

CRISIS SERVICES STANDARDS

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¹ Standards recommended by the Clinical Design Subcommittee are based on the *Organization Accreditation Standards Manual, Eighth Edition*, of the American Association of Suicidology (2006).

² Standards recommended by the Clinical Design Subcommittee are based on the *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services* of the APA Task Force on Psychiatric Emergency Services (2002).

³ Standards recommended by the Clinical Design Subcommittee are based on the *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services* of the APA Task Force on Psychiatric Emergency Services (2002).

⁴ Standards recommended by the Clinical Design Subcommittee are based on Texas Health and Safety Code, Section 531.001(g) and Texas Occupations Code, Section 1701.404.

⁵ Standards recommended by the Clinical Design Subcommittee are based on the *Report and Recommendations Regarding Psychiatric Emergency and Crisis Services* of the APA Task Force on Psychiatric Emergency Services (2002).

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1. Crisis Hotline Services

Definition and Description

Level I: A person specifically on duty for the purpose of serving the agency's callers answers the telephone service 24 hours a day, seven days a week. If a commercial answering service or call management system is used, most callers reach a trained crisis worker within one minute of placing a call. If a commercial answering service is not used, the calls are forwarded to an AAS-accredited center when the center's crisis workers are not available. In this latter case there must be a memorandum of understanding between the center and the backup center.

OR

If the center is serving a specialized, limited population (e.g., teen line, AIDS line, gay/lesbian line, etc.), it does not need to operate 24 hours a day, seven days a week to meet this level. However, in off hours the line must be forwarded to an AAS accredited center. In this latter case there must be a memorandum of understanding between the center and the backup center.

Resource data is available whenever calls are answered. Crisis workers can do an active intervention in life threatening situations without interrupting the initial call. The phone setting must be set up so as to protect confidentiality.

Level II: A trained crisis worker may receive the calls directly, either by relay to the workers' homes or place of business or a commercial answering service may be used up to 50% of the time. There is only one crisis worker on site 75% of the time.

Level III: All telephone service is provided by the program's own trained personnel. While on duty, workers have multiple telephone instruments and lines available for simultaneous calls. The calls may be answered by another service and/or relayed mechanically to workers at home during the least active periods. More than one crisis worker is scheduled to be on-site for the majority of the time or if there is only one, they have others on call for assistance or consultation. There is a system that permits monitoring and supervision of the worker.

Level IV: Crisis hotline services are an integrated component of the crisis program. The hotline is answered in the agency setting by trained personnel. Extra lines and instruments are available for initiating rescue procedures without interrupting the crisis call. The crisis program includes up-to-date telephone equipment to meet the needs of the program. Criss-cross directories and other aids are immediately accessible at all times. There is more than one crisis worker on duty 75-100% of the time. There are well-developed procedures to increase staff capacity should there be a sudden influx of calls.

Standard of Care

The program is accredited by the American Association for Suicidology (AAS) or contracts with an AAS-certified Level III or IV program.

SUMMARY OF AAS CERTIFICATION STANDARDS BY LEVEL

Component	Level I	Level II	Level III	Level IV
ADMINISTRATION AND ORGANIZATIONAL CONTACT				
1. Governance	The program is operated by a separate agency or a local governmental unit under the authority of constitutional officers or elected officials of the governmental entity, however, the board exerts minimal influence in the operation and monitoring of the program.	The program is owned and operated by a private nonprofit corporation for the specific purpose of offering crisis services. OR The program is a part of a for profit organization that is dedicated to serving the general community. There is input into governance.	The legally constituted board monitors and has regular involvement in the program's operation, and meets at least four times a year. The Crisis program is governed in on of the following forms: 1. Governed by the board of directors of a private corporation legally chartered within the state for the specific and primary purpose of offering crisis services in the community. 2. It is part of a direct service agency. A board of directors exists, whether governing or advisory. The board, or a board subgroup specified in writing, regularly and actively reviews, monitors and has influence in the operation of the crisis program.	The crisis program is governed by the board of directors of a private corporation legally chartered within the state for the specific and primary purpose of offering crisis services in the community. The board actively monitors the program through established evaluation/quality assessment procedures. The board meets at regular pre-specified times during the year. There is broad community representation on the board or a highly involved advisory board providing input to the program.
2. Program Management	There is a specifically designated person who serves as director of the program on a salaried basis, either part of full-time, and who assigns specific collateral responsibilities to individuals within the agency who may serve on a voluntary (non salaried) basis	The program director has minimal (i.e., 6 months or less experience in crisis work and no formal education in the fields of crisis, suicidology or management. Supervisory responsibilities of the director are loosely formulated in writing. There may be a list of professional persons to whom requests for consultation may be addressed, but no formal consultation between workers and professionals exists. None of the professional consultants has a specialized background in crisis intervention or suicidology.	There is a full-time salaried program director and one or more additional salaried staff who supervise crisis workers, fulfill various operational duties, arrange professional consultation and provide direct assistance to the crisis workers. The director has a background of at least one-year's satisfactory performance in an AAS accredited crisis program or an alternative qualification in keeping with the standards of the American Association of Suicidology. At least some professional consultants hold similar credentials. Supervisory responsibilities of the program director are clearly specified in writing but are not consistently followed. For example,	There is a full-time salaried director and two or more additional salaried staff who are responsible for the management of the crisis service. These people may hold professional degrees but at least one of the two staff must be a crisis specialist. Professional consultants or staff experienced and trained in suicidology and crisis work according to these AAS standards, are regularly used for the supervision of clients care, training, organizational and program problems. There is an up-to-date organizational chart, which defines areas of supervisory responsibility. The supervisory functions of the program

			Although one hour of formal supervision per 40 hours of work for workers with less than two years experience may be required, documentation of this level of supervision is not complete.	director and others are clearly specified and consistently followed.
3. Accountability	The program has a budget and business records in accordance with generally accepted audit principles (GAAP). Approximately 25% of the operating budget is assured and there is continued financial support. The financial base is tenuous There are no written personnel policies or job descriptions, audit or annual report. Personnel are occasionally evaluated but without an objective format or written record.	Personnel policies are written. There are business records and a detailed budget. Approximately one-third of operating budget is assured. No formal fund raising exists. Job descriptions are written but are not specific in terms of the expected performed functions. Personnel report being evaluated, though written records of evaluations are not always clearly related to the job description. There is a fund development business plan.	Personnel policies are written including job descriptions. There is an informal annual report. Workers are evaluated, although written documentation is not always maintained, and evaluations are not always clearly related to the job description. There is a fund development/business plan.	There are a well-documented personnel policies, business records and procedures, budget, audit and comprehensive annual report. Fund development/business plans are implemented with board involvement*. Written job descriptions specify qualifications and functional tasks expected of management and personnel. Annually personnel are evaluated against clearly defined job performance requirements. There is a written record of the evaluation. *In your agency, if the crisis program is part of a larger organization then it is not expected that the annual report will focus on the crisis program alone, nor will the fund development/business plans of the crisis program be implemented with direct board involvement.
4. Physical Plant	Designated office space for admin and crisis work Phone and service provided off site alot but AAS standards met Protocols for out of office, confidentiality, and crisis worker supervision	Office and crisis work space shared. One room for all during day. Little opportunity for worker-to-worker contact. No specified space for face-to-face counseling.	Central location, separate staff office and a room for crisis workers during day. Crisis workers work from home some part of time. Centrally located client records and training materials. Moderate worker-to-worker contact.	Central publicly visible staff office at least during regular hours. Private space for phone crisis work. Offices for face-to-face contact. Location used 24 hours. All materials and equipment available and accessible. Ample opportunity for worker-to-supervisor and worker-to-worker contact.

Component	Level I	Level II	Level III	Level IV
TRAINING PROGRAM				
5. Planned Curriculum Objectives	Written objectives. Not sharply defined in terms of knowledge, attitude, and skills.	Written objectives in terms of what trainer will teach, not how trainee will be expected to behave. Content and methodology do not flow from stated objectives.	Written objectives defined operationally in terms of knowledge, attitude, and skill outcomes for trainee. Objective form base for content and methodology some, not all, times.	Written objectives defined operationally. Evidence that trainer and trainees aware of relationship between objectives and content and methodology.
6. Planned Curriculum Content and Bibliography	Written outline, no objectives. Content outline unbalanced. Minimal bibliography and written resources.	Balanced content outline. No formal training manual. Some materials not adequate or up to date but are on premises.	Content flows from objectives as stated in written plan. Plan is followed most of the time. Trainees provided updated materials.	Formal syllabus followed. Updated materials and manual with current resources pertaining to essential elements of worker's function. Access to library or internet on premises.
7. Planned Curriculum Methodology	No written plan beyond number of sessions. 32 hours minimum unless workers are MH professional who pass test proving they meet center standards. Minimal interaction between trainer and trainees. Emphasis on knowledge, not attitude or skills. No opportunity for trainees to function as coworker with staff prior to assignment.	Written plan for training methods but not adhered to. Considerable interaction between trainer and trainee. Role play used but not done well or critiqued. Some imbalance. Occasional opportunities for trainees and workers to function as coworker prior to assignment.	Written plan followed most times and adapted to assessed needs of individuals. Total hours between 21 and 31 for trainees with 0 experience. Methods balanced. Opportunity for direct observation of, and supervision by, experience trainer or worker.	Training methodology well planned, in writing, consistently followed. At least 32 plus 8 hours for those with no experience. Recommended training techniques followed and trainer working to improve. Experience trainer or worker completes written report, formally observes trainees.
8. Screening trainees	Written criteria on screening out those assessed as not having the ability to be positive in empathy, show respect for client, and develop good initial contact. Screening extends to training and/or probationary period so that screen-out occurs prior to client contact. Background record checks on regular basis.	Level I plus using written criteria, screening occurs through training. Written records used to screen and assess progress of all. Written notes kept on all. If trainee works in another part of agency, additional screening.	Level II plus evidence that screening continues to evolve as a result of ongoing evaluation of crisis workers. Feedback from evaluations used to sharpen screening process.	Level II plus screening reflect most current research on predicting how best to assess helper performance. Multiple experienced staff is part of ongoing screening and there is a staff person responsible for screening. Results of screening affecting training program and screening is part of program evaluation.
9. Pre- and Post-evaluation of Trainees	Pre-evaluation used to design individual training. Expected achievement in writing. Post-evaluation includes agreed upon helping strategies. Trainees receive ongoing feedback during process. Trainees evaluate trainers and this is part of center's online self-evaluation.	Level I plus objective and subjective pre- and post-evaluation or on-going evaluation. Trainer actively involved in efforts to standardize process.	Level II plus use of wide variety of assessment instruments to ensure that only properly trained and qualified crisis workers move beyond training. Evidence that some have been rejected. Process continues to be modified based on results.	Level III plus there is evidence that the pre and post-evaluative process is an integral part of the screening process, training, and program evaluation activities.

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10. Qualification of Trainers	Trainer has average competency as crisis worker but no special training as trainer.	Trainer has experience beyond one year with above average competence. Interested and enthusiastic.	Trainer has experience beyond one year with above average competence. Interested and enthusiastic. General experience teaching in other areas.	Trainer has extensive experience as crisis worker with record of excellence. Has basic instruction in crisis training techniques. Looks for feedback and to improve knowledge and skills through written evaluation, special consultants, workshops.
11. Quality Assurance for Crisis Workers	In service at least 2x year. Crisis work supervision on planned basis with appropriate monitoring. Written evidence that QA program ensures that quality of crisis work is consistent. Monitoring is ongoing and routine.	Level I plus in-service for 2-3 hours/year. Written policy on supervision and criteria for assessing performance. Crisis workers supervised on an individual basis for one of every 40 hours or 3 months if that comes first.	Level II plus six hours/year instruction. Supervisors training in supervision. Proof that QA monitoring results in praise, discipline, training, or termination. Staff encouraged to the AAS accredited crisis workers.	Level III plus routine focus on objectives of supervision. Written plan for assuring quality of crisis worker intervention monitored, recorded and corrected. At least 50% of eligible clinical staff and volunteer crisis workers are AAS accredited.

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GENERAL SERVICE DELIVERY				
12. Telephone Response	A person on duty to serve the agency's callers answers the telephone service 24 hours a day, 7 days a week. If a commercial service or call system is used, most callers reach a trained crisis worker within one minute of placing a call. If a commercial service is not used, calls are forwarded to an AAS accredited center and there is an MOU between the center and the backup center. Resource data is available whenever calls are answered. Crisis workers can do an active intervention in life threatening situations without interrupting the initial call. The phone setting is set up to protect confidentiality.	A trained crisis worker receives calls directly, either by relay to the worker's home or place of business, or a commercial service is used up to 50% of the time. One crisis worker is on site 75% of the time.	All telephone service is provided by the program's own trained personnel. Workers have multiple telephone instruments and lines available for simultaneous calls. The calls may be answered by another service and/or relayed mechanically to workers at home during the least active periods. More than one crisis worker is scheduled to be on-site for the majority of the time or if there is only one, they have others on call for assistance or consultation. There is a system that permits monitoring and supervision of the worker.	Telephone service is an integrated component of the crisis program. It is answered in the agency setting by trained personnel. Extra lines and instruments are available for initiating rescue procedures without interrupting the crisis call. The crisis program has included up-to-date telephone equipment to meet the needs of the program. Crisscross directories and other aids are immediately accessible at all times. There is more than one crisis worker on duty 75-100% of the time. There are well-developed procedures to increase staff capacity should there be a sudden influx of calls.
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13. Walk-in Services	Walk-in service is not directly provided by the program but is available to clients through referral telephone workers can initiate.	There is no regularly established walk-in service but someone on duty might see clients who happen to come by. Usually such clients receive immediate service by referral.	Walk-in service during office hours if prior appointments are made. Unscheduled walk-in contacts not refused, but this availability is not publicized. The crisis program will handle immediate walk-in service contacts referred either by its own staff or by contracts. OR An equivalent or better level of services is provided by another agency through written agreement. Or, the agency does not operate its own walk-in service but has a seamless referral system and feedback to another service.	Walk-in service, as well as scheduled client contacts, is an integral aspect of the service delivery design. Walk-in service is encouraged and is available at all times.
14. Outreach Services (Internet Service)	Restricted by both location and hours. May be available through an informal agreement with another agency. Outreach may occur under unusual circumstances, but no routine way to call outreach workers into service.	Restricted by either location or hours of operation. Around-the-clock arrangements may exist to transport those in crisis to walk-in services, such as the local mental health center or emergency department offering crisis services.	Available 24-hours a day in many places, including clients' homes. Primarily during the day and in agency settings. Can be mobilized at night and collaborates with police or others in less public areas. OR Equivalent or better services provided by another agency through written agreement or protocols.	Significant part of the crisis intervention directly provided by the program, 24-hours a day by crisis team that collaborates with police, rescue, and others. Written program policies define efforts between the crisis team, police, and mental health personnel responsible for commitment laws.
15. Follow-up	Makes follow-up calls, especially of cases involving life-threatening emergencies, but decisions depend on the individual worker's judgment. Regular effort is made to obtain client identity if callers do not identify themselves spontaneously. Follow-up contacts are held to a minimum, and records of follow-up contacts aren't kept. Initiates active intervention when appropriate with third party calls on behalf of the person at risk.	Makes regular follow-up contacts of clients who are suicidal. While records of such contacts are kept, criteria are informal. Identifying information is routinely elicited from clients.	Using written criteria, the crisis program makes regular follow-up contacts of its clients who are suicidal, victimized, or otherwise at high risk, by contacting other agencies, by encouraging the client to call back, and by directly calling the client. Complete records are kept of all contacts.	Follow-up is a standard procedure for all crisis cases and is incorporated into the client's service plan. A staff member is responsible to see that follow-up contacts are scheduled within the first 24 hours after initial contact, or within a specified time interval, and periodically as needed thereafter. A staff member is responsible for monitoring established standards and procedures whereby follow-up is provided.

Component	Level I	Level II	Level III	Level IV
16. Client Record Keeping	An individual card or record form for each client is completed at the initial call. There is a specific place on the form for recording degree of risk, as well as interventions provided, the emergency nature of call and/or follow up.	Individual client's files are maintained with some degree of orderliness. Basic client information is recorded and updated regularly, but some vital data regarding life-threatening cases is missing and a rescue might not be possible from the material routinely recorded. There is no clear demarcation between a current or active crisis situation, and a previously handled one with the same client.	The client files are organized but not summarized for quick review. Although client records have space for critical items such as lethality assessment, they are not always completed fully. There is no plan to update routinely and review these files, although this appears to occur on an 'as needed' basis.	The client files are well organized on record forms that summarize all necessary data, especially those related to life-threatening emergencies. The files contain evidence that lethality and victimization are assessed in every client. There are systematic procedures to update, review and summarize client files when appropriate for the crisis service. Computerized databases are governed by procedures that protect confidentiality.
17. Technology	Technology is used, but there has been minimal thought and research done on its ethical and responsible use. Training is provided on use of technology, however, there is no a clear consequence if there is misuse.	Some thought has gone into the use of technology, but the policies and procedures are not periodically reviewed.	Extensive thought and research has gone into the development of the practices related to technology. Workers are trained and supervised on program uses of technology, and there are clear consequences for misuse or ethical violations.	The latest generation of technology is used and policies and procedures are in place and supervised. The agency has carefully planned for and integrated technological resources into overall operations. Information gleaned from technological resources is used to make management decisions. There is a designated staff person to oversee technology issues. There is evidence that crisis worker feedback on use is used to modify or make changes as necessary.

Component	Level I	Level II	Level III	Level IV
SERVICES IN LIFE-THREATENING CRISES				
18. Lethality Assessment	Done routinely according to current, updated procedures and includes the items listed in the description for this component. Workers are trained but evidence of application in client records is occasionally inconsistent. There is proof that crisis workers are making suicidal risk assessments on a routine basis and that those with suicidal intention are assessed.	There is evidence from supervisors as well as workers and records that lethality assessment is consistently done according to current written principles and procedures. There is clear documentation in client records that workers are routinely applying the process of lethality assessment as specified in Level I above.	There is evidence that lethality assessments are routinely and appropriately (whenever an emotional component or clear crisis situation is presented) done using the most currently known information about how to make an accurate suicidal risk assessment. It is clear from the training curriculum that crisis workers are trained and assessed on when and how to make the assessments. Client records show that lethality assessments are routinely done with accuracy and that appropriate action is taken based on the assessment. Crisis workers are provided annual updates on lethality assessment criteria.	There is evidence that lethality assessment is a highly developed component of this service. There is proof that the lethality assessment reflects what is most currently known by AAS to be the preferred method of assessing suicidal risk. Crisis workers are routinely supervised about their abilities in this area. There is proof of positive and/or critical feedback, re-training or discipline with regard to suicide risk assessment. Lethality assessment is a routine part of program evaluation. All client records reflect that a lethality assessment was done when appropriate and that action was taken based on the lethality assessment. There is also evidence that the quality assurance program has been influenced by the desire to accurately assess the lethality of clients.
19. Rescue Services	There is a general written procedure for rescue, though it is not closely adhered to in practice. Methods involve considerable interaction between supervisor and worker. Agency resources for rescue are informally organized.	There is a written rescue procedure which is generally adhered to and which includes adaptations based on need. Workers can obtain supervision for problems of rescue. Crisis service resources are listed, but there is no written plan for updating the availability and protocols of these resources.	There is a written rescue procedure including a plan to update resource listings routinely. The rescue procedure is routinely adhered to and is systematically revised and updated. Workers are trained and supervisors are available when difficult rescues or questions arise. Protocols that dictate when rescue services are initiated are in place.	Rescue capability is well planned, in writing, and adhered to consistently. There is evidence that rescue procedures are planned in accordance with highly tested and recommended techniques and that the supervisor is working to improve rescue methods. Interagency resources (including phone companies) for rescue are listed in a current resource manual with brief descriptions of services, policies, and procedures for initiating service. There is a written plan for updating these rescue procedures.

Component	Level I	Level II	Level III	Level IV
20. Victims of Violence or Traumatic Death Services	There is no policy concerning crisis service for victims or survivors. Services are offered infrequently on the telephone and face-to-face, but only at the request of the victims or survivors. As with walk-in, if an agency cannot provide victims outreach as part of its own program it should assure the provision of such services by another agency.	Victim/survivor services are offered sporadically when requested by victims, third parties or when victimization or traumatic circumstances are otherwise brought to the attention of the program.	There are written policies for victim/survivor services, which are adhered to routinely. Services may include victims and their families. Or, there is a letter of agreement or written protocols and procedures with other groups specializing in victim/survivor services for further care as needed.	Victim/survivor services are a highly developed component of the program, which allows the program to respond to victims and survivors in a systematic way. It conducts victim support groups and disseminates information to the community for people at risk of victimization or trauma (e.g., distributes brochures to police departments, courts, funeral homes and hospital emergency services).
21. Suicide Survivor Services	There is no policy concerning crisis service for survivor's services. Such services are offered infrequently on the telephone and face-to-face, but only at the request of survivors.	Survivor services are offered sporadically when requested by third parties, or when suicides are brought to the attention of the program through the media.	There are written policies for survivor services, which are adhered to routinely. Service may include phone calls or letters to survivors. Or, there is a letter of agreement or written protocols and procedures with another group that specializes in survivor care for further services as needed.	Survivor services are a highly developed component of the program. The program has a systematic way of learning about all suicides in the area. The program includes a systematic method to contact survivors by phone, letter or other means. It also conducts a survivors group, and routinely disseminates information for survivors to the community, (e.g., a brochure describing survivor services is made available to funeral homes). Psychological autopsies may be used as an additional avenue for contacting survivors.
22. Community Education	There is no formal policy or procedure for community education. Community education resources are minimally used. No one is responsible for dealing with requests for information from the community, and there is no organized effort to provide information or education to the community.	Some efforts are made to develop community information services such as sporadic media interviews and occasional public speaking in response to a community request. No records are kept concerning community education activities, and no one is responsible for community education.	At least one person has responsibility for community education activities. A written plan exists, but is loosely developed (e.g. records of community education are required and some written materials are available for distribution). Community education activities occur regularly.	Responsibilities for community education activities are clearly defined. All policies and procedures for community education are written and followed regularly, including a plan to keep the information current. Training is available for those who conduct community education activities and, in addition, special programs are conducted (e.g., Suicide Awareness Week).

Component	Level I	Level II	Level III	Level IV
ETHICAL STANDARDS AND PRACTICE				
23. Code of Ethics	The only specific code of ethics is that of crisis workers who are professionals with their own respective professional codes of ethics. Statements relating to ethical philosophy and practice are found scattered through documents such as job descriptions, objectives, the training manual, etc.	A crisis program has its own code of ethics which is largely based on general statements which satisfy the Board of Directors. This statement is filed in the office and referred to as occasions require.	The crisis program has adopted a code of ethics promoted by a national service organization. The adopted code is not specifically geared toward crisis work. OR Crisis workers are mental health professionals and there is a written statement that all professionals will be guided by their respective code of ethics. In addition, there is a written statement specifying the code or principles to be used by those who do not have such a code of ethics. The code is available for all workers to refer to when needed.	The crisis program, after carefully studying several samples of ethical standards (such as the AAS Guidelines for a Code of Ethics), reviewing recent court decisions, and potential problems in risk management, has formulated an ethical code. This code, in addition to dealing with general issues, addresses itself to those issues specific to crisis work. All workers are given a copy of the code and training time is spent on understanding and resolving ethical issues. Workers are supervised on their awareness of the ethical issues involved in their work.
24. Records Security	There is a means of keeping records secure, but it may not always be used. There is some apparent understanding of the need for security, but workers are not carefully supervised in their use of records. The security system pertains only to clinical records of clients.	Record system security includes client and staff/volunteer records. The system shows some planning, but is not periodically reviewed. Training time is spent on the security system and its rationale, but personnel are not supervised in their adherence to record security.	The records security system includes all records affected by confidentiality and/or privacy. The system has been carefully planned and is periodically reviewed. Training and supervision concerning the security of records occurs. However, there are no ramifications for violations of records security.	Clinical and personnel records are maintained under a constant security system which shows extensive planning and regular evaluation of its efficiency. Workers are trained and regularly supervised about issues of record security. The security system shows professional maturity, and includes a written policy which influences the staff.
25. Confidentiality	There is minimal recognition of the importance of confidentiality. Workers are warned and encouraged to be cautious, but no extensive emphasis is placed on this issue during training. Staff is aware of confidentiality when problems are encountered, but there is no usual procedure for evaluating how workers practice.	Confidentiality is included in agency policy and the training program. Workers are required to understand the issues involved. Procedures exist to insure confidentiality. There is a stated policy regarding the consequences of breaking confidentiality.	Confidentiality is a serious concern addressed during training and included in written agency policy. There is a designated staff member responsible for any disclosure of information either from client, or personnel records. Additional training concerning confidentiality occurs as staff becomes aware of new laws, etc.	The staff is well-trained and sensitive to the legal and ethical issues of confidentiality, including when confidentiality is mandated to not apply. Seminars or other in-service training programs are held periodically on the topic, and include updates and a procedure for keeping abreast of current laws regarding confidentiality and related issues. There is an effort at constant monitoring to safeguard confidentiality. Consequences of violating confidentiality are written.

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26. Rescue Procedures	There is some concern about the ethical standards and legal issues related to rescue actions but the complexities of the problems have not been thought out. There are no written policies for considering the ethical issues of rescue procedures. There is evidence that rescue actions are based on lethality assessments and written procedures rather than strictly subjective criteria.	There is some concern about rescue actions but the program has established rescue procedures that don't sufficiently reflect the legal and ethical requirements. Ethical concerns are considered important, but do not enter consistently into actual rescue decisions and actions.	There is a clear indication that the ethical and legal issues are recognized, attended to, and included in the plan for rescue. Rescue and consent procedures have been reviewed by an attorney. The crisis program appears well informed, even if it is potentially vulnerable.	All rescue and consent procedures have been carefully worked out with other agencies and the legal system, including law enforcement agencies, to assure compliance with legal regulations and ethical good practice. All program personnel are fully informed about the legal and ethical issues involved in rescue operations. The crisis program has established a wide base of responsibility for its actions through negotiation with local authorities.
27. Advertising and Promotional Materials	There is an effort made to limit advertising to appropriate messages. However, some brochures are outdated and lack complete information.	The advertising and promotional material includes only what can reasonably be expected from the crisis program. The messages are clearly designed to inform the public of available services, and information is current.	There is evidence of honesty and realism in the advertising and promotional material. Public relations or marketing consultants have reviewed the material before it was utilized.	Unusual care has been taken to develop and implement advertising and promotional material. The materials also strive to educate the public without misrepresenting the issue or services offered. Public relations and clinical experts are routinely and regularly consulted during the entire process of producing promotional materials.

Component	Level I	Level II	Level III	Level IV
COMMUNITY INTEGRATION				
28. Consumers	There is some publicity about the program and limited citizen input. Consumer input is only received through feedback on the telephone line during regular contacts.	A publicity program exists but is not systematically planned. There is some effort to identify and reach specific target groups. Only informal efforts are made to assess consumers reactions to the agency's services. There are efforts to include representation of key community or consumer groups on the Board or program service focus groups or feedback forums.	A written publicity plan exists but is not routinely implemented. Effort is made to identify and focus on specific target groups. A fairly broad spectrum of individuals use the service and the service encourages access to underserved groups.	There is a well-planned publicity program aimed at consumer awareness, needs and satisfaction. The program relies on the responses of citizens and target groups for information and dissemination (e.g., suicide attempters, victims, alcoholics, discharged mental hospital patients, senior citizens, and other high risk groups). There is evidence that high risk groups of all socioeconomic levels use the program. The Board/management actively seeks consumer input and has representation of key consumer groups.
29. Emergency Resources	Access to emergency services is readily and easily available to all crisis workers so that there is no time delay between the time the decision is made that emergency resources are necessary and when that service is made available to the person in crisis. It has made efforts to make itself known to emergency resources. There is some evidence that the crisis program had made use of emergency resources, although there is no written procedure. There is proof that the organization updates it emergency resource data base at least annually.	The emergency resources know of the program's existence. There is evidence that the program makes use of these resources and that there is a working relationship between program and emergency resources.	Emergency resources are aware of the program and its position within the service delivery system. The agency and emergency service deliverers have a contract or letter of agreement specifying the services to be provided by emergency resources. The agreement specifies which services will be provided by one or the other, and the procedures to obtain services.	Emergency resources have an ongoing relationship with the program. There are written agreements, letters of understanding and documentation of consultation. There is evidence that emergency responders and crisis worker are cross trained. These services are responsive to clients regardless of their ability to pay.

Component	Level I	Level II	Level III	Level IV
30. Resource Data	<p>The crisis program's resource data bank is more comprehensive but it has not been tailored for program or client use. Information contained does not exceed general description of services, location, etc. Information regarding emergency rescue resources (police, fire departments, highway police and sheriff) is available 24 hours per day. Total resource information is available 75% of the time. Updating resource material is done sporadically and usually in response to interaction with another agency.</p>	<p>The crisis program has a comprehensive list of community resources. The resource list contains pertinent information such as:</p> <ol style="list-style-type: none"> 1. Agency and individual's name, number, address, contact person (if appropriate), 2. Description of services provided, 3. Client eligibility, 4. Restrictions, 5. Geographical area served, 6. Problems handled or areas of involvement, 7. Referral procedure and fees, and 8. Date information was recorded. <p>An informal plan and procedures exists for tailoring and updating resource data (changing, adding or deleting). Workers have accessibility to the entire resource package 24 hours of the day.</p>	<p>The crisis program has a comprehensive data bank including community resources listed in the component description. Information about resources is tailored to the crisis program and its clients. The resource list contains all pertinent information a crisis worker needs regarding the agency, individuals and services and is easily cross-referenced. There is periodic review of resource listings and there is evidence that they are up-to-date and highly accurate. This resource information is immediately accessible to workers 24 hours a day including persons not at the office site.</p>	<p>Resource data management is a high priority for the program and is integrated into overall service delivery. There is a Memorandum of Understanding or other strong working relationship with the local or State 211 or Information and Referral Service. All of Level III requirements are in place and procedures are followed. The maintenance of all resource data is supervised by a designated staff person. The center has the following policies in place and any changes are immediately available to crisis staff:</p> <ol style="list-style-type: none"> 1. Updating criteria-a formal update is planned annually to insure accuracy. 2. An inclusion/exclusion policy is in place and uniformly applied. 3. Date of last update appears on each referral. <p>The resource information is available to all crisis workers and workers are trained in how to effectively give referrals.</p>
31. General Community Resources	<p>The crisis program is aware of general resources available, but only informal efforts have been made to inform these services or individuals of the program's existence or service. Some evidence exists that the crisis service has referred clients to community and professional resources, but has no specific procedures to use these resources.</p>	<p>The crisis program is known to most of the general resources. Some efforts have been made to make the program known through periodic mailing and phone contacts. The working relationship is informal. Specific procedures for the identification and use of the resources are written. In some specific instances, there are written agreements concerning special projects (e.g., training for AA counselors or AA providing alcohol component in the program's training).</p>	<p>Information regarding the crisis programs is routinely disseminated to these resources and the program has a strong working relationship with several resources. The crisis program has formally surveyed those individuals and organizations and found them appropriate for delivering specific services. General procedures for referral and collaborative work with these community resources exist in writing and are operational.</p>	<p>Collaboration with community resources is an integral part of the crisis program. There are written Memorandums of Understanding and procedures for crisis training, database sharing and collaboration. The crisis program routinely interacts with community resources for purposes of community planning and addressing community needs. Workers are encouraged to visit referrals to better educate them regarding these resources. The program routinely surveys these resources regarding service delivery.</p>

Component	Level I	Level II	Level III	Level IV
PROGRAM EVALUATION				
32. Program Objectives	Few objectives are in writing, and what exists is not necessarily in measurable terms. There is a mechanism for at least annual review and evaluation of objectives by staff and administration.	Objectives for some programs are in writing, though not necessarily in measurable terms. There is a mechanism for at least annual review and evaluation of objectives by staff and administration	Objectives for most programs are written and in measurable terms. These are reviewed systematically, and have some impact on the services, policies or procedures.	All objectives are written in measurable terms. There is a procedure for systematic review, evaluation and redefinition of objectives. There is a mechanism to assure that goals and objectives influence the daily activity of workers, e.g., routine meetings between administration and staff regarding the program.
33. Content Evaluation	There is no method established, or attempt made, to measure activity, achievement, or cost. The service area is undefined either in terms of needs or geographic area.	A basic data gathering system (e.g., tabulating activity such as calls) exists, but is not related to what is needed or does not measure the achievement of program objectives. Service area needs are generally defined, but within little or sporadic input from consumers or providers. The geographic area to which the program delivers is at least roughly defined. Rudimentary cost estimates are done.	There is a systematic and operation data collection mechanism, which is tied to objectives. The geographic area is precisely defined. Service area needs are systematically evaluated but the program uses only one method to obtain information (e.g., board input).	There is a well-organized and operational data collection system, which is closely related to the program objectives and outcomes. Service area needs are systematically assessed through both consumer and providers. Achievement, adequacy and efficiency analysis (e.g., cost-benefit ratios) is done for the purpose of making decisions.
34. Evaluation Scope	There is documented evaluation in two areas within the past 18 months. In order to qualify for AAS accreditation one area evaluated must involve the quality assurance of the crisis work.	Level I plus there is documented evaluation in three areas within the past 18 months	Level I plus there is documented evaluation in four or five areas within the past 18 months.	Level I plus there is documented evaluation in six areas or more within the past 18 months.
35. Evaluation Implementation	Evaluation is performed informally on an on-going basis. Formal evaluations are also performed at least once a year. Program evaluation	Program evaluation is a formal process that has been defined as a priority for the service. However, no single staff person has the responsibility for implementation. Information gathered for the evaluation process is not centrally located. The implementation process is not clearly defined although there is evidence that evaluation is routinely done. Formal evaluations are routinely done	Implementation is described in writing and is clearly an accepted process. Evidence shows that staff and volunteers are aware of the evaluation of their work. Each staff has responsibility for the evaluation process but no one has been designated as solely responsible for implementation. There is evidence of regular discussion and focus on the implementation of program evaluation. Formal evaluations are routinely done. Records are adequate.	It is a well developed component of the service. Attention has been paid to all of the components covered in the Area. There is a staff person designated with responsibility for program evaluation. This staff person makes use of outside evaluators as necessary. Records of the evaluation are easily accessible and are clearly written. There is a written procedure for conducting evaluations and for the use of the outcome.

Component	Level I	Level II	Level III	Level IV
36. Utilization	Administration uses some evaluation outcomes particularly those related to quality assurance Attempts to communicate evaluation outcomes and relate these outcomes to continuing, discontinuing or modifying programs are usually met with resistance by the administration but there is evidence that programmatic decisions are affected by evaluation outcomes.	Administration uses program evaluation results to a significant degree but is hindered in some instances by lack of resources or other factors. There is clear evidence of the utilization of the evaluative results.	There is a focus in the organization on utilizing evaluation results. There is evidence that utilizing the results of program evaluation is regularly discussed with staff. There is clear communication of evaluation results between those responsible for the evaluation and those responsible for program development. There is also an atmosphere of acceptance of the evaluative process within the entire organization	Administration uses program evaluation results to the maximum degree possible and maximizes this effort by drawing on outside resources when ever possible. There is evidence (e.g., new policy and practice based on evaluation procedure on program design) of consistent use of evaluation outcomes and recommendations. Evaluation is specifically designed and undertaken to aid in the decision making process. The board of directors has a program evaluation committee and routinely holds the organization responsible for utilizing program evaluation results

2. Mobile Crisis Outreach Team (MCOT)

Emergencies originate in the community and often persist there at a moderate level of intensity. What distinguishes mobile crisis from other kinds of mobile outreach is the perception of urgency surrounding the referral and the capability of the agency providing the service to respond in a consistently rapid fashion. In addition, mobile crisis outreach teams strive to treat people in their homes, in shelters, or even on the streets to effect least restrictive interventions and mobilize community functioning. Mobile teams may be understood in terms of who they serve, how quickly, and for how long. Public mobile teams serve the entire community and are more likely to go wherever the referral leads them without regard to ability to pay.

Definition and Description

Mobile services that provide psychiatric emergency and urgent care have the capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. Mobile services provide care in the patient's natural environment, and this makes it easier to get a full sense of the environmental and social sources of an emergency. They also allow outreach to individuals who do not meet criteria for involuntary detention, but clearly need psychiatric treatment. In areas that are not densely populated, they may be the ideal way of delivering high quality psychiatric emergency care and in all settings provide a means to deliver emergent (within one hour), urgent (within eight hours), or routine (within 24 hours) treatment to prevent decompensation of individuals at risk of developing psychiatric emergency conditions. Some form of mobile psychiatric urgent care is often provided by comprehensive psychiatric emergency services in urban settings.

MCOT is directed by a psychiatrist. The essential functions of the services are immediate access to assessment and treatment and the ability to manage the most severely ill psychiatric patients at all times.

- Emergency services are available 24 hours a day.
- Urgent care services are available 12 to 16 hours a day, seven days a week.
- They have access to the full continuum of care and have a psychiatrist available by phone or for in-person assessment as needed and clinically indicated.
- There is immediate access at all times to emergency medical care and police backup.

Level of Care Criteria

Mobile psychiatric emergency services manage patients who, as the result of a psychiatric disorder, are at risk of harm to themselves or others. They also manage patients with extreme impairments in functioning and with severe medical, psychiatric, and substance abuse comorbidities.

Patients with fairly severe needs can be managed by mobile urgent care services. Patients with severe impairment in social function are often assessed by urgent care services. Patients with severely stressful environments and no support will often have to be referred to residential services for aftercare but may be assessed by a mobile team. Patients who are at high risk of harm and are extremely frightened or avoidant of treatment may be beyond the capacity of urgent care services, but otherwise minimal engagement in treatment and poor response to prior treatment need not be a barrier to an effective first assessment or intervention by a mobile urgent care service.

Assessments

Telephone Assessments and Triage

- There is 24-hour access to licensed practitioners of the healing arts (LPHAs) who are trained in the assessment and management of crisis phone calls and who are able to assess the priority of the call and provide interventions that are appropriate to level of acuity of the caller.
- Telephone calls are answered within three minutes. If this is not possible there is the opportunity to have the call handled outside the routine system if it is an emergency, i.e., forwarded to a designated staff member or to the crisis hotline where it will be immediately answered.
- A telephone screening to determine the need for assessment includes an evaluation of risk of harm to self or others, need for immediate full assessment, need for emergency intervention, and a medical screening to determine the need for medical assessment, including the presence or absence of cognitive signs suggesting delirium.
- Written procedures for handling phone calls are followed that include prioritization and coordination with available means of performing outreach to callers. A large map to assist in the dispatching process is easily visible.
- There is the capacity for caller identification electronically and call tracing.
- A process for obtaining immediate assistance from other staff when such assistance is needed to safely manage the call (e.g., threats of harm to self or others) is followed.
- Written policies and procedures are followed so that when the level of risk to staff or the patient is significant, a protocol is followed to ensure that police and the mobile response team both meet the patient at the site.
- Two staff are deployed on every emergency outreach, unless cleared by the medical director. When the outreach is to a non-medical facility or into the community, this may include a psychiatrist, nurse, or licensed practitioner of the healing arts (LPHA) on each team. Emergency outreach may be done with a licensed professional and a psychiatric technician if approved. For urgent care outreach in which a psychiatrist, nurse, or LPHA is not on the team, a written procedure for managing psychiatric or medical emergencies is followed.
- Emergent calls lead to an in-person response within one hour, and when this level of response will not be possible, a mechanism for ensuring that the patient receives timely care via the emergency response system is followed. Urgent calls lead to an in-person response within eight hours. Routine calls lead to an in-person response within 24 hours.
- There is a log of all calls. Documentation of the screening of all patients includes the patient name, date of birth, Social Security number (if available), address, telephone number, and the names and contact information for any significant other who is contacted.

Full Assessment

The assessment process includes:

1. Patient interview(s) by LPHAs (including a psychiatrist, nurse, or other practitioner for emergency care);
2. Review of records of past treatment;
3. History gathering from collateral sources (in keeping with laws governing confidentiality);
4. Contact with the current mental health providers whenever possible;
5. In emergency care, an assessment that addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
6. Identification of social, environmental, and cultural factors that may be contributing to the emergency;
7. An assessment of the patient's ability and willingness to cooperate with treatment;
8. 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;
9. 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);

10. In emergency care, an appropriate physical health assessment (see below); in urgent care, a written procedure approved by the medical director should be followed by assessing the need for referral for a physical health assessment;

11. A detailed assessment of substance use, abuse, and misuse conducted by an individual trained in assessing substance related disorders; and

12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

Physical Health Assessment

- For all emergency care patients and for urgent care patients determined to require a physical health assessment, the team has the capacity to conduct an initial evaluation for physical health. The physical health assessment generally includes:
 1. Vital signs;
 2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 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 in all fertile women; and
 6. Other tests and examinations as appropriate and indicated.
- For all patients, a procedure for ensuring immediate access to urgent and emergent nonpsychiatric medical assessment and treatment is followed.
- Due to the high medical and substance abuse comorbidity in this population there is capability for such routine assessments as pulse oximetry, glucometry (or stat blood glucose testing), blood pressure, and temperature with the outreach team when a nurse is available. A nurse may follow up within a reasonable time frame to do these assessments if determined to be necessary by the medical director.

Assessment for Possible Abuse or Neglect

Every patient is assessed for sexual, physical, and verbal abuse or neglect by an LPHA with training in this assessment.

Child Assessments

Every patient less than 18 years of age is assessed (including a developmental assessment) by an LPHA with appropriate training and experience in the assessment and treatment of children in a crisis setting. The mobile crisis medical director establishes the necessary competencies for delivering services to children and adolescents.

Laboratories

The program has the capacity to obtain same-day laboratory studies when indicated, including:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels; and
7. Other studies as appropriate, based on the patterns of illness in the patients served.

Staff Scope of Practice

The scope of practice for all staff involved in the assessment or treatment of patients is defined in writing by the medical director and is appropriate to staff training and experience.

Coordination of Care

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 patient's assessment in the service.

Treatment and Treatment Planning

Stabilizing Care

- There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others).
- A written protocol is followed that 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.

Definitive Care

- An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder.
- The individual treatment plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.
- Patients receive appropriate education that is relevant to their condition. This includes information about the most effective treatment for the patient's psychiatric disorder.

Reassessment and Response to Treatment

- For emergency care patients who require crisis stabilization, there is a protocol and procedure for transporting the patient (if necessary) to a safe environment where they can receive treatment and have their response to treatment assessed.
- Emergency care patient response to treatment is assessed by an LPHA, in consultation with the medical director (if a physician is not present) continuously until a safe disposition is determined.
- Written policy and procedures are developed by the medical director to determine appropriate reassessment intervals (hours to days) needed for reassessment of emergent, urgent, and routine patients.
- Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

3. Psychiatric Emergency Services with Extended Observation—23- and 48-Hour Holds

These hospital-based services support patient autonomy rather than institutional dependency. Many psychiatric emergencies are a function of a transient mental state. Given the brief course of many crises, some form of 24-hour emergency room, capable of accepting involuntary and dangerous patients, is necessary. Observation of the patient in a 23-hour bed can clarify the reasons for the presentation and can serve to divert inappropriate admissions due to misdiagnosis. Brief hospitalization for 48 hours or less provides an alternative to lengthier admissions and enables clinical focus to be maintained on community resources outside the hospital, not on facilitating hospital adjustment. These models of care are particularly well-suited to individuals with suicidal ideation, substance abuse, and serious mental illness exacerbated by transient stressors. Short-term observation or hospitalization can result in improved diagnoses, increased time to develop alternatives to long-term inpatient care, and respite for patients and providers.

Psychiatric emergency services are subject to the same pressures of overcrowding as medical emergency rooms, and as such may need to go on diversion. It is acknowledged that local mental health authorities may need to go on diversion when resources for acute assessment are overwhelmed. Criteria for diversion status are determined either by the policies of the medical emergency room in which the PES is located, or by policies developed by the PES medical director. Diversion policies should reference such standards as the Australian Triage Scale and the Emergency Severity Index.

Definition and Description

Facility-based psychiatric emergency services are the most comprehensive psychiatric emergency services and can include 23-hour observation or 48-hour extended observation and treatment. Facilities that provide 23-hour observation and continuous intensive treatment or 48-hour extended observation and continuous intensive treatment meet all of the standards in this chapter. Standards that are relevant only to 23-hour services are marked **[23]** and standards that are relevant only to 48-hour programs are marked **[48]**.

The essential functions of the services are immediate access to assessment and treatment and the ability to manage the most severely ill psychiatric patients at all times. These programs provide stabilizing treatment for all patients presenting with behavioral emergencies.

- Adequate staff are on hand to complete a full psychiatric assessment and to initiate and monitor response to a treatment plan.
 - Facilities are available at all times.
- There is immediate access at all times to emergency medical care.

Standards apply in a facility-based (hospital) setting in which services are delivered directly or by memorandum of understanding with a medical institution.

Level of Care

These facilities manage patients who, as the result of a psychiatric disorder, are at extreme risk of harm to themselves or others. They also manage patients with extreme impairments in functioning and with severe medical, psychiatric, and substance abuse comorbidities.

Patients who seem to be most appropriate for observation and intensive emergency treatment are patients with:

1. A suicidal crisis that is related to an acute event and/or a pattern of unstable mood or behavior that is longstanding.
 2. A substance-induced or -related emergency that is of relatively short duration.
 3. Other conditions that are likely to significantly improve within a short period of time, after which the patient is likely to be able to return to the community if such significant improvement takes place.
- Written program descriptions for providing patients with 23-hour or 48-hour observation and intensive treatment specify the types of patients who are appropriate for such treatment, which types are not appropriate for such treatment, and the expected outcomes of treatment.

Assessments

Telephone Assessments and Triage

- The program provides 24-hour access to LPHAs who are trained in the assessment and management of crisis phone calls and who are able to assess the priority of the call and provide interventions that are appropriate to level of acuity of the caller.
- Written procedures for handling phone calls include prioritization and coordination with available means of performing outreach to callers.
- The program has caller identification electronically and call tracing.
- A process exists for obtaining immediate assistance from other staff when such assistance is needed to safely manage the call (e.g., threats of harm to self or others).

Screening Assessments and Processes

- Patients undergo nurse or physician triage within 15 minutes of presentation, with procedures to prioritize imminently dangerous patients.
- Until the patient receives that assessment he or she waits in a location with restricted access and egress with constant staff observation and monitoring.
- The screening 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 a medical screening assessment, including vital signs and a medical history, whenever possible.
- A written description of the process for performing this screening assessment 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, staff are on site who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera) at all times.
- Staff who perform this assessment are either registered nurses or physicians who have training in triage and screening assessment.
- A log of all patients who present for services is kept. Documentation of the screening assessment of all patients includes the patient name, date of birth, Social Security Number (if available), address, telephone number, and the names and contact information for any significant other who is contacted.
- Written criteria for determining which individuals presenting for care are referred to another health care facility or provider are followed. These criteria outline a process of assessment that ensures that those referred for care elsewhere are at low risk of harm to themselves or others, have no more than mild functional impairment, do not have significant medical, psychiatric, or substance abuse comorbidity, and have adequate understanding and acceptance of the need for treatment (if such need exists) that they will comply with the referral. A written procedure for ensuring continuity of care and successful linkage with the referral facility or provider is followed.

Full Assessment

- Patients who are not referred for care elsewhere after a screening assessment receive a full psychiatric assessment.
- The assessment is initiated within two hours of the patient's presentation to the service.
- All individuals who receive a psychiatric assessment see a psychiatrist within eight hours of presentation to the service.
- A written process and procedure is followed that ensures that those who require such an evaluation more urgently can be seen and assessed within 15 minutes of that determination.
- The assessment process includes:
 1. Patient interview(s) by board-eligible/certified psychiatrist(s) trained in emergency psychiatric assessment and treatment, or physicians with electronic access to emergency psychiatrists;
 2. Review of records of past treatment;
 3. History gathering from collateral sources in conformance with confidentiality laws;
 4. Contact with the current mental health providers whenever possible;
 5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 6. Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 7. An assessment of the patient's ability and willingness to cooperate with treatment;
 8. 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;
 9. 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);
 10. An appropriate physical health assessment (see following description);
 11. A detailed assessment of substance use, abuse, and misuse conducted by an individual trained in assessing substance related disorders; and
 12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.
- Nursing care plans are developed for all patients in 23- or 48-hour observation.
- A psychosocial assessment and discharge plan is developed for all patients by an LPHA. **[48]**

Physical Health Assessment

- An initial evaluation for physical health generally includes:
 1. Vital signs;
 2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 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 in all fertile women;
 6. A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use, misuse, 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.
- All patients receive a physical health assessment (outlined above) within four hours of presentation.
- A written process and procedure is followed that ensures that those who require such an evaluation more emergently can be seen and assessed within five minutes of initial presentation.
- Immediate access to urgent and emergent non-psychiatric medical assessment and treatment is available and provided as needed.
- 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.

Assessment for Possible Abuse or Neglect

Every patient is assessed for sexual, physical, or verbal abuse or neglect by an LPHA with training in this assessment.

Child Assessments

Every patient less than 18 years of age is assessed (including a developmental assessment) by an LPHA with appropriate training and experience in the assessment and treatment of children and adolescents in a crisis setting.

Laboratories

Immediate access on-site to phlebotomy and same-day laboratory studies include:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels; and
7. Other studies as appropriate, based on the patterns of illness in the patients served.

Staff Scope of Practice

The scope of practice for all staff involved in the assessment or treatment of patients is defined in writing by the medical director and is appropriate to staff training and experience and in conformance with state standards for privileging and credentialing.

Staffing

- Staff are adequate to allow reassessment 1:1 at least every 15 minutes for psychiatric technicians, two hours for nursing, four hours for social services, and eight hours for psychiatrists, and to provide active therapeutic intervention consistent with the patient's clinical state.
- A social worker completes a psychosocial assessment of every patient and works with every patient on a discharge plan. [48]
- An LPHA is assigned to the patient each shift and is responsible for providing the patient with active treatment including psychoeducation, crisis psychotherapy, substance abuse treatment, developing a plan for returning to the community that addresses potential obstacles to a successful return.

Coordination of Care

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 patient's assessment in the service.

Treatment and Treatment Planning

Stabilizing Care

- Immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others) is accessible at all times.
- A written protocol specifies the most effective and least restrictive approaches to common behavioral emergencies in the service and is approved by the medical director and updated at least annually.

Definitive Care

- An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.
- Patients receive appropriate education that is relevant to their condition. This includes information about the most effective treatment for the patient's psychiatric disorder.
- Patients are involved in active treatment that includes psychiatric assessment and treatment (with a psychiatrist doing a face-to-face assessment every eight hours), crisis psychotherapy, psychoeducation, family intervention, substance abuse treatment and relapse prevention [48].

Reassessment and Response to Treatment

- Response to treatment is assessed at least every two hours by nursing staff trained in the assessment of acute psychiatric patients or by a board-eligible/certified psychiatrist.
- Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

4. Crisis Intervention Team (CIT) and Mental Health Deputy/Peace Officer Program

Definition and Description

The crisis intervention team (CIT) is a community-based collaboration of local law enforcement, mental health consumers, and mental health providers. The purpose of the collaboration is to develop, establish, and implement safe and proactive techniques to defuse emotionally charged situations which could lead to violence by

- increasing CIT and public safety by providing CIT members with tactics and techniques that have been proven to help manage situations involving persons in mental health crises;
- reducing tension and misunderstanding about managing people in mental health crises by providing CIT members information about mental illness, suicide, substance abuse, and developmental disorders; and
- facilitating decision-making about obtaining appropriate services for people in mental health crises by providing CIT members information about the criteria and processes involved in obtaining an emergency detention and order of protective custody and the availability of local mental health services.

The Mental Health Deputy/Peace Office Program is supported by Texas Health and Safety Code, Section 531.001(g) (1999), which states, "It is the goal of this state to establish at least one special officer for mental health assignment in each county. To achieve this goal, the department shall assist a local law enforcement agency that desires to have an officer certified under Section 1701.404, Occupations Code."

§1701.404. CERTIFICATION OF OFFICERS FOR MENTAL HEALTH ASSIGNMENTS.

(a) The commission by rule may establish minimum requirements for the training, testing, and certification of special officers for offenders with mental impairments.

(b) The commission may certify a sheriff, sheriff's deputy, constable, or other peace officer, or a justice of the peace, as a special officer for offenders with mental impairments if the officer:

(1) completes a training course in emergency first aid and lifesaving techniques approved by the commission;

(2) completes a training course administered by the commission on mental health issues and offenders with mental impairments; and

(3) passes an examination administered by the commission that is designed to test the officer's:

(A) knowledge and recognition of the characteristics and symptoms of mental illness, mental retardation, and mental disabilities; and

(B) knowledge of mental health crisis intervention strategies for people with mental impairments.

(c) The commission may issue a professional achievement or proficiency certificate to an officer who meets the requirements of Subsection (b).

CIT Standards

The local mental health authority (MHA) ensures that one or more CITs, as appropriate to needs of the local community, are available 24 hours a day, seven days a week.

The local MHA provides curriculum support and training for the CIT program consistent with the training guidelines provided by the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE).

The local MHA trains CIT members using the statewide curriculum approved by the Texas Department of State Health Services.

Mental Health Deputy/Peace Officer Program Standards

The local MHA provides curriculum support and training for the mental health deputy/peace officer program consistent with the training guidelines provided by the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE).

The local MHA trains mental health deputies and peace officers using the statewide curriculum approved by the Texas Department of State Health Services.

Memoranda of understanding will be drafted between local mental health authorities and law enforcement to address mutual training needs and rules of engagement between clinical staff and peace officers.

The transition of patients from police custody to mental health professionals at approved emergency facilities (providing 23- and 48-hour observation) should be performed in less than 30 minutes, targeting an average of 15 minutes. This facilitates the return of law enforcement to the street patrol as soon as possible.

Pursuant to Texas Health and Safety Code, Chapter 573.024, police will be available to transport a person to the location of choice if a person receives a psychiatric screening evaluation and is not found to be in imminent danger.

5. Crisis Outpatient Services

Definition and Description

Psychiatric urgent care services and clinics are an essential component of most mental health systems of care. They serve two purposes: ready access to psychiatric assessment and treatment for new patients with urgent needs, and access to same-day psychiatric assessment and treatment for existing patients within the system. In the latter role, they essentially substitute for the treatment team, either because the team does not have enough time to see the patient urgently, or because the patient's need occurs after hours. While this may not be an ideal way of providing care, it is far better than having no immediate access or after-hours access at all.

Psychiatric urgent care services and clinics are generally much less expensive than psychiatric emergency services. They are often more "patient friendly" since the need for control of behavioral emergencies is less and the physical layout can be more open. They provide care for patients who do not currently have a behavioral emergency (e.g., are not currently likely to hurt themselves or others) but who might develop an emergency if they are not provided with same-day assessment and treatment. Facilities are available during extended hours, particularly evenings and weekends. The facility may be located in the same location as the psychiatric emergency service, but assessment and treatment are less intensive and examinations are targeted to the urgent need only.

Level of Care

Because they have the capacity to provide urgent treatment, they may be able to take patients with fairly severe needs if there is reason to believe that a brief, moderately intensive, intervention might reduce the need for care to the moderate level. For instance, urgent services can often treat patients with a moderate risk of harm if the individual appears to have some ability to control the impulses to harm him or herself. Similarly, some patients with serious impairment in their level of functioning can be treated here as long as there is reason to believe that treatment of the psychiatric symptoms may reduce this impairment to the moderate level. These services are generally more limited in their ability to manage medically complex patients or patients with significant substance-related comorbidity, and generally they are not appropriate places to refer patients with major comorbidity. They are also generally not appropriate places to provide treatment for patients with highly stressful living situations, patients with poor response to previous treatment, and patients with minimal engagement in treatment and recognition of the need for treatment.

Assessments

Telephone Assessments and Triage

A written procedure for handling emergency calls is followed.

Screening Assessments and Processes

- Patients receive a screening assessment within 15 minutes of presentation.

- Until the patient receives a screening assessment the patient waits in a location with rapid access to staff if acuity worsens, or passive observation via video monitoring.
A screening 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 a nurse or psychiatrist.
- A written description of the process for performing the screening assessment is followed. The description addresses the criteria for requesting an immediate medical screening assessment.
- When emergency medical services are not available on site, staff are on site at all times who are prepared to provide first-responder health care (Basic Life Support, First Aid, et cetera).
- Staff who perform the screening assessment should be licensed practitioners of the healing arts (LPHAs) or nursing staff who have training in triage and screening assessment.
- A log is kept of all patients who present for services.
- Documentation of the screening assessment of all patients includes the patient name, date of birth, Social Security number (if available), address, telephone number, and the names and contact information for any significant other who is contacted.
Written criteria are followed for determining which individuals presenting for care are referred to another health care facility or provider. These criteria outline a process of assessment that ensures that those referred for care elsewhere are at low risk of harm to themselves or others have no more than mild functional impairment, do not have significant medical, psychiatric or substance abuse comorbidity, and have adequate understanding and acceptance of the need for treatment (if such need exists) that they will comply with the referral.

Full Assessment

- Patients who are not referred for care elsewhere after a screening assessment receive a full psychiatric assessment which is initiated within three hours of the patient's presentation to the service.
- All individuals who receive a psychiatric assessment see a psychiatrist within six hours of presentation to the service.
- A written process and procedure is followed that ensures that those who require such an evaluation more urgently can be seen and assessed within 15 minutes of initial presentation.
- The assessment process includes:
 1. Patient interviews by LPHAs, including board-eligible/certified psychiatrists;
 2. Review of records of past treatment;
 3. History gathering from collateral sources (in keeping with laws on confidentiality);
 4. Contact with the current mental health providers whenever possible;
 5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 6. Identification of social, environmental, and cultural factors that may be contributing to the urgent need for care;
 7. An assessment of the patient's ability and willingness to cooperate with treatment;
 8. 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;
 9. A general medical history that addresses medical illnesses 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);
 10. An assessment of substance use, abuse, and misuse; and
 11. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

Physical Health Assessment

- An initial evaluation for physical health generally includes:
 1. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;

2. A medical history and review of symptoms;
 3. A pregnancy test in all fertile women;
 4. Blood levels of psychiatric medications that have established therapeutic or toxic ranges; and
 5. Other tests and examinations as appropriate and indicated.
- There is at all times the capability to perform the routine aspects of a physical exam, including vital signs monitoring, on all patients who require it.

Assessment for Possible Abuse or Neglect

Every patient is assessed for sexual, physical, or verbal abuse or neglect by an LPHA with training in this assessment.

Child Assessments

Every patient less than 18 years of age is assessed by an LPHA with appropriate training and experience in the assessment and treatment of children in a crisis setting.

Laboratories

There is at all times the capacity to have urgent phlebotomy with stat lab results on the same day.

Laboratory studies that are available include:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels; and
7. Other studies as appropriate, based on the patterns of illness in the patients served.

Staff Scope of Practice

The scope of practice for all staff involved in the assessment or treatment of patients is defined in writing by the medical director. The scope of practice is appropriate to staff training and experience.

Coordination of Care

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 patient's assessment in the service.

Treatment and Treatment Planning

Stabilizing Care

- There is access to immediate care to reduce the risk from a behavioral emergency (e.g., quiet room, voluntary medications, adequate staff to perform interventions other than seclusion and restraint).
- 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.

Definitive Care

- An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder.
- The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.

- Patients receive appropriate education that is relevant to their condition. This includes information about the most effective treatment for the patient's psychiatric disorder.

6. Community Crisis Residential Services

Crisis residential services include crisis stabilization units, crisis residential units, and crisis respite units. In contrast to the hospital, crisis stabilization units have less intensive biological, psychological, and social treatment modalities, and handle less medically complex patients. They are usually 16 beds in size, and length of stay averages 3-5 days with a maximum of 14 days. Crisis residential units attempt to re-create a normalized environment, e.g., apartments, group and foster homes, and the client's own home. These environments usually have 2-18 beds and deliver biological, psychological, and social interventions targeted at the current crisis while fostering community reintegration. Such units are generally not equipped to prevent elopement or manage the aggressive or seriously suicidal patient. For the populations they serve, the crisis residential services provide safe, cost-effective hospital diversion. Respite services generally serve patients with housing challenges or help caretakers who need short-term housing for the persons for whom they care.

Definition and Description

Crisis stabilization unit: Residential services providing psychiatric emergency care that treat patients with psychiatric conditions that require the highest level of care in a non-hospital environment. They are not the first services to assess patients; that function is generally performed by a mobile or facility-based emergency service. These services can do much to reduce the negative responses to acute care that many patients experience. They are generally limited in their ability to manage severe and acute comorbid medical conditions.

Crisis residential unit: Most residential crisis facilities fall into this category. The facilities provide a safe environment with clinical staff on site at all times, but there is usually not continuous monitoring and reassessment of patients to ensure safety and to provide them with the most vigorous treatment. There is psychosocial programming focusing on a range of topics including problem-solving, communication skills, anger management, community re-integration skills, as well as sobriety and dual diagnosis issues. There is also individual crisis counseling. A physician and RN may be on-site, or there may be ready access to mental health clinic psychiatrists and nurses.

Crisis respite unit: Respite care can occur in houses, apartments, or other community living situations. Respite care is generally provided with limited supervision, primarily psychiatric technicians monitoring patients using SAM (self-administration of medications) procedures. Children and more impaired adults may require the presence of round-the-clock RN or LVN supervision. Occupants must be able to self-care and attend to activities of daily living.

Level of Care

Crisis stabilization unit: These services are able to handle patients with high risk of harm, severe functional impairment, and the most severe psychiatric and substance abuse comorbidity. Most services are voluntary and they are not able to provide care for patients who do not recognize their need for treatment and are not able to consent to treatment. They are usually limited in their ability to handle severe or acute medical comorbidity. They are able to manage patients with the most stressful and least supportive recovery environments and to manage patients who have had negligible response to prior treatment.

Crisis residential unit: Patients can have some risk of harm, but must be able to identify for themselves the need for support from staff in order to ensure safety. Patients may have fairly severe impairments in functioning. Patients may have severe psychiatric comorbidity, but should not have severe medical or substance abuse comorbidity. Patient's home environments can be very high stress and with minimal support. Patients who have had minimal response to treatment in the past will generally not receive adequately intensive treatment in these environments. Patients must have at least minimal engagement; they must have some limited desire to change and to accept responsibility for recovery.

Crisis respite unit: Patients are not at risk for harm to self or others. They must be able to cooperate with staff support, but functioning is usually mildly impaired at the worst. Substance abuse is not present. Mild medical comorbidity is allowed as long as the patient is taking the medical medications. Community meetings are held and there are some recreational activities, but no individual therapy or groups are provided.

Assessments

Screening Assessments and Processes

- Written criteria are used to determine which individuals referred for care are accepted for admission to the program.
- A process is followed to ensure that these criteria are applied consistently.
- Telephone access to the medical director is available at all times for consultation regarding the appropriateness of a patient for acceptance.
- The screening assessment addresses whether the individual is able to recover in the environment.

Full Assessment

- **Crisis stabilization unit:** Patients receive a full psychiatric assessment, which is initiated within two hours of the patient's presentation to the service. Patients receive a full RN evaluation, which is initiated within one hour of presentation. The evaluation includes assessment of medical and psychiatric stability, self-administration of medication capability, vital signs, pain, and danger to self or others.
- **Crisis residential unit:** Patients receive a full psychiatric assessment, which is initiated within 24 hours of the patient's presentation to the service if not referred directly from an active inpatient unit or psychiatric emergency service. A written process and procedure is followed that ensures that those who require such an evaluation more urgently can be seen and assessed within eight hours of initial presentation. Patient should have enough medications on arrival to ensure psychiatric and medical stabilization for at least three days. Patients receive a full RN evaluation, which is initiated within one hour of presentation. The evaluation includes assessment of medical and psychiatric stability, self-administration of medication capability, vital signs, pain, and danger to self or others.
- **Crisis respite unit:** Patients receive a full RN or LVN evaluation, which is initiated within one hour of presentation. The evaluation includes assessment of medical and psychiatric stability, self-administration of medication capability, vital signs, pain, and danger to self or others. The RN should have access by phone to a psychiatrist for consultation. The patient should have enough medications on arrival to ensure psychiatric and medical stabilization for the expected length of stay.

Process for Full Assessment

- **Crisis stabilization and crisis residential units.** The assessment process includes:
 1. Patient interviews by LPHAs, including board-eligible/certified psychiatrists trained in emergency psychiatric assessment and treatment;
 2. Review of records of past treatment;
 3. History gathering from collateral sources (in keeping with laws on confidentiality);

4. Contact with the current mental health providers whenever possible;
 5. A psychiatric diagnostic assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 6. Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 7. An assessment of the patient's ability and willingness to cooperate with treatment;
 8. 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;
 9. 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);
 10. An appropriate physical health assessment (see below);
 11. A detailed assessment of substance use, abuse and misuse conducted by an individual trained in assessing substance related disorders; and
 12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.
- **Crisis respite units.** The assessment process includes:
 1. Patient interview by an RN. There may be additional interviews by other LPHAs, if present;
 2. Review of records of past treatment;
 3. History gathering from collateral sources (in keeping with laws on confidentiality);
 4. Contact with the current mental health providers whenever possible;
 5. A nursing assessment which addresses any medical conditions that may cause similar symptoms or complicate the patient's condition;
 6. Identification of social, environmental, and cultural factors that may be contributing to the emergency;
 7. An assessment of the patient's ability and willingness to cooperate with treatment;
 8. 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;
 9. 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);
 10. An appropriate physical health assessment;
 11. A detailed assessment of substance use, abuse, and misuse conducted by an individual trained in assessing substance-related disorders; and
 12. A treatment plan that addresses at least: immediate treatment in the service, the goals of such treatment, plans for aftercare, ways of addressing barriers to care.

Physical Health Assessment

- **Crisis stabilization units.** Follow state regulations concerning crisis stabilization units in Texas Administrative Code (TAC) 25, Part I, Chapter 411, Subchapter M, governing Standards of Care and Treatment in Crisis Stabilization Units.
- **Crisis residential units.**
 - All patients receive a physical health assessment by an RN within two hours of entering a crisis residential unit. A physician also completes a physical health assessment within the timeframe required for physician assessment.
 - This initial evaluation for physical health generally includes:
 1. Vital signs;
 2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 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 in all fertile women; and

6. A urine toxicology evaluation (unless there is a protocol that specifies another means of adequately assessing for substance use, misuse, and abuse);

As ordered by a physician, the initial evaluation includes

1. Blood levels of psychiatric medications that have established therapeutic or toxic ranges;
 2. Other tests and examinations as appropriate and indicated.
- Immediate access to urgent and emergent non-psychiatric medical assessment and treatment exists.
 - Telephone access to a non-psychiatric medical provider is available at all times.
- **Crisis respite units.**
 - All patients receive a physical health assessment by an RN or LVN within two hours of entering a crisis respite unit.
 - This initial evaluation for physical health generally includes:
 1. Vital signs;
 2. A cognitive examination that screens for significant cognitive or neuropsychiatric impairment;
 3. A mini mental status examination; and
 4. A review of symptoms.
 - Immediate access to urgent and emergent non-psychiatric medical assessment and treatment exists.
 - Telephone access to a psychiatric and non-psychiatric medical provider is available at all times.

Assessment for Possible Abuse or Neglect

Every patient will be assessed for sexual, physical, or verbal abuse or neglect by an LPHA with training in this assessment.

Laboratories

Daily access on-site to phlebotomy and laboratory studies includes:

1. A complete blood count with differential;
2. A comprehensive metabolic panel;
3. A thyroid screening panel;
4. Urine toxicology;
5. A screening test for tertiary syphilis;
6. Psychiatric medication levels; and
7. Other studies as appropriate, based on the patterns of illness in the patients served.

Staff Scope of Practice

The scope of practice for all staff involved in the assessment or treatment of patients is defined in writing by the medical director and is appropriate to staff training and experience and in conformance with state standards for privileging and credentialing.

Coordination of Care

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 patient's assessment in the service.

Treatment and Treatment Planning

Stabilizing Care

- Immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others) is accessible at all times.
- 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.

Definitive Care

- An individual treatment plan is developed for each patient that provides the most effective and least restrictive treatment for the patient's psychiatric disorder. The plan is based on the provisional psychiatric diagnosis and incorporates, to the maximum extent possible, patient preferences.
- Patients receive appropriate education that is relevant to their condition. This includes information about the most effective treatment for the patient's psychiatric disorder.

Reassessment and Response to Emergency Residential Treatment

- Response to treatment is assessed at least every eight hours by nursing staff (RN or LVN) trained in the assessment of acute psychiatric patients or by a board-eligible/certified psychiatrist.
- Whenever it appears necessary, the treatment plan is adjusted to incorporate the patient's response to previous treatment.

Treatment

- Within 24 hours of admission every patient receives an orientation that explains facility rules and expectations, explains patients rights and the grievance policy, and describes the schedule of activities.
- **Crisis stabilization unit.** Follow state regulations concerning crisis stabilization units in Texas Administrative Code (TAC) 25, Part I, Chapter 411, Subchapter M, governing Standards of Care and Treatment in Crisis Stabilization Units.
- **Crisis residential unit.** Every patient is seen at least three days a week by a board-eligible/certified psychiatrist.
- **Crisis respite unit:** Patients are monitored daily by an RN who can refer a patient to an outpatient psychiatrist as needed.
- Treatment in crisis stabilization units and crisis residential units consists of individual or group psychotherapy or psychoeducation, vocational rehabilitation or training, 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 four hours per day of such programming should be provided.
- Patients who have significant substance abuse comorbidity receive counseling designed to motivate the patient to continue with substance abuse treatment following discharge from the program.
- There is access to social, community, recreational, and religious activities that are consistent with the individual's cultural and spiritual background.