

## **CRISIS SERVICE SYSTEM MINIMUM REQUIREMENTS**

It is the intent of these crisis service system minimum requirements, as well as the minimum requirements for Memorandums of Understanding (MOU) to establish one integrated crisis system that provides services for children and adults. This integrated crisis system includes not only the DHHS contracted crisis providers, but also all the hospitals within the district (hospitals with or without psychiatric units). While there may continue to exist separate organizations providing services, from the consumer's and family's perspective the system will be seen and feel as one system and as though it was one entity providing the service. Additionally, it is the intent to ensure smooth linkages between the DHHS contracted providers and the hospitals within the district (hospitals with and without psychiatric units). The following outlines the requirements for this integrated service system.

### **Crisis Services System**

1. Providers of Crisis Services contracted with the Department must meet the DHHS Mental Health Crisis Services Standards of November 30, 2006
2. A public education plan will exist amongst all providers of crisis services and local hospitals to reduce Emergency Department (ED) utilization.
3. Cross training will occur for crisis staff to include developmental disabilities, particularly related to children and youth
4. The 911 providers in the district, the 211 statewide resource number provider the district Warm Line provider, (if any) and the Statewide Warm Line provider will be educated regarding the crisis services available in the district.
5. The provider of crisis telephone services will work with the local 911 system to be able to directly link the caller in distress to the crisis service.
6. The district system will educate the general public, consumers, families, advocacy groups and other providers regarding the local crisis system and what to expect from the crisis telephone service, through face to face assessments and crisis resolution, to admission to crisis stabilization units or to a hospital. This includes a description of what type of questions will be asked and what the process would typically entail.
7. The district system will support not only identified persons in crisis, but also families and other supporters who have managed the crisis up until the formal call for crisis provider assistance.
8. An agreement to participate in debriefings related to situations that did not work smoothly will exist. (Issues of continuity of care, client continuing to be at risk, conflicting clinical opinions that can put the system at stand still, etc.)
9. One of the goals of the crisis system is to minimize and reduce the use of emergency rooms of local hospitals. For the mobile crisis provider it is expected that a minimum of 75% of initial face to face contacts occur outside of the emergency room of the local hospitals.
10. Providers will be culturally and linguistic competent, including:

- a. All crisis staff (face-to-face mobile or crisis stabilization units) will be knowledgeable about the relay system to access language interpreters for non-English speaking consumers.
  - b. Crisis staff must be proficient in the use of a TTY for persons that are deaf.
  - c. Crisis staff must be aware of the impact of a consumer's culture on their presentation during an emergency and how it can impact on the individual's psychiatric assessment. (For example, in some cultures is considered inappropriate for a woman to be in a room alone with a male, the appropriateness of direct eye-contact with a stranger is another factor to consider, and finally when planning to complete an evaluation that in some cultures a large extended family may expect to be present and active participants in the process.)
11. Law enforcement involvement will be minimized and will not be routinely utilized. When police are utilized it should be for a specific purpose where there is a clear safety risk.

### **Mobile Crisis Providers:**

It is expected that the Mobile Crisis Providers will:

1. Be knowledgeable regarding what follow-up services are financially covered ( i.e. under MaineCare, Private Insurance, and State Grant Funds.)
2. Have a psychiatrist available for face to face evaluations to make determination as to appropriate level of care, consult on medications, and negotiate with other physicians regarding the consumer during regular business hours and on occasions weekends and holidays.
3. Have a psychiatrist available for consultation with Emergency Department (ED) doctors on medication recommendations while awaiting crisis resolution.
4. Have psychiatric consultation back up for the on-call psychiatrist for those psychiatric specialties that the on call psychiatrist does not have, i.e. child.
5. Have sufficient crisis offices to allow for face to face assessments outside of the ED and other locations.
6. Establish only one centralized phone number for each district that is linked to the statewide toll free number. Telephone calls are responded to within 5 rings by a live crisis staff person at least at the MHRT level. A district may have a cooperative agreement with another district to centralize a phone number for more than one district.
7. Establish a protocol for dealing with consumers in an ED for over 8 hours internally before involving DHHS.
8. Be the communication connection between other providers and the psychiatric inpatient unit for ISPs and other initial needed documents and information.

9. Respond to calls from concerned others regarding the safety and well being and provide appropriate intervention.

### **Crisis Stabilization Units (CSU)**

It is expected that Crisis Stabilization Units (whether funded as a PNMI or under Section 65) for Children and Adults will in addition to or complimenting the Crisis Standards meet the following expectations:

1. Admission to CSUs should be as timely, streamlined and non-duplicative as possible. At a minimum no additional evaluations beyond that completed by any Mobile Crisis team should be required. Medical clearance is to be required only for persons with acute medical conditions.
2. Being homeless should not be a factor in determining eligibility for admission to a CSU.
3. There will be written protocols for admission to CSUs by Mobile Crisis
4. Admission to CSUs as a step down from an inpatient hospital psychiatric unit can occur without additional evaluations
5. Written protocols will exist for admission to CSUs by inpatient hospital psychiatric units.
6. Individuals in CSUs will have access to psychiatric consultation and medication evaluation and prescription
7. Individuals in CSUs will have active treatment by independently licensed clinicians
8. CSUs will have the capacity to bring in additional staff based on acuity.

### **Crisis Plans**

Crisis Plans are seen as a critical part of ensuring the best possible outcomes for consumers in crisis. While DHHS requires in some circumstances and strongly encourages outpatient, community integration, case management providers to initially work with consumers around a crisis plan, it is also expected that the Crisis Services System also has a role in both development of plans and clearly their implementation.

1. Mobile Crisis Providers will be available to assist consumers in writing their crisis plans in cooperation with primary mental health providers, such as community integration workers, outpatient therapists etc., as well as the Primary Care Providers (medical)
2. The Crisis plans is revised and/or developed post crisis
3. Emergency rooms will participate in crisis plan development as appropriate
4. Crisis plans are collaboratively written and easily accessible.
5. It is the expectation that consumers and their parents, guardians, other family members, and other support persons will be asked about crisis plans and that they will be utilized when available as part of the intervention.

