North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

Improving the mental health and well being of individuals and families in our communities

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NSMHA Contract Memorandum 2014-001

Date: February 5, 2014

To: Tom Sebastian, Compass Health
Donna Konicki, Bridgeways
Michael Watson, Lake Whatcom RTC
Jan Bodily, Whatcom Counseling and Psychiatric Center
Kathy McNaughton, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Ken Stark, Snohomish County Human Services Director
Phil Smith, Volunteers of America
Cindy Paffumi, Interfaith
Sue Closser, Sunrise Services
Christine Furman, Pioneer Human Services
Beratta Gomillion, Center for Human Services
Jerry Jenkins, NWESD 189

From: Joe Valentine, Executive Director

Subject: Revised Policies

Policy 1702.00 – ICRS Outreach Safety Screening for Dispatch
Policy 1703.00 – Duration of Crisis Services

These policies have been through the complete review and approval process. The Executive Director signed and approved these policies January 31, 2014.

Full implementation of these policies should occur no later than 60 days after this memo.

cc: Cindy Ferraro, Bridgeways
Heather Fennell, Compass Health
Kay Burbidge, Lake Whatcom RTC
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Contract File

Effective Date: 9/9/2011; 6/17/2008; 8/30/2007; 12/21/2005
Revised Date: 11/26/2013
Review Date: 11/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services (ICRS):
ICRS Outreach Safety Screening for Dispatch

Authorizing Source: Per NSMHA and ICRS Management, RCW 71.05.700 and 71.05.715, WAC 388-877A-0240, 0260 and 0270
Cancels:
Providers contracted for Crisis Services must have "policy that complies with NSMHA policies"
Responsible Staff: Deputy Director

Approved by: Executive Director Date: 1/31/2014

Signature:

POLICY #1702.00

SUBJECT: ICRS OUTREACH SAFETY SCREENING FOR DISPATCH

PURPOSE

The purpose of this policy is to assure a responsive and consistent safety screening process for crisis outreaches for individuals, family members, community members, and ICRS staff. This policy addresses the roles of the Volunteers of America (VOA) Care Crisis Response Services (CCRS) Triage Clinician (referred to herein as "CCRS Triage Clinician") and the dispatched Mobile Outreach Team (MOT), Emergency Mental Health Clinician (EMHC) and Designated Mental Health Professional (DMHP).

POLICY

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician. Any exceptions shall be clearly documented in the individual's record(s) and are subject to North Sound Mental Health Administration (NSMHA) review. The disposition of all cases referred to the MOT, EMHC, or DMHP by a CCRS Triage Clinician, whether it results in face-to-face services or consultation, will be reported to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case.

Once the safety screening has been completed by the CCRS Triage Clinician and the decision is made to dispatch the MOT, EMHC,or DMHP, the dispatched MOT, EMHC,or DMHP assumes responsibility for further assessing the safety of the situation. The MOT, EMHC,or DMHP must provide the most appropriate clinical intervention (via outreach) in the safest manner possible. There is an understanding that each situation is fluid, and that there is often missing information. The system allows for decisions to be re-evaluated in the face of new or different information.

PROCEDURES

I. Initial telephone safety screening for callers that seem to be under the influence of drugs or alcohol

a. If the caller's judgment is significantly impaired and/or the caller has excessive mood lability and they are a risk to themselves or others and they are unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.
b. If the risk is elevated, but not immediate, the CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.
c. When alcohol or drugs are present (per safety screening assessment tool), the MOT, EMHC, or DMHP will not be dispatched to homes or other unstaffed (less than three staff) locations. Arrangements will be made for the individual in crisis to go to the hospital emergency department or Triage/Crisis Center. Exceptions can be made on a case by case basis, if the CCRS Triage Clinician and the MOT, EMHC, or DMHP agree that an outreach is appropiate in the presence of alcohol or drugs.

II. Initial telephone safety screening for callers that do not seem to be under the influence of drugs or alcohol

a. If the caller is an immediate risk to self or others and unable to maintain safety for up to two (2) hours, 911 must be called to initiate law enforcement response.
b. If the risk is elevated, but not immediate, the CCRS Triage Clinician must complete a more thorough risk assessment. Depending on the clinical assessment, degree of risk, and the individual's needs, the individual will be referred to the appropriate services, which may include 911, hospital emergency department, Triage/Crisis Center, crisis appointment, or other community services. If the individual is able to maintain safety for two (2) hours, per VOA's assessment of risk with the use of the safety screening assessment tool, a crisis outreach may be considered.
c. Ongoing safety screening by the MOT, EMHC and DMHP staff shall occur.

    1. Upon dispatch to an unstaffed location, the MOT, EMHC,or DMHP will continue to perform an ongoing risk assessment.

       The MOT, EMHC, or DMHP must assess risk factors.

        a) Risk factors can include:

            i. Location
            ii. Access to weapons
            iii. History
            iv. Volitility

v. Consistency of known information
vi. Ability to summon assistance if needed (e.g., cell phone coverage)
vii. Time of dispatch
viii. Gender
ix. Age
x. Presence of others at the location
xi. History of ICRS contacts
xii. Presence of animals
xiii. Presence of drugs and/or alcohol

b) The MOT, EMHC,or DMHP must determine (based upon evaluated risk) how and where to see the individual.

2. Options to consider to increase safety include:

a) Arranging for family members or significant others to be present.
b) Moving the location of the outreach to a safer community setting.
c) Arranging for law enforcement to escort the MOT, EMHC, or DMHP.
d) Conducting the outreach with a second ICRS staff person for additional safety.

III. No MOT, EMHC, or DMHP staff shall be required to respond alone to a private home or other private location to stabilize or treat a person in crisis, or to evaluate a person for potential detention under the state's involuntary treatment act. When determined to be necessary for safety, clinical staff who provide outreach to consumers shall engage the use of a second person to accompany them. The second person can be another agency clinical staff, law enforcement officer, or other first responder, such as fire or ambulance personnel. Additionally, the MOT, EMHC, or DMHP who is dispatched on a crisis visit shall have prompt access to information about any history of dangerousness or potential dangerousness of the individual they are being sent to evaluate. At a minimum, information documented in crisis plans or commitment records shall be available without unduly delaying a crisis.

IV. If risk cannot be assessed, clinical staff shall consider other outreach options or arrange to see the individual at a staffed location.

V. MOT, EMHC, or DMHP will re-contact the CCRS Triage Clinician regarding changes in dispatch due to elevated risk concerns.

VI. MOT, EMHC, DMHP staff will be provided with wireless phones and participate in annual safety training as addressed in NSMHA Policy #1557.00 Safety Policy.

ATTACHMENTS

None

Effective Date: 6/17/2008; 1/28/2008; 11/29/2005
Revised Date: 11/26/2013
Review Date: 11/26/2013

North Sound Mental Health Administration

Section 1700 – Integrated Crisis Response Services: Duration of Crisis Services

Authorizing Source: NSMHA and ICRS Management
Cancels:
See Also:
Providers contracted for Crisis Services must have "policy consistent with NSMHA policies"

Responsible Staff: Deputy Director | Approved by: Executive Director | Date: 1/31/2014

Signature:

POLICY #1703.00

SUBJECT: DURATION OF CRISIS SERVICES

POLICY

Crisis Service and Crisis Stabilization Services are provided until the assessor has determined that the individual is stabilized and no longer presents an immediate, acute, or heightened risk of harm to self, others, or grave disability. Crisis Service and Crisis Stabilization Services also may end when the individual is referred to other services.

Crisis Services and Crisis Stabilization Services are short-term (less than two weeks per episode) in nature and are intended to last for a few hours or days and in unusual cases, a few weeks. Individuals may re-enter crisis services if a new crisis arises or the individual's functioning deteriorates.

PROCEDURES

I. Appropriate and timely discharge from Crisis Service and Crisis Stabilization Services are a consideration from the beginning of each crisis intervention.
II. When discharge from crisis services is being planned, the following shall occur:

a. The risk of harm to self or others shall be assessed and documented in the clinical record and any substantial risks have been addressed.
b. The action plan for the continued resolution of the crisis and stability has been developed. This means the following:

i. The action plan has been agreed to by the individual who was in crisis;
ii. The action plan has been coordinated with significant others and other professionals; as appropriate.
iii. If the individual is being referred to another service, the individual has the referral contact information and alternative plans, if this referral does not work out;
iv. The individual and significant others have a plan to respond if the issues of concern become more acute again and
v. The action plan has been documented in the clinical record.

ATTACHMENTS

None