



# Behavioral Health Crisis Services

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# INTRODUCTION

This section contains information on Behavioral Health Crisis Services for staff that provide behavioral health services through network providers under the umbrella of Managed Care Contractors (MCCs). Included in this section are a definition for behavioral health crisis services and service components.

In addition to the definition, guidance for all calls can be found in this section. Service components are also provided and consist of the following:

- Activating Behavioral Health Crisis Services;
- Crisis Services Intervention;
- Mandatory Pre-Screening Agent (MPA);
- Behavioral Health Crisis Respite;
- Crisis Stabilization Services;
- Medically Monitored Crisis Detoxification Units; and
- Follow-Up Services.

# CRISIS SERVICES

## Definition

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available to anyone in Tennessee regardless of insurance type or coverage and are available twenty-four (24) hours a day, seven (7) days a week. Crisis services include twenty-four (24) hour toll free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Peer support specialists shall be utilized in conjunction with crisis specialists to assist adults in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service providers are not responsible for pre-authorizing emergency involuntary hospitalizations.

The Tennessee Department of Mental Health (TDMH) and the Bureau of TennCare issued Community Face-to-Face Response Protocols for crisis response services in June 2010. These protocols were developed to ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

### *Guidance for All Calls:*

- *For calls originating from an Emergency Department, telehealth is the preferred service delivery method for the crisis response service.*
- *After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center.*
- *If a Mandatory Pre-screening Agent (MPA) not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis.*
- *For all other calls, unless specified below, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated*

The Protocols describe calls that are the responsibility of a crisis response service to determine if a Face-to-Face evaluation is warranted and those that are not the responsibility of the crisis response service.

## **SERVICE COMPONENTS**

### **Activating Behavioral Health Crisis Services**

#### *Telephone and Walk-in Triage*

Behavioral health crisis services can be activated by telephone contact or at a walk-in center. A triage screening determines the acuity of the crisis situation and determines the appropriate intervention needed to alleviate and/or stabilize the crisis. The triage screening can be completed via telephone assessment or, in the case of a walk-in service, via a face-to-face assessment. The triage screening also helps to determine the individual's current status such as:

- If there is a behavioral health provider treating the individual;
- The existence/availability of a support system;
- The existence/availability of a treatment plan; and
- If a face-to-face crisis assessment or other services are needed.

### **Crisis Services Intervention**

An intervention may be completed via telephone or face-to-face. At the time of intervention, an assessment is completed to determine the need(s) of the individual including but not limited to the need for active, supportive listening or need for referrals to additional services and/or treatment. It will also be determined if there is an immediate substantial likelihood of serious harm. The intervention is intended to involve the appropriate resources, to include identifying the availability and obtaining a treatment or crisis/wellness plan when possible. All appropriate resources should be utilized in an effort to stabilize the individual and prevent escalation of the crisis.

#### *Telephone Intervention/Consultation*

A telephone intervention or consultation occurs between crisis staff and the individual and/or the family/health care providers, as appropriate. The intervention is intended to assess the need(s) of the individual for possible face-to-face contact with crisis services or a referral to the appropriate resource(s) in order to support and/or stabilize the individual and prevent escalation of the crisis. Consultation is intended to provide information related to available resources to a qualified professional involved in the care and or treatment of an individual experiencing a behavioral health crisis. To ensure consideration is given to all less restrictive alternatives, Emergency Department clinicians are required to complete a consult form when considering hospitalization. The form can then be faxed or read to the crisis clinician via phone during the consultation.

#### *Face-to-face Crisis Intervention*

Crisis staff completes a face-to-face assessment when the triage screening or telephone intervention deems it appropriate due to the nature of the crisis situation. When possible, the individual should either be evaluated via telehealth or directed to the nearest walk-in center for examination. The assessment required for completion during crisis service interventions shall include standardized elements

prescribed by TDMH. The standardized evaluation process shall be followed to ensure consistency and quality of the delivery of behavioral health crisis services. The face-to-face assessment determines the need(s) of the individual, referral(s) to additional services/treatment, and/or intervention(s) to support and/or stabilize the individual and prevent escalation of the crisis. Face-to-face assessments may also be needed to evaluate the risk of immediate substantial likelihood of harm.

### **Mandatory Pre-Screening Agent (MPA)**

Tennessee law requires a face-to-face evaluation, known as pre-screening, of each individual in crisis to assess eligibility for emergency involuntary admission to one of the five (5) Regional Mental Health Institutes (RMHI) and to determine whether all available, less drastic, alternative services and supports are unsuitable to meet the individual's needs. A MPA is required to complete one (1) of the certificates of need (CONs) prior to an emergency admission to a RMHI. If a MPA is not available within 2 hours, a physician or psychologist with Health Service Provider (HSP) designation may complete the CON after consulting with mobile crisis. Private hospitals that have been approved by TDMH and accept the authority of a MPA may also accept CONs from a MPA for emergency involuntary admissions though at least one of the required certificates of need shall be from a professional who is not an employee of the private facility.

### **Behavioral Health Crisis Respite**

All behavioral health crisis service providers must provide access to crisis respite twenty-four hours a day, seven days a week (24/7) for all individuals meeting guidelines for this level of treatment, including but not limited to:

- The individual has a diagnosed or suspected mental illness;
- Mental status exam reveals no immediate intent to harm self or others;
- Respite is deemed a safe level of treatment;
- Respite would be an appropriate and beneficial level of treatment; and
- A brief time of rest and support is considered appropriate to stabilize or alleviate the crisis situation.

Behavioral health crisis respite services are intended to provide immediate shelter to those individuals with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite with overnight capacity for room and board, while meeting the individual's crisis need(s). Trained crisis respite staff members typically provide crisis respite. However, others who are deemed appropriate by crisis staff members may render respite services. For children/youth, authorization must be given for the use of crisis respite services by the parent, legal guardian, legal custodian, legal caretaker, or court with appropriate jurisdiction.

If a behavioral health crisis respite service provider is unable to obtain a current treatment plan, then the behavioral health crisis respite service provider shall complete a respite plan that is developed and agreed upon in writing by the individual, respite staff, and family/care givers/support system as applicable. The plan should include actions to attain stabilization or alleviation of the crisis

situation. Crisis respite must be rendered in a community location approved by the managed care company or a site licensed by TDMH that can be facility-based, home-based or hospital-based in nature, depending on the need and availability.

#### *Facility-based Crisis Respite Services*

Crisis respite services that utilize a placement in a facility with direct care from trained crisis respite staff in direct response to a consumer's acuity level based on the assessment of risk.

#### *Home-based Crisis Respite Services*

Crisis respite services that utilize a placement in a home approved by the behavioral health crisis services provider with direct care from trained crisis respite staff or family members/significant others in direct response to a consumer's acuity level based on the assessment of risk.

#### *Hospital-based Crisis Respite Services*

Crisis respite services that utilize hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the individual and/or the need for a medically supervised setting.

### **Crisis Stabilization Services**

Crisis stabilization services are short-term supervised care services, accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff, and have typically longer stays. For adults, these services are provided in Crisis Stabilization Units licensed by TDMH. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- Individual and/or family counseling/support;
- Medication management/administration;
- Stress management counseling;
- Individualized treatment plan development that empowers the consumer;
- Mental illness/substance abuse awareness/education; and
- Identification and development of natural support systems.

If a crisis stabilization service provider is not able to obtain a current treatment plan, then the crisis stabilization services provider shall complete a crisis stabilization plan that is developed and agreed upon in writing by the individual, staff, and the individual's significant others, if appropriate. This plan identifies services and assistance needed to achieve stabilization as well as the components needed for discharge or transition to a lower level of care. Discharge/transition plans are to address what criteria are needed for the individual to move safely to a less restrictive level of care. This plan may also detail what is needed to move an individual to a higher level of care if it is deemed appropriate.

### **Medically Monitored Crisis Detoxification Units**

Medically Monitored Crisis Detoxification Services (MMCD), ASAM Level 111.7D, is an organized twenty-four (24) hour substance abuse detoxification service provided by medical and nursing professionals and designed to provide brief stabilization, detoxification and evaluation services. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to service recipients whose withdrawal signs and symptoms are sufficiently severe to require twenty-four (24) hour residential care. It is designed to provide brief stabilization, detoxification and evaluation so that an informed decision can be made regarding the individual's clinical needs.

### **Follow-Up Services**

Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the individual, following crisis intervention, respite, or stabilization to ensure the safety of the individual until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services staff contacting the individual only one time or can include several contacts a day for several days, as deemed appropriate by crisis staff.

A follow-up contact with the individual must be made within twelve (12) hours of a MPA face-to-face assessment. A follow-up contact with the individual must be made within twenty-four (24) hours of a crisis specialist face-to-face assessment that does not involve a MPA.