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North Sound BHO Contract Memorandum 2017-013

Date: August 16, 2017

To: Tom Sebastian, Compass Health and Compass Whatcom
Donna Konicki, Bridgeways
Michael Watson, Lake Whatcom RTC
Will Rice, Catholic Community Services Northwest
Claudia D'Allegri, Sea Mar
Cammy Hart-Anderson, Snohomish County MH/CD/Vets Division Manager
Phil Smith, Volunteers of America
Randy Polidan, Unity Care NW
Sue Closser, Sunrise Services
Robert Sullivan, Pioneer Human Services
Beratta Gomillion, Center for Human Services
Corky Hundahl, Phoenix Recovery Services
Julie Lord, Pioneer Human Services
Linda Grant, Evergreen Recovery Services
Marli Bricker, Therapeutic Health Services

From: Joe Valentine

Subject: New Policies

Greetings BHA Providers:

Policy 1587.00 – Crisis Planning for Individuals Receiving Mental Health Services
This **new** policy has been through the review and approval process. The Executive Director signed and approved this policy August 16, 2017.

The NM with policy attachment included below for your convenience.

The highlighted version will be included as separate attachment.

Please ensure all appropriate staff is notified of this new policy.

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

cc: Cindy Ferraro, Bridgeways
Becky Olson-Hernandez, Compass Health
Kay Burbidge, Lake Whatcom RTC
Pat Morris, Volunteers of America
Katherine Scott, Sea Mar
Richard Sprague, Unity Care NW
Danae Bergman, Center for Human Services
Jackie Henderson, Island County Coordinator
Barbara LaBrash, San Juan County Coordinator
Rebecca Clark, Mental Health Program Coordinator Skagit County
Anji Jorstad, Snohomish County Coordinator
Anne Deacon, Whatcom County Coordinator
Marsh Kellegrew, Evergreen Recovery Services
Robert Sullivan, Pioneer Human Services
Perry Mowery, Whatcom County
Contract File

Effective Date: 8/16/2017
Revised Date: 8/1/2017
Review Date: 8/1/2017

North Sound Behavioral Health Organization

Section 1500 – Clinical: Crisis Planning for Individuals Receiving Mental Health Services

Authorizing Source: WAC 388-877A-120; North Sound BHO Contract
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Approved by: Acting Executive Director
Responsible Staff: Deputy Director
Signature:
Date: 8/16/2017

POLICY #1587.00

SUBJECT: CRISIS PLANNING FOR INDIVIDUALS RECEIVING MENTAL HEALTH SERVICES

PURPOSE

To ensure development of crisis plans that are comprehensive, recovery oriented, appropriate to the individual, and useful to providers, individuals, crisis workers, and emergency personnel.

POLICY

Crisis planning is a multifaceted process that should be tailored to the needs of the individual. The crisis plan forms are one aspect of crisis planning.

Crisis planning should focus on using individual strengths and skills, natural supports, and professional intervention to address crisis in the least restrictive manner. It should include information necessary to promote a safe environment for the individual and others.

There are two elements to the crisis planning process. The *Client Crisis Prevention/Safety Plan* is for use by the individual and clinician to prevent and address crisis. The *Clinical Crisis Recommendations* are for use by the clinician, and crisis and emergency department personnel. The information on this form is made available to crisis intervention professionals via the Volunteers of America crisis line. It is also available to Emergency Department personnel through the statewide Emergency Department Information Exchange. Please note: clinicians are to include in the crisis recommendations section of the crisis plan if an individual is enrolled in any high-intensity programs and if so, which ones. Also, clinicians are to include the 24/7 coverage/pager for that specific program.

PROCEDURES

Crisis plans should be completed whenever clinically indicated, including for all individuals with a CA/LOCUS score on Dimension 1 of 3 or higher and/or a composite score of level 4 or higher. Clinicians should consider a crisis plan in circumstances including but not limited to individuals who:

a. Experience an episode of decompensation;
b. Use the emergency department frequently and/or inappropriately;
c. Have multiple contacts with the crisis system;
d. Experience psychiatric hospitalization;

e. Have a history of self-harm, suicide attempts, assault, or other forms of dangerousness to self or others;
f. Experience command hallucinations;
g. Have a recent history of incarceration;
h. Have experienced recent or past suicidal or homicidal ideation;
i. When individuals have discharged, or been diverted from state hospital and placed in a long-term care setting, a multi-system crisis plan with contact information for all parties should be completed.

Crisis plans should be completed collaboratively with the individual and when relevant, their natural supports. Crisis plans should be completed within 30 days of the first ongoing appointment, or as promptly as the individual's condition requires. They should be updated at least every 6 months, but more frequently when clinically indicated. An update to the crisis plan would be indicated for example when the individual experiences a change in their needs such as: recent crisis, change in formal or informal support system, change in symptoms or risk factors, increased availability of coping skills.

When individuals for whom a crisis plan is indicated decline to complete the *Client Crisis Prevention/Safety Plan*, their clinician should document this on the form. The individual's willingness to participate in crisis planning should be revisited every six months. The clinician should complete the *Clinical Crisis Recommendations* as thoroughly as possible. While not required, the clinician may also wish to complete the *Client Crisis Prevention/Safety Plan*.

Elements of a thorough crisis/safety plan include:

a. Individual and family voice – the individual and their natural supports should participate in the development of the plan, if possible.
b. Focus on health and safety of individual – including, but not limited to, information about:

    i. Self-harm – history, level of risk, availability of means, strategies for prevention/intervention;
    ii. Ability for self-care;
    iii. Medical conditions and history of medical hospitalization;
    iv. Developmental issues;
    v. History of psychiatric hospitalization;
    vi. Use of emergency department;
    vii. Substance use – historical and current;
    viii. Ability and willingness to take medication, list of current medications as applicable.

c. Focus on health and safety of family and others (e.g., natural supports, professionals) – including, but not limited to, information about:

    Harm to others (including assaultive behavior, sexual aggression, criminal behavior, history, risk, availability of weapons, strategies for prevention/intervention.)

d. Roles, directives and responsibilities of the individual, family and others.
e. Early warning signs of decompensation.
f. How to contact both formal and natural supports (contact phone number for mental health care provider and Crisis Line at minimum). If the individual is enrolled in a program with 24/7 service availability or a long-term care setting this is clearly identified on the clinical crisis recommendations along with contact information for the facility or program.
g. Proactive measures by the individual, informal and formal supports. These strategies can be used when warning signs are observed to prevent crisis before it occurs.
h. Progressive measures by the individual, informal and formal supports. This means the strategies outlined include a range of less to more intensive/restrictive supports. This may include strategies the individual can try, things their formal or informal supports can assist with, formal interventions, such as, a medication appointment or increased appointment frequency with the primary clinician, crisis respite, etc.

ATTACHMENTS

None