings:
 - a. Crisis plan means an individualized consumer document designed by a consumer with the assistance of the community support worker and other staff to help anticipate and prevent future crisis episodes and direct interventions in the instance of a crisis.
 - b. Crisis services or crisis services programs means programs, funded by the Maine Department of Health and Human Services, to help individuals in crisis.
 - c. CSU means a crisis stabilization unit, which is one of the services provided by some of the crisis services programs.
 - d. CSW means a Community Support Worker. Some persons requesting or receiving crisis services also receive community support services provided by a community agency, including a CSW who provides case management services.
 - e. DHHS means the Maine Department of Health and Human Services.
 - f. ED means the emergency department of a community hospital.
 - g. ICM means a DHHS Intensive Case Manager. Some persons requesting or receiving crisis services also receive intensive case management services provided directly by an ICM.
 - h. ISP means the Individualized Support Plan. If a person in crisis has a CSW or an ICM, then he or she has an ISP that states his or her goals and services.
 - i. Other treatment provider means a community mental health, substance abuse, or medical treatment provider.
 - j. Triage means a classification process to determine priority needs.
3. **Overview of Crisis Services.** This section provides an overview of crisis services.
 - a. **Primary Purpose.** The primary purpose of crisis services is to assess the individual in crisis and determine and assist him/her in receiving the least restrictive, most effective treatment that is
 - b. **Goals.** The goals of crisis services are to:
 - Provide services at locations other than an emergency department of a hospital unless the consumer chooses to receive services in an emergency department, requires treatment for a medical condition, or is in protective custody.
 - Resolve crises in the least restrictive manner and setting possible; and

- Achieve outcomes consistent with the ISP and other mental health treatment goals of the person in crisis, whenever applicable and possible.
- c. Guiding Principles. The following principles guide the delivery of crisis services:
- Crisis services are accessible 24 hours a day, 7 days a week in a variety of community sites and with access at all times via a toll free 1-888 statewide crisis hotline telephone number.
 - Crisis services are provided to all persons in crisis requesting help. In order to achieve the best possible outcomes for those requesting help, it is expected that CSWs, ICMs, and other treatment providers also will help their clients resolve crises prior to the involvement of the crisis service.
 - Crisis services focus on intervention, de-escalation, stabilization, and referral to needed follow-up services.
 - Crisis services are flexible and creative; based on the level of care needed; clinically appropriate; delivered in the least restrictive available setting; and consistent with ISP goals and other treatment goals, whenever possible and applicable.
 - Whenever possible, the same crisis services staff should be involved throughout the course of a crisis episode.
 - Effective crisis services require the cooperation of many organizations and service systems.
 - Crisis services programs and staff:
 - Respect the needs and wishes of each person in crisis;
 - Value and protect the rights, privacy, and confidentiality of each person in crisis, unless the person presents an imminent risk and confidentiality would compromise the required intervention; and
 - Consider the strengths and resources of both the person in crisis and the community; and
 - Collaborate with others involved with the person in crisis, whenever appropriate and possible.
- c. Major Program Components. The major crisis services program components include:
- Qualified crisis services staff;
 - Telephone services;
 - Walk-in services;
 - Mobile outreach services;
 - Crisis stabilization units;
 - Psychiatric consultation;
 - Crisis counseling as well as community resource counseling and referral;

- Crisis assessments and outcome recommendations;
- Incorporation of crisis services plans, whenever possible, especially for persons receiving mobile outreach services or admitted to a CSU; and
- Collaboration, whenever possible and appropriate, with others who are also involved with persons in crisis, such as family members, CSWs, ICMs, other treatment providers, community hospital emergency departments, psychiatric inpatient facilities, law enforcement agencies, and county jails.
- Quality assurance activities.

d. Role of CSW, ICM and CSW Agency, ICM Regional Office

- During regular business hours, the first line of responsibility for crisis resolution is the consumers' CSW, ICM. The CSW, ICM may subsequently involve crisis services
- The CSW is responsible among other duties to develop with the consumer and ISP, crisis plan, and advance directives.
- The CSW Agency, ICM Regional Office is the lead agency for the consumer receiving the services of their respective CSW or ICM.
- The CSW Agency, ICM Regional Office must make available to crisis services and/or hospital emergency departments the consumer's ISP, Crisis Plan, Advance Directives and the name of the prescriber of psychiatric medication and contact information.
- The CSW is responsible for communicating with the crisis provider or the hospital to assure appropriate follow-up services, and for reviewing the ISP and crisis plan with the consumer whenever there is a major psychiatric event, updating the plans as needed.

B. Crisis Services Staff

- 1. Crisis Team.** Persons in crisis will have access to a team of professionals, which must include a psychiatrist and an independently licensed clinical supervisor and may also include other crisis services staff such as a crisis intervention counselor, crisis stabilization counselor (if at a CSU), crisis clinician, nurse, and/or other mental health providers. Each crisis services program will have an adequate number of qualified staff to respond to the number of persons in crisis it serves and to ensure that a person does not wait any longer than an average of 30 minutes from the time that the crisis program is notified until the time of the initial crisis intervention.
- 2. Qualifications.** Each crisis services program will have qualified crisis intervention counselors—or crisis stabilization counselors if the program is a CSU—and other professional staff in accordance with DHHS crisis training and licensing requirements. Crisis intervention counselors, crisis stabilization counselors, and other professional staff will have the minimum credentials and experience defined and approved by DHHS, as well as a license

or other credentials appropriate to the professional requirements of their respective credentialing body.

- 3. Consultation.** Crisis services staff will have access, on a 24-hour basis, to psychiatric consultation and a clinical supervisor licensed at an independent practice level.
- 4. Supervision.** All non-independently licensed crisis services staff will have a minimum of one hour of documented supervision from a licensed clinician for every 20 hours of face-to-face mental health services provided to consumers.
- 5. Training.** The following requirements relate to training of crisis services staff:
 - a. Competency-Based Training. Crisis services staff is expected to participate in competency-based training in crisis intervention approved by DHHS for specific job responsibilities. This standard will take effect upon approval by DHHS of a competency-based training curriculum.
 - b. Consistent Curriculum. Training may be conducted or arranged by an individual crisis services provider or through collaboration among providers, so long as the curriculum is consistent for all providers and has been approved by DHHS.
 - c. Pre-Service and Ongoing-Training. Crisis-services programs will ensure that their staff attends pre-service and on-going training sessions required by DHHS.
 - d. Cross-Training. Crisis services staff will participate in cross training about substance abuse, mental retardation, and trauma when available through DHHS funding.

C. Types of Crisis Services

Persons access crisis services either through the telephone service or walk-in service

1. Crisis Telephone Services. Crisis telephone services will be provided as follows:

- a. Overview; Availability of Services. The goal of these services is to provide the highest quality crisis assessment, intervention, and stabilization services in the least restrictive and least disruptive manner that meets the needs of persons in crisis. These services are available and accessible 24 hours a day, 7 days a week through a statewide toll-free number (1-888-568-1112).
- b. Staffing. Crisis intervention counselors with the qualifications and on-demand consultation and supervision, described in section B, staff these services.
- c. Key Features. Crisis telephone services:
 - Are often the first point of contact with the mental health system for a person in crisis;
 - Promote stabilization and then evaluate the person's need for additional services;
 - Provide triage to identify additional services needed, so that the person may be helped and connected with services without leaving home;
 - Include supportive interventions and problem solving for the person.

- Serve as an ongoing support and backup to mobile outreach services at the site of the crisis unless clinically contraindicated;
 - Offer the least restrictive level of intervention;
 - Assist the person to remain in a community environment, whenever possible; and
 - Provide information regarding services and resources in the community and facilitate referrals to other services and resources.
- d. Crisis Calls and Non-Crisis Calls. Calls by persons in crisis trigger the assessment, intervention, and triage process in order to make a determination of these persons' needs based upon the acuity of their presenting problem(s). For calls concerning non-crisis issues, the callers should be encouraged to contact warm lines, peer support services, and/or their CSW, ICM, or other treatment provider, if any.
- e. TTY; Interpreter Services. A local TTY telephone number will be available for persons in crisis who are deaf. Crisis services programs will strive to provide immediate interpreter services, when needed. When interpreter services are not immediately available, crisis services staff will continue efforts to obtain the services of an interpreter.

2. Walk-In Services. Walk-in services will be provided as follows:

- a. Availability. These services will be available and accessible 24 hours a day in order to provide face-to-face crisis assessments.
- b. Locations. These services may be provided at the offices of the crisis services program or at other sites within the crisis program's service area. Sites may be developed in collaboration with other entities. Site development will take into account:
- The safety of persons in crisis and staff,
 - The availability of adequate crisis staff for that site, and
 - The goal of providing services in the least restrictive setting.

3. Crisis Assessments. Crisis assessments will be carried out as follows:

- a. Assessment by Crisis Intervention Counselor. A crisis assessment will be performed by a crisis intervention counselor in each crisis situation in which there is face-to-face contact with the person in crisis. A full assessment will be conducted for each person being seen by the crisis services program for the first time. Subsequent assessments for the same person will focus on the presenting issue and changes that may have occurred in the person's situation and functioning since the prior presentation. Crisis services programs will approach assessment as a supportive dialogue with the person in crisis.
- b. Involving Others. Others designated by the person may be involved in the assessment, including family members; his or her CSW, ICM, and/or other treatment provider(s); and/or others. When the person has an ISP, a crisis plan, and/or other established treatment plan, the crisis intervention counselor, whenever possible and with the person's consent, will contact the person's CSW, ICM, and/or other treatment provider to gather information to use in formulating the outcome recommendations described in section C1(f).

- c. Comprehensive Interview. All crisis services programs must develop a comprehensive crisis assessment interview that addresses all of the following areas:
- Demographic and diagnostic information.
 - Risk of harm to self and others (including current and history of suicidal/homicidal impulses, thoughts and behaviors; trauma history, risk of victimization, and/or abuse or neglect; physically and/or sexually aggressive impulses or behaviors; and ability for self-care and use of environment for safety).
 - Functional status (including self-care/hygiene; ability to maintain social/interpersonal relationships; changes/disturbances in biologic functioning such as sleep, eating, activity level, etc.; and school and/or work performance).
 - Evidence of co-occurring medical, substance abuse, developmental and psychiatric conditions that may have a potential impact on the course and/or treatment of the presenting condition(s).
 - Environmental stressors (including transitions and losses; current living situation/home environment; serious illness and/or injury of consumer or relative; exposure to substance abuse and its effects; danger or threat in home or community, etc.).
 - Environmental supports (including ability to take advantage of community and professional resources; social and emotional support from friends or relatives, etc.)
 - Current and past experiences with treatment and services (including response to treatment; ability to manage recovery; ability to engage in the treatment process; history of psychiatric hospitalization; history of involvement with crisis services; resiliency following setbacks, etc.).
 - Pertinent medical history, medication history, and current use of medications.
- d. Medication Issues. When a crisis assessment reveals medication issues that need to be addressed, the crisis intervention counselor shall consult the on-call psychiatrist. Crisis services staff will attempt to advise the person's CSW, ICM, and current treatment provider(s), if any, about relevant medication issues so they can develop, follow-up, and assist with compliance plan.
- e. Additional Tools. Crisis services staff may utilize additional assessment tools to support outcome recommendations such as a Level of Care Utilization System.
- f. Outcome Recommendations. After the assessment, written outcome recommendations will be offered based on the person's treatment and support needs. Outcome recommendations may include:
- Referral to outpatient assessment and treatment;
 - Referral to community support services;
 - Referral for continued work with current CSW, ICM, and/or other treatment providers to address unmet needs;
 - Referral for evaluation for hospitalization;
 - Outpatient or residential crisis stabilization support;

- In-home supports;
- Support and involvement by family members, peers, and other natural supports;
- Referral to other resources (e.g. NAMI Maine, AA, trauma services, etc.), as appropriate; and
- A follow-up plan, including information about contacting the crisis services program and other providers and resources.

4. Mobile Outreach Services. Mobile outreach services will be provided as follows:

- Overview; Availability. These services provide support to persons in crisis and their families, including triage, telephone and face-to-face safety assessments, supportive counseling, crisis plan development based on the results of an assessment of the person's immediate safety and support needs, and follow-up. These services will be delivered in a timely manner, on average 30 minutes or less, with availability 24 hours a day, 7 days a week.
- Location. Whenever possible, a person in crisis will be seen and stabilized in his or her residence. Interventions take place in a variety of settings, including private residences, group homes, work sites, shelters, schools, mental health agencies, and hospital emergency departments. To assure safety for persons in crisis and staff, crisis intervention counselors:
 - Will determine the appropriate site for the intervention,
 - May request the services of law enforcement to be present or to transport the consumer to a safer location, and
 - Will not act alone in a questionable situation without law enforcement backup and reliable technical support (e.g. cell phone, pager. etc.)
- Teams. Mobile outreach teams will:
 - Include staff with qualifications and access to clinical consultation, described in section B.
 - Have access to personnel capable of processing involuntary hospitalization.

5. Crisis Stabilization Units. CSUs will provide services as follows:

- Overview; Goals. CSUs provide short-term, supportive and supervised community residences, where the person in crisis can receive assessment and interventions that will stabilize and treat the individual in crisis and readjust to community living. CSUs provide an alternative to hospitalization for a person in crisis who needs a more intensive level of care than outpatient services can safely provide. The goals of CSU are assessment, **treatment**, stabilization and preparation of the person for return to a home environment. When clinically necessary, the person will be referred for a more intensive level of care.
- Staffing. Crisis stabilization counselors will be present 24 hours a day to provide a safe environment, promote health-coping mechanisms, assist in daily living skills, monitor

medication administration, assist in behavioral management, provide supportive crisis interventions, and perform discharge-planning functions.

- c. Psychiatric and Medical Services. CSUs must have access to on-site psychiatric services and off-site medical services.
- d. Assessment. A person admitted to a CSU will utilize the initial crisis evaluation and subsequent evaluation upon admission to the CSU to establish that the CSU continues to be the appropriate level of care. The details provided by the assessment will vary given a variety of factors, including the person's cooperation, the integrity of information sources, the length of services or treatment, and the condition(s) being addressed. The assessment will evaluate mental status; review existing ISPs and treatment plans, when available; deal with relevant clinical concerns; and determine the appropriate level of care for the person.
- e. Short-Term CSU Plan. Within 24 hours of a person's admission to the CSU, a short-term CSU plan will be developed, with the involvement and consent of the person. The plan will be reviewed frequently to assess the need for the person's continued placement in the CSU. At a minimum, this plan will include:
 - A problem statement;
 - Goals consistent with the person's needs and projected length of stay;
 - Objectives that build on the person's strengths and stated in terms that allow measurement of progress;
 - Specification of treatment responsibilities and methods;
 - Evidence of input by the person, including his or her signature;
 - Signatures of all other individuals participating in the development of the plan;
 - A description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals; and
 - Criteria for discharge.
- f. Involvement of Person and Others. The person in crisis will be involved collaboratively in all aspects of CSU admission, treatment planning/intervention, and discharge. The involvement of family members and others will be encouraged. Subject to the person's consent, the CSU will involve his or her CSW, ICM, and/or other treatment provider, if any, in order to coordinate assessment and crisis services with the person's established community support, case management, and/or treatment services.
- g. CSU Summary of Treatment. The crisis services program will have a summary that describes the person's course of treatment and ongoing needs at transition. A copy of the summary will be provided to the person and shared with the person's CSW, ICM, and/or other treatment providers, if applicable and as authorized by the person. At a minimum, each summary will address the following:
 - The assessment of the crisis with challenges and strengths

- Evolution of the mental status to inform ongoing placement and support decisions
- Treatment interventions
- The final assessment, including general observations and significant findings of the person's condition initially, while services were being provided, and at discharge;
- The course and progress of the person with regard to each identified problem;
- Recommendations and arrangements for further service needs;
- The reasons for termination of services; and
- The crisis plan.

6. Psychiatric Consultation. The crisis services program will have access to a psychiatric consultant 24 hours per day, 7 days per week. The psychiatrist will be available to consult with and advise community hospital emergency department physicians on issues relating to medical evaluation and medication treatment of consumers when clinically indicated, as well as, to diagnosis and overall treatment plan. Crisis services programs will participate in local efforts, such as memoranda of understanding, to clarify the respective roles of and relationship between their psychiatric consultant(s) and emergency department physicians.

D. Crisis Plan

- 1. Plan Whenever Possible.** Generally, a person requesting or receiving crisis services will have a crisis plan, which will be available to all crisis services staff prior to and during a crisis contact.
- 2. Roles and Responsibilities.** Keeping in mind that crisis plans generally are developed by CSWs, ICMs, and/or other treatment providers, the crisis services programs will take the following steps:
 - a. Plan Obtained or Developed. If the person already has a crisis plan, the crisis services program will obtain and hold a copy of that plan. If the person does not already have a crisis plan but he or she has a CSW, ICM, and/or other treatment provider, the crisis services program will work in collaboration with the person and those others to develop a crisis plan.
 - b. Content of Plan.
 - Includes a description of possible crisis needs and concrete steps to be taken to prevent or minimize escalation of a crisis by the person who is the subject of the plan; crisis services staff; and the person's family members, CSW, ICM, and treatment providers, if appropriate and applicable; and
 - Uses the person's own words to describe problems and interventions that may alleviate a crisis if and when it occurs.
 - c. Plan Held and Shared. The crisis services program will include the crisis plan, if any, in the person's case file and, when applicable and possible, will share it with the person's

CSW, ICM, and/or other treatment provider(s) if it was developed by the crisis service at the time of the most recent crisis.

- d. Access Not Restricted. Under no circumstances may a person be denied access to crisis services due to failure to comply with his or her crisis plan, nor will the plan be used to restrict his or her access to crisis services.

E. Administrative Requirements

1. **Procedures.** There will be written procedures to guide the delivery of each of the crisis services described in section C.
 - a. Minimum Procedures. All crisis services programs will have written procedures for each crisis service it provides, including the following at a minimum:
 - Techniques for clinical intervention;
 - Contacting other emergency service providers; and
 - Referral of persons to CSWs, ICMs, and other treatment providers, as applicable and appropriate.
 - Coordination of services with existing CSWs, ICMs and other existing treatment providers
 - b. CSU Procedures. In addition to the procedures described in section E1(a), crisis services programs that operate a CSU will have written admission and transition procedures.
2. **Documentation.** Crisis services providers are required to meet the following documentation requirements:
 - a. Documentation Requirements for Crisis Telephone Services. Technology and on-demand access to records are critical to crisis telephone services and will be maintained by each crisis services program directly providing this service. Documentation requirements for crisis telephone services will include the following:
 - The documentation of calls will include a description of the presenting problem, assessment of risk factors, intervention, evaluation of the intervention, and a plan for the management and resolution of the crisis/emergency situation reported; and
 - A log of all contacts with crisis telephone services—including the name of the caller, when available, the crisis telephone worker, and the time and duration of the call—will be maintained for quality assurance review and ongoing staff supervision; and
 - b. Documentation Requirements for Face-to-Face Contacts. For every face-to-face contact with a person in crisis who receives crisis services, documentation requirements will include the following:
 - The person's presenting problem;
 - The person's history and precipitating factors;

- The assessment of the person’s capacity, danger to self and others, and ability to care for self;
 - The sharing of the assessment with the person and the person’s parent(s) or guardian, CSW, ICM, and/or treatment provider(s), when applicable and appropriate;
 - The outcome recommendations for the person, including referrals to other services, as appropriate;
 - Collaboration with the person’s CSW, ICM, and/or other treatment provider, when applicable and appropriate. -
 - Reference to the person’s ISP, when applicable and appropriate;
 - Whether or not a crisis plan exists and, if it does, whether it was utilized during the contact; and
 - Appropriate follow-up contacts for each person, which comply with confidentiality and informed consent standards.
- c. CSU Documentation Requirements. The CSU summary of treatment described in section C5(g) will be documented in the person’s record within 24 hours of discharge.
- d. Documentation Requirements for All Crisis Services. For each crisis service provided, the crisis services program will have documented evidence that crisis services staff meet the qualifications and have received any training required by DHHS.
- 3. Quality Assurance.** Crisis services programs will participate in the collection and submission of financial and program data and the problem-resolution activities established by DHHS. If a crisis-services program is unable to complete requirements due to financial constraints, it will notify DHHS immediately. As part of quality assurance, the crisis-services programs are expected to:
- a. Monitor. Monitor utilization patterns of the types of crisis services; the utilization of crisis services in the community compared to the emergency departments; the timeliness of crisis services by documenting when a request for services is made and when services are delivered; and complaints regarding access to crisis services. All substantiated complaints will be assessed for the seriousness of the violation and actions will be taken to address the delay.
 - b. Documentation. Maintain documentation that crisis services staff have the qualifications and have received training required by DHHS.
- 4. Critical Incidents.** Critical incidents, which represent the most stressful kind of crisis intervention situation, need to be handled in an integrated, ethical, and expedient manner. A critical incident is defined as any incident with serious or potentially serious impact on the person in crisis, staff, volunteers or visitors of a crisis program or facilities. The following steps will be taken regarding critical incidents:
- a. DHHS Procedures. Crisis services programs will comply with procedures established by DHHS for documenting and reporting critical incidents.

- b. Reporting Criteria. Critical incidents will be reported at two levels based on their degree of seriousness, significance, or potential significance. It is important to consider the broader implications of the event, not just the single episode that may have occurred.
- c. Individuals Involved If There is a Question. Since the determination of the seriousness or significance of an incident may involve a judgment call, the following individuals should be contacted in the following order if there is a question about whether a critical incident has occurred: manager or supervisor on call, director of crisis services, director of program operations, and executive director of agency. If one of these individuals is not available, the next person in order of level of responsibility should be contacted.
- d. Determination that Critical Incident Has Occurred. If it is determined that a critical incident has occurred which needs to be reported, the following steps must be taken:
 - For *Level I Incidents*, the director of crisis services, director of program operations, and executive director are responsible for formulating a plan together and contacting DHHS within four hours of the incident becoming known to staff. A faxed, photocopied, or password protected e-mail incident report must be submitted DHHS.
 - For *Level II Incidents*, the director of crisis services, director of program operations, and executive director are responsible for formulating a plan together and contacting DHHS within 24 hours of the incident becoming known to staff. A faxed, photocopied, or password protected e-mail incident report must be submitted to DHHS.
 - For *Level III Incidents*, the director of crisis services is responsible for reviewing and submitting an incident report within 24 hours to DHHS.
- e. Review of Critical Incidents. DHHS will review all critical incidents within 5 working days. If the situation dictates a critical incident review, a team will be formed to review the case. Following a Level I critical incident involving serious consequences to consumers and/or staff, a staff debriefing will be arranged by the director of crisis services of the crisis services program with an outside facilitator trained in critical incident stress debriefing.

F. Relationships with the Public and Others

1. **Community Outreach.** Crisis services programs will facilitate access to intervention by ensuring that information is widely disseminated regarding the services available and how a person may access crisis services. Promotional materials will be honest and realistic in their message. Crisis services programs will enhance public relations by participating in community activities and offering educational programs about crisis intervention to community agencies.
2. **Relationship with Hospital Emergency Departments.** Crisis services programs will strive to develop collaborative relationships with EDs in their service area:
 - a. Mutually Responsive Relationships. In order to meet the needs of the community for emergency mental health services, crisis services programs and EDs will strive to have strong, mutually responsive working relationships. Crisis services programs are available

to work with persons in crisis in their home and community settings. At other times, when safety and medical needs dictate, crisis services programs appropriately direct persons in crisis to a local ED.

- b. ED Requests for Help. Crisis services staff will be available to come to the ED and deliver assessment services for a person in crisis, as established in a memorandum of understanding. The crisis services program will indicate the estimated length of time for response to the ED's request. Assessment services are consultative in nature and focus on the determination of the level of care needed. Following the assessment of the person in crisis, crisis services staff will discuss disposition options with ED staff. These options will be consistent with patient rights and will include available, appropriate resources, whether or not they are affiliated with the parent organization of the crisis services program.
- c. Crisis Services Refers Person to ED. When crisis services staff refers a person in crisis to an ED, they will call to notify the ED of the person's arrival and the nature of the crisis (e.g. security may be needed, serious overdose situation, etc.). Upon the arrival of crisis services staff at the ED, they will immediately consult with the attending physician and/or charge nurse.
- d. Rapid Response Protocol. A rapid response protocol between each ED and crisis program and the Office of Adult Mental Health Services will exist and be modified from time to time as a result of changing personnel or other factors.
- e. Memoranda of Understanding. Crisis services providers will strive to develop MOUs to support an effective a working relationship with the EDs in their area. MOUs should address such issues as:
 - Clarifying admission criteria for the crisis services providers and the EDs;
 - Changes in the staffing capacity of the crisis services providers and the EDs;
 - Performance goals for the crisis services providers and the EDs; and
 - Holding quarterly meetings to discuss these and other issues of concern.

3. Relationships with Law Enforcement Agencies/County Jails. Cooperation and collaboration between the crisis-services program and law enforcement agencies/county jails are essential for ensuring the safety of persons in crisis and the staff who help them:

- a. Violence Occurring or Imminent. In situations when violence to self and/or others is occurring or is imminent, crisis services staff will involve law enforcement immediately. Phone numbers for law enforcement agencies will be readily accessible to crisis services staff at all times. Crisis services staff will not risk their or others' safety and will not enter a potentially dangerous site (i.e. a suicidal consumer with a weapon) until accompanied by law enforcement. Crisis services programs will make every effort to contact a person's CSW, ICM, and/or other treatment provider in these situations.
- b. Other Situations. When there is a documented history of violence, unsafe environmental factors, or serious potential for harm in a particular situation, crisis services providers will contact law enforcement. These contacts are for the purpose of sharing pertinent information and/or requesting accompaniment of the person to the closest ED. The crisis

services program also will make every effort to contact a person's CSW, ICM, and/or other treatment provider in these situations.

- c. Follow-up. Subsequent to all significant communication and/or interventions involving law enforcement or county jails, crisis staff will follow-up as needed and appropriate with the local law enforcement agency or county jail and with the person's CSW, ICM, and/or other treatment provider.
- d. Memoranda of Understanding. Crisis services providers will strive to develop MOUs with law enforcement agencies and county jails in their service area to support an effective a working relationship.

4. Coordination and Collaboration with Others. Unless clinically contraindicated and or not possible given the time of the day or other factors crisis services programs will coordinate services with others who are also involved with persons in crisis, such as CSWs, ICMs, other treatment providers, psychiatric inpatient facilities, and others in their service areas. If due to the time of day or other circumstances the others involved in services to the consumer could not be immediately involved the Crisis services program will apprise them of the crisis and the response as soon as possible. Crisis services programs will:

- a. Communication. Communicate with them about plans, assessments, alerts, and interventions; and
- b. MOUs. Strive to develop MOUs with them that describe each other's role in providing crisis services to mutual clients. Issues considered should include:
 - Availability of psychiatric consultation and clinical staff;
 - Live telephone response;
 - Screening and classification to determine priority needs (triage);
 - Sharing of information and clear channels of communication;
 - Linkages with resources appropriate to identified needs; and
 - Coverage for crisis services during both the workday and after hours.