ACCESS

Community Health & Research Center

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Crisis and Safety Planning Policy Section __/# ____	Ana Dutcher Quality Assurance Manager	3/24/2021	6/24/2021	Page **1** of **5**

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I. POLICY

It is the policy of Arab Community Center for Economic and Social Services Community Health and Research Center (ACCESS CHRC) that all Behavioral Health consumers have a comprehensive crisis plan developed uniquely to the individuals/families, that addresses specific needs and utilizes various services and supports which inspires hope and promotes recovery and self-determination. Individuals with severe mental illness, co-occurring mental health, intellectual/developmental disorders, serious emotional disturbances, substance use and physical health conditions are expected to receive services within a system of care that is welcoming, recovery-oriented and capable of delivering integrated services to meet their needs and preferences. An Individualized Crisis Plan will be developed through the Person-Centered Planning (PCP) process and shall be provided to each individual/family being served.

II. PURPOSE

The purpose of this policy is to ensure all individuals/families receiving services are presented with crisis/safety planning to develop individual crisis plans to assist in preventing crisis situations and/or managing crisis situations that may occur.

III. APPLICATION

This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS Community Health and Research Center.

IV. PROCEDURES

1. ACCESS CHRC will provide Individuals/families served under the Behavioral Health contracts extensive educational tools on the importance of crisis planning and given the necessary support to develop meaningful, effective, and individualized crisis plans.
2. ACCESS CHRC is responsible for ensuring reliable training curriculum while also maintaining records of completion. Staff will be trained on the philosophy, development and implementation of crisis plans.
3. Case Manager or Supports Coordinator or other staff will:
    a. At the time of the member's crisis or initial assessment or pre-planning meeting or as requested by the member or legal guardian or parent, provide informational materials

(brochure) on what crisis planning entails, template of the crisis plan for completion, and an explanation of the process. A "crisis" can be identified as a psychiatric, medical, or natural disaster emergency for the individual and/ or their caregiver.

i. Individual/family decides what questions they want to answer and the people they want to enlist for support in the implementation of the plan. The individual/family also determines who will receive a copy of the plan upon completion. This process is conducted using the person-centered process and the individual/family is involved in the plan at all stages. The crisis plan is completed during the individual treatment planning process. Plans are modified when clinically indicated, within 14 days of a crisis occurring, or at a minimum annually to ensure reliability.

ii. Plans that are rehearsed are more likely to be followed and/or implemented effectively. Plans are practiced and or reviewed minimally at the periodic review and recommended quarterly. Practice is defined as repeated performance or systematic exercise for the purpose of acquiring proficiency. Repetition of the plan ensures quality and/or identify revisions that may need to be implemented to ensure safety for each individual/family served.

b. After the resolution of crises, provider staff elicit feedback from individuals/families served regarding whether the crisis plan was implemented. If implemented, to what degree crisis plan was effective.

i. If it is determined that the crisis plan was not implemented successfully or was ineffective, staff make diligent efforts to re-engage individuals/families served, other natural supports, and/or legally responsible parties in revising the crisis plan to increase the likelihood that it will be implemented and effective.

c. If individuals/families decline to participate in the development of crisis plans, network provider staff clearly document attempts to engage individuals/families in the plan development process. The development of a crisis plan should be revisited with the individual/family within 60 days of declining at the initial appointment or within 14 days of a crisis occurring. Discussion on the development of a crisis plan can be a goal to include in the treatment plan. A crisis occurring would be in the event of a visit to the emergency department, involvement with law enforcement and/or any event resulting in the need to complete A Critical Event or Incident Report. Documented efforts to educate individuals/families on the importance of crisis planning are also completed to ensure safety. If no information regarding individuals/families' preferences about the management of crises can be obtained, then the provider network also documents the reason(s) why it could not be obtained (MDHHS Contract attachment 3.4.1.1).

4. The crisis plan includes proactive and reactive components and are designed to address the needs of individuals/families served 24 hours a day, 7 days per week. (Collaborative Crisis Planning with Families-Patricia Miles 2012)
5. The Crisis Plan will provide assistance and interventions to avert hospitalization for individuals/families who frequent the emergency rooms (ER), have multiple hospital admissions, frequent contact with law enforcement or multiple crisis situations. This section of the crisis plan focuses on the following for each individual/family served:
    a. Identifying triggers and/or psychosocial stressors that have historically led to ineffective or dangerous coping and or crises.
    b. Identifying alternatives for ineffective or dangerous coping behaviors that are likely to lead to crises such as substance use, self-harm, suicidal behavior (threats, gestures, ideations), aggressive behavior towards others, destruction of property, neglect of physical health needs, and/or other highrisk behaviors;
        i. Risk factors to assist in identifying individuals at high risk for suicide include but are not limited to: prior suicide attempt(s), misuse and abuse of alcohol or other drugs, certain mental health diagnoses-- particularly depression and other mood disorders, access to lethal means, knowing someone who died by suicide (particularly a family member), social isolation, chronic disease and disability, and lack of access to behavioral health care. Examples of tools to assess risk are the PHQ-9 and the Columbia-Suicide Severity Rating Scale (CSSRS).
        ii. Individuals at risk for suicide minimally have the following included in their crisis plan: steps to reduce access to weapons or other potentially lethal means (i.e., prescription drugs).
    c. Identifying individuals'/families' strengths and alternative coping behaviors that are safe and likely to be effective based on individual's, natural supports/legally responsible parties, and/or providers knowledge of individuals' unique histories.
    d. Identifying professional and natural supports who are able and willing to intervene to support individuals/families served in coping safely and effectively with triggers and/or psychosocial stressors that have historically led to ineffective or dangerous coping and or crises.
6. The crisis plan provides direction regarding the care to be provided on his/her behalf during a crisis. This section of the crisis plan has multiple components which must minimally include:
    a. Specific designated persons who will be involved in making decisions for the individual (name, relationship, phone number, and assigned tasks).
    b. Current medications and allergies.

c. Physicians/psychiatrist involved in care and treatment.
d. Identifying the role of all professional and natural supports while implementing these interventions.
e. Preference for hospitals/treatment facilities. However, depending on the severity of the crisis, the individual will need to be taken to the nearest hospital/treatment facility.
f. Preference for the management of personal effects/affairs.
g. Any specific interventions or activities that can be used to help the individual during the crisis, reduce anxiety and regain control. The overall goal in addressing situations in which crises are likely to continue and escalate despite the application of all the documented preventive interventions, focus on the following for each individual/family served:
    i. Identifying interventions that are likely to mitigate/ameliorate crises based on individual's family's, natural supports/legally responsible parties, and/or providers knowledge of individuals' unique histories, progress, or mental state.
    ii. Identifying and documenting a course of action that will assure continuity of care across all parties involved in addressing crises (e.g., providers, Community Outreach for Psychiatric Emergencies, other professional supports including medical supports, and natural supports/legally responsible parties);
    iii. Identifying and documenting the preferences of individuals/families served regarding the following subjects:
        1. Preferred hospitals, however noting that depending on the crisis, the nearest emergency department or immediate inpatient bed available must be utilized.
        2. Who shall be notified during crises?
        3. Who will assist individuals/families served in handling things such as paying bills, managing finances, care for pets, etc. should individuals/families be away from home because of crises?

7. ACCESS CHRC maintains primary responsibility for ensuring continuity of care by providing access to crisis intervention service 24 hours per day, 7 days a week. The staff who respond to the crisis is responsible for ensuring the safety of individuals served and providing support in accessing higher levels of care as needed.
8. If a Psychiatric Advance Directive is in place, it is referenced in the crisis plan.
9. If a Physical Advance Directive is in place, it is referenced in the crisis plan (e.g. a chronic and complex health condition)

10. When a crisis responder who is not the primary staff (e.g. on-call staff) intervenes to assist during a crisis situation, he/she communicates and coordinates care regarding the crisis with the primary staff by the beginning of the next working day or sooner if necessary.
11. The Case Manager, Supports Coordinator or Therapist should assist the individual with identifying as many natural supports as possible to assure the plan is followed through to its fullest extent as identified in the crisis plan. If a crisis should occur, the plan will show what the individual's preferences are, who should be contacted by whom and any other valuable information on how to implement the plan. A signed consent should list the natural supports included in the plan to enable communication during the individual's crisis.
12. The Crisis Plan is a separate document from the Individual Plan of Service (IPOS) or Master Treatment Plan. The Crisis Plan must be uploaded into DWIHN's electronic system MHWIN).

VI. QUALITY ASSURANCE/IMPROVEMENT

ACCESS reviews and monitors adherence to this policy as one element of the Quality Improvement Performance Improvement Plan-Goals and Objectives. The agency's quality improvement program must include measures for both the monitoring of and continuous improvement of the program or process described in this policy

VII. COMPLIANCE WITH ALL APPLICABLE LAWS

Agency staff, contractors, and subcontractors are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

VIII. LEGAL AUTHORITY AND REFERENCES

1. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program
2. Michigan and the Integrated Care Organizations MI-HEALTH LINK Contract (The Three Way Contract) in effect, and as amended

IX. EXHIBITS

None