CARE COMPASS NETWORK

Title: Definition of Crisis Stabilization Services, BH Crisis, and Community Wide Treatment Protocol
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Purpose: Project 3a.ii Crisis Stabilization aims to provide community-based alternatives to Emergency Departments for individuals experiencing an acutely psychotic episode or who are otherwise behaviorally unstable. The core crisis stabilization services include Crisis Phone Hotline (Phone Triage), Mobile Crisis Outreach, Short-Term Community Respite, and Observation. Additional services may be included; the core services are a minimum required set.

The purpose of this document is to define a behavioral health crisis, define crisis services (and their components), and outline how services would be accessed by patients. This document will form the basis for a Community-wide Crisis Stabilization Protocol, which will define how the network of core service providers will interact to stabilize behavioral health crises in the community.

I. General Definition:

Crisis Stabilization Services consist of an integrated community wide response to individuals who are experiencing a behavioral health crisis. Some or all of these services are available 24 hours a day/seven days a week to assist individuals who are in need of assistance to manage their current crisis situation and return to a pre-crisis level of stability. Services included in this response include, but are not limited to, Crisis Phone Hotlines (Phone Triage), Mobile Crisis Outreach, Short-Term Community Respite, Walk in Crisis Clinic Services, Peer Warm-lines and support, and when necessary local law enforcement and the hospital Emergency Departments. The variety of these services are intended to give individuals, family members, treatment providers, and law enforcement some alternatives for providing crisis intervention and de-escalation in the community.

Purpose:

- Provide a timely community based crisis intervention response
- Provide a variety of options for care and treatment for individual and family during crisis situation
- Provide person-centered, evidence based assessment and interventions
- Provide a crisis service that is culturally competent and respectful of the individual in crisis
- Whenever possible stabilize crisis in community setting without transport to hospital emergency department
- Provide extended crisis intervention services to ensure individual achieves and maintains stability within community setting
- Assist individuals in identifying and using natural supports where appropriate to maintain stability
- Ensure individual is connected to appropriate treatment providers and social supports

Definition of Behavioral Health Crisis:

A behavioral health crisis exists when an individual is experiencing psychiatric symptoms, emotions, or behaviors that they are unable to cope with and that interfere with their ability to manage everyday life tasks. The following

describes three levels of acuity. The Crisis Stabilization project is best suited to address crises that are Low and Medium. Individuals in a Low or Medium level crisis can potentially be stabilized using community-based services and may not need law enforcement and/or Emergency Departments for stabilization. We reserve the highest level of acuity for those resources.

Potential Crisis Definition – Defining Levels of Acuity

LOW- *The individual is experiencing agitation or crisis due to an inability to cope with daily problems and activities. Some examples could include a sense of hopelessness, restlessness, excessive worry, fear or anxiety, irritability, significant changes in eating or sleeping patterns, racing thoughts, provocative or aggressive behavior, initiation of or increase in alcohol/substance use, inappropriate sexual behaviors and/or a vague sense of wanting to harm self/others.*

Response: This type of crisis can typically be de-escalated by phone or through in-person support in the community. Intervention would include supportive listening and directed questions to determine if agitation or crisis is greater than the original presentation. Ideally, intervention results in a verbal plan of action that the individual believes can assist them in managing their current situation. Crisis intervention does not require a licensed clinician or mobile outreach for de-escalation, however, knowledge of potential symptoms/behaviors of a mental health crisis is important. Whenever possible a follow-up call will be offered/provided to offer further support and/or a "warm hand-off" to other recommended mental health or community based services.

Deliverables/Documentation:

1. Identification of the Crisis – what is the problem/concern, how long has the individual been experiencing this particular situation?
2. Completed risk assessment of individual regarding risk of harm to self/others, physical safety, basic needs such as food, clothing, shelter.
3. Level of Care Determination – can crisis be de-escalated through phone triage or is higher level of service needed. Refer to Mobile Crisis or 911 as appropriate to situation.
4. Development of an individualized action/safety plan – hat can the individual do to manage current crisis/stressors within the next 24-48 hours.
5. Offer follow-up phone call.
6. Reconnect individual with known treatment providers
7. Provide referral and linkage to other services that individual might need including mental health, substance abuse, social services, peer support etc.
8. Navigation to services which will address the source of stressors.

MEDIUM- *The individual is experiencing or is at imminent risk of having a psychiatric crisis. The individual or family/friends may be concerned regarding a significant change in attitude, behaviors or psychiatric symptoms which may lead, or have led, to ED visits or inpatient hospitalizations in the past. For example, the individual may have stopped taking psychotropic medications, may be exhibiting severe mood swings, expressing suicidal/homicidal ideation/intent, may not be eating or sleeping adequately, have poor hygiene, may exhibit increased hostility or increased isolation, refusal to attend routine psychiatric or medical appointments. Substance use/abuse may be interfering with the individual's ability to function adequately in everyday tasks and responsibilities.*

Response- Mobile crisis intervention for further assessment of risk, mental status, medical stability, the need for further evaluation and/or other mental health/substance abuse services, and the ability to remain within the home setting. The goals of the Mobile Crisis Intervention Services are engagement, symptom reduction, and

stabilization. Service will be provided by a licensed mental health professional with the assistance of a peer specialist or other qualified non-professional individual. This team may be involved for a period of time (up to 3 months) to assist with ongoing crisis stabilization and ensure connection with needed mental health/community based services.

Deliverables/Documentation:

1. In depth risk assessment of crisis situation including risk of harm to self/others, substance use/abuse
2. Level of Care Determination – is crisis resolved at this level or is respite or ED needed
3. Documentation of Crisis Intervention including development of action/safety plan developed with the individual
4. Inform current treatment providers of crisis and intervention, share action/safety plan. Collaborate with treatment providers for future crisis intervention plans as appropriate.
5. Plan for follow-up services to ensure crisis de-escalated and client engaged with services.
6. Reconnect individual with known service providers.
7. Referral and linkage to community services as needed.
8. Transport or arrange transport to any additional crisis services needed including respite services.

HIGH/Emergency- *Life threatening or violent situations which require immediate response. Examples include individuals who are imminently at risk of harm to self/others, or have expressed violent intent/actions, or who have a known history of violent behavior, and/or are severely impaired or non-responsive due to substance use.*

Response: Concerned individual will contact 911 for police assessment and intervention. Crisis Stabilization Team will work with local law enforcement to offer follow-up crisis intervention services.

Deliverables/Documentation:

- Documentation of the action taken regarding crisis situation.
- When appropriate provide follow-up crisis stabilization services after police intervention.

II. Core Crisis Stabilization Services

A. Crisis Phone Hotline (Phone Triage)

Crisis Phone Hotline (Phone Triage):

Crisis Phone Hotlines (Phone Triage) is a first line assessment, crisis intervention, referral, and support service that is potentially available 24 hours a day/seven days a week. A primary role of this service is to assess and de-escalate a crisis when possible and/or to activate a higher level of service (i.e. mobile crisis or local law enforcement) when needed.

Components:

- Initial assessment to determine level of danger to self or others, and level of care/intervention needed
- Directed questioning
- Active and supportive listening
- Develop, with individual, plan of action/safety plan to assist with current situation
- Encourage individual to return to known treatment providers
- Referral to appropriate service including mobile crisis, law enforcement, treatment providers, social service agencies, etc.
- Follow-up phone service as appropriate

Warm-lines:

Peer warm-lines offer on-going social and emotional support to individuals with mental illness or co-occurring disorders. A warm-line can identify when an individual is beginning to experience a crisis situation and can provide appropriate referral information.

Components:

- Active and supportive listening
- Building peer support networks and establishing relationships
- Routine check-in with individuals at risk of crisis
- Encourage individuals to return to known service providers
- Activate mobile crisis or contact 911 as needed

B. Community-Based Respite Services

Short Term Crisis Respite Services:

A short term intervention (no longer than one week per episode) for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person's home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person's symptoms are beginning to escalate

Note: defined in 1915i waiver and recommended by 3aii Project Team.

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an in-patient setting. Crisis respite is provided in a site-based residential setting.

Respite services may be provided by peers who are certified by either OMH or OASAS working under appropriate supervision.

Service Components:

- On-site peer support during respite stay
- Health and wellness coaching
- Relaxation techniques to help reduce stress, anxiety, and other emotions
- Wellness Recovery Action Plan (WRAP)
- Conflict resolution
- Coordination with existing treatment providers, primary care, care coordinators, social services
- Collaborate with family, friends and other natural supports to assist individual during and after respite stay as appropriate

Drop In Centers:

Peer run drop in centers are an integral part of the crisis stabilization service. At those settings individuals with mental illness or co-occurring disorders can find a social and emotional support system as well as companionship, when appropriate, while navigating the larger community network of services. Certified peers can offer follow up support after a crisis situation or hospitalization.

Components:

- Safe place
- Active and supportive listening
- Companionship
- Support while navigating community network of services
- Encourage individuals to return to known service providers

C. Mobile Crisis Outreach

Mobile Crisis Intervention: Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation. Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis.

Note: Recommended by 3aii Project Team; OMH recommendation in 1915i, but waiver not approved by CMS.

Components:

- Preliminary face to face assessment of risk, mental status, medical stability, substance use/abuse, and ability to remain in community. Includes contact, as appropriate, with the consumer, family members and/or other collateral sources.
- Crisis resolution and consultation with the individual and the treatment provider
- Referral and linkage to appropriate Behavioral Health Community Services to avoid more restrictive levels of treatment.
- Linkage to Short Term Crisis Respite or Intensive Crisis Respite when clinically appropriate and notification, when appropriate to family members and treatment provider(s).
- Follow-up with the individual to ensure ongoing crisis de-escalation/stabilization, follow-through with developed safety plan and medication regiment, and connection with treatment provider.
- Non-clinical follow-up with individual, family/support network could be provided by Certified Peer Specialist in order to confirm linkage to Care Coordination, outpatient treatment and/or other services as needed.
- Consultation with physician and other qualified providers to assist with the individual's specific crisis and plans for future crisis stabilization. (i.e. safety plan, medications, etc.)

D. Hospital Observation

Intensive Crisis Respite/Observation Beds: This is a higher level of respite/observation service. Depending on situation this could be offered in community residential settings or in an ambulatory (non- admitted) hospital based setting. This service is a short-term, residential care and clinical intervention for individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. The individual may be at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. In order to be eligible, the individual must be able to contract for safety. This level of care may be used as a step-down from inpatient hospital care as appropriate.

Note: Based on 1115i Waiver service of Intensive Crisis Respite; recommended by 3aii Project Team.

Service Components:

- Comprehensive Risk Assessment
- Ensure both medical and psychiatric evaluations for medication needs
- Individual and group counseling
- Training in crisis de-escalation skills
- Training in relaxation skills for stress reduction
- Referrals and linkage to appropriate mental health and/or substance abuse treatment providers
- Peer support
- WRAP (Wellness Recovery Action Plan)
- Wellness activities
- Family or natural support system, as appropriate
- Conflict resolution

E. Other Services

Walk-In Crisis Services:

Most out-patient mental health clinics and drug and alcohol treatment agencies offer walk-in crisis services during business hours.

Components:

- Screening and assessment
- Crisis intervention service
- Development of action/safety plan as appropriate
- Follow-up treatment
- Referral and linkage to other needed services

III. Assessment Guidelines

The following represents the significant elements of an overall crisis assessment. Some or all of these elements may be necessary to evaluate in order to determine the acuity level of the crisis and the level of care determination. This document brings together assessment guidelines from multiple sources in order provide a larger context through which to choose appropriate screening/assessment tools. Some validated, and recommended, assessment screening tools are included where appropriate.

A. Universal Risk Assessment:

The Crisis Intervention clinician needs to be able to quickly complete a bio-psychosocial assessment that will provide an understanding of the following:

- Understanding of current stressors that have led to the crisis situation (suicidal ideation, interpersonal conflict, mood instability, loss of housing, etc.)
- Medical illness, and current medications
- Psychiatric illness and current medications
- Substance use/abuse -current substances used
- Suicidal ideation, sense of hopelessness, despair
- History of harm to self/others
- History of violence, criminal behavior, use of weapons
- Social stressors (lack of food, housing, interpersonal conflicts, criminal behavior)
- Current victim of emotional, physical, or emotional abuse
- Current or past trauma

- Existing social supports

B. High Acuity Crisis:

If someone is experiencing the following symptoms, then 911 or police should be contacted:

- Unresponsive due to known/unknown substance use
- Individual has harmed self with intent to kill (gunshot, serious cutting, overdose, etc.)
- Individual is in clear need of medical assessment/treatment
- Individual may be responsive but has ingested combination of legal and/or illegal substances that could cause serious medical issues or be life threatening
- Individual threatening to harm self or others with weapon
- Individual has known history of violence toward self or others
- Individual/family has threatened others with weapons
- Individual has history of excessive substance use, including prior overdoses
- Domestic violence/severe family conflict is present
- Attempts to engage individual has failed and there is a concern for the welfare of the individual
- Current participation in criminal behaviors
- If environment is known to have, or appears to have, dangerous elements such as drug lab, violent friends/relatives on premise, uncontrolled dogs, unsafe apartment building, etc.

C. Suicide Risk Assessment:

The National Suicide Prevention Lifeline has identified the following as risk factors for suicide:

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Previous suicide attempt
- Family history of suicide
- Job or financial loss
- Loss of relationship
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of health care, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

Essential Elements of Suicide Assessment:

Suicide Care in Systems Framework (2011) -developed by the National Action Alliance: Clinical Care and Intervention Task Force utilized the work of Thomas Joiner, Ph.D. (*Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline, 2007)* which identified the following as critical factors related to assessment of suicide risk:

- ***Suicidal desire****:* including suicidal ideation, psychological pain, hopelessness, helplessness, perceived burden on others, feeling trapped, and feeling intolerably alone;

- ***Suicidal capability****:* including history of suicide attempts, exposure to someone else's death by suicide, available means of killing self/others, currently intoxicated, substance abuse, acute symptoms of mental illness, and extreme agitation/rage;
- ***Suicidal intent****:* including attempt in progress, plan to kill self/others, preparatory behaviors, and expressed intent to die;
- ***Buffers/connectedness****,* including immediate supports, social supports, planning for the future, engagement with helper, ambivalence for living/dying, core values/beliefs, and sense of purpose.

High Suicidal Risk Symptoms: (not conclusive)
Some or all of the following symptoms may be present in someone who is imminently suicidal:

- Presents with clear intent to take their own life
- Has an identified plan which includes the method and date/time
- Has access to the identified method of suicide
- Individual has history of suicidal attempts or exposure to someone else's death by suicide
- Individual has no future orientation or sense of hope
- Individual has given away important personal items

Recommended validated suicide screening tools:

- Columbia Suicide Assessment Scale
- UHS Suicide Assessment Scale
- CMC Psychiatric Assessment Tool

D. **Violence Risk Assessment:**

The NYS Office of Mental Health has published MH Clinic Standards of Care for Adults. The best known predictor of future violence is a history of past violent behavior. The following recommendations for an initial risk assessment are:

- History of physical or sexual aggression towards other people
- Deliberate self-injury
- Emergency room visits or hospitalization related to threatening or violent behavior
- Arrest or orders of protection related to the client's threatening or violent behavior
- Current or recent thoughts or behaviors that others have interpreted as threatening
- History of difficulty controlling anger
- Expulsion from school related to violent behavior
- History of workplace or domestic violence

A more in-depth assessment would include:

- Details regarding the history of violence or violent ideation, including severity, context and use of weapons
- Past incidents of aggression have resulted from/included – interpersonal conflict, unstable relationships, poor social support, employment or financial problems, substance use due to active intoxication, withdrawal or craving
- Psychiatric conditions or active symptoms, including those related to personality disorder
- Treatment non-compliance or lack of insight
- Criminal behavior
- Ongoing access to weapons

Essential Elements of a Violence Assessment:

This is adapted from the above elements of a suicide assessment:

***Violence ideation*:** Includes a wish to harm other(s), blames others for situation, may be agitated and angry, or coldly believes they have a mission to fulfill (personal or faith-based)

Violence capability: Includes history of violence/aggression towards others, has available means of killing self/others, may be intoxicated, may have difficulty controlling emotions, impulses and behavior; may have psychopathic traits

Violence intent: Wants to harm a specific individual or group of individuals, has an identified plan, has identified a method and obtained any necessary weapons to complete plan, intends to act on plan.

Buffers/connectedness: has social supports, ability to engage with clinician, has outside monitoring such as Probation, Assisted Outpatient Treatment, able to recognize consequences of proposed behavior (prison, being killed, etc.) Able to establish or express positive non-violent goals for future

High Violence Risk Factors (not conclusive):

- Constant, persistent, intense fantasies or thoughts of wanting to harm/kill others
- Recently obtained weapon, or has cache of weapons
- Identified a specific individual or group of individuals
- Command hallucinations with violent content
- Lack of empathy for others
- History of violent and/or criminal behavior or delinquency

Recommended validated Violence Assessment Scales:

- UHS Violence Risk Assessment Scale

E. Substance Use/Abuse Assessment:

The OASAS approved New York State Level of Care for Alcohol and Drug Treatment Referral 3.0 identifies the following as essential elements in a Substance Use assessment:

- Type and amount of alcohol/substance used
- Individual is using in dangerous situations and at high frequency
- Individual is experiencing, or at risk, of experiencing life-threatening withdrawal symptoms
- History of alcohol/substance abuse or dependence diagnosis
- History of serious and persistent mental illness diagnosis and recently prescribed medications
- Medical illness and prescribed medications
- Ability or lack of ability to stop using substance once started in a day
- Lost marriage, family, employment due to substance use
- Persistent thoughts/cravings for alcohol/substance
- Uses significant time and energy to obtain alcohol/substance
- Uses a mixture of alcohol, legal medications and illegal substances
- Significant others (family and/or friends) state concern about individual's use
- Individual is pregnant
- Lack of regard for social norms, rules, personal obligations
- Level of support system in the community

High Substance Use/Abuse Factors: (not conclusive)

- Individual is at risk for or experiencing symptoms of withdrawal that cannot be managed on an outpatient basis
- Type of substance, amount and frequency
- History of alcohol/substance abuse/dependence disorder
- Co-morbidity with psychiatric illness and/or medical illness
- Constant and persistent cravings for alcohol/substance
- Use of multiple substances at one time

Recommended validated Substance Use/Abuse Screening Scales:

- AUDIT
- ASSIST
- CAGE
- CAGE-AID
- DAST
- SBIRT

F. Social Determinants of Crisis

The following social or environmental circumstances can result in a crisis or increase the level of hopelessness/anger experienced (not conclusive):

- Loss of housing
- Loss of employment
- Loss of relationship
- Death of a loved one
- Divorce
- Chronic or life-threatening illness
- Mental illness
- Individual's baseline level of functioning
- Lack of money for food, medications, rent, etc.
- Past or present incidents of trauma
- Intoxication with alcohol or other substances
- Allegations or arrest for criminal behavior
- Isolation
- Lack of transportation

Validated Assessment Scales:

- None known – It is recommended that the above items be included in the overall assessment of the individual as any specific or combination of social factors can increase the overall sense of crisis.

IV. Follow Up Guidelines

Overall Definition: The purpose of follow-up services, both phone and mobile, is to ensure continued emotional and psychiatric stabilization for an individual in the community after an in-patient hospitalization, emergency department visit, or recent community based crisis stabilization services. In general, the individuals who will be offered follow-up phone/mobile visits will be individuals who are not otherwise connected within the provider network and/or those who have a short wait time before their first appointment. In some instances, a provider may request follow up calls or visits for individuals who are experiencing extreme crisis situations and who may need additional support within the home or community.

It will be the responsibility of those agencies providing phone and/or mobile services to connect with, and maintain, open communication with local health home providers, and all behavioral health providers. Documentation of all contacts is essential.

Timeframe: In each county, the timeframe for follow-up after a behavioral health crisis will be determined appropriately given the available resources.

A. Phone Triage and follow-up:

The following situations would be appropriate for follow-up phone contact:

The crisis was successfully de-escalated through phone triage and follow-up call is offered to ensure that the individual in crisis remains stable and is successfully following the action/safety plan created during call. At each call the crisis worker will evaluate the level of crisis to determine level of stability, appropriateness of original plan, and suggest changes in plan or level of care as indicated through assessment.

After a Behavioral Health evaluation, the emergency department may offer follow up phone contact for individuals not well known within the provider network or for those individuals who they think may not follow through with referrals to appropriate providers. The purpose of the follow-up call would be to assess/ensure stability, determine if individual attended referral appointment, assistance with connection to services if needed.

The Behavioral Health unit may request follow up phone contact for individuals being discharged from the inpatient unit to ensure stability in the time before first appointment with providers, or for those individuals not otherwise connected within the provider network.

The Emergency Departments, inpatient behavioral health units, and outpatient behavioral health providers may request follow-up phone contact in situations when appropriate services are not immediately available.

B. Follow up phone services include:

- Assessment of the individual's current level of crisis and ability to function in daily activities manage the crisis
- Assess to determine appropriateness of current level of care (i.e. phone triage, mobile crisis intervention, or Emergency Department)
- Active and supportive listening to assist in ongoing crisis stabilization
- Evaluate effectiveness of original action/safety plan and change as appropriate
- Support and encourage individual to continue to utilize the action/safety plan and their own strengths to maintain stability in community.
- Encourage connection with appropriate providers and assist as appropriate
- Connect with providers as appropriate for the benefit of the individual

C. Mobile Crisis Services follow-up services:

The mobile crisis team may be requested in the following situations:
Local law enforcement requests that the mobile crisis worker accompany them on a behavioral health call and mobile team determines follow up for continued de-escalation or to ensure current emotional and psychiatric stability is needed

- Local law enforcement request a follow up mobile crisis visit after a police intervention to further assess crisis level, de-escalate as needed and/or ensure stability in the community.
- Mobile team had successfully de-escalated a crisis in the home or community and follow-up is needed to continue a crisis intervention strategy
- Mobile team provides follow-up to ensure ongoing stability and connection to appropriate providers.
- Local emergency departments, or inpatient behavioral health units, and outpatient behavioral health providers may request mobile visits as follow up to ensure stability within the community, provide clinical intervention as needed and ensure connection with appropriate connection with providers.
- Local phone triage units determine that a follow-up mobile visit for further assessment, intervention, and level of care determination

D. Follow-up mobile services include:

- Continued clinical crisis intervention to further de-escalate crisis situation
- Continued clinical risk assessment and level of care determination
- Further development of action/safety plan utilizing individual strengths and skills
- Work with known behavioral health service providers to ensure connection and coordinate intervention

V. Access to Crisis Stabilization Services

Through execution of Project 3aii, Care Compass Network aims to establish a provider of each core service in each of the nine service counties. In some cases, a provider of a service will serve multiple counties. But, in each county, providers will be connected to one another, and will be able to call upon each other. Care Compass Network will establish a Community-wide Crisis Stabilization Protocol for each community, connecting the various service providers.

The following will be the core components of the Community-wide Crisis Stabilization Protocol:

1. Standardized Safety Plan to be completed with crisis worker and individual.
2. Community-specific Resource Guide: material to support triage and activation of additional services for crisis de-escalation.
3. Regular meetings and modes of communication to connect service providers within a community.
4. Includes method to evaluate efficacy of Crisis Stabilization project.

When PPS clinical protocols and pathways are developed through the Clinical Governance Committee(s) of the PPS and approved by the CCN Board of Directors and are applicable to Partner Organization's delivery of health care services and project participation, such protocols and pathways shall not (1) override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases or (2) interfere with the governing body/established operator of any licensed health care facility or its medical staff in overseeing the provision of clinical services to patients and the quality of care

Policy Board Approval History:

Policy Revisions:

Date	Revision Log	Updated By
January 29, 2016	Initial Recommendation	
February 22, 2016	Addition of Assessment tool guidelines and recommended tools	Emily Pape/Sue Romanczuk
April 28, 2016	Addition of Follow Up Guidelines	Emily Pape/Sue Romanczuk

This Policy and Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.