A Community-Based Comprehensive Psychiatric Crisis Response Service

April 2005

An Informational and Instructional Monograph

Prepared by the Technical Assistance Collaborative, Inc.

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Crisis Services Monograph Contents

Chapter One: Introduction

Since publication of the **Surgeon General's Report on Mental Illness** in 1999, there has been renewed attention and energy focused on improving public mental health systems of care, especially through the implementation of evidence-based practices. Comprehensive crisis response and stabilization services, although not yet deemed an evidence-based practice, have long been considered a crucial element of public mental health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary mental health services and supports. In many communities, crisis response services also perform important public health, public safety, and community well-being functions.

▶ *Why Have a Psychiatric Crisis System?*

★ *Prevalence*
One in every five individuals will experience a mental illness during the course of a year.[1] Furthermore, a 1997 National Hospital Ambulatory Medical Care Survey indicates that the frequency of mental disorder presentations in outpatient departments ranks only second to diseases of the respiratory system.[2]

★ *Impact*
"The Global Burden of Disease" study conducted by the World Health Organization, found that 50 percent of the ten leading causes of disability for persons five years of age and older is due to mental disorders.[3]

Whether long-term or intermittent, mental illness is sufficiently prevalent in and costly to our communities across the nation that it can no longer be ignored. Therefore, an integrated psychiatric crisis services response system that is coordinated with a range of supportive and social services is necessary to meet the community's needs.

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[1] National Association of Psychiatric Health Systems. (2000). *Fact sheet: Behavioral health is an integral part of overall health*. Retrieved from website: http://www.naphs.org/News/benefits.html.
[2] National Center for Health Statistics. (1997). *National Hospital Ambulatory Medical Care Survey*. Retrieved from website: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm.
[3] Murray, C. J. L., Lopez, A. D. (1996). *The Global Burden of Disease.* Cambridge, MA: Harvard School of Public Health.

▸ *Purpose of a Psychiatric Crisis System*

For persons experiencing psychiatric crises, a competent crisis response service system should be able to:

- Provide timely and accessible aid;
- Provide access to a wide range of crisis stabilization options;
- Stabilize them as quickly as possible and assist them to return to their pre-crisis level of functioning;
- Increase and maintain their community tenure;
- Increase their ability to recognize and deal with situations that may otherwise result in crises; and
- Increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention.

In order to fulfill the operational capabilities listed above, a crisis response system **must** be able to:

- Resolve crises for persons with serious mental illness, 24 hours a day, seven days a week;
- Recruit and retain appropriately skilled and trained, linguistically and culturally competent staff that are capable of serving adults, children, adolescents, and families;
- Serve as a community resource for crisis response, stabilization, and referral of individuals, including children and adolescents, who are in crisis;
- Provide appropriate linkages and arrangements that alleviate the use of law enforcement as the primary responder to individuals in crisis, thus, minimizing the criminalization of persons with mental illness;
- Provide services that are adequate for individuals with multiple service needs, specifically individuals with co-occurring disorders and/or accompanying medical conditions;
- Provide a range of crisis services that divert people from inpatient psychiatric hospitalization, emergency rooms to less costly service alternatives;
- Directly transport and/or arrange for the transport of individuals in crisis for treatment;
- Establish links with healthcare resources to provide and/or arrange for medical clearance, toxicology screens, and lab work, as well as medical and non-medical detoxification services;
- Coordinate with the consumer's primary behavioral health provider for follow-up and post-crisis care; and
- Incorporate evaluation protocols to measure the effectiveness of the crisis services.

Examples of crisis program components might include:

☎   Telephone crisis services staffed by skilled professionals to assess, make appropriate referrals, and dispatch mobile teams;

🚓   Mobile crisis units with the ability to respond within one hour to a psychiatric crisis in the community (e.g., homes, schools, or hospital emergency rooms);

🏠   A range of short-term crisis residential services (e.g., supervised apartments/houses, foster homes, and crisis stabilization services); and

☞   Urgent care services with the capacity for immediate clinical intervention, triage, and stabilization.

▶ *Crisis Services as an Integral Part of the Health Care System*

There is growing recognition that psychiatric crisis services cannot and do not operate on the fringe of the health care system, but rather are mainstream activities necessary to complete the health care continuum. Crisis services cut across many different systems, including:

- **Social services**: Housing, medical benefits, child welfare, etc.;
- **Legal**: Involuntary confinement or detainment for the purpose of treatment and evaluation;
- **Health**: Medical services; and
- **Community and personal safety**: Law enforcement assessment of danger to self or the community.

Due to this multi-system involvement in delivering crisis services, a **psychosocial rehabilitation framework** is promoted through the application of a "systems" approach to crisis service intervention. Such an approach ensures that no aspect of the life of the individual with mental illness is ignored or denied the necessary assessment or intervention.[4]

▶ *Information about this Monograph*

This document is intended to be used as a tool by any individual or group who is considering developing a new crisis service delivery system, expanding an existing crisis service system, or improving the effectiveness of an existing system.

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[4] Hughes, R. & Weinstein, D. (2000). *Best Practices in Psychosocial Rehabilitation*. International Association of Psychosocial Rehabilitation Services.

The potential audience includes:

- Local mental health authorities;
- Behavioral health service providers, including crisis service providers, health systems planners, and service partners such as law enforcement;
- Hospital emergency rooms;
- Inpatient provider;
- Consumers;
- Families; and
- Advocates.

Topics in the Monograph include:

- The evolution of crisis services over the past 50 years;
- The role of a crisis service system in the care continuum;
- The goals, components, and functions of a crisis system design;
- The roles and responsibilities of key players in collaboration with the crisis service system;
- Staffing and financing considerations for a crisis service system; and
- Three detailed models (two urban and one rural) of actual crisis service delivery systems operating in local communities.

In addition, the **Appendix** provides key contacts of managers of successful programs who are available to provide consultation regarding system development, implementation, and evaluation.

For the purpose of this document, <u>**crisis services are defined as**</u>:

A collection of integrated services that are available 24 hours a day, seven days a week to respond to and assist individuals in a mental health emergency. These services are provided to persons who are in an emergency condition or crisis situation. The person's need may be such that they require treatment to reduce the likelihood of death, harm to themselves or someone else, serious injury or deterioration of a physical condition or a major setback in their condition or illness. Examples of these services include but are not limited to: crisis hotlines, crisis residential and respite services, crisis/mobile outreach, short-term crisis counseling, crisis walk-in clinics, and crisis stabilization services to name just a few.

Chapter Two: History of Crisis Services

Crisis services have evolved against a backdrop of major changes in the public mental health system.

▶ Evolution in the Location and Provision of Psychiatric Crisis Services

In 1950, state-operated psychiatric facility beds numbered 569,455.[5] The main purpose of state institutions during this period was to admit and house, often indefinitely, persons presenting in a psychiatric crisis state. The **state psychiatric institutions**, or local "asylums for the insane," were seen as serving a higher societal purpose by removing persons with "anti-social and disturbing" behaviors from the view of the community. During this period, treatment and the return to the community were not the primary goals of state institutions in response to a psychiatric crisis.

In 1963, the passage of the **Community Mental Health Act** fueled a transition in the location of psychiatric crisis service delivery. The Act mandated emergency psychiatric care as one of the "five essential services" in all federally funded community mental health service systems.[6] The Act also made hospital emergency rooms more accessible by shifting the responsibility for seriously mentally ill individuals from institutional settings to community centers and general hospitals.[7]

With this shift, the communities where hospital emergency rooms were located became the primary venue for the management and delivery of psychiatric crisis services. From 1950 to 1990, the number of state-operated psychiatric beds fell to 98,304, while the number of state hospitals declined from 322 to 272.[8] Although psychiatric hospitalizations increased during this period, many of those admissions represented short stays at psychiatric units of general and private hospitals rather than longer stays at state hospitals.[9] Not unexpectedly, **hospital emergency rooms** quickly became the default location of psychiatric crisis management.

It became painfully clear that the use of hospital emergency rooms to manage psychiatric crises had severe limitations, often resulting in the following:

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[5] Geller, J. L. (2000). The last half-century of psychiatric services as reflected in Psychiatric Services. *Psychiatric Services*, *51*, 41-67.

[6] Claassen, C.A., Hughes, C.W., Gilfillan, S., McIntire, D., Roose, A., Lumpkin, M., & Rush, A.J. (2000). Toward a Redefinition of Psychiatric Emergency. *Health Services Research*, *35:3*.

[7] Bassuk, E. (1985). Psychiatric Emergency Services: Can they Cope as the Last Resort Facilities? In Lipton, F.R. & Goldfinger, S.M. (eds.), *Emergency Psychiatry at the Crossroads,* San Francisco, CA: Jossey-Bass Publishers.

[8] Geller, J.L., 2000

[9] Geller, J.L., 2000

(1) Admission or release of the consumer without follow-up;

(2) Unnecessary hospitalization;

(3) Inefficient use of resources; and

(4) Missed opportunities to link new consumers to appropriate resources or to mobilize existing networks to help manage crisis situations. [10,11]

Thus, the outcome of using the hospital as a primary provider of crisis services was binary – admission or release were the only options for the consumer.

More recently, a shift toward non-hospital based, non-traditional, community-oriented approaches has emerged. The goal of community-based providers in delivering psychiatric crisis services is to stabilize the crisis in the **least restrictive and most natural** setting possible and to provide the necessary **rehabilitation and recovery-oriented** supports that will allow the consumer to maintain and enjoy long-term community tenure. The development of community-based crisis service systems across the nation was driven by a number of often interrelated factors. Those factors include the:

- Increased emphasis on the development of humane, respectful, and cost-effective approaches to addressing psychiatric crises;
- Increased emphasis on treatment in the least restrictive environment available;
- Increased number of persons presenting in psychiatric crisis in the general hospital emergency rooms;
- Increased use of more stringent inpatient admission criteria;
- Decreased availability of general and state hospital psychiatric inpatient beds;
- Community desires to assure consistent, predictable, and user-friendly access to care;
- Increased numbers of homeless individuals and families, many of whom suffer from mental illness, substance abuse, or co-occurring mental health and substance abuse disabilities; and
- Increased number of individuals who are arrested and potentially jailed for non-violent misdemeanor offenses committed as a result of their untreated mental condition.

While the current delivery of crisis services has shifted out of emergency rooms and into the community, the hospital emergency room remains a pivotal component in the overall delivery system. In 1993, a survey of 185 communities conducted by the Center for Mental Health Services indicated that the vast majority of these communities, roughly 84 percent, reported having a separate unit (or agency) to provide crisis services. [12]

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[10] Clarke Institute of Psychiatry. Health Systems Research Unit. *Best Practices in Mental Health Reform: Crisis Response Systems/Psychiatric Emergency Services*.

[11] Cesnik, B.I. & Stevenson, K..H. (1979). Operation Emergency Services. *New Direction for Mental Health Services*, 1.

[12] Stroul, B.A. (1993). *Psychiatric crisis response systems: A descriptive study*. Collingdale, PA: DIANE Publishing Company.

▶ *Evolution In the Purpose of Psychiatric Crisis Services*

Finally, the societal view of hospitalization for psychiatric conditions has evolved considerably since the 1950s. Today there is a growing awareness that:

(1) In some instances, long-term hospitalization can and may, in fact, be detrimental to the management of a number of psychiatric conditions; and
(2) Brief hospitalizations are just as successful as longer ones.[13]

These two facts reinforce the importance of establishing comprehensive crisis response services as part of a community's continuum of physical and mental health care.

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[13] Slaby, A.E. (1985). Crisis Oriented Therapy. In Lipton, F.R. & Goldfinger, S.M. (eds.), *Emergency Psychiatry at the Crossroads,* San Francisco, CA: Jossey-Bass Publishers.

Chapter Three: Service Components

A comprehensive psychiatric crisis system (CPCS) is designed to address and overcome many of the **constraints** inherent in a hospital-based setting, including time, space, and a lack of community treatment orientation.

Community-based crisis services, when well coordinated and implemented, are an effective and humane approach to service delivery for persons in psychiatric crisis. Rather than a single service response, a CPCS encompasses a range of timely services that are integrated across multiple providers.[14] A well-designed CPCS can provide backup to community providers, perform outreach by connecting first-time users to appropriate services, and improve community relations by reassuring that persons with severe mental illness will be supported during crises.[15]

Of equal importance, a CPCS must have the ability to address the needs of individuals with **co-occurring mental illness and substance abuse disorders**. Such co-occurring disorders are remarkably common. An estimated 10 to 12 million people live with co-occurring mental and addictive disorders nationwide.[16]   According to a paper written by Sciacca, 50 – 75 percent of those with severe mental illness also have a substance-related problem.[17]   Research suggests that the mental health problems often predate the substance abuse problems by 4-6 years; alcohol or other drugs may be used as a form of self-medication to alleviate the symptoms of the mental disorder.[18]   The capacity to address co-occurring disorders should be viewed as a **fundamental feature** of an effective CPCS based upon the prevalence of co-occurring disorders in the population served.

The information in this section of the report will provide a general description of the core components of a comprehensive psychiatric crisis system. The core components of a CPCS system include:

- 24-Hour Crisis Telephone Lines (including Warm Lines)
- Walk-In Crisis Services
- Mobile Crisis Services
- Crisis Residential/Crisis Respite Services
- Crisis Stabilization Units

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[14] Cesnik, B.I. & Stevenson, K..H. (1979).
[15] Review of Best Practices in Mental Health Reform (undated)
[16] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[17] Sciacca, L. (1991). An integrated approach for SMI individuals with substance disorders. *New Directions for Mental Health Services*.
[18] Sciacca, L. (1991).

Although the names of the particular services may differ from system to system, their function is the same or very similar.

☎ *24-Hour Crisis Telephone Lines*

The telephone is often the first point of contact with the crisis system for a person in crisis or a member of his/her support system. Telephone crisis services should be available 24 hours per day to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated.

⊠ *Warm-Lines*

Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre- and post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers. Warm lines focus on the following:

(1) Building peer support networks and establishing relationships,
(2) Active listening and respect for consumer boundaries, and
(3) Making sure callers are safe for the night.[19]

👫 *Walk-in Crisis Services*

Walk-in crisis services are provided through Urgent Care Centers in some communities. Services typically include:

(1) Screening and assessment;
(2) Crisis stabilization (including medication);
(3) Brief treatment; and
(4) Linking with services.

Single or multiple community agencies may be identified to address walk-in crisis and "urgent" situations on a 24-hour basis or through extended service hours.

🚔 *Mobile Crisis Outreach*

Mobile crisis teams are one of the most innovative components of a CPCS. Mobile teams have the capacity to intervene quickly, day or night, wherever the crisis is

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[19] Pudlinski, C. (2001). Contrary themes of three peer-run warm lines. *Psychiatric Rehabilitation Journal*, *24:4*.

occurring (e.g., homes, emergency rooms, police stations, outpatient mental health settings, schools, etc.). These teams can serve persons unknown to the system and often work closely with the police, crisis hotlines, and hospital emergency services personnel. Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in serving adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. Thus, an "extended intervention," which can include short-term counseling, may be necessary. In this instance, a mobile team member may act as the primary care provider until it is appropriate to transition the family into mainstream services.

Some mobile teams may have broad authority and responsibilities for service management that include, but are not limited to:

(1) Providing pre-screening assessments or acting as gatekeepers for inpatient hospitalization of consumers utilizing public services; and

(2) Managing and controlling access to crisis diversionary services.

In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Some mobile teams operate 24 hours a day, whereas others operate only during nights and weekends, relying on community agencies or walk-in centers to handle crises during regular working hours. In some systems, mobile teams provide preventive support in the form of "wellness checks" for persons felt to be fragile or at risk.

While one of the goals of a mobile crisis team is to link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort.

Crisis Respite/Residential Services

On occasion, resolution of a crisis may require the temporary removal of a consumer from his or her current environment. The purpose of crisis respite/residential services is to provide the individual in crisis with support in a calm, protected, and supervised non-hospital setting. During this period, the person can stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings for residential/respite crisis support should be available to meet the varying needs and desires of individuals. Residential supports can be classified as either individual or group.

⊠ *Individual Residential Supports*

Individual approaches serve one or two persons in a particular setting. Examples include **family-based crisis homes** where the person in crisis lives with a screened and trained "professional family." In addition to practical and

emotional support from "family" members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services.

A **crisis apartment** is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports. In a **peer support** model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere.

Finally, an **in-home support** approach, similar to a crisis apartment but in the person's own residence, can be considered if separation from the natural environment is not felt to be necessary. A similar range of services as described in the family-based peer model above are available to consumers in their own home.

⊠ *Group Residential Supports*

Group respite/residential approaches have the capacity to serve more than two consumers at a time. These services are generally provided through crisis residences that combine two types of assistance – crisis intervention and residential treatment. **Crisis residences** offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a step-down resource upon hospital discharge.

☞ *Crisis Stabilization Units (CSUs)*

Crisis Stabilization Unit services are provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multi-disciplinary teams of mental health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

🕐 *23-Hour Beds*

Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

🚌 *Transportation*

Transportation is an essential ingredient of the crisis system that ties all the service components together. The ability to transport individuals in need of crisis services in a safe, timely, and cost effective manner is critical to operations. The requirements for individuals who are authorized to transport persons in crisis vary between communities and may be determined by the legal status (voluntary versus involuntary) of the individual in need of treatment.

In some circumstances, mobile teams will coordinate transport with local law enforcement or emergency medical vehicles to assist individuals in receiving necessary care. Transportation within a crisis service system may also take other, less expensive forms. For example, crisis systems may arrange with private commercial entities, such as taxi companies, to transport individuals who are willing and able to be transported for treatment, but who lack resources to make the trip. Regardless of how a crisis system decides to provide transportation, there are several key factors for consideration in arranging or providing transportation for individuals seeking crisis services. These factors include:

(1) Reliability;
(2) Availability; and
(3) Skill level of those involved in the transport.

Chapter Four:
Organizational Arrangements and Contracting Issues

This section of the report focuses on the organizational design of crisis service systems. In many states, the State Mental Health Authority (SMHA) has primary responsibility for the organization and financing of mental health services. In other states, county governments hold the primary responsibility for designing and implementing public behavioral health services. In either case, the state or local authority must oversee the organizational design as well as identify and secure funding for the crisis response system. Regardless of the arrangement, each crisis service system starts with a funder or a purchaser of services.

> In this document, the term "**primary funder**" refers to the state mental health authority (**SMHA**) and/or local mental health authority (**LMHA**).

Once the decision is made to develop and provide a psychiatric crisis response service in a community, funding arrangements may take several forms, including the funder as provider, the funder as purchaser, and other various configurations. This section includes examples for each organizational arrangement.

▶ *Funder as Sole Provider*

First, a state or local mental health authority may decide to be the sole provider of comprehensive psychiatric crisis response services. This arrangement is a self-contained system in which the LMHA provides all the crisis components as described in the "Service Components" chapter.

An example of an LMHA that both funds and operates crisis service systems exists in *Washington County, Vermont*. The crisis services are under the clinical, managerial, and administrative authority of the LMHA.

▶ *Funder as Provider and Purchaser*

Illustrated below is an example of an organizational arrangement where the funder provides some service functions and contracts for the others.
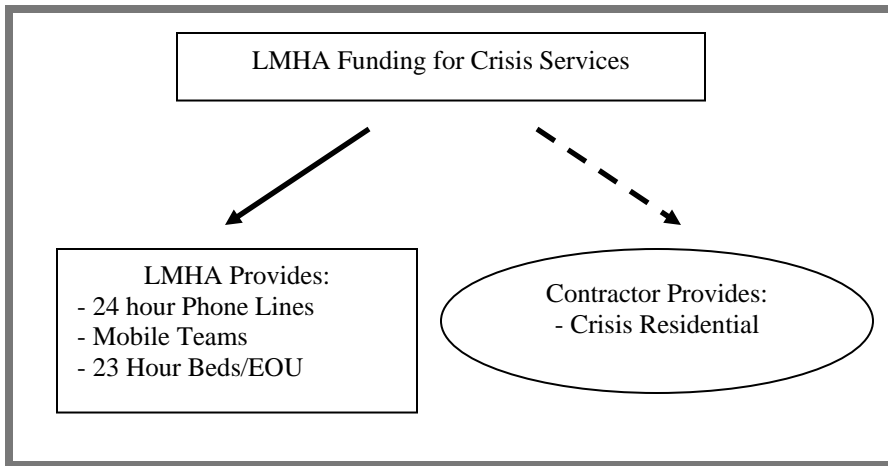
An example of an LMHA that both operates and contracts for crisis service components exists in *Phoenix*, *Arizona*.

▶ *Funder as Purchaser Only*

Next is an example of an organizational arrangement in which the LMHA contracts with a single, non-governmental agency to provide crisis services in the community.
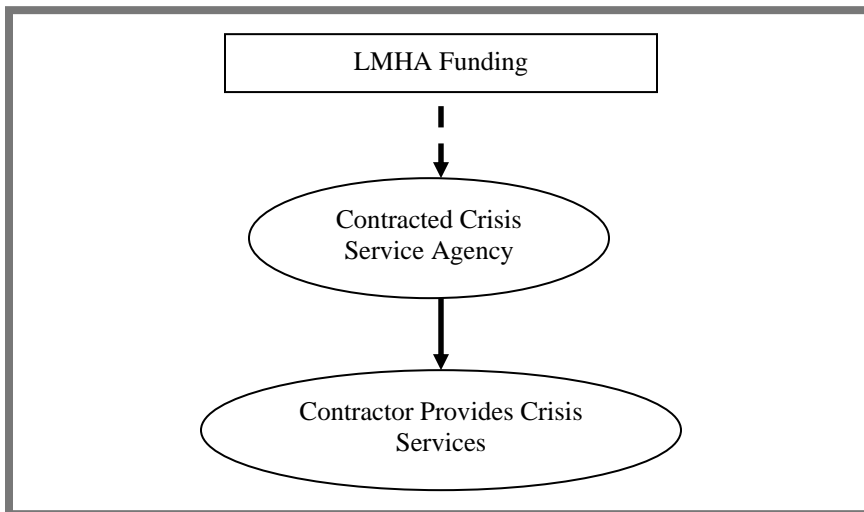
An example of this arrangement can be found in *Baltimore*, *Maryland* and *Lucas County*, *Ohio*.

▶ *Contractor as Provider/Purchaser*

Finally, the LMHA may contract with a single, non-governmental agency to provide or arrange for the delivery of crisis services. The contract provider may provide some crisis services and/or sub-contract for some or all of the crisis components with other providers. This arrangement is illustrated below:
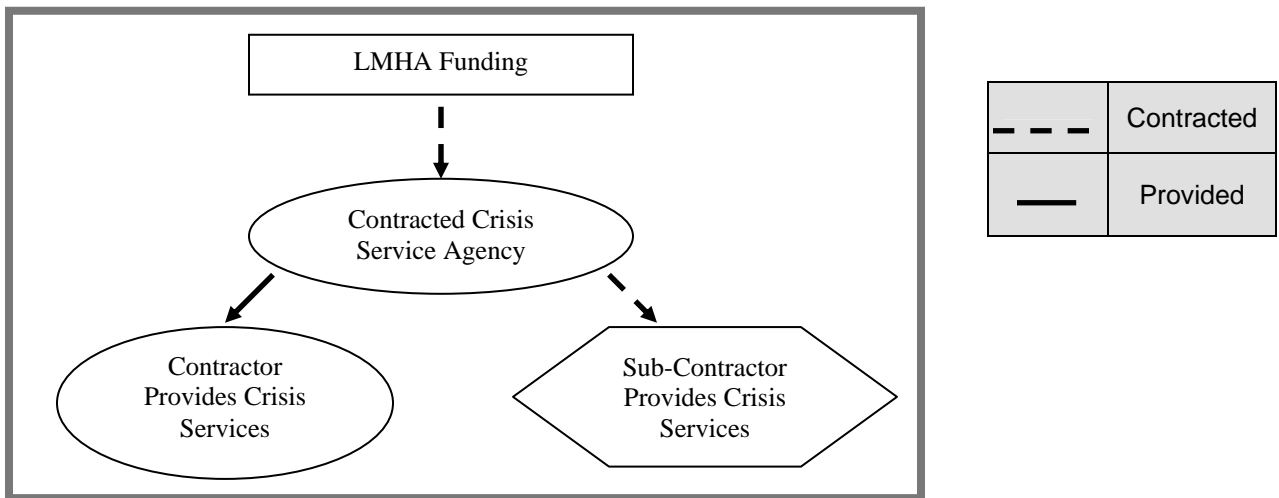
Examples of the arrangement above exist in *Columbus, Ohio.*

▶ *Contracting Issues*

For the purchaser of crisis services, a solid contract is a critical starting point. A contract will define the expectations, duties, and obligations of the contractor(s) and purchaser(s), as well as the rights of consumers. When a governmental entity moves from a distributor of funds to a purchaser of services on behalf of a population in need, the contracting, monitoring, and oversight processes become even more critical. Some state and/or local mental health authorities may elect to purchase crisis services from one or many providers.

Regardless of the program design, funders should consider developing contracts that address **five critical areas**:

(1) Benefits and service duties;
(2) Relationship with other providers of the service delivery system;
(3) Data and reporting;
(4) Performance standards; and
(5) Financing/compensation.

This list above and the sections that follow were adapted from a special report by the Center for Mental Health Services on contracting for public mental health services.[20]

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[20] Savela, T., Robinson, G., Crow, S. (2000). *Contracting for public mental health services: Opinions of managed care behavioral health care organizations*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

➲ Area #1: Benefits and Service Duties

It is essential that the purchaser of services clearly define the crisis addictions and/or mental health services it wants to purchase, as well as the target or eligible population to receive those services, in both the initial Request for Proposals (RFP) and the contract itself.   A purchaser may choose either to develop its own definitions or reference existing definitions of crisis addictions and/or mental health services.

SERVICE DEFINITIONS

Definitions have been developed by the addictions and mental health fields as well as a variety of Federal and State agencies, national associations, and credentialing organizations, including those listed below.

- The Council on Accreditation of Services for Families and Children (COA)
- The Family Treatment Association (FTA)
- The National Association of State Mental Health Program Directors (NASMHPD)
- The National Alliance for the Mentally Ill (NAMI)
- The Federation of Families for Children's Mental Health (FFCMH)
- The National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- The American Public Welfare Association (APWA)
- The Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- The Committee for Accreditation of Rehabilitation Facilities (CARF)

It is essential that a **purchaser** adopt very precise descriptions of services but avoid definitions that unnecessarily impede the contractor network from delivering individualized, person-centered care in a flexible and creative manner, especially if a risk-based payment system is utilized. All service definitions developed by a contractor should be subject to the review and approval of the purchaser.

For potential **contractors** of crisis services, clearly defined services and benefits will leave contractors less vulnerable to legal and financial complications. Contractors should seek contracts that specify a well-defined but flexible core service package that permits additional wraparound services for consumers and families based on the contractors' determination of cost effectiveness and medical and psychosocial necessity. Contractors should also seek contracts that have the potential to integrate substance abuse and mental health services. The existing separation of funding streams for these services in public programs has created fragmentation and confusion, resulting in poor outcomes for consumers with co-occurring disorders. Contractors should pursue opportunities with the purchaser to unify funding streams and create coordinated programs that center on consumer and family needs.

➲ Area #2: Relationships to Other Parts of the Crisis Delivery System

It is important for purchasers to require contractors of crisis services to coordinate their traditional services with other social services outside of behavioral health and to

support the contractor's efforts to do so. To avoid potential "responsibility creep" or misunderstandings between the contractor and purchaser, arriving at a clear delineation between coordination and service delivery requirements is a necessity.

➲ Area #3: Data and Reporting

The contractor and public purchaser of crisis services must address "nuts and bolts" operational questions in the contract about the data, including:

- What data will be supplied;
- Who will supply it;
- How the data will be exchanged;
- What data will be maintained; and
- How the data will be kept secure.

The contract serves two primary data and reporting functions. First, the contract must enable the contractor to support daily operations, monitor the integrity of the service system, and evaluate the performance of service subcontractors or other partners. Second, for the purchaser, the contract must provide for the continued management and improvement of operations, including the ability to assess the contractor's performance of required functions.

The purchaser may also supply some information essential to provider operations (e.g., eligibility data and benefit limits) and to the analysis of the success of the crisis service provider (e.g., actuarial projections, payments to contractor(s), clinical grievance reports, and audit reports). This topic is discussed in greater detail in the "Data Collection" chapter of this report.

➲ Area #4: Performance Standards

It is important for purchasers to include some performance measures in their crisis behavioral health contracts but resist the urge to include performance measures that:

- Divert attention from essential program goals and objectives;
- Seem difficult or impossible to measure; or
- Are simply too numerous.

Too many measures can distract the contractor and divert attention from key aspects of the program's success. The expense of tracking a large number of measures is wasteful for both the contractor and the purchaser. Similarly, holding contractors to performance standards that are out of their control should be avoided. For example, the time required to schedule appointments with outpatient providers may be a desirable measure; however, if the contractor has no control or ready access to urgent care appointments, the contractor may not be able to fulfill this performance requirement. If the contractor cannot improve its own performance throughout the

year because it lacks the necessary authority and control over the outpatient providers, the contractor's performance cannot be measured in this way.

While there are several characteristics of effective performance measurement approaches, the most important involves focusing performance measures on **essential operations during the first contract year** to ensure stability of services. Such measures include timely provider claims payments (e.g., clean claims processed within 30 days) and responsiveness to enrollees and providers (e.g., acceptable telephone abandonment rates). Other characteristics of an effective performance measurement approach include:

- Tying performance measures to program objectives;
- Introducing standards or increasing targets on an incremental basis while maintaining a core set of measures across contract years;
- Developing a reasonable number of performance measures and maintaining that number by eliminating less important measures when new indicators are added;
- Involving all stakeholders in the identification of proposed measures;
- Developing and documenting detailed methodologies for data collection and analysis;
- Finalizing performance measures each year through collaboration between the purchaser and the contractor; and
- Developing routine procedures to use performance data to assess system adequacy and initiate quality improvement efforts.

➲ Area #5: Financial/Compensation Issues

Purchasers often have a variety of goals when developing and overseeing a crisis services program. Typically, these goals involve some combination of:

- Containing or reducing costs of inpatient services;
- Expanding access to services; and
- Improving the quality of care.

The vehicle by which the purchaser defines its goals and objectives is the contract; the structure required to achieve those goals will be a carefully designed financing and payment system. For instance, a purchaser whose main priority is to increase accountability, enhance quality, and/or improve efficiency might establish a flat payment fee and then challenge potential contractors to compete based on access and quality of care issues. On the other hand, a purchaser whose main priority is to maximize cost savings and strictly control its financial risk may want to use financially competitive processes and have shared risk payment arrangements.

In addition to considering its primary goals, the purchaser should consider the following in financial and compensation arrangements when contracting with potential crisis providers:

- Shifting of financial risk from the purchaser to the contractor;
- Applying incentives and sanctions to contractors;
- Dealing with third-party payments;
- Making decisions about co-payments and deductibles;
- Detailing reinvestment requirements; and
- Requiring financial reports by contractors.

The capacity to bear financial risk varies widely among contractors and providers, and it is imperative that public purchasers of crisis services not assign risk to any contractors or providers that lack sufficient capacity to absorb and manage that risk. To develop risk sharing strategies in the design of a crisis service compensation/financing package, a purchaser and potential contractor must thoroughly analyze the financial resources available, the capacities of the existing provider pool, and the demographic and utilization characteristics of the eligible population.

Chapter Five:
Roles of Crisis Services in the Care Continuum

Often the breadth and scope of a crisis system's role is driven by two primary factors:

(1) What new or existing resources are available; and
(2) What set of core values and/or guiding principles regarding crisis service delivery are held by the community.

Depending on resource availability, communities may purchase **all** crisis service components or **selectively** develop specific services to resolve the community's concerns. For example, a community with low inpatient psychiatric hospitalization rates may choose not to design a system that includes the inpatient authorization capacity. Rural areas may have particular challenges establishing mobile crisis teams. In response to an increased number of persons with mental illness who are in jail or waiting for long periods of time in local emergency rooms, communities may choose to develop and purchase the necessary array of services to divert persons with mental illness from jail or the emergency room and into treatment.

In general, most communities develop crisis service systems for altruistic reasons that are based upon the philosophy that persons in crisis can and will recover when treated in their homes and communities. The most restrictive setting, usually hospitalization, should generally be the last resort if other safe and effective alternatives are available.

Although most crisis service systems share this philosophy of community-based care, the ways in which they connect consumers to that care will vary from system to system. Crisis services usually serve one of three basic roles in the care continuum:

- The front door to access care;
- The back door to access care; and
- The manager of service resources.

▶ The Role of Crisis Services as a Front Door to Access Care

In some communities, crisis services have been designed as the "front door" or the primary and preferred point of access for individuals in need of crisis assessment and referral services. The role of a "front door" is particularly important to accomplish the following objectives:

- Articulate a clear and consistent message regarding the services available;
- Create a main repository of information regarding provider services, capabilities, and specialties;

- Provide uniformity in assessing, triaging, and tracking service requests;
- Facilitate prompt access to services;
- Serve as a resource to guide consumers to appropriate non-mental health services (e.g., child and family services, aging services, alcohol and drug services, etc.); and
- Reduce customer frustration in attempting to negotiate the maze of available mental health services and providers.

Persons who use the crisis delivery system as a front door to access care will primarily utilize the **assessment and referral features** of the service and may never receive a face-to-face intervention with the other service components of the crisis system. The assessment and referral functions of the "front door" crisis system are critical means to prevent initial requests for services from spiraling into full-blown crisis situations that could have been avoided if handled effectively through the initial assessment, referral, and linkage processes.

In its front door role, the crisis delivery system must have effective working relationships with other parts of the health care and human service system to assure that consumers will get the services they need once the assessment and referral have been provided. To achieve this goal, the crisis service system will have either a specific designation by the local mental health authority or working agreements and/or contractual relationships with community-based health and human service providers and relevant state agencies to complement and maximize available resources.

These **contracts and/or agreements** describe, at a minimum:

(1) The responsibilities of each party;
(2) The target populations served;
(3) How coordination will occur; and
(4) The referral mechanisms, including timeframes for service delivery.[21]

▶ *The Role of Crisis Services as a Back Door to Access Care*

For psychiatric crisis systems that have multiple points of access for consumers, the term "back door" indicates that the primary role of the crisis system is to ensure that consumers move through the system smoothly once they have entered it through whatever channel. In practical terms, this function may include connecting the consumer to more intensive services, such as residential care, or to less intensive services as crises move toward resolution. In this latter capacity, the system may function as a **"step-down"** upon hospital discharge into other, less restrictive crisis alternatives.

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[21] Hyde, P. (2001). Recommendations regarding contracting and related services and MHO functions. Unpublished Technical Assistance.

In general, a crisis system functioning as a "back door" to access care would have the same options available to consumers as in the "front door" function.

▶ *The Role of Crisis Services as a Manager of Service Resources*

In addition to the "front and back door" functions previously discussed, crisis service systems can also perform the role of service utilization manager. In this capacity, as a manager of crisis resources, the crisis service system ensures that scarce and expensive inpatient resources are utilized efficiently and that the entire system continues to flow with consumers moving easily among services that are appropriate to their needs. To do so, the crisis service system must have the necessary information and authority to facilitate access among crucial behavioral services system-wide. Probably the most familiar role of a crisis system as a service utilization manager occurs when there is a **centralized point of access and authorization** for inpatient admissions.

> The role of a service utilization manager is often compared to that of an air traffic controller. Like an air traffic controller, the system is responsible for coordinating a vast network of services to ensure that consumers "arrive" at their services' location safely and on time.

Crisis systems operating in this role coordinate the movement of consumers and staff in ways that maximize efficiency and promote safety for all involved.

Chapter Six: Collaboration and Coordination

A well-designed crisis service cannot and does not exist in isolation. It is essential that each crisis system partner understands its responsibility before attempting to carry out its functions. Thus, cooperation with other health and human service systems is a key ingredient of the overall success of the crisis system.

The following section identifies key system partners and discusses their potential role, function, and interface with the crisis system. Unless otherwise noted, information in this chapter comes from the 1996 ComCare Crisis Service Manual.

▶ *Outpatient Providers*

In many communities, outpatient providers such as community mental health centers and lead service agencies are considered the primary behavioral health provider or "clinical home" for consumers. For a crisis service system to be effective, it must have the cooperation of outpatient providers to assist in the coordination of services after the crisis episode is resolved or stabilized. The successful transition of a consumer from crisis care to care by an outpatient provider reinforces the continuum of community-based, least restrictive care.

Ideally, the crisis service and outpatient providers will formalize their relationship through **memoranda of agreement** that may address the following responsibilities and expectations:

- Accessibility of outpatient provider staff after-hours to coordinate care and provide information on behalf of persons in their care;
- Role of case management staff in developing crisis plans and discharge planning with crisis service providers;
- Availability of convenient urgent care appointments for new or existing consumers referred for the crisis service and follow-up with consumers who do not keep their appointments;
- Availability of case management staff to participate in treatment planning when a consumer is placed in a short-term diversionary residential crisis/respite service or admitted to the hospital;
- Acceptance of referrals of new consumers from the crisis service within a reasonable period of time, or the availability of blocks of appointment times for the exclusive use of the crisis service; and
- Provision of case management services during extended hours to high need consumers.

▶ *Hospital Emergency Rooms (ERs)*

Quite often persons in a psychiatric crisis interact with hospital emergency rooms before reaching the crisis system. Hospital emergency rooms are required by law to treat the emergency medical needs of anyone who presents to them, including persons in a psychiatric crisis. Some emergency rooms are specifically equipped to deal with the immediate psychiatric needs of emergency room users by calling a **psychiatric consult** or conducting a **simple detoxification**. Some hospitals also have **medical detoxification units** or **psychiatric inpatient beds** to which they can admit persons from the emergency room when they need such care.

A crisis response system can also provide and assist ER personnel with training on the behavioral health and human/social services available in the community and how to access such resources. For crisis response systems that have the authority to manage service utilization and authorize inpatient stays, crisis system personnel will be available by phone 24 hours per day to authorize emergency room decisions.

The frequent overlap of medical and psychiatric emergencies requires that hospital emergency room staff and crisis service system staff coordinate their activities closely. It is essential that all participants in the system have a working knowledge of each other's policies, procedures, roles, and responsibilities. The goal of the mobile team staff should be to help the ER staff as much as possible, while attending to the needs and safety of the person requiring care. Furthermore, mobile team staff must remember that hospitals generally do not have the resources to hold persons in the emergency room whose medical condition has been stabilized but who cannot be safely released to the community because of a psychiatric condition. Nor are hospitals able to wait long periods of time for authorization for admission to their inpatient or detoxification beds.

▶ *Law Enforcement – Local Police and County Jail*

Other than the collaboration with hospital emergency rooms, the most significant relationship of a crisis response system is with law enforcement. The **goal** of most crisis service systems in their interface with the local police officers is to have the officers in and out of the interaction as quickly as possible. This commitment alone is a very important service feature that encourages police officers to seek treatment for, rather than incarcerate, individuals in need of psychiatric care.

Local police personnel are or can become frequent users of the mobile teams, crisis stabilization unit, and walk-in clinics. Depending on the design of the system, officers will call the crisis phone lines to request mobile teams to assist with a community member who has a behavioral health need, is substance abusing, and/or is homeless.

The Crisis Phones prioritize these calls and process information, as well as contact and dispatch a team to assist the officers on-site in the community.

A crisis service system can also provide much-needed **education and training** to new recruits and veteran officers regarding working with individuals who may have a mental illness, as well as providing information concerning how to access the services available. Regular forums should be established between the crisis service system and law enforcement to trouble-shoot, problem solve, and make recommendations regarding system improvements.

One model of a collaborative partnership between law enforcement and mental health providers is the Memphis Police Department's **Crisis Intervention Teams**.

<u>EXAMPLE</u>: Memphis Police Department's
Crisis Intervention Teams (CITs)

The CIT is a police-based program with specially trained officers who are called to respond to mental disturbances and suicide attempts in the community. CIT officers are skilled in de-escalating potentially volatile situations, gathering relevant history, and assessing information related to medication and social support. The CIT officers have the capacity to transport individuals to the University of Tennessee psychiatry emergency services after the situation has been assessed and diffused. The CIT is considered the most visible pre-booking diversion program in the nation and has been replicated in: Seattle, WA; San Jose, CA; Albuquerque, NM; and Waterloo, Iowa.[22] The CIT is a partnership with local mental health providers, the local chapter of the Alliance for the Mentally Ill, and the Universities of Memphis and Tennessee.[23]

When pre-jail diversion options are not available to officers, it is important for incarcerated persons with mental illness that the crisis service system remain a critical link for jail staff to refer for services consumers whose release is pending. Unfortunately, the majority of police departments in US cities with populations of 100,000 or more do not have a specialized strategy to respond to persons in crisis who may have a mental illness;[24] therefore, procedures and policies must be established to create a connection between behavioral health care providers and law enforcement for individuals getting out of jail as well as a pre-booking service option, either on a voluntary or involuntary basis.

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[22] Steadman, H.J. & Deane, M.W. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, *51*, 645-649.
[23] Retrieved from the CIT website at: http://www.memphispolice.org/communit.htm.
[24] Deane, M.W., Steadman, H. J., Borum, R., Veysey, B.M., & Morrissey, J.P. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services, 50*, 99-101.

▶ *The Courts*

In some comprehensive crisis service systems, **court-ordered psychiatric evaluations** are initiated by the crisis service provider. Within the laws of a given state, any responsible adult may apply for a court-ordered evaluation of a person who, as a result of a mental disorder, is alleged to be a danger to self or others, persistently acutely disabled or gravely disabled, and who is unwilling to undergo a voluntary evaluation. In providing this service, the crisis system must have the capacity and authority to begin the necessary legal process for an evaluation even if the consumer does not agree voluntarily. Once determination has been made about the existence of a mental disorder, the court can assess whether treatment is required and in the best interest of the consumer.

The process of obtaining a court ordered evaluation and making treatment decisions requires timely collaboration between the crisis service system and the courts, regarding such details as:

- How the process and paperwork will flow;
- What the orders say;
- When the hearings are needed and where they are held;
- The identification of primary points of contact;
- The regular meeting of principal players to ensure smooth operation of the system; and
- How the services will be paid for.

Addressing these issues is vital to the success of a crisis delivery system that incorporates the courts into its service design. This partnership is essential to NetCare ACCESS, a model featured in the "Crisis Service Models" chapter of this document.

▶ *Primary Care Physicians and Health Plans*

All crisis service systems will come in contact with consumers who may be enrolled in private or public health plans. It is critical to be aware of the primary health plans in the community and, ideally, establish protocols for communication with **primary care physicians** (PCPs) when care is rendered to their members. PCPs may interact with the crisis service system in a variety of ways, including:

1) Identifying individuals in need of behavioral health care and making referrals;
2) Seeking help for a consumer about whom they have concerns; and
3) Seeking help for a consumer on behalf of a family member, clergy, or other community member.

The relationship between the crisis service system and the PCP or health plan ensures that critical medical information, such as medication type and dosage, is

communicated and that the most effective interventions are utilized to resolve the crisis without escalation. Strategies to help facilitate this collaboration include developing educational material together and participating in joint trainings, seminars, and monthly coordination meetings.

▶ *Fire Departments – Paramedics and 911*

A well-designed crisis service system will interface with the local municipal fire departments at two critical points. First, fire departments may contact the crisis service system for assistance, an interface that generally occurs through the Crisis Phone Lines initially. Fire personnel call the Crisis Phones and request a mobile team intervention when they have responded to a 911 call that involves a continuing psychiatric crisis. Second, the crisis service system will call 911 (fire, rescue, and ambulance service) to facilitate transportation and emergency medical intervention when a consumer has been identified by the crisis phones, mobile teams, crisis stabilization units, or walk-in centers as having a medical emergency. Operating procedures, clearly defined roles and responsibilities, and timely responses are all key to the success of this overlapping systems relationship.

▶ *Social Services - Community Information and Referral*

The crisis service system should be available to all persons in the designated community, including those served by county, state, and private agencies and social service agencies. Social service agencies that may come into contact with the crisis system include: Child and Family Services, Adult Protective Services, Adult and Juvenile Corrections, Developmental Disabilities, and Substance Abuse Services. These agencies will access crisis services on behalf of their clients like any other community resident, generally through the crisis phones or walk-in/urgent care clinics.

The crisis phone system must also have the capacity to continuously update its **database of community agencies**, including the services they provide, their contact numbers, and their access procedures. This capacity is necessary to provide accurate information to consumers who may contact the crisis system regarding non-behavioral health needs. To the extent possible, the crisis phone service should be able to connect the consumer to another community agency that may be able to help. The crisis service system should gather information from community providers on a regular basis in order to maintain relationships and ensure the accuracy of the information in their database.

▶ *Schools*

On occasion, schools will encounter crisis situations with children, adolescents, or their families during school hours. These situations are opportunities for the crisis service system, as a community resource, to interface with the school system.

EXAMPLES: Crisis Situations at Schools

(1) Incidents involving students with behavioral health problems that go beyond the ability of school personnel to manage.
(2) Behavior that prevents the involved student or other students to be taught.
(3) Incidents that affect individual students or the whole student body and require immediate intervention (e.g., a shooting or an accident resulting in death or serious injury to a student or teacher).

A mobile team that serves only children and adolescents (C&A) or a team with C&A expertise can be dispatched to assist the school, the students, and the families until the crisis is resolved. On-site intervention may the best way to address the problem or a determination might be made to transport the child to his or her home, a walk-in/urgent care clinic, a crisis stabilization unit, or a hospital emergency room. Follow-up may be provided to create an opportunity for further learning concerning behavior management and coping skills.

This kind of presence by crisis service providers is one of the best ways to help prevent crises for schools and their students. Crisis services may want to consider devoting staff exclusively to coordinating activities between schools and the crisis service system.

▶ *Child-Serving Agencies*

Children and adolescents who are served by child serving agencies should have complete access to crisis services, just as any other resident of the community that the crisis system is designed to serve. At times, child-serving agencies are overwhelmed by or untrained in managing the needs of the children for whom they are responsible. These agencies may look to the behavioral health system to remove children from their care rather than helping them to receive the necessary behavioral health services that would enable the children and their caregivers to cope in the situation.

Therefore, crisis systems must clearly communicate with these child-serving agencies regarding what they can and cannot do for the children in their care. Working with child serving agencies can be challenging, but these relationships are manageable if

the roles, responsibilities, and expectations of each system are known and respected. To further this understanding, crisis service systems should provide training to child serving agency staff on how and when to use the crisis system.

Chapter Seven: Crisis Service System Financing

The development and delivery of psychiatric crisis services is not an inexpensive proposition. However, if well managed and designed, the cost to serve an individual through a crisis service system is often less than the cost of an inpatient episode of care. How the crisis service system and its components are financed is driven by a variety of questions, including:

- Who is the target population?
- Is the purchaser buying capacity or individual units of services?
- Can the service generate revenue or income from non-traditional sources (i.e., will managed care companies pay for the service)?
- Is the anticipated volume under a purchase of service or fee for service arrangement sufficient to cover operations?
- Who are the traditional payers for the types of services proposed in the crisis service model?
- How will services to consumers without an identified payer source be handled?

These questions represent a sample of the types of financial considerations communities must evaluate before building a new or restructuring an existing crisis service system.

> Crisis service components may be financed through a variety of methods, such as:
>
> (1) Fee-for-service;
> (2) Grant funding;
> (3) Case rates;
> (4) Sub-capitation;
> (5) Partial capitation; and
> (6) A combination or one or more of these financing mechanisms.

► Reimbursement Options

☑ **Fee-For-Service**: A traditional method of reimbursement based on a specific unit rate of payment for specific services rendered. Payment may be made by an insurance company, the consumer, or a government program such as Medicare or Medicaid.

☑ **Grants**: Federal, state, or local government funds used to underwrite or subsidize all or a portion of a project or service.

☑ <u>Case Rate</u>: A flat fee paid for a consumer's treatment based on their diagnosis and/or presenting problem. The provider covers all of the services the consumer requires for this fee for a specific period of time. A flat fee rate is sometimes referred to as a bundled rate. In this model, the provider accepts some risk, but has considerable flexibility in meeting the consumer's needs. Factors to consider in this model include:

   (1) Properly pricing the case rate (if provider has control over it); and
   (2) The number of eligible persons.

☑ <u>Capitation</u>: A method of payment in which providers are paid a fixed amount for each person for whose care they are responsible, regardless of the actual number of persons who require care or the types or amounts of services delivered.

☑ <u>Sub-Capitation</u>: This arrangement exists when an organization being paid under a capitated system contracts with other providers on a capitated basis, sharing a portion of the original capitated premium.

☑ <u>Partial Capitation</u>: A contract between a payer and a sub-capitation provider or other payer whereby payments made are a combination of capitated premiums and fee-for-service payments. Sometimes certain outliers are paid as fee-for-service, while routine care or services for incidental users of care are paid via capitation.

The "Crisis Service Models" chapter (Chapter 12) of this document includes a grid that illustrates how each model's service components are financed using one or more of the reimbursement methods described above.

▶ *Purchasing Capacity Versus Individual Services*

Whether a purchaser is buying capacity or individual services will, in some cases, define how a crisis service component will be paid for. Purchasing capacity is generally understood to mean that the purchaser wants the service to be available to the community regardless of how often it gets used. Purchasing services means that the purchaser desires to pay for individual units of service.

Example: The Fire Department

Local tax dollars support the local fire department. The city pays for the capacity of the fire department to respond immediately to life threatening emergencies any time of day or night, with the knowledge that the fire department will have significant down time and may not respond to an emergency for several days. However,

because the ability to respond anytime is more important than the number of times the department responds, local government officials have decided to purchase the *capacity* for fire safety services in order to ensure safety and a prompt response.

As with local fire departments, some components of the crisis system may warrant the purchase of around-the-clock capacity. How much capacity to purchase is driven by the community's needs and whether there are **other payer sources** for the services provided. So, in the instance of crisis psychiatric services, there may be some components in a crisis system design that one believes are essential to have available around the clock and for which there may be no other payer source providing services in the local community. To determine whether each component within the crisis delivery system is essential, it must be evaluated within the parameters of safety (consumer, community, and staff), availability, and the existence of payers who are willing to pay adequate rates for the service.

▶ *Expanding the Service Base*

The development of some crisis service components may create opportunities to "market" the service to non-traditional payers and thereby generate revenue to offset some of the cost for a portion of a service component. For example, some psychiatric crisis service systems have leveraged their capabilities for 24-hour crisis phone line service to get paid for providing the following:

- First line after-hours telephone coverage for outpatient providers;
- Crisis phone line coverage for neighboring communities;
- After-hours coverage for individual private practitioners; and
- Twenty-Four-hour phone coverage for other governmental agencies.

Crisis service providers should think broadly about payer sources and market niches to supplement and/or sustain the financial viability of their operations when public resources remain fixed, are unable to keep pace with inflation, or are decreased.

▶ *Target Populations*

When designing a crisis service system, one must keep in mind the intended target population. The system may initially be designed to serve and treat consumers who utilize public mental health services, thus, anticipated volume and payer mix can be projected to develop budgets and consider which methods of reimbursement are available and best suited to finance the service.

Similar to an emergency room, most crisis service systems operate utilizing a **"No Reject"** policy, treating all consumers who present in their facilities regardless of ability to pay. Once a crisis service system is open, however, it can quickly become a

magnet for a variety of social problems that arise in the community. A crisis service system can easily become the unintended safety net for child welfare agencies, schools, homeless agencies, adult protective services, and substance abuse agencies if agreements are not negotiated in advance. Without careful planning and coordination with other key components of the system and an understanding of who is responsible for serving populations that the crisis system was not originally designed to serve, the system will quickly find itself overwhelmed by demand and in financial peril.

▶ *Staffing Requirements*

Personnel expenses constitute a major portion of any crisis system's budget. The range of behavioral health professionals, para-professionals, and consumer staff that are required in most crisis service systems include:

- Psychiatrists;
- Registered and Licensed Practical Nurses;
- Masters and Bachelors level Social Workers;
- Addictions Counselors;
- Peer Counselors; and
- Mental Health Counselors.

The range of services that are provided by each of these professionals is typically governed by the state and, in some cases, the payer. Staff titles and position descriptions may vary from state to state. In addition, many crisis service systems include security officers in the staffing pattern.

The use of psychiatrists in crisis service systems is often a combination of on-site availability and back up or "on-call" consultation, often by telephone, to support and/or approve the clinical decisions of the crisis services staff.

▶ *Sample Budget and Staffing for Crisis Service Components*

Illustrated below is an actual sample budget for the development of a comprehensive psychiatric emergency program (CPEP), operated by the Mental Health and Mental Retardation Authority (MHMRA) of Harris County, Houston, Texas. The services proposed would work in concert with the existing psychiatric emergency room. The MHMRA of Harris County, which serves a catchment area of over three million residents, has developed a proposal that they believe will meet the needs of County residents experiencing mental health crises. The budget proposal takes into account many of the financial considerations discussed in this section.

CPEP Projected Budget

Crisis HelpLine			
Positions	**FTEs**	**Service Utilization**	**Projected Budget**
Crisis HelpLine Director Volunteer Coordinator Phone Counselors Volunteers	1.0 1.0 8.0 80-100	Total calls: 8,200/month Emergency calls: 1200 Urgent Calls: 1300 Routine: 3000 Referral: 2700	Personnel: $375,326 Operations: $16,200 _____ Yearly $391,526 • One Time Expenses: $55,000

Mobile Crisis Outreach Team (MCOT) and Child and Adolescent Psychiatric Emergency Services (CAPES) Mobile Unit			
Positions	**FTEs**	**Service Utilization**	**Projected Budget**
Psychiatrist / Director Administrative Assistant Registered Nurse Social Work Manager Clinical Social Worker Mental Health Counselor	1.0 1.0 3.0 1.0 8.0 10.0	Urgent Crisis: 361 Interim case management: 348 Transports: 212 Education: 12 _____ Total: 933 / month	Personnel: $1,298,080 Operations: $44,000 Yearly: $1,342,080 • One Time Expenses: $3,000

Crisis Stabilization Unit (CSU)			
Positions	**FTEs**	**Service Utilization**	**Projected Budget**
Psychiatrist Chief Nurse Registered Nurse LV Nurse Mental Health Counselor	1.0 1.0 5.0 4.0 9.0	Admissions: 120 / month Length of stay: 3.5 days	Personnel: $1,200,000 Operations: $252,000 _____ Yearly: $1,452,000

Crisis Respite Beds (CRB)			
Positions	**FTEs**	**Service Utilization**	**Projected Budget**
Psychiatrist / Director Registered Nurse CRB Managers (CSW) LVN Psychiatric Technicians	1.0 1.0 2.0 1.0 12.0	Admissions: 90 Length of stay: 5 days	Personnel: $680,760 Operations: $125,902 _____ Yearly: $ 806,662 • One Time Expenses: $23,000

Crisis Counseling Services (CCS)			
Positions	**FTEs**	**Service Utilization**	**Projected Budget**
LMSW-ACP	2.0	Referrals: 60/month Contacts: 1 – 3 / referral _____ Total contacts: 120 ~ 360/month	Personnel: $107,360 Operations: $1,600 _____ Yearly: $108,960 • One Time Expenses: $7,000

Chapter Eight: Accreditation and Regulatory Requirements

▶ *Accreditation Requirements*

There are many national accrediting and certifying bodies that have developed and published standards of program performance to serve as guidelines for the field in the delivery of crisis and emergency psychiatric services. An overview of four accrediting organizations is presented below, and standards for two of the organizations are found in the appendices of this document.

☑ American Association of Suicidology[25]

The American Association of Suicidology (AAS) promotes research and public awareness, trains professionals and lay persons, serves as a national clearinghouse, provides networking, and establishes national standards for organizations and individuals who work with self-destructive behavior, people in crisis, and people who are suicidal. AAS has developed a **certification method** that has encouraged and enabled suicide prevention, crisis intervention, and specialized crisis response programs to improve, develop, and be recognized for their outstanding work.

☑ American Association of Emergency Psychiatry[26]

The American Association of Emergency Psychiatry (AAEP), a national organization devoted to the advancement of crisis and emergency psychiatry, has published standards for the provision of psychiatric emergency services. These standards fall into four domains:

- Accessibility;
- Staffing;
- Management; and
- Facilities.

☑ Joint Commission on Accreditation of Healthcare Organizations[27]

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a private, non-profit organization dedicated to improving the quality of care in organized healthcare settings. JCAHO evaluates, accredits, consults, and sets standards for long-term care facilities, ambulatory healthcare organizations, home care agencies, hospices, hospitals, healthcare delivery networks, and organizations offering major mental health services. JCAHO offers accreditation to healthcare

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[25] Retrieved from AAS website at: http://www.suicidology.org/.
[26] Retrieved from AAEP website at: http://www.emergencypsychiatry.org/.
[27] Retrieved from JCAHO website at: http://www.jcaho.org/.

organizations throughout the United States, and its standards are recognized as representing the **contemporary national consensus** on quality patient care.

☑ <u>Commission on the Accreditation of Rehabilitation Facilities</u>[28]
The Commission on the Accreditation of Rehabilitation Facilities (CARF) is a private, non-profit organization that grew out of a need in the medical and vocational rehabilitation fields to promote quality programs for people with disabilities and others in need of services. CARF has developed and maintained **practical, customer-focused standards** to help organizations measure and improve the quality, value, and optimal outcomes in the lives of the persons they serve. The standards development process provides the opportunity for consumers and other stakeholders to be actively involved. CARF accredits the following services that are found in a comprehensive crisis response system:

- Assessment and Referral;
- Crisis Intervention;
- Crisis Stabilization; and
- Detoxification.

▶ *Regulatory Requirements – State and Federal*

Each **state** has its own standards through which it evaluates the credentials, qualifications, and capacity of individual providers to render crisis psychiatric services. Often these standards are applicable only to specific components within the crisis response system and not the entire system. The culmination of the state's assessment of a provider usually results in a **license and/or certification** to provide specific services. This licensure/certification is what allows providers to bill the public payer (Medicaid and/or Medicare) for these services. The provisions and requirements for crisis service programs and providers will vary from state to state.

Federal requirements are mainly based on EMTALA and Medicaid/Medicare regulations:

☑ <u>EMTALA</u>[29]
The Emergency Medical Treatment and Active Labor Act (EMTALA), also referred to as COBRA (Consolidated Omnibus Budget Reconciliation Act) and the Anti-Dumping Law, was passed by Congress in 1985, though guidelines were not issued or uniformly enforced until 1996. The goal of EMTALA is to prevent hospitals from sending indigent patients to public hospitals for financial reasons. EMTALA ensures that anyone presenting

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[28] Retrieved from CARF website at: http://www.carf.org/.
[29] The information was adapted from: Coyne, S. (2002). Proposed revisions to EMTALA, the "Patient Anti-Dumping" act. *Health Law Update*: Quarles & Brady LLP and affiliates.

at a hospital requesting an emergency service will be screened and, if an emergency exists, stabilized before being transferred or discharged. While the Act primarily applies to hospitals with an organized emergency department that participates in the Medicare program, some non-hospital-based psychiatric crisis/emergency services operating in community settings may be required to abide by the guidelines established in EMTALA.

☑ **Medicaid and Medicare**[30]
The Center for Medicaid and Medicare Services (CMS), is the federal agency that administers Medicare and Medicaid. Medicaid, a jointly funded Federal-State health insurance program for certain low-income and needy people, covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Medicaid can be a major source of funding for crisis psychiatric services if those services are included in the State's Medicaid plan as either clinic or rehabilitation option services.

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[30] Retrieved from CMS website: http://www.cms.hhs.gov/.

Chapter Nine: Essential Policies, Procedures, and Protocols

This section of the report describes some of the essential policies, procedures, and protocols that a crisis response system must develop. The policies presented here are only a representative sample of policies, not an exhaustive list.

▶ *Safety*

Safety is always the first priority. Crisis service providers play an essential role in ensuring that the treatment environment is a safe one, both for staff and consumers. Because crisis service staff provide services both in the community and in the more structured settings of treatment facilities, the ability of staff in either setting to identify, assess, and manage risky situations is a major factor in minimizing safety concerns.[31] Therefore, crisis service providers must have policies in place to identify and correct safety issues for both staff and consumers through risk management protocols.

Services in the community, such as **home visits**, may be of particular concern, especially if the crisis provider is assessing a consumer for potential involuntary hospitalization, is uninvited, or is seeing a consumer who feels very threatened. If there is any suggestion that a home visit is likely to be dangerous, it is essential that protocols are in place to assess risk and that workers are accompanied by law enforcement if necessary.

Crisis service staff must strive to protect both the **rights and safety** of the persons served. However, if a consumer is making a choice that could lead to injury unless action is taken, then crisis staff have a duty to ensure the safety of the person despite a possible violation of the person's rights.

▶ *Informed Consent*

There cannot be successful active participation in treatment unless consumers are truly informed about their condition and treatment options. Given the multitude of barriers in this exchange of information – which may be even more challenging for consumers of mental health and addictions services than for consumers of other health services – the principles of informed consent are of major importance in protecting the rights of both consumers and providers.

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[31] *Best Practices Manual* of the Texas Homeless Network. Retrieved from: http://www.thn.org/bpm/index.htm.

CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The principles below, extracted and adapted from the *Consumer Bill of Rights and Responsibilities* developed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, should be considered in the development of informed consent treatment policies and protocols for consumers in crisis.

☑ Clearly explain to the consumer the following:
   (1) The nature of his or her condition;
   (2) The benefits of the proposed treatment;
   (3) The risks and side effects of the proposed treatment;
   (4) The probability of a successful outcome;
   (5) The problems of recuperation; and
   (6) Plausible alternatives to treatment, including the option of no treatment.

   Information sheets can be effective in assisting consumers, but must be clearly written and available in the language of the consumer.

☑ The provider should:
   (1) Offer to answer any questions about the proposed treatment;
   (2) Make clear to the consumer that it is his/her decision whether to accept a particular treatment and what the implications are of refusing treatment when committed or court ordered to undergo treatment;
   (3) Inform the consumer that he/she can consult family or friends before making a decision; and
   (4) Inform the consumer that he/she may discontinue treatment at any time.

☑ When appropriate and with consumers' consent, family members or other persons of the consumers' choosing should be actively engaged to act as "**treatment advocates**" for consumers of mental health or addictions services who are unable to participate in these decisions themselves because of their illness. This decision should be left to the consumer unless state law or court orders require otherwise.

☑ **Passive acceptance** of treatment does **not** mean that the consumer has granted informed consent. The consumer may be accepting unwanted treatment because he/she is intimidated or frightened.

☑ The provision of information about treatment must be an **ongoing process** through continued dialogue between the consumer and the provider. Be aware that the consumer's circumstances at the time the information is first provided may affect his or her ability to fully understand that information.

   Peer support groups can facilitate this ongoing communication process.

☑ Even when there is a court order requiring a particular kind of treatment, the consumer must be consulted. Also, consumers should be provided with full, clear, and understandable information about their rights and about when involuntary treatment may be necessary.

▶ *Psychiatric Advance Directives*

Traditionally, advance directives have been used primarily for "end of life decisions." In recent years, however, advance directives have been recognized as potentially helpful in empowering individuals suffering from mental illnesses to communicate treatment preferences in advance of periods of incapacity. Consumers in many states are now beginning to utilize psychiatric advance directives (PADs) as a means of informed consent that prescribes a course of treatment in the event that they become incapable of making treatment decisions for themselves in an emergency or crisis situation. The presence of a psychiatric advance directive will, in some instances, reduce the need for crisis services providers to pursue involuntary treatment or commitment actions to the extent that the PAD covers the particular situation. The information that follows regarding PADs was adapted from research by the National Alliance for the Mentally Ill (NAMI).

There are two types of advance directives:

(1) "**Instruction directives**," such as living wills, provide specific information about the treatment-related wishes of the individual consumers drafting them should they lose capacity to make decisions on their own.
(2) "**Proxy directives**" assign "health proxies" or "health care powers of attorney" to individuals who have been entrusted to act as substitute decision-makers should a consumer lose the capacity to make his or her own decisions.

Frequently, advance directives combine **both** of these forms, blending specific instructions about healthcare preferences with identification of individuals assigned as "health proxies."

Supporters of PADs view these instruments as potentially helpful for at least four reasons:

(1) PADs can **empower consumers** to assume control over treatment decisions.
(2) PADs can **enhance communication** about treatment preferences between consumers, their families, and treatment providers.
(3) PADs may facilitate appropriate and **timely treatment interventions** before situations deteriorate to emergency status.
(4) PADs may lead to **reductions in adversarial court proceedings** over involuntary psychiatric treatment.

Currently, **twelve states** have laws authorizing psychiatric advance directives. The first law was enacted in Minnesota in 1991 and then eleven more states followed suit (Alaska, Hawaii, Idaho, Illinois, Maine, North Carolina, Oklahoma, Oregon, South Dakota, Texas, and Utah). All of these laws establish the right of persons with mental illnesses to write directives, when competent, indicating their wishes concerning acceptance or refusal of psychiatric treatment. Some of these laws (e.g., Alaska and Oregon) apply only to written declarations concerning inpatient psychiatric

treatment, psychotropic medications, and electroconvulsive therapy (ECT), while others apply more generally to all forms of psychiatric treatment.

As evidenced by the limited number of states with PAD laws, the use of advance directives for psychiatric decision-making is still in its infancy. While advance directives have many proponents, there are also some who argue that PADs will be used as vehicles for avoiding psychiatric treatment altogether. Ongoing research projects and pending court decisions should provide more comprehensive information in the future. In the meantime, advance directives should be strongly considered as a way to empower consumers to take a more active role in their own treatment and as a way to avoid damaging, divisive conflicts over treatment and medication issues.

▶ *Training*

Training provides an opportunity for staff to function effectively and confidently in their respective roles and assures providers that a basic level of competency is achieved among staff. Ongoing training is essential to remain current in the treatment approaches that produce the best outcomes for consumers and minimize risk for staff. Crisis programs should develop policies that specify both training requirements and training opportunities.
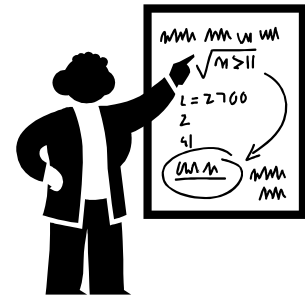
Typical training topics in crisis services may include, but are not limited to:

- CPR and First Aid;
- Techniques to Avoid Restraint and Seclusion;
- Infection Control;
- Fire Safety;
- Assessment and Interviewing Techniques;
- Cultural Competency;
- Clinical Record Management and Documentation;
- Staff Safety in the Community;
- Risk Management;
- Medications Management;
- Rehabilitation and Recovery;
- Crisis De-Escalation Techniques;
- Passive Restraint and De-Escalation Techniques;
- Substance Abuse and Co-Occurring Disorders;
- Involving Families in Treatment; and
- Brief Therapy Techniques.

Some training courses will be **mandatory** for all staff, while other courses may be geared specifically for **selected** professionals.

In addition to training mandated by crisis service system providers, licensed professionals may be required to actively participate in accredited **continuing education** conferences, workshops, or seminars as a condition of licensure. Each state's professional licensing boards govern the number, hours, and types of continuing education courses that must be maintained annually to continue licensure status.

▶ *Confidentiality and Exchange of Information*

The right of all consumers to confidentiality of health care information is an essential element of their right to privacy, a legal right that has been recognized by the U.S. Supreme Court, lower Federal and State courts, as well as Federal and State legislatures.

Confidentiality is an important part of the **recovery** process. A consumer's concern that his or her behavioral health condition or treatment may be revealed to parties other than the provider may compromise their progress. The assurance that their health information will remain confidential can be critical to a consumer's effective diagnosis, treatment, and healing. Without such assurance, the consumer is less likely to:

- Seek treatment;
- Share information necessary for the provider to treat him or her appropriately; and
- Comply with treatment requirements.

While the need for confidentiality is not unique to consumers of mental health or addictions services, these consumers and their families are **especially vulnerable** to being stigmatized by information that may be disclosed when they seek treatment. The disclosure of mental health or addictions treatment may unfairly jeopardize a consumer's job, housing, or reputation and can result in discrimination. Likewise, disclosure of treatment to a consumer's family can cause conflict among family members. For consumers receiving behavioral health services, there must be a heightened level of concern and protection of the right to confidentiality. It is important that providers share only the types of information necessary to administer benefits and coordinate care.

On November 3, 1999, the U.S. Department of Health and Human Services published proposed regulations to protect privacy of medical records pursuant to a requirement of the **Health Insurance Portability and Accountability Act** (HIPAA) of 1996. These rules were finalized and published in December 2000. Although statutory authority only allows application to information entered into a computer or transmitted electronically, not information kept only in a paper record, the privacy rules nonetheless contain important protections for health care confidentiality.

HIPAA PRIVACY REGULATIONS

The HIPAA Privacy Rule provides the following protections:

☑ For purposes other than "treatment, payment, and health care operations," the consumer must **provide consent** before information can be shared.

☑ **Psychotherapy notes** cannot be shared without the consumer's authorization, and health plans cannot condition treatment or payment on access to such notes.

☑ Consumers of mental health services will have **access to their own records** on the same grounds as others. Access can be denied when a licensed health care professional determines that release of the information is likely to endanger the life or physical safety of the consumer or another person. Also, under limited circumstances, consumers have the right to amend their records.

☑ Consumers have a right to receive a **written notice** from health plans and providers of how they use health information and have a right to an accounting of instances when protected information about the consumer has been disclosed for purposes other than treatment, payment, or health care operations.

☑ Entities covered by these rules must have in place administrative systems that enable them to protect health information; must designate a **privacy official** responsible for privacy policies and for ensuring that they are followed; must train their workforce on the entity's privacy policies and procedures; and must establish sanctions for violation of privacy rules.

▶ *Grievances and Complaints*

Fair and efficient complaints and appeals procedures ensure that consumers' rights are protected and enforced by:

- Educating and informing consumers about benefits and services, as well as their general rights and responsibilities;
- Providing valuable counsel, advice, and assistance in connection with the resolution of consumer problems;
- Monitoring and promoting provider accountability and responsiveness; and
- Collecting and analyzing data, thereby serving as a catalyst for systemic change.

The goals of a complaints and appeals process are generally:
- To help consumers obtain appropriate services at appropriate times, thereby increasing the chances of positive behavioral health outcomes.
- To help consumers communicate with providers by providing information regarding effectiveness of treatment and consumer needs.

- To maintain the individual dignity of consumers and the integrity of the service operations of providers through consumer empowerment.

External consumer assistance programs represent an important component of a complaints-and-appeals process. Such programs include:

- Ombudsman programs;
- Consumer quality assurance teams;
- Consumer satisfaction teams;
- Citizen monitoring teams;
- Coalitions of consumer-based organizations;
- Information, counseling, and assistance programs;
- Federally funded protection and advocacy agencies; and
- Other advocacy programs, including independent peer advocacy.

These programs serve as a source of information for consumers and provide valuable assistance with the resolution of consumer problems, although they are not a replacement for the grievance and appeals process.

OMBUDSMAN PROGRAMS

An ombudsman is: *An individual appointed to receive, investigate, report on and (in some instances) resolve complaints against institutions*.

Ombudsman programs are, or should be, impartial and independent programs that advocate on behalf of consumers even if funded by the local mental health authority. These programs are important safeguards of access to and quality of health care, as well as instruments for systemic improvements. By collecting and analyzing data regarding consumer problems and the strengths and weaknesses of individual plans or providers in resolving such problems, ombudsman programs offer an indication of provider performance and consumer usage. By sharing this information with providers, purchasers, regulators, policymakers, and other stakeholders, ombudsman programs help identify and correct systemic problems.

▶ *Continuity and Coordination of Care*

Continuity of care procedures focus on interactions between community-based service providers and the crisis service system provider as they share responsibilities for pre-admission, discharge, and follow-up activities. The policies and procedures for continuity of care should outline the basic operational roles, responsibilities, and expectations of community providers. Crisis service systems should also have policies and procedures in place to ensure that individuals who require services and supports upon discharge to the community are connected to a provider who can provide the necessary treatment beyond the crisis episode.

▶ *Seclusion and Restraint*
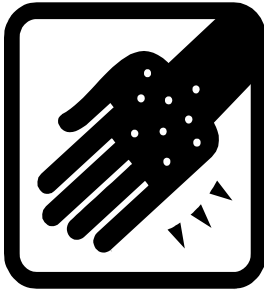
All crisis service systems should adopt and implement specific standards concerning the safe use of seclusion and restraint practices. The dignity and privacy of restrained and/or secluded consumers should be preserved and re-traumatization should be avoided to the greatest extent possible during the use of these interventions. Most importantly, restraint and seclusion should be the interventions of **last resort**.

The following are **foundational, pre-requisite standards** developed by the National Association of State Mental Health Program Directors (NASMHPD) that should be addressed in mental health providers' policies and procedures:

☑ Restraint and seclusion should **never** be used:
- As a threat of punishment;
- In lieu of adequate staffing;
- As a technique for behavior management or control;
- As a replacement for active treatment or as part of a treatment plan; or
- As a convenience.

☑ Seclusion and restraint orders should always be **time-limited**, and should be removed as soon as it becomes safe to do so, even if the time-limited order has not expired. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards should be adopted and viewed as a minimum guideline in this area.

☑ Consumers being restrained or secluded should always be **verbally informed** about what is happening during the restraint period. Information should include what events or behaviors precipitated the use of restraint or seclusion, and when and under what circumstances they can expect to be released.

☑ The following should not be used under any circumstances:
- Face down restraint with back pressure;
- Any technique that obstructs the airways or impairs breathing;
- Any technique that obstructs vision; or
- Any technique that restricts the recipient's ability to communicate.

☑ **Vital signs** should be checked initially and regularly thereafter (every fifteen minutes at a minimum, if abnormal).

☑ Only accepted, **professionally recognized restraint devices** should be used under any circumstances.

☑ No form of restraint that places the individual in a lying down position should be done in a public place. **Privacy and respect** for the individual should be paramount when implementing seclusion and restraint.

☑ The following should be **prohibited** under all circumstances:
- Consumer protocols (i.e., orders that trigger seclusion or restraint without an individual assessment of need).
- Policies automatically assigning consumers in crisis service locations or emergency room settings to seclusion or restraint.
- "Automatic revocation" of release. Any instance of seclusion or restraint ordered subsequent to a prior incident should require a new evaluation and order.

☑ Individuals who have been secluded or restrained and staff who have participated in these interventions should participate in **debriefings**, both separately and together, after every incident of seclusion or restraint. Gender concerns should be addressed as part of the debriefing. These debriefings may pose administrative or other challenges but are critical to maintaining a culture of respect and reducing the future need for seclusion or restraint.

☑ Only staff who have been adequately **trained** should ever be involved in the use of seclusion or restraint procedures.

☑ **Oversight** of seclusion and restraint should be an integral part of the organization's ongoing quality improvement process. This process should include:
- Baseline measures for comparison;
- The sharing of data and analyses of seclusion and restraint rates with external stakeholders as well as clinical and administrative leadership;
- Tracking of all serious injuries and deaths that occur during seclusion and restraint;
- A mechanism to identify and respond to trends that emerge in the data; and
- The involvement of service recipients as quality improvement monitors, peer supports, and trainers.

In addition to the NASMHPD standards, CMS released in 2001 the interim final rule 66 Fed. Reg. 714, which applies to children and adolescents under the age of 21 who receive inpatient services under Medicaid in "psychiatric residential treatment facilities." The rule provides these consumers freedom from restraints or involuntary seclusions utilized for coercion, discipline, retaliation, or convenience.

Any organization using any form of seclusion or restraint should have an established **internal review process** and should carefully review every occurrence of seclusion or restraint. In order to ensure that the oversight process has credibility, the organization should be open to some form of independent, external review process, in

addition to JCAHO, state licensing, and other quasi-independent review entities. The external review entity should have access to aggregate data and incident reports and should also have the authority to do an independent review of any death or serious injury occurring during restraint or seclusion.

A review of the literature identified many **factors that contribute to a safe environment** in which the use of seclusion and restraint can be minimized in crisis service settings. These factors include:

- ✓ Employing a public health model that stresses prevention and early intervention.
- ✓ Sensitizing staff to the power differential that exists between themselves and the people they serve in order to prevent the misuse of power. Experiential training that involves consumers can be particularly useful in this regard.
- ✓ Implementing individualized treatment plans that are mutually determined by consumers and staff and that effectively emphasize the consumer's assessment of what works and what doesn't.
- ✓ Using clearly defined clinical interventions.
- ✓ Making sure that multiple treatment options are available at all times.
- ✓ Involving families and others (with permission of the consumer) who have helpful information about what has and has not worked in the past.
- ✓ Teaching skills of self-monitoring and self-control as part of the rehabilitation/recovery process.
- ✓ Ensuring that both staff and consumers have access to mechanisms for resolving disputes without resorting to force.
- ✓ Creating a physical environment that minimizes the over-stimulating conditions that may lead to conflict or agitation, particularly (but not exclusively) for elderly individuals.
- ✓ Developing a clinical paradigm that addresses past trauma as part of the clinical picture.
- ✓ Considering the use of seclusion or restraint as a reflection of a failure to intervene earlier and aiming for a goal as close to "zero use" as possible.
- ✓ Ensuring adequate ongoing staff training specific to the situation and patients being served.

Similarly, many factors were identified that contribute to an **environment in which safety concerns are likely to emerge**, and in which seclusion and restraint are likely to be misused. These factors include:

- ✗ Lack of adequate attention to safety issues and risk factors at intake. Most episodes of seclusion and restraint occur within the first few hours or days after admission.
- ✗ Lack of an organizational culture of respect.
- ✗ Not believing what consumers say; labeling consumers as "manipulative."
- ✗ Lack of adequate attention to language accessibility and cultural uniqueness (e.g., race, gender, sexual orientation, trauma history).

- � Inadequate staffing in quantity, training, or both. Inexperienced staff are assaulted more frequently; short staffing and the use of temporary staff also increase the likelihood of violence.
- ✖ The assumption that "compliance" is important for recovery.
- ✖ A culture that permits the misuse or display of power, even in "small" ways, such as using threats to intimidate consumers.
- ✖ The assumption that "structure" and/or rules for behavior are in and of themselves therapeutic, or that they are the only mechanisms for maintaining a therapeutic milieu.
- ✖ Responding to violence with violence.
- ✖ Inadequate monitoring and debriefing; a culture of secrecy.
- ✖ A culture in which direct care staff feel disrespected and "pass on" that disrespect to service recipients.

▶ *Level of Care Criteria*
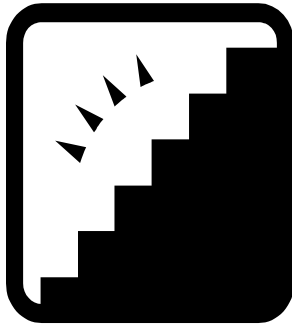
Crisis service systems must establish policies concerning level of care criteria for access to the spectrum of crisis services provided. Level of care criteria establish a systematic process for crisis service providers in identifying what symptoms, behaviors, or functioning an individual must exhibit to warrant access to a particular service. Effective utilization of services through level of care criteria would avoid assignment of consumers into high intensity services when lower intensity services would be equally effective.

Level of care criteria contains **three essential components**:

    (1) Admission criteria;
    (2) Criteria and timeframes for continued stay within an assigned service; and
    (3) Criteria for discharge from an assigned level of care.

The use of level of care criteria will provide the following **benefits**:

- Assurance of clear, consistent and predictable access to crisis services;
- A mechanism to aid the crisis system in identifying current and future service needs of consumers that may fall outside of or in between the existing service continuum;
- A method for overall management of service utilization by individual consumers and by the system as a whole; and
- An objective means to assure that consumers are likely to receive no more and no less than they need.

The effective implementation of level of care criteria will have residual resource management benefits. **Resource management**, in combination with utilization

management, ensures that resources are fully used and are expanded or contracted as needed to serve the population(s) for which the crisis system is responsible. Case managers, utilization reviewers, and providers all use resource management information, such as service capacity and availability, to make sure that people who need services of a certain type are not "stuck" in another type while waiting for the more appropriate service to become available. The level of care criteria is an accepted and recognized means to ensure that consumers will not linger in the crisis system without focused and effective treatment reviews to remedy the presenting crisis.

Included in the appendices of this document are examples of level of care admission criteria for crisis services from several of the crisis service models featured in this report.

▶ *Medications*

Crisis service systems must develop policies and procedures governing the voluntary and involuntary use of psychotropic medications. These policies and procedures typically include:

- Protocols for physicians' written and verbal orders for psychotropic medications in appropriate dosages;
- Requirements that verbal orders be entered in the clinical record within a specified timeframe;
- The length of time voluntary and involuntary medications may be ordered and administered before re-evaluation by a physician;
- The provision that consumers who are on psychotropic medications prescribed in the community are continued on their medications pending re-evaluation and further determination by a physician;
- The provision that the necessity for continuation on psychotropic medications is addressed in discharge planning and prior to transfer/referral to another service provider or program; and
- The provision for regular clinical and administrative review of utilization patterns for all psychotropic medications, including every crisis situation.

In general, medication protocols will minimally assure that:

- Consumers should be informed of the expected benefits, potential side effects, and alternatives to psychotropic medications.
- Absent an emergency, consumers may refuse treatment.

Consumers found by a clinician to be a danger to themselves or others by reason of a mental disorder may be **involuntarily** given the psychotropic medication immediately necessary for the preservation of life or the prevention of serious bodily harm when

there is insufficient time to obtain consent from the court or parent/guardian (in the case of a minor) before the threatened harm would occur. It is not necessary for harm to take place or become unavoidable prior to initiating treatment. Psychotropic medication in a crisis service system, as in other settings, should never be used as a disciplinary intervention or chemical restraint.

Finally, the state in which crisis services are provided will have specific statutes and regulations that govern both voluntary and involuntary consumers who refuse treatment and specifically medication. Therefore, crisis service providers should refer to the prevailing case law in their states for guidance in developing policies and protocols concerning medication.

▶ *Medical Clearance*

Many consumers with psychiatric or emotional disorders also have significant medical problems that contribute to their psychiatric conditions. The purpose of a medical clearance is to identify specific health needs and medical conditions that may require specialty management, follow-up, or monitoring to eliminate underlying medical conditions as a cause of the consumers' psychiatric symptoms.[32]
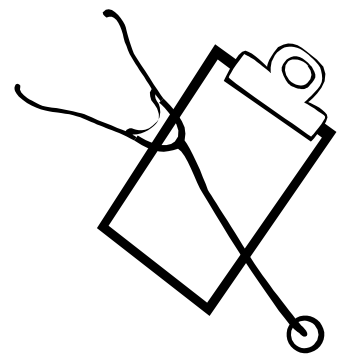
Policies concerning medical clearance should address:

- Transportation/transfer issues (to a hospital emergency room, an urgent care center, or a community provider);
- Arrangement with medical providers to issue the medical clearance; and
- Protocols and screening tools to determine if a medical clearance is necessary.

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[32] University of California San Francisco. (2000). *Policy on Medical Clearance of Psychiatric Patients in the ED*.

Chapter Ten: Data Collection

Integrated clinical, financial, and management data systems are vital to a crisis service system. Communities that develop crisis services but neglect to invest in data collection systems do so at risk to the quality and effectiveness of the services, as well as to proper accountability for the investment of resources. On the other hand, crisis services providers should resist the urge to gather data that has no value, cannot be interpreted, or will not be shared with key stakeholders.

For the purposes of this section, it is important that we distinguish between data and information. "**Data**" generally refers to numerical information or codes that can be processed by computers and statistical tools. "**Information**" is the meaning drawn out of that data through interpretation and comparison with other data by the end users, such as managers and stakeholders.

> The rule of thumb concerning the use of data in the operation of a crisis service delivery system is: "**You can't manage what you can't measure.**"

There are two central objectives related to data and information management within a comprehensive crisis system:

(1) To use the best service modalities available; and
(2) To keep improving upon the services provided.

Restated in today's behavioral healthcare terminology, these two objectives would be:

(1) To implement best-practice models; and
(2) To strive for continuous quality improvement.

In developing a data collection system, it is essential to consider the identities of the **key stakeholders** (e.g., funders, advocates, legislators, board members) and their information needs, as well as how data can be transformed into useful, accessible information for the purpose of dissemination.

The principal stakeholders of any crisis service system are the **consumers**. Consumers may be interested in assurances that access to mental health care is efficient, timely, and operating in a fair and predictable manner. Once access has been initiated, consumers are then concerned with the quality of care they receive and the continuity of their care when moving between different service providers. Consumers, their families, and other caregivers are also particularly concerned that

any personally identifying information be held securely and that only individuals directly involved in providing care should have access to such information.

At the same time, any proposed system must satisfy the needs and interests of service **administrators, clinical managers and clinicians** if it is to be credible and useable.

In 1989 the U.S. Department of Health and Human Services argued that the questions asked by clinical managers and service administrators could be reduced to a basic set of five, very general questions, summarized succinctly as "Who receives what services from whom, at what cost, and with what effect?" These five questions define the core requirements of any information system.[33]

⮑ Question 1: Who Receives?

The answer to this question is best given in terms of the demographic factors of consumers that determine risk of illness and access to services, as well as the clinical profiles of those who have contact with the service. The critical demographic variables to consider include gender, age, ethnicity, place of birth, preferred language, place of residence, and employment status. The major clinical variables to consider include indicators of the nature of the problem, usually indicated by diagnosis, and a broad description of the type of care required. In addition, crisis systems must also be able to distinguish between new consumers and existing consumers.

⮑ Question 2: What Services?

Answers to this question should describe the pattern and frequency of use of various crisis services. This data has a number of potential uses, including:

(1) The evaluation of consumer care;
(2) The management of the service delivery system;
(3) The development of funding arrangements that promote, reflect, and encourage best clinical practices; and
(4) The assessment of the efficacy of specific interventions or procedures.

⮑ Question 3: From Whom?

Clinicians, clinical managers, and administrators may each have different individuals or groups in mind when they ask the question, "From whom have these services been

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[33] Leginski W., Croze C., Driggers J., Dumpman S., Geersten D., Kamis-Gould E., Namerow J., Patton R., Wilson N., & Wurster C. (1989). *Data Standards for Mental Health Decision Support Systems: A Report of the Task Force to Revise the Data Content and System Guidelines of the Mental Health Statistics Improvement Program*. National Institute of Mental Health, US Department of Health and Human Services, Washington.

received?" Clinicians generally want to know the personal identity of other clinicians involved in the consumer's care, while clinical managers and service administrators may be looking for answers to questions of a more general nature, such as those related to service volume, flow, and timeframes. Examples of such questions include:

- How many calls are received through the Crisis Phone Lines per day, from whom, and during what time of day?
- How many calls result in a face-to-face intervention or dispatch of the mobile crisis teams?
- What is the average amount of time spent by the mobile teams responding to calls for adults, versus children and adolescents?
- How many assessments result in diversion to which services?
- How many crisis encounters result in inpatient admissions?
- What is the number of new versus known consumers utilizing the services?
- What is the timeframe from referral to scheduled follow-up appointment?
- How are consumers unknown to the system referred for services and by whom?

➲ Question 4: At What Cost?

The usual measure of cost is the dollar value of the resources used. Human and capital costs may also be measured in terms of the actual utilization of resources by staff type, numbers, and time, as well as by administrative resources, residential days, etc. While the financial cost of services is of particular interest to administrators and managers, other kinds of costs such as staff turnover and burnout, paperwork, regulatory requirements, clinical record management, and medication errors, also figure prominently in the day-to-day management of cost.

➲ Question 5: With What Effect?

Clinical managers and service administrators must have access to information on the outcomes produced as a result of the services provided. While crisis system components have been developed in communities around the nation, more research and evaluation is needed to assess the overall effectiveness of the entire system, rather than its component parts. Examples of crisis system outcomes may include:

- Reduction in hospital days;
- Restoration of consumers to previous functional levels;
- Timely referral and access to post-crisis care;
- Reduction in the number of persons with mental illness jailed on non-violent misdemeanors;
- Consumer and family satisfaction; and
- Reduction in spending on inpatient care.

▶ *Minimum Data Set*

In addition to answering these five core questions, the crisis service should, at a minimum, have the capacity to capture the following data items about consumers:

- Gender
- Date of birth
- Ethnicity
- Country of birth
- Marital status
- Residence
- Medicare, Medicaid and/or other payer source
- Employment status
- Income
- Problem status
- Service date
- Discharge date
- Disposition
- Source of referral
- Referral to further care
- Total inpatient/residential days
- Time from referral to treatment
- Mental health legal status
- Principal diagnosis
- Primary care provider/case manager
- Eligibility for services
- Invoice and billing information
- Additional diagnoses
- Frequency of restraints
- Number, length and type of mobile and crisis phone contacts
- Cost by service
- The ability to identify frequent users of crisis services

Given that the repeated assessment of a consumer's clinical status is an integral component of clinical practice, the lack of routinely collected information about consumer outcomes may at first seem surprising. Yet evaluation of the effectiveness of interventions is only one of many often overlooked areas of information management. Although the issues of choosing what should be measured and finding suitable instruments have begun to be addressed in the larger behavioral health field, more attention is needed for crisis services specifically.

Chapter Eleven:
A Crisis Service System Assessment Checklist

The following checklist has been developed to assist future and current crisis service systems in assessing their ability to meet the needs of their communities. For communities planning a new crisis service system, this checklist should be used to consider the most essential elements in the planning and implementation processes. For those communities with existing crisis service systems, this checklist has a two-fold purpose:

(1) To pinpoint areas within each category where further development or improvement is needed or should be considered; and
(2) To validate that the system has the basic requirements in place to build a competent crisis service delivery.

The checklist includes **five key elements**:

(1) Planning;
(2) Coordination;
(3) Services;
(4) Staffing; and
(5) Financing.

The responses to the questions listed under each element establish a baseline against which crisis systems can measure improvement and progress. These standards do not represent an exhaustive list, but rather focus attention on those **common features** that are most critical to the effective operation of the crisis system. Planners may wish to include additional standards that are uniquely important within their communities.

> It should be the goal of each crisis service system provider to respond **affirmatively** to each standard. A negative response may indicate that plans to develop new or change existing procedures in order for the crisis system should be considered to achieve the standard.

Crisis Service System Checklist PLANNING	In Place Now?		If NO, what are the plans for development or change?
	YES 👍	NO 👎	
1. A broad spectrum of stakeholders has participated in the planning process for crisis services in the community.			
2. Stakeholders are involved in the ongoing policy direction of the crisis service system (i.e., board membership).			
3. The crisis service system seeks regular feedback from service users and stakeholders through a formalized process (i.e., surveys, etc).			
4. The community has identified service issues and problems that the crisis service system will resolve.			
5. The crisis service provider has the capacity to track and measure progress in achieving crisis service system goals.			
6. The crisis service system periodically contracts for the independent evaluation of the effectiveness of its system in achieving stated goals and objectives.			
7. The crisis service system provides periodic reports available to the public on its performance.			
8. The crisis service system reviews the feedback, and where appropriate, incorporates feedback to improve services.			
9. The purchaser of crisis services has or can identify a sufficient number of qualified providers in the community to deliver the service.			

Crisis Service System Checklist	In Place Now?		If NO, what are the plans for development or change?
COORDINATION	YES 👍	NO 👎	
1. There is a single agency that has broad authority and responsibility for coordinating all crisis service system components, thereby avoiding the bifurcation of authority.			
2. Written and working agreements with other providers (law enforcement, CMHCs, emergency rooms, homeless shelters, social service agencies) are in place.			
3. The single unit/agency responsible for coordinating crisis services has the authority to approve or deny hospital admissions.			
4. The crisis system has protocols for the development of crisis plans and joint interventions with a consumer's primary case manager.			
5. The crisis system holds regular meetings with stakeholders and providers to identify, review, assess, and resolve service and policy barriers across the system.			
6. The crisis system is designated by the LMHA as the central point of access to inpatient services for publicly funded service recipients.			
7. The crisis system provides training to its service partners (law enforcement, substance abuse providers, schools, social service agencies, emergency rooms) on mental illness and how and when to use crisis services.			

Crisis Service System Checklist SERVICES	In Place Now?		If NO, what are the plans for development or change?
	YES 👍	NO 👎	
1. The crisis system has a 24/7-telephone response.			
2. The crisis system has the capacity for face-to-face assessment within one hour of dispatch.			
3. The crisis system provides access to urgent care crisis intervention and stabilization services up to 12 hours per day.			
4. The crisis system provides 24/7 mobile capacity to support police, emergency rooms, homeless shelters, jails, schools, etc.			
5. The crisis system provides 24/7 mobile capacity to children, adolescents and adults.			
6. The crisis system has a range of crisis residential (in-home and out-of-home) or respite resources as hospitalization diversion options.			
7. The crisis system has linkages with primary care and medical clearance.			
8. The crisis system has the capacity to serve consumers presenting with substance abuse conditions.			
9. The crisis system has the capacity to serve involuntary consumers in a non-hospital-based setting.			
10. The crisis system has established access, clinical, community, outcome, and performance standards for each service component.			
11. The crisis systems' role as the "front/back-door" and/or manager of access to crisis services is clearly defined.			

Crisis Service System Checklist STAFFING	In Place Now?		If NO, what are the plans for development or change?
	YES 👍	NO 👎	
1. The crisis service system promotes the incorporation of current or former consumers in service delivery.			
2. The crisis service system has highly trained and clinically qualified professionals to staff the service components.			
3. The crisis system has culturally and linguistically competent staff.			
4. The crisis system has access to translators and ASL services.			

Crisis Service System Checklist FINANCING	In Place Now?		If NO, what are the plans for development or change?
	YES 👍	NO 👎	
1. The crisis service system has identified a potential payer source for users of the system within the target population.			
2. The crisis system has assessed the volume and utilization potential of service components that are financed utilizing a fee-for-service reimbursement method exclusively.			
3. The crisis system has assessed its cost structure in comparison to established rates.			
4. The crisis system components that will be financed through grant-based funding have developed an operating budget that can be supported for at least three years with no anticipated increases in the original grant amount.			
5. The crisis system has explored opportunities to market its services to payers beyond the originally designated target population.			
6. The cost of each crisis episode does not exceed to cost of the most restrictive form of care in the community.			

Chapter Twelve: Crisis Service Models

According to a 1993 survey of crisis service systems conducted by the Center for Mental Health Services,[34] the majority of crisis service systems operate in a mixed geographical community (an urban population center with rural or suburban outlying areas). This section of the report will highlight three models of crisis service delivery. Two of the models operate in mixed geographical communities, while the third operates in a rural area. These crisis response service models were selected based upon the criteria that they:

- Represent the range of different organizational, payment, and financing strategies as presented in this report;
- Incorporate the basic components of a comprehensive crisis system tailored to meet community needs;
- Embody the goals, purpose, and operational features of a comprehensive crisis response system;
- Are viewed as an important resource in the communities they serve;
- Have experienced leaders who are available to serve as expert consultants to others who are developing new crisis systems or improving existing ones;
- Possess one or more features that have achieved service excellence; and
- Actively involve community stakeholders in the planning, development, design, ongoing evaluation, and/or governance of their systems.

Two of the models (*Baltimore Crisis Response Inc.*, and *Washington County Mental Health System, Inc.*) provide services within a Medicaid mental health managed care waiver for behavioral health services; the third, *NetCare ACCESS*, does not currently provide mental health services under any mental health waiver arrangement. Because each model was designed to meet the specific needs of its local community, some of the models will have special features, processes, and procedures that are unique.

For each of the models, additional information about service components and staffing patterns can be found in the Tables in **Appendix I**, along with a consolidated grid comparing certain key features across all three models.

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[34] Stroul, B.A. (1993).

NetCare ACCESS

Franklin County

Columbus, Ohio
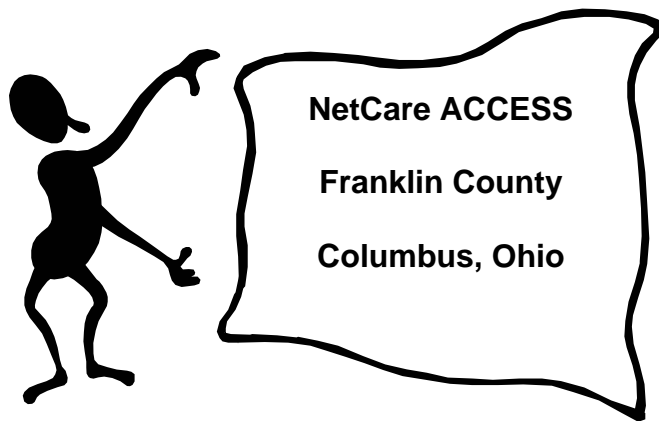
NetCare ACCESS provides both mental health and addictions services to adults, children, adolescents, and families. NetCare may be one of the most comprehensive crisis response systems operating in the nation, as defined by the scope and content of its service array, the number of special populations served, and the high degree of collaboration it has achieved with other critical partners in its system. What sets NetCare ACCESS apart from most crisis systems is that it has developed a range of specialized services designed for populations, such as:

- Homeless individuals;
- Persons in court custody;
- Children and families in the child welfare systems;
- The forensic population; and
- The elderly.

While it is not unusual for these services to be present in the larger behavioral health care system, it is unique that such a range of services are made available through a centralized crisis service system.

For nearly 30 years, the NetCare Corporation has been a major provider of mental health, alcohol, and drug-related services to Central Ohio communities. After more than five years of community planning with the Franklin County Alcohol, Drug Addiction, and Mental Health (ADAMH) Board, NetCare launched the NetCare ACCESS program in 1996, aiming to become Franklin County's primary provider of crisis intervention and assessment services. The Franklin County ADAMH Board's decision to develop this crisis capacity grew out of a "perceived dissatisfaction by consumers with the decentralized system and confusion as to how and where to access services when needed."[35] NetCare ACCESS has the designated authority, granted by the Franklin County ADAMH Board, both to manage and access services for persons in crisis.

NetCare ACCESS is a private **non-profit 501(c)(3)** organization that is designed to serve as the primary point of entry for the entire county's public mental health and addictions service system. The Franklin County ADAMH Board is the authority responsible for planning, funding, monitoring, and evaluating the local behavioral

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[35] ADAMH Board of Franklin County. (2001). *A comprehensive review of "front door services," 1996-2001.*

health system of care. The county then contracts with NetCare ACCESS for the provision of crisis intervention and assessment services.

One of the many goals of the NetCare ACCESS system is to reduce and/or eliminate unnecessary inpatient hospitalization to the state-operated psychiatric facility in Franklin County. To that end, NetCare ACCESS is the designated "**gatekeeper**" for all potential inpatient admissions, and approximately 99 percent of all admissions from Franklin County are processed through NetCare ACCESS.

The heart of the NetCare ACCESS system is its **Emergency Response System** (ERS), home to the **telephonic triage intake process**. Individuals calling for services will reach a trained, caring, and clinically and culturally competent professional who determines the caller's needs and recommends the most appropriate way to assist him or her. NetCare ACCESS' ERS does not operate a Warm Line; however, a Warm Line is operated by and available to the community through another community provider. An illustration of the relationship between ERS and some of the other components of the crisis service system design is highlighted below:

NetCare Access Crisis Intervention and Assessment Services
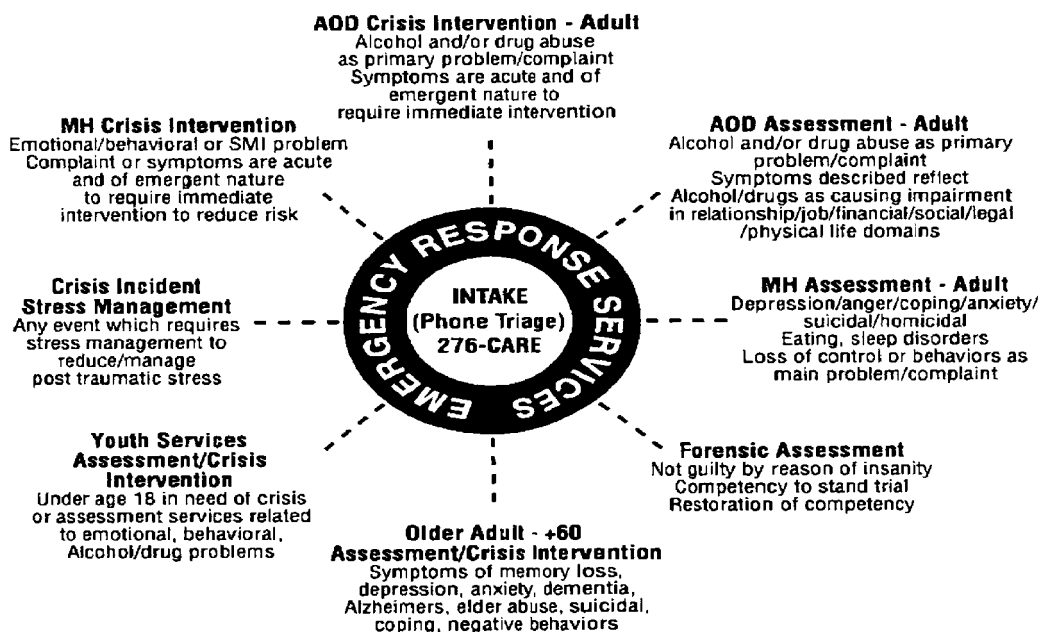
NetCare ACCESS' services are organized into **three general categories**:

(1) Crisis Intervention and Assessment Services, including the ERS telephonic triage intake process;

(2) Emergency Response Services; and

(3) Residential Services.[36]

(1) Crisis Intervention and Assessment Services include the following:

⊠ **Crisis Intervention Service (CIS)** – Similar to an emergency room for individuals in need of behavioral health care crisis services, CIS is open 24 hours a day, 7 days a week. Individuals can walk in or be brought in to one of two sites by the mobile crisis team or by police and receive crisis intervention and assessment services, such as nursing assessments, physicians' evaluations, crisis stabilization, community linkage, referral, hospitalization, and probate pre-screening.

⊠ **Youth Alcohol and/or Drug (AOD) Assessments** – Trained clinicians identify substance abuse issues and prioritize treatment needs for youth under 18 years of age and their families, then refer the youth to a treatment provider specializing in children and adolescents.

⊠ **Youth Mental Health (MH) Services** – For children and youth under 18 years of age who are experiencing mental health problems, NetCare dispatches a team of trained clinicians into the community to provide crisis and assessment services 24 hours a day, 7 days a week. Clinicians are also working at the Franklin County Children's Services Intake Department to provide mental health and alcohol or drug addiction services for children, family members, and other adult caregivers.

⊠ **Adult Alcohol and/or Drug (AOD) Assessments** – AOD assessments are provided as a walk-in service 8:30-3:30, Monday through Friday. AOD staff evaluate the severity of substance use and abuse, prioritize treatment needs, and refer persons to the most appropriate treatment provider. Women who are pregnant, persons with HIV, and intravenous drug users are priorities for care and services.

⊠ **Adult Mental Health (MH) Assessments** – These assessments are performed at the two central NetCare sites by independently licensed clinicians. Assessments are available to adults 18-60 years of age on a walk-in basis, 8:30-3:30, Monday through Friday.

⊠ **Older Adult Services** – MH and AOD crisis and assessment services for persons 60 years of age and older are conducted in the community 24 hours a day, 7 days a week by clinicians experienced in working with older adults.

⊠ **NetCare Forensic Psychiatry Center** – This assessment program is certified by the Ohio Department of Mental Health to provide comprehensive diagnostic evaluations, including those designed to look at competency to stand trial, criminal responsibility, drug treatment in lieu of conviction, and competency to waive Miranda rights. This program provides evaluations for the Common Pleas, General (criminal) Division for an eight county area.

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[36] Bostick, M.R. (2000). *Front door to care: Managing the maze*. Franklin County Access Model.

☒ **Court Assessments** – The Franklin County Municipal Court, the Court of Common Pleas, and the Juvenile Detention Center (JDC) refer persons for assessments to determine the extent to which mental health and/or addictions issues were a factor in the crime or should be considered in treatment, sentencing, or parole. Clinicians work on-site in jails and detention facilities to provide crisis intervention and work closely with probation officers, judges, magistrates, and the child welfare system.

(2) Emergency Response Services include the following:

☒ **Community Crisis Response (CCR)** – Specially trained mental health clinicians work with police, fire departments, and the Red Cross to provide on-site mental health support in emergency and traumatic situations, such as homicides, the traumatic death of a child, bomb threats, natural disasters, and hostage situations.

☒ **Critical Incident Stress Management (CISM)** – CISM assists emergency personnel, victims, or witnesses of trauma to deal with the aftermath of a traumatic event. As an extension of CCR, CISM provides structured group interventions, debriefings, consultations, and one-on-one interventions to aid individual recovery.

☒ **Reach Out** – Reach Out is a mobile intervention service designed to protect the health and safety of publicly intoxicated individuals. The Reach Out vans operate 24 hours a day, 7 days a week to help intoxicated individuals off the streets and into safe shelters. The program also collaborates with AOD and MH providers, homeless shelters, the Veteran's Administration, and community hospitals.

(3) Residential Services include the following:

☒ **Crisis Stabilization Unit (CSU)** – CSU is an eight bed voluntary residential setting that provides assistance for adults experiencing a moderate to high behavioral health care crises to achieve stabilization. Persons who are not in need of hospitalization may stay for up to seven days to receive services and supports before returning safely to the community.

☒ **Miles House** – Miles House is a 16-day program in a community crisis/respite facility designed to meet the needs of up to eight individuals. Miles serves as an alternative to hospitalization for adults who are in need of treatment while stabilizing from a crisis.

☒ **The Buckeye Ranch** – The Ranch offers crisis respite for children and adolescents, ages 6-17, and its primary objective is to divert hospital admissions. NetCare and its Intensive Treatment Team manage and approve admissions and discharges to the Ranch, which has two beds for adolescents and three beds for children. To assure appropriate utilization of services, daily staffing and continued stay reviews

are required. While NetCare ACCESS manages this service, the ADAMH Board contracts with the Buckeye Ranch and has delegated authority to NetCare to manage the resource. The maximum length of stay is seven days, but the average length of stay is less than two days.

☒ **Huckleberry House** - Huckleberry House offers emergency shelter for runaway and homeless youth ages 12-17. This 16-bed crisis center also offers brief respite for teens who do not feel able to remain at home. Huckleberry House is an unlocked facility; teens may leave the property, make and receive phone calls, and have visitors. Huckleberry House will not stop teens who choose to leave, although they will notify the parent and/or referral agency. Length of stay is one to seven days. NetCare ACCESS does not have a contractual relationship with Huckleberry House, but refers adolescents to the service when deemed necessary.

☒ **Rosemont Center** – The Rosemont Center provides unlocked residential services for children and adolescents through a contract with Franklin County Children's Services. Rosemont provides brief respite stays for boys and girls ages 6-12 and girls ages 13-17 on the residential unit. Although NetCare does not mange or control access to Rosemont's services, it has an informal agreement to pay for the respite with the use of limited discretionary funds. The maximum length of stay at Rosemont is seven days, but the average length of stay is less than two days.

☒ **St. Vincent Family Centers** - St. Vincent is an unlocked residential treatment program offering crisis respite for children ages 6-12. St. Vincent bills the ADAMH board directly when this service is used for NetCare ACCESS consumers who have been referred there for services. The maximum length of stay is seven days; however, the average length of stay is less than two days.

Figure 1: A diagram of how consumers flow through the service system

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CLIENT/CUSTOMER FLOW

                              Intake
                    • Phone/in person contact
                    • Engagement by clinician,
                      goal = face to face contact

   Contact Access          yes      Customer presents          Data System Info
 • Provide safe environment  ←──      in crisis          ──→
 • Stabilize                                    │
   (involve physician                           │ no
   if necessary)                                ▼

                         Consultation & Triage
                    Clinician and support staff gather data:
                    • demographics
                    • financial & clinical resources available
                    • psychiatric/chemical dependency
                    • brief clinical history & brief assessment
                    • review & involve physician if necessary
                    • recommendation of level & type of treatment
                      (if SMD, must contact lead agency for treat-
                      ment decision)

   Access Assessment      yes        SMD/SED/AOD        no
 • bio/psycho/social      ←──                          ──→
 • NSG
 • MD                                              Closure
 • AT (interdisc & comprehensive)          • Treatment placement
                                           • Interface with referral
                                           • Follow up/outcome

         [ ]  = Process

         ◯   = Decision
```

In the past, NetCare ACCESS served consumers in the Temporary Assistance for Needy Families (TANF) program. However this service was discontinued as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, popularly known as "welfare reform," which dramatically lowered the number of families receiving assistance. In addition, NetCare ACCESS recently relinquished direct operation of its Deaf Community Treatment Team (DCTT), which is operated by another community provider.

Developing a comprehensive crisis service system is a major investment. In FY 2001, NetCare's total **budget** was $12,744,582.

NetCare tracks **sixteen indicators** as measures of its effectiveness, including: client satisfaction, provider satisfaction, Medicaid compliance, timely linkage to treatment, and cost per consumer served. The status of NetCare ACCESS as a leader in the provision of crisis services was recently affirmed in a July 2001 independent evaluation of their crisis services by their primary funder, the Franklin County ADAMH Board. Excerpts from the review's questions and answers can be found in Appendix H.

▶ *The Future of NetCare ACCESS*

Both civil and criminal liability for providers is higher than ever. Litigation has successfully been brought against NetCare for "false imprisonment," related to a clinical decision to restrain an individual. Litigation is also pending based on

allegations of a situation in which NetCare should have, but did not, restrain an individual.

NetCare ACCESS, which is currently certified and licensed to provide crisis services by the Ohio State Alcohol and Drug Addiction Services and the Mental Health Departments, plans to pursue accreditation from the Commission on the Accreditation of Rehabilitation Facilities (CARF) in the next two years. As in the past, NetCare ACCESS and the ADAMH Board will continue to work collaboratively with their community partners in order to reach optimal operational efficiency of the system.

Baltimore Mental Health System, Inc.

Baltimore County

Baltimore, Maryland
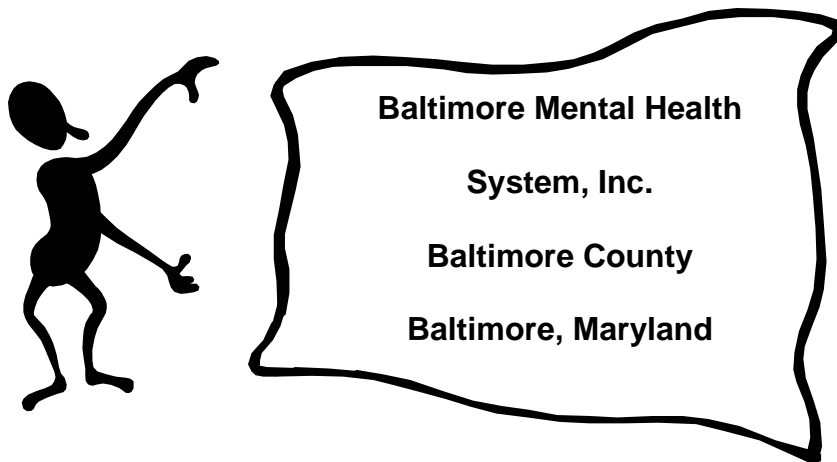
Baltimore Mental Health System (BMHS), Inc. has a unique beginning and role in the Baltimore service system.

In 1986, the Baltimore City Health Department (BCHD) received a five-year, $2.5 million grant from the Robert Wood Johnson Foundation (RWJ) Program on Chronic Mental Illness to create a local mental health authority. The grant established the **Baltimore Mental Health Systems, Inc.** (BMHS) as the local mental health authority for the city of Baltimore. BMHS is a 501(c)(3) public non-profit entity, which maintains accountability to local government. BMHS is the manager, funder, coordinator, and local authority for mental health services in the city of Baltimore but not a direct service provider.[37]

After two years of broad-based community planning efforts, BMHS established the **Baltimore Crisis Response, Inc.** (BCRI) in 1992 as a separate nonprofit entity to provide a range of crisis interventions to the adult citizens of the city of Baltimore. The establishment of BCRI was motivated by a number of factors, including:

- The lack of coordination and continuity between community mental health centers and emergency rooms;
- The long waiting time in emergency rooms before receiving an evaluation;
- The lack of a mobile crisis response in the community;
- The need for a single point of entry to the mental health system; and
- The need to have crisis workers who can respond quickly to crisis calls regardless of whether the consumer is known to the system.

BCRI, the city's first comprehensive crisis service, provides mobile crisis services, community-based crisis residential alternatives, and an information and referral hotline service. BCRI has become an essential part of Baltimore's mental health system.

While BCRI addresses the needs of the adult population, BMHS and the Maryland Public Mental Health System jointly fund and contract with the **Baltimore Child & Adolescent Response System** (B-CARS) to meet the psychiatric crisis needs of Baltimore city youth and their families. B-CARS, which has been in operation since May of 2001, is housed within the Department of Community Resources at Villa Maria Behavioral Health Clinic.

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[37] Retrieved from BMHS website: http://www.bmhsi.org/.

Services for adults are provided through BCRI; services for children and adolescents are provided through B-CARS.

(1) Services provided by or through BCRI:

⊠ **Information and Referral Crisis Hotline:**[38]   The hotline is available to the metropolitan Baltimore area 24 hours a day, 7 days a week, to provide crisis counseling, suicide prevention, and referral to community services. The hotline also operates as the gateway to the Mobile Crisis Team.

⊠ **Mobile Crisis Team (MCT):** The MCT can be dispatched throughout the city of Baltimore and includes a psychiatrist, nurse, mental health counselor, and case associates. The team operates from 8 am - 11 pm, responding to people in crisis in their homes, shelters, hospitals, and other community locations. The MCT assesses the person in crisis, initiates interventions (e.g., crisis counseling or medication), and makes linkages to mental health services and other community resources. In addition, a psychiatrist and mental health professional are available 24 hours a day, 7 days a week through the MCT.

⊠ **Crisis Residential Alternatives:**

◆ *In-Home Mental Health Counselors* – In the event that the consumer needs additional support, BCRI can provide in-home mental health counselors who stay in the person's home to assist in transporting the person to appointments, monitor medications, and provide emotional and behavioral support. This service can be provided for up to 48 hours around the clock or in increments totaling 48 hours (e.g. 8 hours daily for six days).

◆ *Crisis Residential Units (CRU)* – For consumers who do not have a supportive home environment, the CRU is a controlled, supervised residence located within the city of Baltimore. The goal of the CRU is to provide persons with the most appropriate treatment in the least restrictive setting possible. Services are provided to the person under a voluntary, mutually agreed upon contract, developed by BCRI staff and the person. Persons are admitted into the CRU through the BCRI Mobile Crisis Team. The CRU is in operation 24 hours a day, 7 days a week, and the average length of stay in the residential unit is five days. While in the CRU, BCRI staff work with the person (and when appropriate, the person's family or significant others) to identify the cause of the crisis, alleviate its effects, and begin the development of effective crisis management/resolution skills.

◆ *Detoxification Unit* – A 10-day detoxification program provides medical detoxification, residential crisis stabilization, and substance abuse treatment and

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[38] The BCRI Hotline is the single point of entry for both BCRI and B-CARS referrals. B-CARS contracts with BCRI for Hotline services.

education to individuals addicted to substances. As part of this comprehensive detoxification program, individuals are linked with ongoing community support services prior to discharge.

(2) Services provided by or through B-CARS:

☒ **Crisis Mobile Crisis Teams (CMCT):** The CMCT may intervene with a child, adolescent, and/or family, providing them with ongoing mental health treatment services throughout a two-week period or until linkage with a therapist in the community takes place. Based on the initial assessment, the CMCT decides whether the person can be maintained in his or her current situation with additional supports such as Enhanced Client Support or In-Home Intervention Services. In assessing the person's need for the various levels of services available, the CMCT considers the safety, appropriateness of care, monitoring, and follow-up needs of each consumer and family.

☒ **In-Home Intervention:** The primary role of the In-Home Intervention Specialist is to provide ongoing crisis management, conflict resolution, crisis planning, parent education, and behavior management intervention to stabilize the youth and his/her family. In-Home Specialists are assigned cases by the Team Coordinator and follow the timeline identified in the assessment. For example, if the youth needs hospitalization for one night, but requires In-Home Intervention the next day, the CMCT Coordinator will arrange for a specialist to be available the next day. If a Residential Crisis Bed is determined to be the appropriate diversion, the In-Home Specialist can assist in the transition home and help prepare for future incidents.

☒ **Enhanced Client Support (ECS):** ECS services provide short-term, intensive, one-on-one supervision and support to children and adolescents experiencing an increase in psychiatric symptoms. The goal is to provide these children with stabilization services in home, school, community, foster care, or group home settings and thereby prevent hospitalization. When a child or adolescent requires one-on-one supervision for a period of four or more hours, the In-Home Specialist or ECS staff will provide that service. ECS services may include the following:

- ♦ Behavior management and monitoring;
- ♦ Basic skills development;
- ♦ Maintaining the safety and stabilization of the child/adolescent in their home; and
- ♦ Assisting parents in learning and implementing behavior management skills taught through the psychiatric rehabilitation program.

☒ **Crisis Beds:** Residential Crisis Beds provide brief, intensive residential care for the purpose of preventing psychiatric hospitalization of youth and/or reducing the

length of hospitalization. Appropriately credentialed staff provide intensive care 24 hours daily. Three beds in the unit are available to children served by B-CARS.

⌧ **Families Involved Together (FIT):** B-CARS contracts with FIT, a family advocacy agency, to conduct and analyze consumer satisfaction surveys. The goal of the surveys is to evaluate the extent to which consumers, families, and referral sources are satisfied with the services provided by B-CARS and to identify improvement opportunities for the program. Information gathered and analyzed by FIT is reported to B-CARS' Quality Council and Advisory Board.

Figure 2: A diagram of how consumers flow through the service system
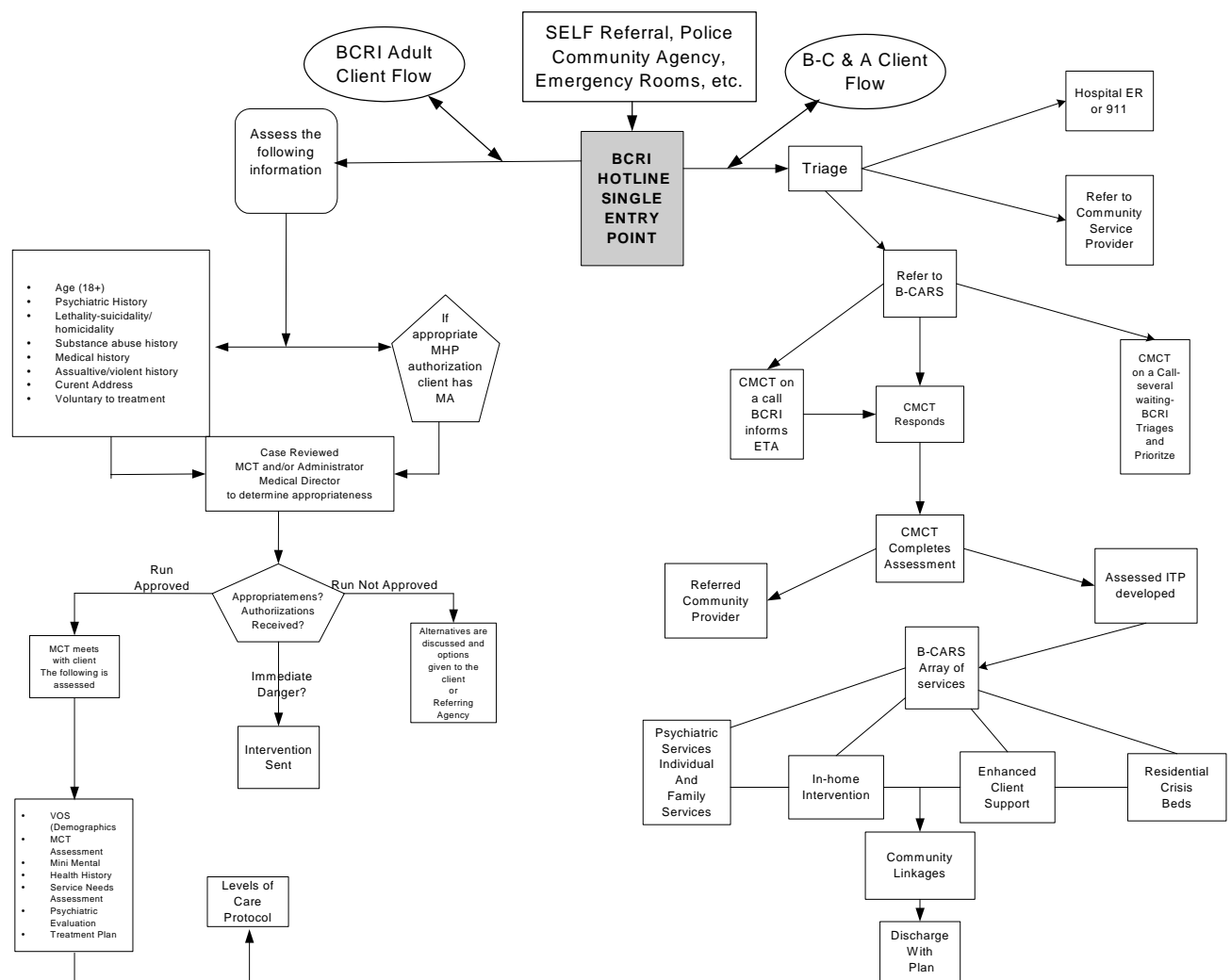
The BCRI annual operating **budget** is approximately $3,388,325 and the B-CARS budget is $881,760, making a total of $4,270,085.

The BCRI and B-CARS systems measure and track their performance based upon the **increased utilization of services**. This **indicator** is significant to BCRI and B-CARS because one of the initial challenges faced by both was being viewed as a relatively new and unknown provider in a vast sea of nationally renowned health care providers. Therefore, increased utilization of services is an important measure of how potential users view and accept the services as an asset in the community. From FY 2000 to FY 2001, BCRI experienced a 50 percent increase in hotline calls, a 36 percent increase in in-home supports, a 4 percent increase in crisis bed utilization, and a 3 percent decrease in mobile crisis responses. As BCRI moves into its tenth year of operation, BCRI is proud to report that it has not experienced a consumer death during service receipt since its inception.

BMHS management note the following **observations** on the creation of BCRI and B-CARS:

- Consumers can be diverted from inpatient hospitalization and treated effectively in the community;
- Crisis services must have the ability to deal with active substance abuse problems;
- Moving the treatment philosophy from a hospital-based to a community-based focus takes time and ongoing education of providers and citizens;
- BCRI and B-CARS are both viewed as a valuable asset in the community, and the city of Baltimore promotes the hotline as the primary contact for crisis services; and
- Emergency rooms that make to the greatest use of BCRI and B-CARS services express a high degree of satisfaction.

▶ *The Future of BCRI and B-CARS*

As previously stated, no system is perfect. BMHS management indicate that BCRI and B-CARS currently work with up to 10 emergency rooms, and this broad dissemination of resources may not be an optimal organizational arrangement for maximum efficiency. Regarding system improvements, BMHS management advocate movement toward fewer sites or even one single designated site to process the majority of the psychiatric emergencies in the city.

**Washington County Mental
Health Services, Inc.
Washington County
Montpelier, Vermont**
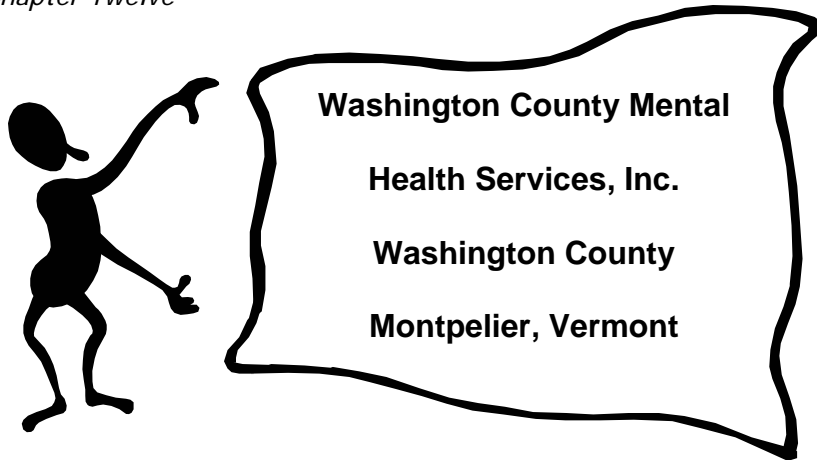
Washington County Mental Health Services (WCMHS) Inc. is a **non-profit 501 (c)(3)** entity that provides comprehensive, community-based services to adults with serious and persistent mental illness, developmental disabilities, mental retardation, and autism; children with severe emotional disturbances and their families; as well as children and adults with other kinds of acute behavioral problems.[39]

WCMHS functions as the local mental health authority and is the sole provider of crisis services in this sparsely populated county of approximately 59,000 residents in a forty square mile geographical area. The largest town has approximately 9,000 residents, giving Washington County the designation of a **rural** service area.

Crisis services provided by the WCMHS system include five program components that are together referred to as **Intensive Care Services** (ICS). These programs are combined under the umbrella of ICS due to their common purpose in providing brief, crisis-oriented services to WCMHS consumers.

The **ICS components** include:

(1) 24-hour phone Coverage (not a Crisis Hotline as described in the previous models),
(2) Emergency Mobile Screening,
(3) ACCESS,
(4) ASSIST, and
(5) Home Intensive (HI).

☒ **24-hour Phone Coverage:** Access to emergency services is gained by calling the 24-hour number, which is advertised in local papers on a daily basis. During regular office hours, this line is answered by a receptionist who directs the call appropriately. After hours, the line is answered by operators at the local hospital who can reach the screener on call by telephone, beeper, or two-way radio within minutes of receiving an inquiry. There is no expectation that the operator or receptionist will provide triage or assessment services. Screeners provide the assessment function and determine disposition alternatives to alleviate the crisis.

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[39] Retrieved from the WCMHS website at: http://www.wcmhs.org/.

☒ **(Mobile) Emergency Screening:** The Emergency Screening program is the initial responder to requests for mental health assistance by the general public, other mental health providers, police, and various other community agencies. Primarily these requests involve crisis situations such as attempted suicide, bizarre or psychotic presentations, and life adjustment or transition issues. The **primary role** of screeners is to assess whether there is a danger to the consumer or others, an immediate need for medication or placement, and/or an indication that other immediate intervention services are necessary. If these areas are not of concern, then the screener ensures that the consumer understands what steps need to be taken to resolve the current situation. The **secondary role** of screeners is that of a support and planning person for consumers, family members, and/or service professionals. This role includes assisting families in obtaining support resources, emergency appointments with doctors, and referrals to private therapists. For all functions, services are provided at sites with the greatest degree of safety and convenience for consumers and providers, including the local emergency room, schools, police departments, consumers' homes, a WCMH site, or even a parking lot.

In addition to their main duties, the screeners provide **coverage** for Central Vermont Medical Center's emergency room after hours, on weekends, and on holidays. Members of the team are also trained in **Critical Incident Stress Debriefing** and provide support for emergency personnel or the general public who have experienced a recent traumatic incident, such as a teen suicide or a natural disaster. This latter effort is supported by various agency staff who have received Red Cross disaster training.

☒ **ACCESS/FAMILIES FIRST:** The ACCESS program began in April of 1995 as a joint effort by multiple programs under a federal grant to reduce the number of children entering the custody of Social and Rehabilitation Services. ACCESS is a brief, family strengths-based intervention program that helps stabilize children and families at times of crisis. Services are designed to be highly intensive and can last up to 24-hours a day for three to four weeks after intake. At the conclusion of services, either crisis stabilization itself has been adequate to allow the family to continue on its own or a more long term program is in place for them. A key component of ACCESS is its intentional integration with a wide variety of local agency services. For example, a person in ACCESS may be residing at the Home Intervention program, receiving counseling from Children, Youth, & Family Services, obtaining psychiatric coverage from the WCMHS Children's division, and receiving case management from the ACCESS brief treatment case manager.

☒ **ASSIST:** The ASSIST program provides pre and post-crisis services to consumers. ASSIST supports the Emergency Screening program because it takes calls off of the emergency line, organizes transportation for consumers, and helps with pre-crisis and crisis planning. Each member of the ASSIST team may have one or two consumers that they directly case manage, as well as covering some of the caseload for case managers who are on vacation. A main function of ASSIST is to

create a **medication delivery plan** with consumers and their case managers or therapists in order to help consumers take their medication at the level prescribed. The program is utilized in situations when the consumer may be at risk of overdosing, and therefore should not have access to the entire medication supply, or may have difficulty managing his or her medication independently. The plan is reviewed on a bi-weekly basis and adjusted to meet the specific needs of the consumer. When the consumer, the case manager or therapist, and an ASSIST Team member agree that the consumer can manage his/her medication consistently (usually on a twice a week drop-in basis), a referral is made to the **Rehabilitation, or "Rehab," team** who then work with consumers to achieve independent medication management.

The ASSIST team may also be called upon to provide **pre-crisis services**. This service involves meeting with the consumer to identify his or her current status, then organizing a treatment team meeting to create a plan that de-escalates the sense of crisis experienced by the consumer. This plan might include medication management, daily contacts with ASSIST, a crisis plan for screeners, and appointments with a psychiatrist or support workers as necessary. ASSIST also makes similar plans for persons being discharged from a hospital or Home Intervention to help reduce the likelihood or frequency of subsequent hospitalizations.

☒ **Home Intervention (Residential Service):** The Home Intervention (HI) program began in 1989 with a team of five staff and a part-time psychiatrist who were working intensively with an individual consumer to reduce admissions to Vermont State Hospital (VSH). By 1992, HI had grown to include twenty full and part time staff able to work with as many as four at-risk consumers concurrently. The program became recognized for its ability to get very high-risk persons, who otherwise would be admitted to the hospital, to voluntarily agree to medications, curfews, and other crisis stabilization techniques. In 1995, the HI program joined efforts with the ACCESS/FAMILIES FIRST initiative and became the first non-hospital based community program to work both with adults and children at risk of hospitalization. Though children and adults receive services in separate parts of the facility, or in their own homes, the same staff provide these services. Though the majority of services are now provided in the main HI facility, a house in a residential neighborhood, the team remains committed to providing services in a homelike setting. The program has consistently been able to help consumers with lengths of stays, averaging 6 days for adults and 4 days for children, that are shorter than typical hospitalizations.

EMERGENCY SERVICES

Referral for Home Based Supports

Contract for Ongoing Contact

Family / Support Network

C.I.S.D.

Paraprofessional Respite

Support

Refer for Outpatient Care

Home Intervention

Triage

Placement

Refer for Immediate Case Management

Voluntary Hospitilization

Refer for Immediate Psychiatric Visit

Initial Forensic Evaluation for Hospitilization

A.O.D. Assessment / Placement

Involuntary Hospitilization

Figure 3: Illustrated above is a diagram of the WCMHS crisis system.

Intake
- Phone
- 3rd Party Referral
- Walk-In

Consumer in Crisis?
No — Yes

Refer to Consumers 'Warm Line

Brief Support & Referral

Determine Need for Face-To-Face
No — Yes

Home Based Resolution
- ACCESS
- ASSIST
- Crisis Plan with Family/ Support

Family / Support Network Can Assist Consumer

Telephone Support with Contract for Follow-Up

Home Visit
- Site Known
- Site Secure
- No Weapons

Field Visit
- Site Secure
- Promotes Consumer Safety
- Neutral Site

Clinic Visit
- Site Secure
- Access to Immediate Assistance

Emergency Dept. at CVMC
- Medical Care Stat
- Emergency Psychiatric Need
- Hospitilization Likely

No

Consumer Refuses Services

Yes — Yes

Assess Degree of Danger

Consumer Collaborative
- Respite Home
- Psychiatric Review / Medication
- Home Intervention
- Voluntary Hospitilization
- WRAP for Return Crises
- ACCESS / ASSIST

LOW
- Refer for Follow-Up

MEDIUM
- Outreach Contact
- Plan with Support Network

HIGH
- Meets Criteria for Involuntary Care

Voluntary Agreement for Home Intervention

72-Hour Involuntary Hospitilization

Refer to Care Coordinator for Follow-Up

Figure 4: A diagram of how consumers flow through the service system is presented above.

The annual operating **budget** for the WCMHS is approximately $1,300,000.

WCMHS utilizes the following measures as **indicators** of their effectiveness and success:

(1) An annual survey is given to all consumers of Emergency and Long Term care services.

(2) An annual survey is conducted of private providers, schools, and other human services organizations.

(3) Keeping the number of out-of-home placements of children, both for social service custody and hospitalizations, below the state average.

(4) Maintaining below targeted usage of involuntary hospital days for adults.

(5) One-hundred percent of initial calls for assistance receive a response within 15 minutes.

(6) Forty percent or more of persons placed in protective custody for intoxication to levels of incapacity receive follow-up.

(7) ES Director meets with the Consumer Advisory Board bi-monthly for service feedback.

(8) Local Standing Committee — a state empowered team of family members, consumers, and members of the agency Board meet on a monthly basis with the ES Director.

(9) Services are given a basic review by a state team from the Department of Developmental and Mental Health Services on an annual basis; a more extensive review is done every 4 years.

Conclusion

Given the growing prevalence of behavioral health needs in our communities, recognizing the need for comprehensive crisis response systems is timely and critical. Such systems serve the needs of persons in crisis in a manner that emphasizes:

- Rehabilitation,
- Recovery,
- Natural supports, and
- Community integration.

The primary **goal** of this document is to present in general terms the purpose, function, and features of a comprehensive crisis response system. A secondary goal is to guide the reader from theory to practical application of these service concepts utilizing actual models that are in operation in communities across the country. These service models are not perfect; however, they have worked to move their systems toward the ideal as presented in this document. Furthermore, this document does not subscribe to a "one size fits all" approach to crisis services but instead presents both the basic, required components of a crisis system as well as other special service features that can be tailored to fit the community in which the system will operate.
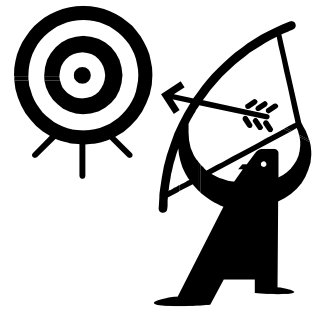
Finally, critical to the success of a comprehensive crisis system, current and future purchasers and providers of services should not underestimate the value added through **stakeholder involvement** in crisis response systems. Such stakeholders might include: consumers, families, legislators, commissioners, providers, agency heads, funders, and hospital representatives. All of these groups will have a vested interest in how crisis services are designed and delivered and should become active participants in the oversight, management, and evaluation of the system's performance.

As a result of the information presented here, it is hoped that crisis systems will be able to:

(1) Appropriately serve more consumers,
(2) Provide quality services,
(3) Be cost effective, and
(4) Validate their service delivery systems as a best practice in the behavioral health care field.

Appendix A:
American Association for Emergency Psychiatry Standards

Accessibility
1. There will be a 24-hour phone with a listed number.
2. There will be 24-hour walk-in capability.
3. There will be coordination with those doing outreach in the community (e.g. police, tire, rescue, etc.).
4. No one will be denied care due to lack of ability to pay.
5. Transfer to and from the service will be based on written policies.

Staffing
1. A mental health professional will be designated to direct the psychiatric emergency component.
2. The mental health professionals staffing the psychiatric emergency service will have documentation of training and experience in psychiatric emergency and crisis work.
3. Staff without documented training in emergency psychiatry will be supervised by staff that have that training and experience.
4. Mental health professionals may include a psychiatrist (at least at the PGY 2 I level, registered nurses, psychiatric social workers, and clinical psychologists. Mental health workers without advanced degrees will act under the supervision of licensed mental health professionals.
5. Security officers will work with the mental health professionals to protect the safety of patients, staff, other professionals, and families
6. A psychiatrist will be available 24 hours a day, and there will be a psychiatrist who serves as Medical Director of the unit who will be responsible for the quality of the medical care provided.
7. One of the mental health professionals will be assigned to coordinate the are of each patient in the service.
8. Medical consultation will be readily available.
9. Laboratory and x-ray technicians will be available when needed.
10. A list of translators for the most commonly encountered languages will be maintained and available.

Management
1. Patients will have their vital signs taken and recorded upon arrival.
2. Initial signs and symptoms will be reviewed promptly to prioritize needed care.
3. A log will be kept of phone calls including: nature of call, name of caller, time and date of the call, actions suggested or taken, and the name of the staff member receiving the call.
4. A log will be kept of all walk-ins including: names, nature of the patient's problem, time and date of arrival, persons accompanying them and disposition.

5. An evaluation will be done on all cases including: a mental status examination; vital signs and a screening medical examination, a medication history; a history of recent psychiatric care and a brief psychosocial assessment.

6. There will be a documented effort to contact all current sources of mental health care. Available interventions will include crisis assessment and intervention work with family and friends, medication assessment and resources for detoxification from alcohol (or other drugs either on site, or easily accessible).

7. Patients should not stay more than 23 hours in the psychiatric emergency service, unless there are licensed emergency services holding beds or psychiatric inpatient beds within the service.

8. A comprehensive list of dispositions should be available, including: voluntary and involuntary hospitals, respite care, out-patient treatment, home visiting services, day treatment, drug and alcohol programs, geriatric resources, child and adolescent services, mental retardation resources and social services.

9. Transportation resources and information will be available in order to ensure safe referral of PES patients.

10. Reference materials will be immediately available for the psychiatric emergency staff, including: a policy and procedure manual which will include guidelines for patient assessment (medical and psychiatric), involuntary treatment (where appropriate), transfer, consultation and referral, as well as a disaster plan. There will be basic pharmaceutical, psychiatric and medical texts available for ready reference.

11. Records will be kept on each patient seen. Every effort should be made to standardize patient assessments.

12. A quality assurance and improvement program will include review and reporting of adverse events (including drug reactions and death or injury in the service or within 72 hours of discharge), as well as ongoing efforts to assess and improve the quality of care delivered.

Facility-Equipment

1. Patients will have easy access to information about patients' rights, patients' advocates, and medication risks, benefits, and side effects. Patients will be made aware of this information both verbally and by clearly visible signs.

2. There will be a private room available for the evaluation of psychiatric emergency patients, in order to respect the patient's dignity and privacy.

3. There will be a room to restrain and seclude potentially dangerous patients in order to ensure the safety of all those within the service.

4. There will be immediate access to basic emergency medical services.

5. There will be a separate room for staff to discuss cases with other professionals (in person and on the phone).

The basic needs of all patients and relatives will be met including: toileting, washing, protection of property, and food and drink.

Appendix B:
American Association of Suicidology Standards

The AAS evaluation focuses on seven areas, each with its separate standards. These areas are:

Area I: Administration and Organizational Structure
Area II: Training Program
Area III: General Service Delivery System
Area IV: Services in Life-threatening Crises
Area V: Ethical Standards and Practice
Area VI: Community Integration
Area VII: Program Evaluation

The standards for each area follows:

AREA 1: ADMINISTRATION AND ORGANIZATIONAL STRUCTURE

Explanatory Statement

The Administration and Organizational Structure provides three important lines of authority. It functions as the official decision making body concerning agency policy. It is responsible for the operation and monitoring of agency services. It establishes and helps maintain liaison with other community services. Therefore, the quality of the Administration and Organizational structure is vital to the stability of the agency, a key factor in insuring consistency and continuity, and, ultimately, the quality and effectiveness of the agency's program. Agency administration should be responsible to a board or parent governmental body. For example, an agency which has no formal system of getting advice from or measuring its accountability to governing boards and consumer groups run the risk of jeopardizing its program's effectiveness, relevance, continued funding and community support.

Administration determines personnel policies, job descriptions and performance requirements, which in turn directly affect the quality of service delivered to clientele. It is the administration which is responsible for initiating, supporting, and implementing program evaluation and outcome recommendations. Administrations

should also maintain current financial records according to the prescription of established laws and regulations.

The Components of Administration and Organizational structure are:

1. Governance
2. Program Management
3. Accountability: Administrative, Personnel and Financial
4. Physical Setting

AREA II: TRAINING PROGRAM

Explanatory Statement

The desired end product of a training program is a worker with the requisite knowledge, attitudes, and skills to perform at a minimum accepted standard level of service on behalf of those in crisis.

Seven standards apply to training programs for crisis workers. These standards may also apply to front line crisis workers such as nurses, clergy, police or others whose routine work brings them into contact with persons in life-threatening or other crises, even though their full time occupation may not be crisis work.

The importance of training standards cannot be overemphasized. As high quality service delivery is related to the skill of workers, so is the skill of workers related to training. Training activity should be evaluated in terms of behavioral outcomes. As a result, application of a training standard to a prospective worker's previous training might result in the reduction of training time for some trainees and extension of training time for others. The application of behaviorally stated training standards can have significant implications for planning the agency's budget. Some costly training might be eliminated in one agency. Another director may decide to increase the budget allocation for training and thereby reduce other waste such as a disproportionate unit of service cost which evaluation reveals is related to inadequate training of workers. Also, the expenditure of money in aimless activity of poorly trained workers might be invested instead in a highly qualified trainer.

These standards are derived from the experience of trainers in the field of crisis intervention.

The total training time is an essential aspect of thorough planning. <u>Needs of trainees should be determined by pre- and post-evaluation</u>. In general, a minimum of <u>40 hours</u> of training is indicated for those without previous formal training in suicidology, crisis management, and mental health counseling. The 40 hours should include a minimum of 32 hours formal training plus eight hours of co-worker experience prior to 'independent assignment. Further experience with a co-worker is recommended, when indicated, by a trainee's needs. The co-worker experience should include active, supervised participation in management of at least three crisis situations.

If less than 40 hours of training is required, there should be evidence obtained that the worker has acquired the required knowledge, attitudes and skills through other sources, e.g. a university sponsored crisis course with supervised clinical practice.

Components of the training program area are:

1. Planned Curriculum Objectives
2. Planned Curriculum Content and Bibliography
3. Planned Curriculum Methodology
4. Screening
5. Pre- and Post-Evaluation of Trainees
6. Qualification of Trainers
7. Quality Assurance for Crisis Workers

AREA III: GENERAL SERVICE DELIVERY

Explanatory Statement

Just as there exist a wide variety of life crises (e.g. suicide, sexual assault, etc.) and situational issues (e.g. being severely mentally disabled) so are there a variety of effective service modalities in crisis intervention practice. The evaluation standards in this area relate to:

1. To what degree is a program willing and prepared to offer necessary help during crisis, and

2. How well is the program organized for the efficient and effective practice of crisis intervention

This section is designed to evaluate a crisis center's ability to respond to its clients.

Standards for the five (5) components of General Service Delivery System include:

1. Telephone response,
2. Walk-In Services,
3. Outreach service, (Internet Service)
4. Follow-up, and
5. Client record Keeping.

If, for example, a program does not provide walk-in counseling and outreach services itself, it must be able to secure such help for its callers from other community agencies. (See Area VI: Community Integration) The crucial question is that quality care is available immediately. 24 hours a day.

AREA IV: SERVICES IN LIFE-THREATENING CRISES

Explanatory Statement

Provision of effective services to people in life-threatening crises is the most important objective of the American Association of Suicidology. Crisis intervention services offer an effective means of reducing harm to oneself or others by providing primary suicide prevention, bereavement assistance to survivors of suicide, prevention and intervention around assault, and community information about these issues. Secondary prevention and intervention are also provided for persons who have attempted suicide, for the chronically self-destructive person, and for victims of violence, since these critical events increase one's vulnerability to crisis.

Components of services in life-threatening crises are:

1. Lethality assessment
2. Rescue services
3. Victims of violence or traumatic death services
4. Suicide survivor services
5. Community education

AREA V: ETHICAL STANDARDS AND PRACTICE

Explanatory Statement

Human rights and client protection are basic issues whether the organization is rendering human service area treatment, training or research. A code of ethics covers a variety of issues. Of particular concern is that organizations promoting a particular religious or treatment orientation are open and honest about this orientation with the community and their clients.

Since 1966, the Public Health Services, DREW, has had a policy requiring specific administrative procedures for the protection of human subjects in activities supported by grants and contracts. In 1974, DREW issued a set of regulations and essentially codified these policies. All professional organizations have developed codes of ethical behavior for persons providing professional services. Local and regional associations maintain Ethics Committees to insure that when reports on violations by practicing members of the association are received, there is a formal investigation and appropriate action is taken.

To be certified by the American Association of Suicidology crisis programs must operate according to ethical standards.

Components dealing with ethical issues are:

1. Code of Ethics;
2. Records Security;
3. Confidentiality;
4. Rescue Procedures; and

5.   Advertising and Promotional Methods.

AREA VI: COMMUNITY INTEGRATION

Explanatory Statement

Integrating crisis services into the community is crucial because integration facilitates reaching all potential clients in the target community. It also promotes acceptance of the crisis program by both consumers and providers while enhancing the possibility of identifying with, and becoming part of the community's total care system.

> Community or service area is defined as all the persons in a specific geographic area. This identified population can be divided into consumers and providers of services.

> Community integration is a reciprocal process between the crisis program, consumers and providers directly or indirectly related to crisis services.

Community integration process consists of the following four key elements.

(1) Knowledge: The pool of information the crisis service, consumers and providers have about each other which forms the basis for present and future collaboration and utilization.
(2) Communication: A verbal or written method of exchanging and obtaining information, promoting collaboration and utilization.
(3) Collaboration: Working together for the purpose of teaching mutual goals.
(4) Utilization: The actual use of available services.

To ensure that this reciprocal process exists, the following five community integration components have been defined:

(1) Consumers,
(2) Emergency Resources,
(3) Resource Data,
(4) Professional Resources, and
(5) General Community Resources.

AREA VII: PROGRAM EVALUATION

Explanatory Statement

Evaluation is an important element of service delivery. In the broadest sense, program evaluation tells providers whether what they are doing is effective. It offers a mechanism through which programs can be examined, monitored and

changed when indicated by evaluation outcomes. In this way evaluation becomes a critical and useful administrative tool.

Evaluation can give staff information about needs, about the results of the effort (amount of time, materials, money, human resources) that has gone into responding to these needs. Such evaluations (done on an ongoing and/or periodic basis) provide the staff or venders information about whether these effects
are desirable in relation to the needs and whether they were worth the effort it took to produce them.

The critical importance of program evaluation is highlighted by the increasing emphasis on providers' accountability to consumers and funding bodies for quality service.

Any service program should ask itself three basic evaluation questions:

1. Are our program objectives reasonable, given the condition and need of the community and its citizen?

2. Is our program meeting its objectives, and if so, at what costs:

3. What else is happening within the program and as a result of the program:

To help answer these questions, program evaluation should include the following:

1. A means to determine that every program activity is related to the program's objectives.

2. A method to evaluate the programs:

    a. Activity: Resources available to and used by the program and activities planned and carried out by the program.

    b. Achievement: Changes which take place in people who have been involved in the program. We are usually concerned with changes in clients, but changes in staff may also be considered.

    c. Adequacy: Program impact on the community's total needs.

    d. Efficiency: A determination of the cost in resources personnel, funds, materials and facilities) in attaining the objectives.

In summary, each objective needs to be evaluated in terms of activity, achievement, adequacy and efficiency.

The Standards for Program Evaluation include the following components:
1. Program Objectives
2. Content Evaluation
3. Evaluation Scope
4. Evaluation, Implementation, and
5. Utilization

Appendix C:
Emergency Medical Treatment and Active Labor Law (EMTALA)/COBRA/ Anti-Dumping Laws Background and Summary

Emergency Medical Treatment and Active Labor Act (EMTALA) also referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) and also referred to as the Anti-Dumping Laws
by Paul Hudson
ACUTE CARE, INC.

In an effort to assist emergency care practitioners in coping with the increasing medical-legal complexity of the practice of medicine, ACUTE CARE, INC. has undertaken a review and discussion of current legal issues of interest to its associates. This article is the first of a series exploring the law as it applies to the Emergency Department.

The Emergency Medical Treatment and Active Labor Act (EMTALA) establishes specific responsibilities for physicians attending to the Emergency Department patient. "Emergency Department" is actually an inexact term, in that the provisions of the law apply to patients who present, on hospital property, for purposes of examination and treatment of medical complaint.

- Hospital property includes patients attended to by the staff of hospital-based ambulance services.
- Hospital property includes the arrival of an ambulance in the Emergency Department's entry with a patient who was not expected or diverted to another facility by direct radio contact.

EMTALA describes the need for an examination of each patient for the purpose of determining if that patient possesses an "emergency medical condition." An emergency medical condition is defined as a medical condition manifesting itself by symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the health of the individual or with respect to a pregnant woman , the health of the woman (or her unborn child) in serious jeopardy;
(2) Serious impairment of bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

- Active labor is addressed as well. A pregnant woman who is having contractions is said to be in true labor unless a physician certifies that , after a reasonable time of observation, the woman is in false labor.

The Act describes the need for the provision of stabilizing treatment for all patients who possess an emergency medical condition. There exists an element of controversy in that EMTALA preempts state law and does not make exceptions for anencephalic infants, comatose patients, cancer patients, or others with chronic conditions that affect quantity or quality of life. The physician is held to this standard of care in making decisions regarding the stabilization of the Emergency Department patient.

A large number of EMTALA investigations arise because on-call physicians refuse to come in to see the patient, come in late, or order the patient transferred without coming in to stabilize the patient. The Act is specific in its application to on-call physicians. Generally, on-call physicians are expected to attend the patient physically. If the on-call physician refuses to attend to the patient or fails to appear within a reasonable time this fact must be reflected in the patient record and transfer materials. Furthermore, the hospital's records must reflect quality assurance and disciplinary records regarding the incident.
The patient's decisions during the emergency department visit are also addressed in EMTALA. Documentation is required in each of the following instances.

- Refusal to consent to treatment. The record must reflect the examination and/or treatment refused by the patient.
- Refusal to consent to transfer. Documentation must reflect if the patient refuses a transfer recommended by the physician after being informed of the risks and benefits of that transfer. The medical record must include notation of that refusal, details of the proposed transfer and the risk/benefit ratio as described to the patient.
- Request for transfer. If the patient or their delegate requests a transfer the record is to include that request, its rationale and the fact that the individual had been made aware of the risks and benefits of the transfer.

EMTALA also addresses the matter of transfer of the Emergency Department patient to another facility. The Act imposes restrictions upon how and when a patient may be transferred.

- The hospital is obligated to assure (and document) that the patient has been provided information regarding the hospital's obligation for examination and treatment and the risk/benefit ratio of the proposed transfer.
- The transfer is only deemed appropriate if qualified staff possessing adequate equipment provide "necessary life support measures" en route to the receiving facility and that facility has agreed to accept the patient.
- Complete documentation, including consent forms and records of the medical examination and treatment of the patient, are delivered to the receiving facility.

*Violation of the Emergency Medical Treatment and Active Labor Act
can yield significant penalties.*

- A hospital knowingly, willingly or negligently violating EMTALA is subject to termination of its provider agreement.
- A hospital may be fined between $25,000-$50,000 per violation
- The physician responsible for examination, treatment or transfer can be fined $50,000 per violation for knowingly and/or willfully violating EMTALA. This provision applies to on-call physician violations as well.
- The physician involved can be excluded from Medicare and Medicaid programs.
- A patient can sue the hospital for personal injury in civil court.
- A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover those damages.

The Emergency Medical Treatment and Active Labor Act serves to provide structure to the proper examination, treatment and transfer of Emergency Department patients. Adherence to the law is dependent upon attendance to those who present for care on hospital property, life sustaining care, and informed patient transfer. Documentation of each aspect of care and communication is central to compliance with the law.

EMTALA establishes the following general requirements:

- Medical Screening Examination. A hospital that operates an emergency department must provide a medical screening examination to anyone on whose behalf a request is made for examination or treatment. The purpose of the examination is to determine whether or not the individual is in an emergency medical condition
- Necessary Stabilizing Treatment. If the individual has come to the hospital and the hospital has determined that he or she is in an emergency medical condition, the hospital must provide further medical examination and treatment to stabilize the medical condition.
- Restricting Transfers Until Stabilization. A hospital may not transfer an individual unless:

(1) The individual requests transfer having been informed of the hospital's obligation to provide further examination and treatment and of the risks of transfer, or a physician certifies in writing that the benefits reasonably expected from treatment at another facility outweigh the increased risks to the individual and/or the unborn child from effecting the transfer (if the physician is not present in the emergency department, a "qualified medical person" may sign the certification if a physician consulting with that person has made the determination that the benefits of transfer outweigh the risks, and subsequently countersigns the certification); and

(2) The transfer is an appropriate transfer.

- Appropriate Transfer.

(1) Transferring hospital provides medical treatment to minimize risks to the individual and/or unborn child.
(2) Receiving facility has available space and qualified personnel to treat the individual and has agreed to accept transfer of the individual.
(3) Transferring hospital sends all medical records related to the emergency condition, including emergency medical records, observations of signs and symptoms, preliminary diagnosis, treatment provided, results of any tests, the informed consent and/or certification provided under EMTALA and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.
(4) Transfer is effected through qualified personnel and transportation equipment as required, including the use of necessary medically appropriate life support measures during transfer.
(5) Meet other requirements imposed by the Secretary.

Appendix D:
Confidentiality and Exchange of Information Barriers

CONFIDENITALITY AND EXCHANGE OF INFORMATION BARRIERS

While the right to confidentiality of health information is generally acknowledged by health systems, providers, and payers (State Medicaid agencies, insurance companies, etc.), a substantial number of barriers complicate adherence to and/or enforcement of the right, several of which are summarized below.

1. Federal substance abuse treatment regulations, 42 C.F.R. require that providers of substance abuse services maintain the confidentiality of consumers and families, prohibit unauthorized disclosure of consumer-specific information, and limit ways in which disclosure can occur. These regulations protect the privacy of individuals entering treatment and help ensure that information about participation in treatment, including the fact of participation, cannot be disclosed without consent. However, these regulations do not apply to mental health services (unless the mental health services are part of the substance abuse treatment received by the consumer). Federal regulations comparable to the chemical dependency confidentiality rules should be promulgated for mental health services.

   Even the Federal protection for consumers of substance abuse services is somewhat limited because these rules apply only to programs where Federal funds are involved and because they lack strong enforcement provisions. They do not give the consumer a private right of action; that is, the consumer is unable to take the person who has violated the rule to court. In addition, some providers of chemical dependency services may not be aware of these Federal rules. This is particularly true for those providing mental health services to consumers of chemical dependency services as part of their chemical dependency treatment. These recipients of confidential information may not be aware of confidentiality requirements and may not know that, at least under Federal confidentiality regulations, they are prohibited from disclosing information.

2. Many States have confidentiality requirements regarding health care for mental health and substance abuse services and/or for health care consumers generally, but these laws vary in breadth and comprehensiveness as well as in enforcement. Also, the degree of confidentiality of information between one jurisdiction and another may be affected by a number of other relevant laws, such as HIV confidentiality statutes, "duty to warn" court decisions and

statutes, abuse, and neglect reporting and decisions about the status of provider-patient communications (i.e., that this is considered privileged and confidential information between a consumer and his or her provider). "Duty to warn" State statutes or court decisions, for example, may permit or require a provider to disclose confidential information without the consumer's consent.[2] At a minimum, consumers should be notified about circumstances under which confidentiality protection may be superseded by other laws or considerations, such as the threat of physical harm to self, or abuse or neglect of a child.

3. Considerations of confidentiality can collide with the consumer's need for coordination and a continuum of care. It may be in the consumer's best interest to be referred by a provider to a number of additional providers for treatment and services. In addition, the structure of a managed care program may require referral to behavior health organizations (BHOs) and their providers. Yet each time a referral takes place or a consumer is required to enter into another plan or health care system, patients records are transferred, phone calls are made, letters are exchanged, and consumer confidentiality may be jeopardized. This regular exchange of consumer health information, which can be an important aspect of ensuring quality care to the consumer, further jeopardizes consumer confidentiality when still other "players"—such as employers, public health authorities, courts, State welfare programs, or researchers—become part of the information exchange.

   On a broader level, the changing structure of the health care system and advances in information technology and medical and health research increase the demand for and supply of health information among the treating physician, provider network, information management companies, and quality and utilization review committees. Technological advances in storing and communicating health information now include computers, databases, audio tapes, video tapes, Internet transmittals, and facsimiles. The various exchanges of information inherent in each of these interactions increases the likelihood of the consumer's loss of confidentiality—at each juncture there is a chance of information being erroneously or wrongfully exchanged and becoming public.

   In addition, some MCO's, providers, and other recipients of confidential consumer health care information simply may not have a very good system of keeping information secure. MCOs, providers, and all other "players" in the system(s) must establish strategies that maximize patient confidentiality, and MCOs, particularly, must install confidentiality protections in their management information systems.

4. When information concerning a consumer must be exchanged for purposes of ensuring appropriate care to the consumer, there is often a failure to limit the disclosure to the least amount necessary for the purpose. For consumers of mental health or chemical dependency services, this issue arises particularly

with regard to separate psychotherapy notes that may be taken during their treatment. The degree of personal information in these notes may be much more sensitive than information generally found in a consumer's medical records. If they are sent to employers, insurance companies, or others, these notes can cause great harm to the consumer (e.g., loss of coverage, loss of job). As already noted, the failure of providers and others involved in the health care system to recognize these kinds of information as discrete not only results in consumers' loss of privacy and confidentiality, but also results in reluctance on the part of some consumers to communicate fully and honestly with mental health and substance abuse providers because of fear that their confidences will be exposed in the transfer of information and records.

5. Consumers' confidentiality can sometimes be compromised because of the process and system through which they *entered* treatment. Consumers are often required to enter into treatment for chemical dependency services or mental health services by court order or through the State or county child welfare system. Confidentiality becomes a greater problem when there are court records, court orders, State child welfare documents, and "public" documents that concern treatment the consumer is required to receive from chemical dependency or mental health providers. Confidentiality safeguards must be built into public law and public programs, including, for example, provisions regarding sealing of court records and expunging records under certain circumstances.

6. Sometimes consumers are unable to rely on confidentiality protections because they are threatened (or believe they are threatened) with a denial of care unless they waive their rights. Providers may tell consumers that if they do not waive their confidentiality rights, the provider will not treat them. Similarly, MCOs may require a waiver of confidentiality before they are willing to authorize a service or approve a referral. State welfare and health care laws may contain provisions or rules that will deny the consumer or the consumer's provider reimbursement for a service unless the consumer reveals otherwise confidential information and/or waives confidentiality rights. A consumer's waiver of rights or agreement to the release of confidential information should be based on having received full information about the effects of such a waiver or release, and MCOs and providers should not be permitted to ask consumers to sign a blanket waiver of their privacy rights. Also, consumers should have the right to revoke a waiver.

7. Consumers are sometimes required to waive confidentiality rights and protections at a time when they do not have the capacity to knowingly consent. They may be inebriated or may be going through a mental health emergency and may agree to waive confidentiality protections that they would not otherwise waive. Consumers should be informed about and provided an opportunity to establish an advance directive document that includes instructions as to how they wish confidential information to be handled.

8. A consumer may agree to waive health care confidentiality protections, but the provider or MCO may then release much more information than the consumer had agreed to, or the MCO may end up sharing the information with persons or organizations other than those agreed to, or anticipated by, the consumer. Consumers must be clearly notified of whom and which agencies will receive confidential information if the consumer agrees to release of information, or if information will be released without the consumer's consent. *Recipients* of this information must be notified of their obligation to maintain consumer confidentiality and must be required to establish confidentiality safeguards.

9. Consumers are sometimes concerned that if confidential information concerning mental health and chemical dependency services is released to their primary care providers, the provider will attribute the consumer's complaints of physical illness to his or her "mental condition"; that is, conclude that the consumer is not really experiencing a physical condition, but, rather, that "it is all in his or her head," or that he or she is a hypochondriac. The consumer therefore becomes reluctant to have confidential information released for fear of getting inadequate or inappropriate care.

Consumers often object to confidentiality rules and laws concerning release of information *to* "next of kin," or permission to release *by* "next of kin." Sometimes these rules are poorly written so that "next of kin" is defined too broadly, including individuals who are not closely related to the consumer or aware of his/her circumstances. Consumers may not want certain family members to receive confidential information on their mental health or chemical dependency treatment. Sometimes "next of kin" may not be in a good position to determine whether the consumer's confidentiality right should be waived, nor the right person to determine to whom confidential information should be released. Laws and regulations relating to disclosure to next of kin must be drafted carefully to protect consumers who do not want next of kin to be aware of their situation, to ensure that next of kin cannot take wrongful advantage of the consumer's circumstances, and to ensure that next of kin are clearly informed of the confidentiality rights of the consumer that they may now be obligated to enforce on behalf of the consumer.

Appendix E:
Level of Care Criteria for Selected Crisis
Service Components

Level of Care Criteria

Admission of CRT Consumers to Home Intervention

Following are the DDMHS Clinical Guidelines for Crisis Stabilization Services:

Inclusion Criteria
1. Client admission is voluntary.
2. Client requires respite or early intervention to prevent decompensation.
3. Client needs safe environment until inpatient admission is possible.
4. Client is homeless and cannot be managed in a shelter.
5. Client needs overnight stay in a structured setting in order to implement intensive outpatient treatment plan.
6. Client is at significant risk for deterioration to inpatient level of care.
7. Client is unable to function outside a structured environment due to current crisis which is related to his/her mental illness.
8. Client is known to the CMHC and determination of clinical need is made by CRT/Crisis team.

Exclusion Criteria
1. Client needs a secure environment.
2. Client is an elopement risk.
3. Client requires seclusion or restraint.
4. Client has co-morbid medical condition which requires hospitalization.

Appendix F:
Studies of Crisis Response System Components

Summary Of Studies of Crisis Service System Components

AUTHORS	COMPONENTS OF CRS STUDIED	STUDY POPULATION	METHOD	*RESULTS*
Meson et al., 1992	Community care vs. inpatient	Patients with SMI presenting at ER	RCT	Greater satisfaction with services, reduced inpatient utilization
Bond et al, (1989)	Comparison of 2 crisis housing alternatives	Patients with SMI presenting at ER	Non random, 4 month follow up	Clients in unsupervised housing used more services staff turnover was high in supervised crisis house; otherwise no differences found
++Lambert (1995)	After hours crisis intervention	Patients presenting to a VA ER	Evaluation	Reduced hospitalization and costs
Gillig et al; (1994)	24 hour holding beds, compared 2 hospitals, one with and one without	Patients presenting to ER	Comparison group	Reduced hospitalization rates
Reding & Raphelson (1995)	Mobile Crisis Unit/effect of adding psychiatrist	SMI patients in crisis	Retrospective Evaluation	Adding a psychiatrist to mobile unit reduces hospitalization
Fisher et al; (1990)	Mobile Crisis Units	40 Counties, 20 with MCUs & 20 without	Comparison review of admission rates	No differences between counties in rates of hospitalization
Leaman (1987)	Crisis homes	All patients admitted	Program description/evaluation	Improved clinical status; patient satisfaction was high; considerable cost savings
Peladeau et al; (1991)	Crisis centre	All clients referred	Descriptive; quantitative/qualitative	Most of the presenting problems were psychosocial

ER = Emergency room SMI = seriously mentally ill VA = Veteran's Affairs hospital (USA)

Appendix G
Contact List of Crisis Service Models Featured in this Report

Contract List of Programs Featured

Another Directions Eugene Johnson, President CEO Val Everton , VP/Chief Clinical Officers 2701 North 16th Street Suite 316 Phoenix, AZ 85006 (P) 602 – 636-4401 e-mail: val.everton@METAservices.com Eugene.Johnson@METAservices.com	Baltimore Crisis Response, Inc. Edgar Wiggins, Director (P) 410-576-5076 Baltimore Mental Health System, Inc Steven Baron, President 201 East Baltimore Suite 1340 Baltimore, Maryland 21210 (P) 410-837-2647 e-mail: sbaron@bmhsi.org
NetCare Access Allen Mosser, Director 199 South Central Avenue Columbus, OH 43223 (P) 614-274-9500	Washington County Mental Health Services, Inc. Michael Hartman, Director P.O. Box 647 Montpelier, VT 05601-0647 (P) 802-223-6328 e-mail: MICHAELH@WCMHSI.org

Appendix H:
Excerpts from the Evaluation of Net Care Access by the Franklin County Alcohol, Drug Addiction, and Mental Health (ADAMH) Board

Question 1: Is the "front door" achieving the desired goals and objectives of the original design for Franklin County residents?

Answer:
"NetCare ACCESS has achieved or exceeded the fundamental goals and objectives of the original design, that being to provide 24 hour a day, seven day a week access to crisis services in addition to providing assessment, pre-hospital screening, holdover and voluntary crisis stabilization and acute short-term residential stays as an alternative to hospitalization."

Evidence:
- ✓ NetCare ACCESS served over 14,200 persons for assessment and crisis-related services and accounted for over 52% of all first services to new persons.
- ✓ In FY 2000, NetCare ACCESS provided 161,433 service units in 12 service categories to 14,200 consumers at an average cost of $775.00 per client.
- ✓ NetCare ACCESS also provides several levels of care in terms of crisis services. Acute crisis intervention services that typically require only a few hours of service constitute the bulk of the program.
- ✓ Over the past two years, NetCare ACCESS has served, on average, about 1,700 persons per month for assessment and crisis services, and of those, approximately half (860 persons) are seen in crisis.
- ✓ In FY 2000, NetCare ACCESS provided 75,000 units of crisis intervention services, which together constitute 98% of all units provided in the system. This is more than a 40% increase over four full years of operation.
- ✓ NetCare ACCESS has established 17 additional on-site assessment locations in various other human service organizations (courts, hospitals, jail, etc).
- ✓ A 24-hour call-in service was also established as planned and now receives over 67,000 calls per year.

Question 2: Does the program meet related standards and performance measures as contained in the contract, quality assurance plans, and ongoing monitoring activities?

Answer:

"Overall, NetCare ACCESS meets or exceeds State standards related to quality improvement planning and reporting, based upon a review of quality improvement plans, quarterly and annual reports, and their internal process for continuous quality improvement, reviewed over the last two years."

<u>Question 3:</u> What lessons have been learned in the creation of NetCare ACCESS?

Answer:

According to Bobbe Fulton, former Director of NetCare ACCESS, "With all that NetCare ACCESS has achieved, we have learned, or at least experienced, several important lessons." These lessons include:

1. NetCare ACCESS has become a "default" provider due to limits in system capacity.
2. Operating in a claims environment without adequate reserves has made NetCare ACCESS over-reliant on ADAMH funding exclusively. ADAMH funds over 90% of the NetCare ACCESS budget, placing NetCare ACCESS in a vulnerable and dependent financial position. To avoid "self-dealing," NetCare ACCESS was required to divest of all treatment services, several of which were helpful in developing a risk reserve.
3. The development of effective electronic clinical tools to facilitate the gathering of clinical documentation and billing data is essential to manage the increased regulatory and accountability pressures in the NetCare ACCESS system.
4. Trying to manage risk in an increasingly litigious environment continues to be a challenge. Keeping staff informed and well trained is one key to minimizing this aspect of risk.

Appendix I: Crisis Service Models –Tables

▶ *NetCare ACCESS Tables*

Table 1: A summary grid of the service components of the system with information on:
(1) who provides the services (NetCare ACCESS or a contractor), (2) how services
are funded, and (3) the number of consumers served over a fiscal year.

Service Component of the NetCare ACCESS System	Service Provided By? (Contractor, NetCare, or both)	Number of Consumers Served (Unduplicated)	How Are Components Funded		
			Grant?	Fee-for-Services?	Case Rate?
Crisis Intervention and Assessment					
ERS - Telephone Triage	NetCare	108,000 calls	✔		
Crisis Intervention Services	NetCare	8,800		✔	
AOD & MH Adult Site Assessments	NetCare	4,038	✔	✔	
Youth AOD Assessments & Youth Mental Health Services	NetCare	2,561	✔	✔	
Older Adult - +60 Services	NetCare	727	✔	✔	
NetCare Forensic Psychiatry Services	NetCare	509	✔		
Court Assessments	NetCare	3,580	✔		
Emergency Services					
Community Crisis Response & Critical Incident Stress Management	NetCare	N/A	✔		
Reach Out Program	NetCare	N/A	✔		
Residential Services					
Crisis Stabilization Unit	NetCare	658	✔		
Miles House	NetCare	321	✔		
Rosemont Center	Rosemont Ctr.			✔	

Table 2: The staffing patterns that support each of the NetCare ACCESS crisis service components.

Service Component	Number in FTE's & Type of Staffing	Annual Operating Budget for Each Component	Hours of Coverage				
			24 hours 7 days per week	0-12 hrs		Weekends?	
				7 days per week	Week-days (Only M-F)	Yes	No
Crisis Intervention and Assessment							
ERS - Telephone Triage	3 – LISW and 13 – LSW	$843,018	✔	NA		NA	
Crisis Intervention Services (Mobile Outreach for adults is provided through this service)	8 – LISW; 28 – LSW; 1- LPCC; 12 – RN; 4 – MD; 10 - Other	$5,389,501	✔				
AOD & MH Adult Site Assessments	7 – LISW; 3-LSW; 3-LPCC; 1-LPC; 3-Other	$977,947	✔				
Youth AOD Assessments & Youth MH Services	4 – LISW; 13 – LSW; and 3 - Other	$1,102,408			✔ 8am to 10pm		
Older Adult - +60 Services	3 - LISW	$168,739			✔		
NetCare ACCESS Forensic Psychiatry Services	1 – LSW; 4-PhD Psychologist; and 1 -Other	$483,053			✔		
Court Assessments	8 –LISW; 4 – LSW; 1 – LPCC; and 2 - Other	$909,594			✔		

Service Component	Number in FTE's & Type of Staffing	Annual Operating Budget for Each Component	Hours of Coverage				
			24 hours 7 days per week	0-12 hrs		Weekends?	
				7 days per week	Weekdays (Only M-F)	Yes	No
Emergency Services							
Community Crisis Response & Critical Incident Stress Management	2 - LISW	$147,271	✔				
Reach Out Program	10 - Other	$441,991	✔				
Residential Services							
Crisis Stabilization Unit	1 – LISW; 2 – LSW; 5 – RN; and 5 - Other	$972,713	✔				
Miles House	1 – LSW; 9 - Other	$453,933	✔				
Rosemont Center	N/a		✔				

Note: In addition to the staff included above, four psychiatrists are on-site for a total of more than forty hours per week, and a psychiatrist is always on-call the remainder of the week. Physicians receive a flat rate for being on-call and an hourly rate from portal to portal.

▶ *BCRI and B-CARS Tables*

Table 3: The staffing patterns that support each of the BCRI and B-CARS crisis service components.

Service Component	Number & Type of Staffing in FTEs	Annual Operating Budget for Each Component	Hours of Coverage				
			24 hours 7 days per week	0-12 hrs		Weekends?	
				7 days per week	Weekdays Only M-F	Yes	No
BCRI							
Phone Hotline	1- HL Coordinator MA 3- HL Counselors MA 3 -HL Counselors BA/AA	$ 229,548	✔				
Mobile Crisis Response	1- Coordinator MSW 13 -Counselor MA/MSW/MS 3 -Case Managers BS 10-Psychiatric Nurses 1 -Psychiatrist .5 -Psychologist. & 5 On Call Staff	$1,694,453	✔				
B-CARS	N/A	$49,938 *Hot Line*	✔				
In-Home Support	MCT Staff provide service	NA	✔				
10-Bed Detox. Service	1 -Program Manager, MA 1 -Addiction Counselor, BA 10 -Residential Counselors, AA 1 -Addiction Counselor, AA 2 -RN 1 -LPN .5 –Psychiatrist	$784,000	✔				

Service Component	Number & Type of Staffing in FTEs	Annual Operating Budget for Each Component	Hours of Coverage				
				0-12 hrs		Weekends?	
			24 hours 7 days per week	7 days per week	Weekdays Only M-F	Yes	No
B-CARS							
Child and Adolescent Mobile Crisis Team	.5 FTE Psychiatrist 1 FTE Director 1 FTE Clinical Manager 4 FTE Therapist	$466,522	Ongoing Behavioral Health Treatment is available 24/7.	Monday through Friday 8 hours/day for Intakes.			
In-Home Intervention/Enhanced Client Support	5 FTE In-Home Specialists	$239,112	✔				
Residential Crisis Beds	Sub-Contract for 3 beds	$48,191	✔				
Consumer Satisfaction	Subcontract	$7,380	N/A	N/A		N/A	

Table 4: A summary grid of the service components of the BCRI/B-CARS system with information pertaining to who provides the services (BCRI/B-CARS or a contractor), how services are funded, and the number of consumers served over a fiscal year.

Service Component of the BCRI System	Service Provided By? (Contractor, BCRI or both)	Number of Consumers Served FY 01 (unduplicated)	How Are Components Funded?		
			Grant?	Fee-for-Services?	Case Rate?
BCRI					
Crisis Hotline	BCRI	15,342	✔		
Mobile Crisis Team	BCRI	2,299	✔		
In-Home Mental Health Counselors	BCRI	171	✔		
Crisis Residential Units	BCRI	754	✔	✔	
10-Unit Detox Service	BCRI	74	✔		
B-CARS					
Crisis Hotline	BCRI	694	✔		
Child and Adolescent Mobile Crisis Team	Villa Maria	584	✔	✔	
In-Home Intervention	Villa Maria	300	✔	✔	
Enhanced Client Support	Villa Maria	176	✔	✔	
Residential Crisis Beds	Woodborne Inc.	56	✔	✔	
Consumer Satisfaction Evaluation	Families Involved Together	N/a	✔		

▶ *WCMHS Tables*

Table 5: The staffing patterns that support each of the WCMHS crisis service components.

Service Component	Number & Type of Staffing	Annual Operating Budget for Each Component	Hours of Coverage				
			24 hours 7 days per week	0-12 hrs		Weekends	
				7 days per week	Weekdays Only M-F	Yes	No
24 Phone Coverage	HS grad. – 1 FTE Hosp. Staff – 3 FTE with other duties as well	$30K for WCMHS/Hosp. Does not charge for phone services	✓				
ASSIST Program	BA/BS/BSW – 2 FTE	$75,000			✓		✓
Mobile Crisis Team/s ▪ Emergency Screeners / Services	MD/NP - .25 LCMHC – 1 EMT – 1 RN – 1 MA – 2 BA/BS/BSW – 6	$620,000 (includes emergency time billed by Outpatient Services)	✓				
Crisis Residential/ Respite Services ▪ Home Intervention	MD/NP - .33 FTE RN – 2.5 FTE BA/BS/BSW – 15 FTE	$750,000	✓				
ACCESS Interim Case Management for C&A	MD/NP - .20 MA/MSW – 2	$90,000			✓		✓

Table 6: A summary grid of who provides the services (WCMHS or a contractor), how services are funded, and the number of consumers (unduplicated) served over a fiscal year.

Service Component of the WCMHS	Service Provided By? (Contractor, WCMHS or both)	Number of Consumers Served Annually (unduplicated)	How Are Components Funded		
			Grant?	Fee-for-Services?	Case Rate?
24 Phone Coverage	Contractor: Central Vermont Medical Center and WCMHS	10,484 (total number of calls)	✔	✔	✔
ASSIST Program	WCMHS	75	✔		✔
Mobile Crisis Team/s ▪ Emergency Services	WCMHS	834	✔ ✔		✔
Crisis Residential/Respite Services ▪ Home Intervention	WCMHS	82	✔		✔
ACCESS Interim Case Management for C&A	WCMHS	179	✔		

▶ *Consolidated Comparative Grids*

Table 7: Budget and per Capita Spending for each crisis program.

Crisis Program	Catchment area Served	Annual Operating Budget	Per Capita Spending
NetCare ACCESS, Columbus, Ohio Franklin County	1, 068,978	$12, 000,000	$11.22
Baltimore Crisis Response and Child and Adolescent Response Baltimore City, Maryland	651,154	$4,270,085	$6.55
WCMHS, Montpelier, Washington County, Vermont	56,289	1,500,000	$26.64

Table 8: Size and characteristics of population served.

Crisis Program	City	County/State	Catchment area Served	Population Served	Disabilities Served
NetCare ACCESS	Columbus	Franklin County, OH	1, 068,978	Adults and Children all ages	Mentally Ill, and Substance Addicted; Hearing Impaired, Forensic, recipients
Baltimore Crisis Response Inc.	Baltimore	Baltimore County, MD	754,292	Adults and Children all ages	Mentally Ill and Seriously Emotionally Disabled
Washington County Mental Health Services, Inc.,	Montpelier	Washington County, VT	56,289	Adults and Children all ages	Mentally Ill and Seriously Emotionally Disabled

Glossary of Terms

Access – The availability of appropriate services to people who need them in a manner that facilitates their use.

Administrative Costs – Expenses incurred to provide the administrative services required by a provider plan such as claims processing, billing, enrollment, and other overhead costs.

Appropriateness – The degree of positive fit between a person's specific healthcare need and the services provided; parameters by which appropriateness is determined include overall service quality, informed consent, the array of available treatment options, culturally competent services and staff, and conformity to standards of care.

At-Risk Contracting – A contractual arrangement between a payer and service provider that: (1) assigns prospective and pre-set funding, generally on an annual basis; (2) makes continued funding contingent on performance; (3) involves a risk and reward sharing arrangement that transfers some or all of the utilization risk to the service provider; and (4) allows the service provider flexibility in the design of services, as long as outcomes are achieved.

Average Length of Stay – The average number of days that an episode of care lasts; calculated by the total number of patient days and units of service incurred over a given period, divided by the total number of episodes.

Behavioral Healthcare – Care provided for the treatment of mental and/or substance abuse disorders.

Capitation (Informal Usage) – A term often used to refer to any type of at-risk contracting arrangement that provides funds on a prospective basis per person in return for the risk of the costs of healthcare provided to those persons.

Capitation Funding – A method of At-Risk Contracting between a payer and provider that involves prospective and pre-set funding that is assigned on the basis of the number of persons covered (as opposed to the number and type of persons who present for services).

Carve Out – A program delivery and financing arrangement by which certain specific healthcare services which are covered benefits (e.g., behavioral healthcare) are administered and funded separate from general healthcare services.

Case Management – A process by which the services provided to a consumer are coordinated and managed to achieve optimum outcome in the most cost-effective manner.

Case-Rate Funding – A method of At-Risk Contracting between a payer and provider that involved prospective and pre-set funding that is assigned on the basis of the number and type of enrolled persons who present for services (as opposed to number of person covered by the benefit plan).

Centralized Utilization Management – Utilization is managed prospectively and/or retrospectively for multiple service providers by a centralized agency.

Consumer/Recipient – An individual who receives and/or purchases services; some differentiate a consumer from a customer in that a consumer also advocates for service quality and appropriateness.

Consumer Satisfaction – A subjective evaluation by a recipient of service with the services they received and/or the manner in which they were provided.

Continuous Quality Improvement (CQI) – A management principle that emphasizes the ongoing improvement of the process of service delivery through the incorporation of empirically derived approaches and the institution of systems of internal monitoring, feedback and organizational learning.

Continuity of Care – Coordination of the range of services available to an individual consumer so that an optimal service mix is provided at all times without disruption; the concept can apply to the current services mix, the flow of services over time and the consistency of the consumer-provider relationship.

Continuum of Care – A comprehensive array of available services that adequately fits the needs of the covered population in a rational and cost-effective manner.

Crisis Services – A collection of integrated services that are available 24 hours a day, seven days a week to respond to and assist individuals in a mental health emergency. These services are provided to persons who are in an emergency condition or crisis situation. The person's need may be such that they require treatment to reduce the likelihood of death, harm to themselves or someone else, serious injury or deterioration of a physical condition or a major setback in their condition or illness. Examples of these services include but are not limited to: crisis hotlines, crisis residential and respite services, crisis/mobile outreach, short-term crisis counseling, crisis walk-in clinics, and crisis stabilization services etc.

Delivery System – An organized array of service providers coordinated to deliver a set package of services

Designated Mental – An organization or individual with which a purchaser contracts to Health Provider provide services.

Dumping – Generic term referring to the practice by a provider of obtaining care for a consumer at the expense of another party

Enrolled Population – The entire group of persons covered by a particular purchaser.

Episode of Care – A construct that groups all the treatment provided for a specific condition over a continuous, defined period of time; often used to analyze service cost, quality and utilization patterns

Essential Providers – Types of providers or provider organizations (e.g. physicians, psychologists, licensed social workers, community mental health center, community health centers) whose services are required to be included in the delivery of crisis services by state or federal statute.

Fee-for-service Reimbursement – A payment system that pays providers for each unit of service delivered

Full Capitation – A term often used more broadly than the strict definition of capitation to refer to any payment system in which provider provides and bears the utilization risk for all services included in the benefit package according to a prospectively funded at-risk contracting arrangement tied to covered lives.

Full Utilization Risk – Risk sharing arrangement in which the payer transfers to the service provider full responsibility for the potential rewards and costs of service utilization.

Funding Authority – The agency authorized to award and oversee contracts with all service providers within a defined geographic area.

Funding Method – The mechanism through which a payer (e.g., Medicaid, employer, LMHA, SMHA) pays for the healthcare of its eligible persons.

Gatekeeping – The use of primary care clinicians, case managers or some other mechanism as the initial contact for care in order to ensure that only appropriate and cost-effective care is utilized.

Center for Medicaid & Medicare services (CMS) – The federal agency that administers Medicare and oversees states administration of Medicaid.

CMS Waivers – Agreements with the federal government that allow state's that hold them specific flexibility in the administration of their state's Medicaid plan.

Integrated Behavioral Health Network – A carved-out health plan that combines various managed behavioral healthcare services in a single, coordinated delivery system.

Integrated Delivery System – A generic term that refers to any of a variety of types of joint efforts between clinicians and service providers

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – A private, not-for-profit organization that set standards, evaluates and accredits hospitals, healthcare organizations and networks

Lead Agency – An organization that serves as a single clinical and fiscal authority that provides and/or subcontracts for services toward the achievement of a desired outcome.

Length of Stay (LOS) – The duration of an episode of care for a covered person.

Local Mental Health Authority – Local organization entity (usually with some statutory authority) that centrally maintains administrative, clinical and fiscal authority for an organized system of behavioral healthcare.

Managed Care – Various strategies that seek to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performances to ensure cost-effectiveness.

Medicaid Managed Care Demonstration – A state initiated managed healthcare plan undertaken in accordance with a procedural waiver for some or all of a state's Medicaid eligible persons.

Medicaid – A federal program administered individually by participating states and territorial governments that share in the program's costs to provide medical benefits to specific groups of low income and/or categorically eligible persons.

Mixed Capitation/Case Rate Funding – A method of At-Risk Contracting between a payer and provider that involves prospective and pre-set funding that is assigned partially on the basis of the number of persons covered by the plan and partially on the basis of the number and type of eligible persons who present for services.

Multiple Funding – Funding method in which funding flows to a service provider Streams in independent streams from various funding sources.

Outcome Measures - Indicators used to gauge the effectiveness of treatment for a specific disease or medical condition.

Outcome – The results of a specific healthcare service or benefit package.

Outcomes Management - Systematic efforts to improve the results of healthcare services, generally through the incorporation of empirically derived feedback on the effectiveness of services provided.

Outcomes Research – Formal studies designed to measure the effectiveness of a given service or benefit package.

Outlier – An observation in a distribution that falls significantly outside the range of most of the data and skews statistics calculated upon the data in a particular direction, for example, when calculating average length of stay, one or two especially long stays can make the average LOS appear longer than it practically is.

Partial Capitation – Generic term that refers to a payment system in which some services included in the benefit package are funded according to an at-risk contracting arrangement and some are funded through fee-for-service or other traditional form of reimbursement.

Participating Provider – A provider who has contracted with a purchaser to provide specific service for a negotiated reimbursement.

Payer/Payor – The public or private organization that is responsible for payment for healthcare expenses.

Pre-Admission Certification (PAC) – A prospective review of the need for a specific healthcare service according to specific criteria.

Prior-Authorization/Pre – A prospective procedure used to optimize the value of service Admission Screening   provided by subjecting requests by consumers for services to review prior to the service being provided and/or paid for.

Private Behavioral – Corporations mostly started in the 1980's that manage, administer Healthcare Organizations and/or provide mental health and substance abuse benefits carved out from the general health plan provided by insurers and self-insured companies.

Provider – An organization or individual that provides and is reimbursed for a healthcare service.

Public - Private Partnerships – Joint ventures between public and private organizations that attempt to combine private sector expertise on manage care models and techniques with public sector expertise in models of care for seriously impaired or low income populations.

Resource Management – Systematic efforts to improve the base and allocation of resources to achieve optimally cost-effective and efficacious care.

Risk – The difference between projected and actual experience.

Risk Shift – The transfer of risk for the costs of services from one responsible party to another, either through explicit contract or de facto practice.

Stakeholders – Group of persons with a vested interest in the design and functioning of a service or product; for public behavioral healthcare, stakeholders include consumers, family members of consumers, service providers, legislators, SMHAs.

State Mental Health Authority or Agency – State government agencies charged with administering and funding their state's public mental health services.

State Plan – The strategy developed by a SMHA to implement its mission to provide public mental health services.

Subcapitation – An arrangement whereby a capitated health plan pays its contracted providers on a capitated basis.

Subcontract – The act of delegating through a second contract with a third party contractual obligations between two original parties.

Third Party Payer – A public or private organization which is responsible for the healthcare expenses of another entity.

Unbundling – Treating several units as separate that might otherwise be considered to be a single package; in reference to claims processing, this can refer to the practice by providers of billing separately for services that are customarily billed as a single overall service, in reference to pricing, an MCO might bill separately for different services it provides such as network administration, utilization review, and services.

Utilization – The level of use of a particular service over time.

Utilization Gatekeeper – The agency or agencies responsible for managing service utilization.

Utilization Management – A system of procedures designed to ensure that the services
provided to a specific client at a given time are cost-effective, appropriate and least restrictive.

Utilization Review – Retrospective analysis of the patterns of service usage in order to determine means for optimizing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

Wrap-around Coverage – A continuum of benefits organized around an individual consumers' treatment needs.

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