

Information Item V

Crisis Services Redesign Standards

A. Hotline

I. **Definition**

A Hotline is continuously available telephone service staffed by trained and competent crisis counselors that provides information, screening and intervention, support, and referrals to callers 24 hours per day, 7 days per week. Any entity providing Crisis Hotline service for any portion of the day must be accredited by the American Association of Suicidology (AAS).

II. **Goals**

- Immediate telephone response to a real or potential crisis situation.
- Immediate activation and coordination of the mental health crisis response system.

III. **Description**

Crisis hotline services are an integrated component of the overall crisis program, operate continuously and are accessible toll-free throughout the local service area. The crisis hotline serves as the first point of contact for mental health crises in the community, providing confidential telephonic triage to determine the immediate level of need and to mobilize emergency services for the caller if necessary. Trained and competent paraprofessionals may answer the Hotline and provide information and non-crisis referrals, however a trained and competent Qualified Mental Health Professional (QMHP-CS) is required to provide screening and assessment of the nature and seriousness of the call. The initial assessment leads to immediate and appropriate referrals for assistance or treatment. The hotline facilitates referrals to 911, a mobile crisis outreach team, or other crisis services and conducts follow-up contacts to ensure that callers successfully accessed the referred services. If an emergency is not evident after further screening or assessment, the hotline service includes referral to other appropriate resources within or outside the LMHA. The hotline service works in close collaboration with local law enforcement, 211, and 911 systems.

IV. **Standards**

Hotline services must be accredited by the American Association of Suicidology (AAS) and are integrated with the LMHA's local crisis response system including the Mobile Crisis Outreach Team, other crisis services in the LMHA's crisis service array. If the LMHA contracts with an outside entity to provide all or part of the hotline service, the contractor must also be AAS-accredited and remains contractually responsible for compliance with the applicable standards. If the LMHA provides all or part of the service, the contractor must be AAS-accredited. The 8th Edition of the AAS Organization Accreditation Standards Manual can be found at the following link: <http://www.suicidology.org/displaycommon.cfm?an=7> under "Organization Accreditation Manual."

Listed below are the **minimum** scores acceptable in each area to meet DSHS standards. The AAS Organization Accreditation Standards Manual describes how the evaluation process focuses on seven areas. A high score in one area will not compensate for a less-than-minimum score in another. There cannot be a score below Level I in any area.

AREA	MINIMUM SCORE
1. Administration	12

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2. Training Program	24
3. General Service Delivery	21
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B.**Mobile Crisis Outreach Teams****I. Definition**

Mobile Crisis Outreach Teams (MCOTs) provide a combination of crisis services including emergency care, urgent care, and crisis follow-up and relapse prevention to the child, adolescent, or adult in the community.

II. Goals

- Prompt assessment and evaluation in the community
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services
- Reduction of inpatient and law enforcement interventions

III. Description

MCOTs are clinically staffed mobile treatment teams that can provide prompt face-to-face crisis assessment, crisis intervention services, and crisis follow-up and relapse prevention services for individuals in the community. These services are designed to reach individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. Although the MCOTs may transport an individual for the purpose of obtaining crisis services, if the MCOT determines that they cannot transport the individual safely, the MCOT may arrange for or coordinate transportation with law enforcement. MCOTs have arrangements for back-up and linkages with other services and referral services.

Children and their families receive crisis services unless contraindicated. Children's Crisis Services are flexible, multi-faceted, and immediately accessible services provided to children and adolescents at high risk for hospitalization or out-of-home placement and their families. Services are provided in-vivo, primarily in the home but may also be delivered at other locations such as the school, and are designed to be family-focused, intensive, and time-limited.

IV. Standards**A. Availability**

- 1) Emergency care services are available 24 hours per day, seven days per week.
- 2) Urban LMHAs:
 - a) A minimum of one MCOT is on duty during peak crisis hours 84 hours per week; and
 - b) One additional MCOT is on call 24/7.
- 3) Rural LMHAs:

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- a) One mobile crisis outreach team is on duty during peak crisis hours 56 hours per week in a location based upon local needs; and
 - b) MCOT capability is maintained throughout the local service area 24/7.
- 4) The mobile crisis outreach team responds to emergent crises within one hour and to urgent crises within eight hours.
 - 5) Service hours are flexible to meet family needs, including the capacity to respond 24 hours a day, 7 days a week.
 - 6) Initial crisis follow-up and relapse prevention services performed by the mobile crisis outreach team shall be completed within 24 hours.

B. Staffing

- 1) A physician, preferably a psychiatrist serves as the medical director for all crisis services and approves all policies, procedures, and protocols used in crisis services.
- 2) Duties and responsibilities for all staff involved in the assessment or treatment of a crisis are defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 3) All MCOT staff receive crisis training that includes but is not limited to:
 - a) Signs, symptoms, and crisis response related to substance use and abuse;
 - b) Signs, symptoms, and crisis response to trauma including sexual, physical, and verbal abuse and neglect; and
 - c) Assessment and intervention for children and adolescents.
- 4) All MCOT staff providing screening, assessment, and intervention are physicians, preferably psychiatrists, RNs, LPHAs, or QMHP-CSs.
- 5) A MCOT, at a minimum, is comprised of 2 QMHP-CSs or where appropriate 1 QMHP-CS and law enforcement:
 - a) For Urban LMHAs, a QMHP-CS is deployed with a physician, preferably a psychiatrist, RN, or LPHA on every emergent care call;
 - b) For Rural LMHAs it is recommended that a QMHP-CS be deployed with a physician, preferably a psychiatrist, RN or LPHA. If not deployed as part of the MCOT, a physician, preferably a psychiatrist, RN or LPHA must be available to provide face-to-face assessment as needed or clinically indicated.
- 6) Written policies and procedures exist so that when the level of risk to staff or the individual in crisis is determined possibly to be significant, a protocol is implemented to ensure that law enforcement and MCOT members meet the individual in crisis together.
- 7) The LMHA's policies, procedures, and protocols, approved by the medical director, may define circumstances in which only one MCOT member responds emergent or urgent crises.
- 8) A physician, preferably a psychiatrist, is available by telephone for consultation or for face-to-face assessment as needed or clinically indicated. In compliance with House Bill 518 (Texas Health & Safety Code §573.021a and b, and §574.021d), a physician, preferably a psychiatrist, must be available to examine an individual as soon as possible within 12 hours after the time the individual is apprehended by a peace officer or transported for emergency detention by the individual's guardian.
- 9) One MCOT member may be deployed for subsequent contacts or crisis follow-up and relapse prevention services in accordance with approved policies, procedures, and protocols.

C. Screening and Assessment

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- 1) Emergent calls lead to a face-to-face crisis response within one hour. After MCOT crisis intervention services, if the individual is still in need of emergency care services, then the individual is assessed by a physician, preferably a psychiatrist, within 12 hours.
- 2) If a telephone screening has not been completed prior to the MCOT's arrival, individuals receive a screening by a QMHP-CS immediately upon arrival.
- 3) A crisis assessment is performed using the crisis elements of the Adult Texas Recommended Assessment Guidelines (Adult-TRAG) or the Child and Adolescent Texas Recommended Assessment Guidelines (CA-TRAG) or other DSHS-approved screening tool.
- 4) A crisis assessment includes an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and an evaluation of the need for an immediate medical screening assessment by an RN or physician, preferably a psychiatrist.
- 5) A written description of the process for performing the screening is followed. The description addresses the criteria for requesting an immediate crisis assessment, medical screening assessment, and psychiatric evaluation.
- 6) The crisis assessment process includes:
 - a) Client interviews by a physician, preferably a psychiatrist, LPHA, RN, or other qualified mental health professional with training in behavioral health crisis care;
 - b) Review of records of past treatment (when available);
 - c) History gathering from collateral sources. The team is proactive in gathering input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support around the individual in crisis while maintaining confidentiality.
 - d) Contact with the current mental health providers whenever possible;
 - e) If available, a history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional.
 - f) A detailed assessment of substance use and abuse, including the quantity and frequency of all substances used;
 - g) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - h) An assessment of the individual's ability and willingness to cooperate with treatment;
 - i) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma); and
 - j) In emergent care, an assessment that addresses any medical conditions that may cause similar symptoms or complicate the individual's condition.
 - k) In emergent care, an appropriate physical health assessment. In urgent care, a written procedure approved by the medical director is implemented to assess the need for referral for a physical health assessment including laboratory screening.
- 7) Every individual is assessed for possible trauma, including sexual, physical, and verbal abuse or neglect, and identified cases of potential abuse or neglect are appropriately reported.

D. Intervention and Coordination of Care

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- 1) A written protocol approved by the medical director is implemented that specifies the most effective and least restrictive approaches to common behavioral health emergencies seen by the MCOT.
- 2) If screening or assessment indicates the need for transportation to a more restrictive environment to ensure safety or further treatment, a protocol and procedure is used for providing immediate crisis intervention and transporting the individual to an appropriate facility. The individual is monitored continuously until transferred.
- 3) An individual crisis plan is developed and implemented for each individual that provides the most effective and least restrictive available treatment. The plan is based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The crisis plan addresses intervention, outcomes, plans for follow-up and aftercare, and referrals.
- 4) Children's Crisis Services are provided by a QMHP-CS with additional experience, training, and competency in children and family crisis and treatment issues and working with children and families in crisis.
- 5) Counseling is provided by LPHAs with additional experience, training, and competency in child/adolescent treatment issues and working with children and families in crisis.
- 6) Individuals and families receive appropriate educational information that is relevant to their condition. This includes information about the most effective treatment for the individual's behavioral health disorder.
- 7) Written policies and procedures approved by the medical director define appropriate reassessment intervals needed for reassessment in emergency, urgent, and routine care.
- 8) Whenever it appears necessary, the crisis plan is adjusted to incorporate the individual's response to previous treatment.
- 9) Coordination of crisis services is provided for every individual. Coordination of crisis services consists of identifying and linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up, and relapse prevention services to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.
- 10) Upon resolution of the crisis, every eligible individual shall be transitioned to a non-crisis service package as medically necessary, or receives crisis follow-up and relapse prevention either by the MCOT or from another community service provider throughout a 30-day period (Service Package 5) until he/she is stabilized and/or transitioned to appropriate behavioral health services.
- 11) Services link children and families with intensive evidence-based treatments aimed at reducing further the risk of out of home placement as soon as possible.

C. Walk-in Crisis Services

I. Definition

Walk-in Crisis Services are office-based outpatient services providing immediate screening and assessment and brief, intensive interventions focused on resolving a crisis and preventing admission to a more intensive level of care.

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II. Goals

- Prompt screening and assessment
- Stabilization in the least restrictive environment
- Crisis resolution
- Linkage to appropriate services

III. Description

Walk-in Crisis Services are immediately accessible services for adults, children, and adolescents that serve two purposes: ready access to psychiatric assessment and treatment for new individuals with urgent needs, and access to same-day psychiatric assessment and treatment for existing clients within the system. For persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment, rapid transfer to a higher level of care is facilitated. If extreme risk of harm is ruled out, brief crisis intervention services are provided on-site. Walk-in Crisis Services are designed to be intensive and time-limited, and are provided until the crisis is resolved or the person is referred to another level of care. After the initial crisis assessment and intervention, continuing services may be provided in the office or in vivo (through mobile crisis outreach services) for up to 30 days until the individual is stabilized and/or transitioned to appropriate behavioral health services. Walk-in Crisis services are offered in the local service area based on availability of LMHA funding.

IV. Standards

A. Availability

- 1) If provided, there is immediate access to staff qualified to provide crisis screening, assessment and intervention services during hours of operation.
- 2) If provided, then Children's Crisis Walk-in service hours are flexible to meet family needs.

B. Physical plant

- 1) The location of the crisis outpatient services are clearly marked from the street, and can be found in LMHA service literature, community media and telephone directories.
- 2) Offices meet all Texas Accessibility Standards.
- 3) Offices have at least one designated area where persons in extreme crisis can be safely maintained until transported to another level of care (e.g., hospital or crisis stabilization unit).
- 4) Office spaces afford privacy for protection of confidentiality.

C. Staffing

- 1) A psychiatrist serves as the medical director for all crisis services and approves all written procedures and protocols.
- 2) Duties and responsibilities for all staff involved in assessment or treatment are defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 3) All crisis services staff receive crisis training that includes but is not limited to:
 - a) Signs, symptoms, and crisis response related to substance use and abuse;
 - b) Signs, symptoms, and crisis response to trauma, abuse and neglect; and
 - c) Assessment and intervention for children and adolescents.
- 4) All crisis services staff members are trained psychiatrists, RNs, LPHAs, QMHP-CSs or Behavioral Health Technicians (Paraprofessional).

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- 5) All staff providing crisis screening, assessment, and intervention are physicians, preferably psychiatrists, RNs, LPHAs, or QMHP-CSs.
- 6) As clinically indicated, a physician, preferably a psychiatrist, is available for telephone consultation or face-to-face assessment/telemedicine assessment.
- 7) When the level of risk to staff or the individual exceeds the capability of on-site staff, a written protocol is implemented to access emergency LMHA resources.
- 8) When emergency medical services are not available on site, trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) are on site at all times.

D. Screening and Assessment

- 1) Individuals receive a face-to-face crisis triage or screening by a QMHP-CS within 15 minutes of presentation.
- 2) After the person presents on the physical premises for a crisis screening, the individual waits in a location with rapid access to staff. If acuity worsens, trained Behavioral Health Technicians may be utilized to provide observation.
- 3) Crisis screening is performed using the crisis elements of the RDM-TRAG or a DSHS-approved screening tool.
- 4) Crisis screening is documented and evaluates risk of harm to self or others, contributive medical issues and the need for immediate full assessment, emergency intervention, and an immediate medical screening assessment by an RN or psychiatrist.
- 5) A written procedure for performing the crisis screening is implemented. The description addresses the criteria for requesting an immediate crisis assessment, medical screening assessment, and psychiatric evaluation.
- 6) An assessment is completed by an LPHA or RN within one hour of referral from the screening process.
- 7) A written process and procedure is implemented that ensures that those who require a more immediate assessment can begin the full assessment by an LPHA or RN within 15 minutes of initial presentation to Walk-In Crisis Services.
- 8) A physician, preferably a psychiatrist, must be available to examine and complete a psychiatric assessment for an individual in emergent crisis between three and eight hours from presentation to the services.
- 9) The assessment process includes:
 - a) Client interviews by a psychiatrist, RN, LPHA or other Qualified Mental Health Professional (QMHP-CS) with training in behavioral health crisis care;
 - b) Review of available records of past treatment (as available and in keeping with laws governing confidentiality);
 - c) History from collateral sources, including input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support around the individual in crisis maintaining confidentiality.
 - d) Contact with the current mental health providers whenever possible;
 - e) If available, a history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional.
 - f) A detailed assessment of substance use, abuse, and misuse that includes the quantity and frequency of all substances used;

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- g) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
- h) An assessment of the individual's ability and willingness to cooperate with treatment;
- i) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma); and
- j) In emergent care, an assessment addresses medical conditions that may cause similar symptoms or complicate the individual's condition. There is access to phlebotomy with same day lab results if ordered. Laboratory studies that are available include:
 - a) A complete blood count with differential;
 - b) A comprehensive metabolic panel;
 - c) A thyroid screening panel;
 - d) Urine toxicology;
 - e) A pregnancy test;
 - f) A screening test for tertiary syphilis;
 - g) Psychiatric medication levels; and
 - h) Other studies, as appropriate, based on the patterns of illness in the individuals served.
- k) Every individual is evaluated for possible trauma, abuse, or neglect, and identified cases of potential abuse or neglect are appropriately reported.

E. Intervention and Care Coordination

- 1) A written protocol is implemented that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the walk-in crisis services.
- 2) If screening or assessment indicates the need for transportation to a more restrictive environment to ensure safety or further treatment, a protocol and procedure is used for providing immediate crisis intervention and safe transporting the individual to an appropriate facility. The individual is monitored continuously until transferred.
- 3) An individual crisis plan is developed and implemented for each individual that provides the most effective and least restrictive available treatment. The plan is based on the provisional psychiatric diagnosis and incorporates, to the extent possible, individual and family preferences. The crisis plan addresses intervention, outcomes, plans for follow-up and aftercare, and referrals.
- 4) Whenever necessary, the crisis plan is adjusted to incorporate the individual's response to previous treatment.
- 5) Individuals and families receive appropriate educational information that is relevant to their condition. This includes information about the most effective treatment for the individual's behavioral health disorder.
- 6) The medical director defines appropriate reassessment intervals needed for reassessment in emergency, urgent, and routine care.
- 7) Walk-In Services for children and adolescents are provided by a QMHP-CS with additional experience, training, and competency in children and family crisis and treatment issues.
- 8) Counseling is provided by LPHAs with additional experience, training, and competency in child/adolescent treatment issues and working with children and families in crisis.
- 9) Services provided link families with intensive evidence-based treatments aimed at reducing further the risk of out of home placement as soon as possible.
- 10) Coordination of crisis services is provided for every individual. Coordination of crisis services consists of linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care, provides necessary assistance in accessing

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those services, conducting follow-up, and relapse prevention services to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing service providers in a timely manner and in conformance with applicable confidentiality requirements.

- 11) Upon resolution of the crisis, every eligible individual shall be transitioned to a non-crisis service package if determined to be medically necessary, or receives crisis follow-up and relapse prevention either by the Mobile Crisis Outreach Team or from another community service provider throughout a 30-day period (Service Package 5) until the he/she is stabilized and/or transitioned to appropriate behavioral health services.

D. Extended Observation Unit

I. Definition

Extended Observation Units are emergency and crisis stabilization services that provide emergency stabilization to individuals in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care when needed.

II. Goals

- Prompt and comprehensive assessment of a behavioral health crisis
- Rapid stabilization in a secure and protected environment
- Crisis resolution
- Linkage to appropriate aftercare services
- Reduction of inpatient and law enforcement interventions

III. Description

An Extended Observation Unit provides access to emergency care at all times and has the ability to safely and appropriately manage the most severely ill psychiatric individuals. It is designed to provide a safe and secure environment for short-term stabilization of behavioral health symptoms that may or may not require a continued stay in an acute care facility. Extended observation and treatment can take place for up to 48 hours. Individuals who cannot be stabilized within that timeframe would be linked to the appropriate level of care (inpatient hospital unit or CSU). The availability of an extended observation unit is dependent on LMHA funding.

IV. Standards

A. Availability

- 1) If provided, this service is available 24 hours a day, seven days a week throughout the participating service areas.

B. Physical plant

- 1) The extended observation unit is in a secure location.
- 2) The physical plant is accessible and meets all Texas Accessibility Standards.
- 3) The physical plant has provisions for ensuring environmental safety.

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- 4) The physical plant has designated area where persons in extreme crisis can be observed and safely maintained until the crisis is resolved or the individual is transported to another level of care (e.g., hospital or crisis stabilization unit).
- 5) The physical plant affords privacy for protection of confidentiality.
- 6) If services are provided for children and adolescents, the physical plant must have separate child, adolescent, and adult observation areas.

C. Staffing

- 1) A psychiatrist serves as the medical director for all crisis services and approves all procedures and protocols used in crisis services.
- 2) Duties and responsibilities for all staff involved in assessment or treatment are defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 3) All staff involved in assessment or treatment receive crisis training that includes but is not limited to:
 - a) Signs, symptoms, and crisis response related to substance use, misuse, and abuse;
 - b) Signs, symptoms, and crisis response to trauma including sexual, physical, and verbal abuse and neglect; and
 - c) Assessment and intervention for children and adolescents.
- 4) The unit has sufficient physicians, preferably psychiatrists, RNs, LPHAs, QMHPs, and behavioral health technicians to ensure:
 - a) Individual reassessment at least every 15 minutes for behavioral health technicians, two hours for nursing, four hours for QMHPs, and 12 hours for physicians, preferably psychiatrists;
 - b) Active therapeutic intervention consistent with the individual's clinical state;
 - c) A QMHP on each shift is assigned to identified individuals; and
 - d) Patient and staff safety including one to one observation as needed.
- 5) Staffing shall include:
 - a) A physician preferably a psychiatrist on call 24 hours/day to evaluate individuals face to face or via telemedicine as needed;
 - b) At least one LPHA on site 24 hours/day, seven days/week;
 - c) At least one RN on site 24 hours/day, seven days/week; and
 - d) Behavioral health technician(s) on site 24 hours/day, seven days/week.

D. Assessment

- 1) Triage:
 - a) Individuals undergo triage by an RN or physician, preferably a psychiatrist trained in triage within 15 minutes of presentation, with procedures to prioritize imminently dangerous individuals. The psychiatrist triage may be performed via telemedicine.
 - b) Until the individual receives that triage he or she waits in a safe and secure location with constant staff observation and monitoring.
 - c) The triage includes an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and need for a medical screening assessment, including vital signs and a medical history, whenever possible.
 - d) A written description of the process for performing this triage is followed. The description addresses screening for emergency medical conditions and the process for accessing emergency medical intervention. When emergency medical services are not available on site,

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- trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) are on site at all times.
- e) Written criteria determine which individuals presenting for care are referred to another health care facility or provider. These criteria ensure that those referred to a lower level of care are at low risk of harm to themselves or others, have no more than mild functional impairment, and do not have significant medical, psychiatric, or substance abuse comorbidity. Referral decisions consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.
- 2) Assessment Process:
- a) Individuals who are not referred for care elsewhere after triage receive a full assessment.
 - b) The assessment is initiated within one hour of the individual's presentation to the extended observation services.
 - c) All individuals who receive an assessment see a psychiatrist within eight hours of presentation to the extended observation services.
 - d) A written procedure is implemented that ensures that individuals who require a psychosocial or psychiatric assessment more immediately can be seen and assessed within 15 minutes of that determination.
- 3) Psychosocial and Psychiatric Assessment:
- a) The psychosocial and psychiatric assessment includes:
 - i) Patient interview(s) by physicians, preferably psychiatrists trained in emergency psychiatric assessment and treatment, or physicians with electronic access to trained psychiatrists;
 - ii) Review of records of past treatment (when available);
 - iii) History gathering from collateral sources. Staff are proactive in gathering input and/or corroboration of events from family members whenever possible. Every effort should be made to engage family support while maintaining confidentiality.
 - iv) Contact with the current mental health providers whenever possible;
 - v) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional;
 - vi) A detailed assessment of substance use and abuse, including the quantity and frequency of all substances used;
 - vii) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - viii) An assessment of the individual's ability and willingness to cooperate with treatment; and
 - ix) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
 - b) Every individual is screened for possible trauma, abuse or neglect, and identified cases of potential abuse or neglect are appropriately reported.
 - c) Every individual less than 18 years of age is assessed (including a developmental assessment) by an LPHA with appropriate training in the assessment and treatment of children and adolescents in a crisis setting.
- 4) Physical Health Assessment
- a) All individuals receive a physical health assessment within four hours of presentation.

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- b) A written process and procedure is followed that ensures that those who require a physical health assessment more immediately can be seen and assessed within five minutes of initial presentation.
- c) An initial evaluation for physical health generally includes:
 - i) Vital signs;
 - ii) A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 - iii) A screening neurological examination that is adequate to rule out significant acute pathology;
 - iv) A medical history and review of systems;
 - v) Other tests and examinations as appropriate and indicated.
- d) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment is available and provided as needed.
- e) Due to the high medical and substance abuse comorbidity in this population, on-site capability exists for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), urgent urine toxicology (results available within four hours), and a targeted physical examination.
- f) Immediate access to on-site to phlebotomy and same-day laboratory studies include:
 - i) A complete blood count with differential;
 - ii) A comprehensive metabolic panel;
 - iii) A thyroid screening panel;
 - iv) Urine toxicology (unless there is a protocol that specifies another means of adequate assessment for substance use and abuse);
 - v) A pregnancy test
 - vi) A screening test for tertiary syphilis; and
 - vii) Psychiatric medication levels.

E. Treatment

- 1) A written protocol is implemented and updated at least annually that specifies the most effective and least restrictive approaches to common behavioral emergencies in the service.
- 2) Immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the individual or to others) is available at all times.
- 3) A nursing care plan is developed for every individual.
- 4) An individualized treatment plan is developed for each person that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences. The crisis plan addresses intervention, outcomes, plans for follow-up and aftercare, and referrals.
- 5) Treatment planning places emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
- 6) Response to treatment is assessed at least every two hours by RNs trained in the assessment of acute behavioral health patients or by a psychiatrist.
- 7) Whenever necessary, the treatment plan is adjusted to incorporate the individual's response to previous treatment.
- 8) Individuals and families receive appropriate educational information that is relevant to their condition. This includes information about the most effective treatment for the individual's behavioral health disorder.

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- 9) An LPHA is responsible for providing the individual with active treatment including psychoeducation, crisis counseling, substance abuse counseling, and developing a plan for returning to the community that addresses potential obstacles to a successful return.

F. Continuity of Care

- 1) A discharge plan is developed for every individual.
- 2) If inpatient treatment is not indicated, the discharge plan includes appropriate education relevant to the individual's condition, information about the most effective treatment for the individual's behavioral health disorder, information about follow up care, and appropriate linkages to post discharge providers.
- 3) If a physical health issue requires hospitalization, the individual is transferred to appropriate community hospital to address the physical health issue.
- 4) A written procedure is implemented for ensuring continuity of care and successful linkage with the referral provider.
- 5) Continuity of care is provided for every individual. Continuity of care consists of identifying and linking the individual with all available services necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.

E. Crisis Residential Services

I. Definition

Community crisis residential services provide short-term, community-based residential, crisis treatment to persons with some risk of harm who may have fairly severe functional impairment. These facilities provide a safe environment with clinical staff on site at all times however they are not designed to prevent elopement and individuals must have at least a minimal level of engagement to be served in this environment. Utilization of these services is managed by the LMHA based on medical necessity. The recommended length of stay is from 1-14 days.

II. Goals

- Conduct or ensure a comprehensive assessment has been conducted.
- Stabilize the immediate crisis
- Restore sufficient functioning to allow transfer to a less intensive level of care
- Provide the client with critical coping skills to prevent or minimize relapse
- Mobilize individual/family/community resources and support systems
- Link the client with continuing care and appropriate support services
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

III. Description

Crisis residential treatment involves 24-hour residential services that are usually short-term and offered to individuals who are demonstrating psychiatric crises that cannot be stabilized in a less intensive setting.

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The availability of crisis residential services is dependent on LMHA funding for these types of services. This level of care provides a safe environment to individuals with clinical staff on site at all times; however, there is only moderate/limited monitoring and reassessment of individuals to ensure safety.. Community crisis residential services attempt to recreate a normalized environment. A physician and RN may be on site or readily accessible. Psychosocial programming focuses on a range of topics including problem-solving, communication skills, anger management, community re-integration skills, as well as dual diagnosis issues. Individual counseling may also be provided. Individuals should have enough medication on arrival to ensure psychiatric and medical stabilization for at least 3 days and processes exist to obtain medical and psychiatric medications as needed by the individual. The recommended maximum length of stay is 14 days and the average anticipated length of stay is between 3 and 7 days.

IV. Standards

A. Availability

- 1) If provided, this service is available 24 hours a day, seven days a week and crisis residential services are made available to individuals in crisis in the local service area.
- 2) Admission to Crisis Residential is determined by the LMHA and based on medical necessity determination by an LPHA.

B. Physical Plant

- 1) Crisis residential services units provide a safe environment. .
- 2) Crisis residential services attempt to create as normalized environment as possible.
- 3) Crisis residential services are not designed to prevent elopement.
- 4) Crisis residential services contain 16 beds or less.
- 5) All medications are securely stored.
- 6) Crisis residential units are subject to licensing regulations of the Department of Aging and Disability Services (DADS) as Assisted Living Facilities, or other license as applicable.

C. Staffing

- 1) Duties and responsibilities for all staff involved in the assessment or treatment of individuals is defined in writing by the medical director (a board eligible or certified psychiatrist) and is appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 2) The competence of all staff is continuously evaluated, monitored and expanded.
- 3) There is an on-call roster of clinical and nursing staff. There is a process for assessing and anticipating staffing needs to ensure clinical and nursing staff are on-site at all times.
- 4) Staff on duty remain awake at all times.
- 5) An LPHA is immediately available during the day and is responsible for ensuring the individual is provided active treatment defined in a crisis plan.
- 6) There is a sufficient number of trained staff available to ensure that when residents show signs of agitation there is immediate verbal intervention.
- 7) No less than two staff members trained in verbal and physical management of assaultive/aggressive behavior (APA) are on site at all times to ensure a safe environment
- 8) At least one LPHA is available to conduct patient interviews and initiate a full assessment within eight hours of presentation to the unit.
- 9) Active psychosocial programming is also provided for at least 4 hours per day .

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- 10) Post admission, a physician, preferably a psychiatrist sees every individual at least once per week or more frequently as clinically indicated and is on call 24 hours a day to evaluate individuals as needed and to provide supervision and consultation.
- 11) An RN is on call for emergencies, supervision and consultation 24 hours a day.

D. Assessment

1) Full Assessment

- a) Prior to admission to the Crisis Residential Unit individuals receive a full psychiatric assessment within 24 hours of the individual's presentation to the service if not referred directly from an active inpatient unit or psychiatric emergency service.
- b) A written process is implemented that ensures that those who require a full psychiatric assessment more quickly, can be seen and assessed within 8 hours of initial presentation.
- c) Individuals receive a full RN evaluation within 1 hour of presentation.

2) Assessment Process

- a) The assessment process includes patient interviews by LPHAs, including physicians, preferably psychiatrists trained in emergency psychiatric assessment and treatment;
- b) The assessment process includes a review of available records of past treatment;
- c) Proactive history gathering from family and collateral sources and in keeping with laws on confidentiality;
- d) Contact with the current behavioral health providers whenever possible and in keeping with laws on confidentiality;
- e) A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
- f) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
- g) An assessment of the individual's ability and willingness to cooperate with treatment;
- h) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and compliance, and an up-to-date record of all medications currently prescribed, and the name of the prescriber;
- i) A general medical history that addresses conditions that may affect the patient's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma);
- j) A detailed assessment of substance use or abuse conducted by an individual trained in assessing substance related disorders;
- k) An assessment for trauma, abuse or neglect by trained clinical staff, preferably an LPHA, with training in this assessment; and
- l) A physical health assessment as outlined below.

3) Physical Health Assessment

- a) Individuals receive a full physical health assessment by an RN, within two hours of entering a crisis residential unit unless already conducted within the last week. This evaluation includes assessment of medical and psychiatric stability, self- administration of medication capability, vital signs, pain, and danger to self or others.
- b) The initial evaluation for physical health generally includes:
 - 1) Vital signs;
 - 2) A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;

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- 3) A screening neurological examination that is adequate to rule out significant acute pathology;
 - 4) A medical history and review of symptoms;
 - 5) A pregnancy test;
 - 6) A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use and abuse);
 - 7) Blood levels of psychiatric medications that have established therapeutic or toxic ranges; and
 - 8) Other tests and examinations as appropriate and indicated.
- c) Access to phlebotomy and laboratory studies shall exist.
- d) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment exists.

E. Interventions

- 1) Upon admission but no later than 24 hours, every individual receives an orientation that explains facility rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of activities.
- 2) A written protocol specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service and is approved by the clinical director and updated at least annually.
- 3) An individual crisis treatment plan is developed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. This information is shared with the individual and the individual's family, as appropriate. The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences.
- 4) An array of treatment interventions may exist in the crisis residential setting and may include individual or group psychotherapy or psychoeducation, crisis intervention and crisis psychotherapy, family therapy, advocacy, help with obtaining community supports and housing, help developing social skills and a social support network, substance abuse treatment, and relapse prevention. A minimum of 4 hours per day of such programming should be provided. Individuals who have significant substance abuse comorbidity receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- 7) Individuals have access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- 8) The program provides a stable therapeutic environment that includes consistently assigned personnel and consistently scheduled activities.
- 9) Individuals practice self-administration of medication under supervision. When needed same-day access to medications is available and staff members provide medication education.

F. Coordination of Care

- 1) Coordination of emergency services is provided for every individual. Coordination of emergency services consists of identifying and linking the individual with all available services necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- 2) A written policy defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- 3) A written procedure is implemented to ensure continuity of care and successful linkage with the referral facility or provider.

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- 4) A discharge plan is developed for every individual, and shall include:
 - a) appropriate education relevant to the individual's condition;
 - b) information about the most effective treatment for the individual's behavioral health disorder;
 - c) identification of potential obstacles to a successful return to the community and means to address these obstacles; and
 - d) information about follow-up care, and appropriate linkages to post discharge providers.

F. Crisis Respite Services

I. Definition

Community crisis respite services provide short-term, community-based residential, crisis treatment to persons who have no risk of harm to self or others and may have some functional impairment who require direct supervision and care but do not require hospitalization. These services can occur in houses, apartments, or other community living situations and generally serve individuals with housing challenges or assist caretakers who need short-term housing for the persons for whom they care to avoid a mental health crisis. Utilization of these services is managed by the LMHA based on medical necessity. The recommended length of stay is 1-7 days

II. Goals

- Ensure a comprehensive crisis assessment has been conducted.
- Avoid an impending crisis due to housing challenges or other identified stressors in the family.
- Provide the client with critical coping skills to prevent or minimize relapse
- Mobilize individual/family/community resources and support systems
- Link the client with continuing care and appropriate support services
- Prevent unnecessary hospitalization and assist the individual in maintaining residence in the community

III. Description

Crisis respite treatment involves 24-hour care that is usually short-term and offered to individuals who are at risk of psychiatric crises due to a housing challenge and/or severe stressors in the family, but are not at a risk of harm to self or others. Individuals must be able to cooperate with staff support, but functioning is only mildly impaired. Intoxication is not present and there are defined processes in place to address substance abuse problems. Mild medical co-morbidity is allowed while individual is taking his/her medications. Individual and group skills training are provided at the crisis respite site and are based on the needs of the individual and the goals of their individual crisis plans. Limited supervision exists, primarily by psychiatric technicians. Individuals exhibit self-care, can attend to activities of daily living and are monitored for self administration of medication. Individuals should have enough medications upon arrival to ensure psychiatric and medical stabilization for the expected length of stay. There are procedures in place to obtain medications for individuals when needed. The primary objective of crisis respite services is stabilization and resolution of a crisis situation for the individual and/or the individual's caregiver(s). Crisis respite is available for children, adolescents, and adults. The availability of facility based respite units is dependent on LMHA funding for this type of respite. Children and adolescents are provided in-home crisis respite services.

IV. Standards

A. Availability

- 1) This service is available 24 hours a day, seven days a week and respite services are made available to individuals throughout the local service area.
- 2) Admission to crisis respite is determined by the LMHA and based on medical necessity determination by an LPHA
- 3) In home crisis respite must meet the rules set forth in the Texas Administrative Code and Texas Health and Safety Code, §534.057.

B. Physical Plant

- 1) Contracted facility-based crisis respite units are subject to licensing regulations of the Department of Aging and Disability Services (DADS) as Assisted Living Facilities.

C. Staffing

- 1) Duties and responsibilities for all staff involved in the assessment or treatment of individuals is defined in writing by the medical director and is appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 2) The competence of all crisis respite staff members is continuously evaluated, monitored and expanded.
- 3) There is a process for assessing and anticipating staffing needs.
- 4) Staff members on duty remain awake at all times.
- 5) There is a defined process for on-site staff to obtain supervision, consultation, and evaluation when needed and for medical and psychiatric emergencies 24 hours a day from a physician, preferably a psychiatrist, APN, or PA.
- 6) Mental health aide/technician(s) are on site 24 hours a day, with numbers, qualifications, and training sufficient to ensure patient and staff safety and the provision of needed services.
- 7) Staff members are trained in CPR, management of seizures, choking, and first aid as well as crisis respite protocols and procedures, and supervision of self administration of medications.
- 8) Staff members providing in-home crisis respite services to children or adolescents are Qualified Mental Health Professionals competent to provide crisis services to children and adolescents.

D. Assessment

- 1) Prior to admission to Crisis Respite Services individuals receive a full crisis assessment by a physician, preferably a psychiatrist, LPHA, RN or other Qualified Mental Health Professional.
- 2) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment exists.

E. Interventions

- 1) Upon admission, every individual receives an orientation that explains rules and expectations, explains patients' rights and the grievance policy, and describes the schedule of any activities.
- 2) Immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the individual or to others) is accessible at all times.
- 3) A written protocol specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service and is approved by the medical director and updated at least annually.
- 4) An individual crisis treatment plan is followed for each individual that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. This

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information is shared with the individual and the individual's family, as appropriate. The plan is developed by qualified crisis staff and based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences.

- 5) Individual and group skills training are provided at the crisis respite site and are based on the needs of the individual and the goals of their individual crisis plans.
- 6) Each client's response to treatment is reassessed daily by staff. This response is reflected in an updated crisis treatment plan.
- 7) Individuals have access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.
- 8) A stable therapeutic environment exists in facility-based crisis respite units that includes assigned personnel and scheduled activities.

F. Coordination of Care

- 1) Coordination of emergency services is provided for every individual. Coordination of emergency services consists of identifying and linking the individual with all available services necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service.
- 2) A written policy defines the steps to be taken to ensure that every effort is made to contact existing treatment providers during the course of the individual's assessment in the service.
- 3) A written procedure is implemented to ensure continuity of care and successful linkage with the referral facility or provider.
- 4) A discharge plan is developed for every individual, and shall include:
 - a) appropriate education relevant to the individual's condition;
 - b) information about the most effective treatment for the individual's behavioral health disorder;
 - c) identification of potential obstacles to a successful return to the living situation of the individual's choice and means to address these obstacles; and
 - d) information about follow-up care, and appropriate linkages to post discharge providers.

G. Psychiatric Emergency Service Centers

I. Definitions

Psychiatric Emergency Service Centers (PESCs) provide immediate access to assessment and a continuum of stabilizing treatment for individuals presenting with behavioral crises. These units are co-located with licensed hospitals or Crisis Stabilization Units (CSUs) and have the ability to manage the most severely ill individuals at all times, including immediate access to emergency medical care. PESCs must be available to individuals who walk in, and contain a combination of service types including Extended Observation and Inpatient Hospital Services or a CSU.

- A. Extended Observation Unit:** Emergency and crisis stabilization services that provide emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment.
- B. Inpatient Hospital Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff provide intensive

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interventions designed to relieve acute symptomatology and restore the individual's ability to function in a less restrictive setting.

- C. Crisis Stabilization Unit (CSU):** Short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code.

II. Goals

- Prompt and comprehensive assessment
- Stabilization in a secure environment
- Crisis resolution
- Reduction of inappropriate inpatient admissions
- Referral to clinically appropriate levels of care

III. Description

The PESC is co-located with a licensed hospital or CSU with immediate access to emergency medical services, and is staffed by medical personnel and mental health professionals. Medication and crisis intervention services are provided to stabilize individuals with the goal of transitioning them to clinically appropriate levels of care.

The PESC includes extended observation services, which may be appropriate for individuals who cannot be promptly stabilized and discharged to a lower level of care. The service offers observation beds in a secure and protected, clinically staffed, psychiatrically supervised treatment environment. These programs are designed to provide a safe and secure environment for short-term stabilization of symptoms that may or may not require a continued stay in an acute care facility. Duration of extended observation services shall not exceed 48 hours, by which time stabilization and/or a determination of the appropriate level of care shall be made. Continuity of care is provided to ensure transfer to continuing treatment and linkage with necessary support services.

The PESC also includes inpatient hospital or crisis stabilization beds for individuals who cannot be stabilized within 48 hours. These individuals receive more extensive treatment for up to 14 days, with an average length of stay of 3-5 days. The availability of PESC is dependent on LMHA funding.

IV. Standards

A. Availability

- 1) If provided, this service is available 24 hours a day, seven days a week throughout the participating service areas.

B. Physical Plant

- 1) Services are co-located with a DSHS licensed hospital or CSU.
- 2) The LMHA must have a written agreement with the hospital or CSU with which the PESC is co-located.
- 3) Facilities are accessible and meet all Texas Accessibility Standards.
- 4) Facilities have provisions for ensuring safety.
- 5) Offices have at least one designated area where persons in extreme crisis can be safely maintained until transported to another level of care (e.g., hospital or crisis stabilization unit).

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- 6) Facility spaces afford privacy for protection of confidentiality.
- 7) If services are provided for children and adolescents, the facility must have separate child, adolescent, and adult treatment and observation areas.

C. Staffing

- 1) A physician, preferably psychiatrist, serves as the medical director for all crisis services and approves all procedures and protocols used in crisis services.
- 2) Duties and responsibilities for all staff involved in assessment or treatment are defined in writing, appropriate to staff training and experience, and in conformance with the staff member's scope of practice (if applicable) and state standards for privileging and credentialing.
- 3) All staff involved in assessment or treatment receive crisis training that includes but is not limited to:
 - a) Signs, symptoms, and crisis response related to substance use and abuse;
 - b) Signs, symptoms, and crisis response to trauma including sexual, physical, and verbal abuse and neglect; and
 - c) Assessment and intervention for children and adolescents.
- 4) The unit has sufficient trained physicians, preferably psychiatrists, RNs, LVNs, LPHAs, QMHPs, and behavioral health technicians (paraprofessionals to ensure:
 - a) Individual reassessment at least every 15 minutes for behavioral health technicians, two hours for nursing, four hours for QMHPs, and 12 for physicians, preferably psychiatrists;
 - b) Active therapeutic intervention consistent with the individual's clinical state;
 - c) A QMHP on each shift is assigned to identified individuals; and
 - d) Patient and staff safety including one to one observation as needed.
- 5) Staffing shall include:
 - e) A physician, preferably a psychiatrist on call 24 hours/day to evaluate individuals face to face or via telemedicine as needed;
 - f) At least one LPHA on site 24 hours/day, seven days/week;
 - g) At least one RN on site 24 hours/day, seven days/week; and
 - h) Behavioral health technician(s) on site 24 hours/day, seven days/week.

D. Assessment

- 1) Triage:
 - f) Individuals undergo triage by an RN or physician, preferably a psychiatrist trained in triage within 15 minutes of presentation, with procedures to prioritize imminently dangerous individuals. The psychiatrist triage may be performed via telemedicine.
 - g) Until the individual receives that triage he or she waits in a safe and secure location with constant staff observation and monitoring.
 - h) The triage includes an evaluation of risk of harm to self or others, presence or absence of cognitive signs suggesting delirium, need for immediate full assessment, need for emergency intervention, and a medical screening assessment, including vital signs and a medical history, whenever possible.
 - i) A written description of the process for performing this triage is followed. The description addresses screening for emergency medical conditions and the process for accessing emergency medical intervention. When emergency medical services are not available on site, trained staff who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) are on site at all times.
 - j) Written criteria determine which individuals presenting for care are referred to another health care facility or provider. These criteria ensure that those referred to a lower level of care are at

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low risk of harm to themselves or others, have no more than mild functional impairment, and do not have significant medical, psychiatric, or substance abuse co-morbidity. Referral decisions consider the individual's ability to understand and accept the need for treatment (if such need exists) and to comply with the referral.

2) Assessment Process:

- a) Individuals who are not referred for care elsewhere after triage receive a full assessment.
- e) The assessment is initiated within one hour of the individual's presentation.
- f) Individuals who receive an assessment see a psychiatrist within eight hours of presentation to the PESC.
- g) A written procedure is followed that ensures that individuals who require a psychosocial assessment more immediately can be seen and assessed within 15 minutes of that determination.

3) Psychosocial and Psychiatric Assessment:

- a) The psychosocial and psychiatric assessment includes:
 - i) Patient interview(s) by board-eligible/certified psychiatrist(s) trained in emergency psychiatric assessment and treatment, or physicians with electronic access to emergency psychiatrists;
 - ii) Review of records of past treatment (when available);
 - iii) History gathering from collateral sources (as available and in keeping with laws governing confidentiality);
 - iv) Contact with the current mental health providers whenever possible;
 - v) A history of previous treatment and the response to that treatment that includes a record of past psychiatric medications, dose, response, side effects and adherence, and an up-to-date record of all medications currently prescribed, and the name of the prescribing professional;
 - vi) A detailed assessment of substance use, abuse, and misuse that includes the quantity and frequency of all substances used;
 - vii) Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 - viii) An assessment of the individual's ability and willingness to cooperate with treatment; and
 - ix) A general medical history that addresses conditions that may affect the individual's current condition (including a review of symptoms focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of trauma).
- b) Every individual is screened by trained staff for possible trauma, abuse or neglect, and identified cases of potential abuse or neglect are appropriately reported.
- c) Every individual less than 18 years of age is assessed (including a developmental assessment) by an LPHA with appropriate training in the assessment and treatment of children and adolescents in a crisis setting.

4) Physical Health Assessment

- f) All patients receive a physical health assessment within four hours of presentation.
- g) A written process and procedure is followed that ensures that those who require a physical health assessment more immediately can be seen and assessed within five minutes of initial presentation.
- h) An initial evaluation for physical health generally includes:
 - i) Vital signs;
 - ii) A cognitive examination that screens for significant cognitive or neuron-psychiatric impairment;

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- iii) A screening neurological examination that is adequate to rule out significant acute pathology;
 - iv) A medical history and review of systems; and
 - v) Other tests and examinations as appropriate and indicated.
- i) Immediate access to urgent and emergent non-psychiatric medical assessment and treatment is available and provided as needed.
 - j) Due to the high medical and substance abuse comorbidity in this population, on-site capability exists for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), urgent urine toxicology (results available within four hours), and a targeted physical examination.
 - f) Immediate access on-site to phlebotomy and same-day laboratory studies include:
 - i) A complete blood count with differential;
 - ii) A comprehensive metabolic panel;
 - iii) A thyroid screening panel;
 - iv) Urine toxicology (unless there is a protocol that specifies another means of adequate assessment for substance use and abuse);
 - v) A pregnancy test (women);
 - vi) A screening test for tertiary syphilis; and
 - vii) Psychiatric medication levels.

E. Treatment

- 1) A written protocol is implemented and updated at least annually that specifies the most effective and least restrictive approaches to common behavioral emergencies in the service.
- 2) Immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others) is available at all times.
- 3) A nursing care plan is developed for every individual.
- 4) An individualized treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the individual's behavioral health disorder. The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, individual preferences. The crisis plan addresses intervention, outcomes, plans for follow-up and aftercare, and referrals.
- 5) Treatment planning places emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.
- 6) Response to treatment is assessed at least every two hours by RNs trained in the assessment of acute behavioral health patients or by a psychiatrist.
- 7) Whenever necessary, the treatment plan is adjusted to incorporate the individual's response to previous treatment.
- 8) Individuals and families receive appropriate educational information that is relevant to their condition. This includes information about the most effective treatment for the individual's behavioral health disorder.
- 9) An LPHA is responsible for providing the individual with active treatment including psychoeducation, crisis counseling, substance abuse counseling, and developing a plan for returning to the community that addresses potential obstacles to a successful return.

F. Inpatient and Crisis Stabilization Services

- 1) Individuals who cannot be stabilized within 48 hours are admitted to inpatient or crisis stabilization services. If a bed is not available, a client may also be transferred to an appropriate State mental health hospital or community based psychiatric hospital.

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- 2) Each client admitted receives a psychosocial assessment by an LPHA.
- 3) Clients are involved in active treatment that includes psychiatric assessment and treatment, psychotherapy, psycho-education, crisis counseling, family intervention, substance abuse treatment, and relapse-prevention.
- 4) CSUs comply with Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code.
- 5) Inpatient units comply with TAC Chapter 411 Subchapter J Standards of Care and Treatment in Psychiatric Hospitals.

G. Continuity of Care

- 1) A discharge plan is developed for every individual.
- 2) If inpatient treatment is not indicated, the discharge plan includes appropriate education relevant to the individual's condition, information about the most effective treatment for the individual's behavioral health disorder, information about follow up care, and appropriate linkages to post discharge providers.
- 3) If a physical health issue requires hospitalization, the individual is transferred to appropriate community hospital to address the physical health issue.
- 4) A written procedure is implemented for ensuring continuity of care and successful linkage with the referral facility or provider.
- 5) Continuity of care is provided for every individual. Continuity of care consists of identifying and linking the individual with all available services necessary to stabilize the crisis and ensure transition to routine care, providing necessary assistance in accessing those services, and conducting follow-up to determine the individual's status and need for further service. This includes contacting and coordinating with the individual's existing services providers in a timely manner and in conformance with applicable confidentiality requirements.