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CHAPTER: Board Services and Program Administration		
SECTION: CMH Crisis Stabilization Services		
SUBJECT: General Policy		
Administrative Approval:	Date of Governing Board Action: 2/20/96	Page 1 of 7

I. **PURPOSE:** To establish policy and procedures for the development and implementation of a Crisis Stabilization Services (CSS) program.

II. **APPLICATION:** All mental health programs and services operated by the West Michigan Community Mental Health Governing Body.

III. **REQUIRED BY:** Public Act 258 of 1974, as amended, the Michigan Department of Health and Human Services (MDHHS) Administrative Rule 330.2006 and Accrediting Bodies.

IV. **DEFINITIONS:**

Individual: A person requesting or currently receiving CMH services, or a third party, such as law enforcement, guardian, custodian parent of a minor, or a representative from a foster care home, hospital or nursing facility requesting CMH Crisis Stabilization Services for a person in its care.

Confidentiality: All information received and maintained by CMH regarding an individual shall not be disclosed to any other entity without specific written authorization of the individual or their court appointed guardian, except under provisions of Public Act 258, of 1974, as amended.

Crisis Stabilization Services: 24/7/365 Crisis Stabilization Services provide the following services: (1) 24 hour mobile crisis teams, (2) emergency crisis intervention services, (3) crisis stabilization services, (4) suicide crisis response; (5) services for substance abuse crisis and intoxication, including ambulatory detoxification services; (6) pre-admission screenings for inpatient hospitalizations; (7) DBT Coaching; and (8) ACT-specific crisis services. Crisis Stabilization Services may be provided on site or through mobile response at an approved secure location such as the county jail, a law enforcement office, a community member's home, or Emergency Department and may be face to face or by telephone.

Crisis Stabilization Services Manual: A manual, which is updated at least annually by the Service Entry Team Leader, on Crisis Stabilization Service protocols for use by mental health professionals during the delivery of Crisis Stabilization Services.

Crisis Stabilization Services Program Supervisor: The Service Entry Team Leader or another senior professional staff person designated to directly supervise the Crisis Stabilization Services program and its assigned mental health professional staff in the delivery of services.

Crisis Stabilization Services Program Team Meetings: Service Entry team meetings that are held on an annual basis and are attended by all Crisis Stabilization Services Program staff and at times by other pertinent clinical or administrative staff. The purposes for team meetings are to review problematic crisis stabilization incidents, discuss and examine specific clinical issues, discuss and review contractual and legal procedures, to review program monitoring and evaluation activities, and for routine group supervision by the program supervisor. The Service Entry Team Leader is responsible for insuring that accurate minutes of the meetings are recorded and distributed.

CSS Check-In Meetings: Crisis Stabilization Services daily staff meetings are held every morning with the Service Entry Administrative Assistant/designee, Service Entry team members, the Crisis Stabilization Services worker for the weekend or night before and the Service Entry Team Leader. The purpose of the meeting is to ensure quality of services, documentation, adequate referral and follow-up as necessary. In lieu of these face to face meetings, communication on CSS activities and necessary follow up planning may occur via phone or email communication.

Mobile Crisis Services: Mobile Crisis Services is a specific service within WMCMH's Crisis Stabilization Program. It provides 24/7/365 acute mental health crisis stabilization services to individuals by phone, within their own homes, or in other secure community sites outside of an ED, jail, or other traditional clinical settings. The primary purpose is to meet acute needs and thereby reduce Emergency Room usage and inpatient psychiatric hospitalizations. Psychiatric consultations are available as a part of this service as needed.

V. **POLICY:** It is the policy of West Michigan Community Mental Health to implement and maintain a catchment area twenty-four (24) hour Crisis Stabilization Services program in accordance with the written Crisis Stabilization Services Program Plan.

VI. **PROCEDURES:**

A. The Service Entry Team Leader, or an appointed designee, shall be responsible for:

1. The implementation and maintenance of Crisis Stabilization Services in accordance with the Crisis Stabilization Program Plan.

2. Periodically publishing a schedule of mental health professionals responsible for the provision of after-hours CSS services.

3. Developing, issuing and annually reviewing the Crisis Stabilization Services Manual.

4. Issuing a Crisis Stabilization Services manual to each mental health professional responsible for the provision of CSS services.

5. Scheduling, chairing and recording CSS team meetings.

6. Providing routine group supervision.

7. Ensuring that the provision of CSS is held confidential in accordance with CMH policy.

8. Ensuring CSS are provided regardless of ability to pay for services and regardless of residency of the individual, including individuals who live out of state.

9. Ensuring agreements/contracts are in place with Inpatient psychiatric treatment, including substance use disorder services facilities to provide services at the clinically appropriate level, and residential programs.

10. Ensuring the implementation and maintenance of a CSS documentation system.

11. Monitoring the need for continuing staff education as it pertains to the delivery of CSS services and seeking out administrative authorization to address such training needs as they are identified.

12. Ensuring care coordination agreements that require coordination of consent and follow-up within 24 hours from ED mental health visits, continuing until the consumer is linked to services or is assessed as being no longer at risk, for consumers presenting to the facility at risk for suicide, making and documenting reasonable attempts to contact all consumers discharged from these settings within 24 hours of discharge.

13. Reviewing consultation and referral agreements with other service providers that typically interface with the Crisis Stabilization Services Program; Hospitals, Law Enforcement, etc. Ensuring that such Coordination of Care agreements are in place addressing: (1) coordination of services when consumers present to local emergency departments (EDs); (2) involvement of law enforcement when consumers are in psychiatric crisis; and (3) reducing delays in initiating services during and after a consumer has experienced a psychiatric crisis.

14. Reviewing the CSS Program plan with the Service Entry and CSS staff members on an annual basis.

15. Coordinating the CSS systems for Primary CSS, DBT on call services, Mobile Crisis Services, and ACT. In the rare event that multiple emergency responses are requested of one of the two CSS teams (Primary CSS or ACT) simultaneously, the on-call staff member of that team shall contact the on-call staff member of the other team to request back up assistance.

16. Coordinating the CSS system in the event of a community-wide disaster. In the event of a community-wide disaster, more staff may be required to respond. The policy and procedure that guide on-call back up assistance for this type of emergency on-call event is covered in the Community Disaster Policy and is coordinated by the Service Entry Team Leader.

17. Ensuring communication to the public of the availability of these services, as well as to consumers at intake, and that the latter are provided in a way that ensures meaningful access.

18. Ensuring provisions are in place for tracking consumers admitted to and discharged from high acuity facilities such as crisis residential, partial hospitalization, and inpatient psychiatric hospitalization.

19. Ensuring there are protocols in place for transitioning consumers from emergency departments to a safe community setting, including transfer of medical records, prescriptions, active follow- up, and, where appropriate, a plan for suicide prevention and safety, and for provision of peer services.

B. The Service Entry/CSS Service Staff are charged with:

1. Stabilizing the situation as quickly as possible. Responding to crisis requests immediately and determining a course of action within 2 hours for Mobile Crisis Request. For Pre-Admission screenings for hospitalization, a disposition must be made within 3 hours of the request. However, it is the expectation and practice of all CSS clinicians as quickly as possible to any crisis service request.

2. Completing a written crisis note or pre-admission screening document that includes the presenting complaint or concern, issues since last stabilization if applicable, current living situation, availability of supports, suicide risk/potential for harm to self or others, current medications and compliance, use of alcohol or drugs, applicable medical conditions, evidence of trauma, abuse or domestic violence, legal involvement, and history of previous psychiatric hospitalizations or crisis contacts with results. The documentation will conclude with a plan for crisis

stabilization; including immediate needs, identified follow-up, and the statement of crisis resolution or hospitalization.

2.1 WMCMH staff will coordinate discharge planning with an involved facility, starting at time of admission.

2.2 WMCMH staff will initiate discharge planning by a phone contact with the facility's discharge planning unit.

2.3 WMCMH monitors progress in the facility via phone contact or face to face depending on the type of emergency and location of facility.

2.4 At time of discharge, WMCMH requires a copy of the safety plan (for those at risk of suicide) and discharge plan from the facility. WMCMH requires documentation that the safety plan is reviewed with the consumer. The consumer and trusted allies have a copy of the plan as evidenced by consumer signature on the document.

2.5 WMCMH routinely contacts the consumer directly within 24 hours of discharge to assist with any barriers to treatment, assess suicide risk, provide care coordination, confirm a next appointment, and provide information about 24 hour Crisis Stabilization service availability.

2.6 If the consumer does not answer the phone, WMCMH will leave a message, encouraging the individual to call back. If no return phone call is received, a WMCMH peer or care manager will attempt to reach the individual again by phone.

2.7 Documentation of all contacts are recorded in the EMR.

3. The crisis assessment results in an initial crisis intervention plan that includes identified immediate response needs, identified, follow up when a referral is made, and a statement of crisis resolution.

4. A Second Opinion is offered to all individuals when he/she disagrees with the recommendation/disposition of the assessment.

5. CSS Clinicians/workers are to complete a standardized agency approved risk assessment tool when indicated and included in the crisis documentation.

6. No waiting list is maintained for Crisis Stabilization Services.

7. CSS Clinicians/workers are to determine a clinically appropriate and medically necessary course of action by making timely referrals to emergency medical services and local law enforcement or human service agencies, when indicated.

8. CSS Clinicians/Workers are to identify, obtain consent, and communicate appropriately with the primary care physician of the individual providing necessary documentation for appropriate coordination of care.

9. CSS Clinicians/Workers will provide assistance to the community with involuntary psychiatric hospitalization requests and follow all applicable laws and rules relating to the courts and necessary legal processes.

10. CSS Clinicians/Workers will include family members, identified legal representatives, and other collateral sources with the consent of the persons served.

11. CSS Clinicians/Workers are to be familiar with and demonstrate knowledge of community resources, crisis intervention techniques, and procedures for involuntary hospitalization.

12. CSS Clinicians/Workers are to consult with other team members as needed.

VII. **SUPPORTING DOCUMENTS:** N/A