SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES
System Requirement: REGISTERED

SERVICE DEFINITION

Service Name	CRISIS STABILIZATION
Funding Source	Behavioral Health Services
Setting	Facility Based
Facility License	MHC or SATC as required by DHHS Division of Public Health
Basic Definition	Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individualôs typical living situation.
Service Expectations	• Multidisciplinary/bio-psychosocial assessments, including a history and physical, and substance use within 24 hours of admission • Assessments and treatment must integrate strengths and needs in both MH/SUD domain • A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), developed within 24 hours of admission and adjusted daily or as indicated • Interdisciplinary treatment team meetings daily or as often as medically necessary including the individual, family, and other supports as appropriate • Psychiatric nursing interventions are available to patients 24/7 • Medication management • Individual, group, and family therapy available and offered as tolerated and/or appropriate using a brief therapy/solution focused approach • Addictions treatment initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate • Intense discharge planning beginning at admission

Service Name	CRISIS STABILIZATION
	• Consultation services available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services as needed • Access to community-based rehabilitation/social services to assist in transition to community living
Length of Services	The individualôs current crisis is resolved.
Staffing	• Medical Director/Supervising Practitioner: Psychiatrist • Clinical Director: APRN, or RN with psychiatric experience • Therapist: Psychologist, APRN, LIMHP, PLMHP, LMHP/LADC (prefer dual licensure) • Nursing: APRN, RNôs (psychiatric experience preferred) • Direct Care Worker, holding a bachelorôs degree or higher in psychology, sociology or a related human service field are preferred but two years of coursework in a human services field and/or two years of experience/training or two years of lived recovery experience with demonstrated skills and competencies in treatment with individuals with a behavioral health diagnoses is acceptable.
Staffing Ratio	• 1 staff to 4 clients during client awake hours (day and evening shifts); • 1 awake staff to 6 clients with on-call availability of additional support staff during client sleep hours (overnight); access to on-call, licensed mental health professionals 24/7 • RN services and therapist services are provided in a staff to client ratio sufficient to meet client care needs
Hours of Operation	24/7
Desired Individual Outcome	• Symptoms are stabilized and the individual no longer meets clinical guidelines for crisis stabilization • The precipitating condition and relapse potential is stabilized such that individualôs condition can be managed with professional external supports and interventions outside of the crisis stabilization facility.
Rate	1 Unit = 1 Day

UTILIZATION GUIDELINES
CRISIS STABILIZATION

I. Admission Guidelines

***All** of the following guidelines are necessary for admission to this level of care:*

1. Individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required; and
2. Individual demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention; and
3. Clinical evaluation of the individual's condition indicates dramatic and sudden decompensation with a strong potential for danger
   (but not imminently dangerous) to self or others and individual has no available supports to provide continuous monitoring; and
4. Individual requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting; and
5. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame; and
6. A less intensive or restrictive level of care has been considered/tried *or* clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.

II. Continued Stay Guidelines

***All** of the following Guidelines are necessary for continuing treatment at this level of care:*

1. The individual's condition continues to meet admission guidelines at this level of care.
2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan.
4. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
8. There is documented active discharge planning.

Service Name	**TREATMENT CRISIS INTERVENTION**
Setting	Facility-based program where patients in urgent/emergent need can receive crisis stabilization services in a safe, structured setting.
Facility License	As required by Division of Public Health
Basic Definition	This level of care provides a facility-based program where patients in urgent need can receive crisis stabilization services in a safe, structured setting. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from emergency services prior to ongoing services being established. The primary objective of the crisis stabilization service is to promptly conduct an assessment of the patient and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the patient to a level of functioning that requires a less restrictive level of care.
Service Expectations basic expectations for more detail see Title 471 chapter 20	• Services at this level of care include crisis stabilization, care management, medication management, and mobilization of family support and community resources. • Complete an initial diagnostic interview (IDI) if one has not been completed within the preceding 12 months, or if one is not available. • If the IDI was completed within 12 months prior to admission, and is available, a licensed professional should review and update as necessary via an addendum to ensure the information is reflective of the individual's current status and functioning. • Substance use disorder assessment if deemed necessary in the IDI. • A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), developed within 24 hours of admission and adjusted as needed. • Addictions treatment initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate. • Discharge planning begins at admission. • Individual, group, and family therapy services if medically necessary. • Ancillary service referral as needed (dental, optometry, physical health, other mental health and/or social services, etc.) • All staff should be educated/trained in recovery principles, and trauma informed care.
Length of Service	Until the individual is stabilized and meets the conditions of the discharge plan. Not to exceed seven days.
Staffing	Clinicians acting within their scope of practice may provide this service. • Initial Diagnostic Assessment: Psychiatrist/Physician, APRN, Psychologist, LIMHP • Therapist: Psychiatrist/Physician, Psychologist, APRN, LIMHP, LMHP, PLMHP, or a dually licensed LMHP/LADC • Direct Care Worker, holding a bachelor's degree or higher in psychology, sociology or a related human service field are preferred but two years of

	course work in a human services field and/or two years of experience/training or two years of lived recovery experience with demonstrated skills and competencies in treatment with individuals with a behavioral health or a behavioral health/ substance use co-occurring disorder is acceptable.
Hours of Operation	The program has the ability to accept admissions at any time and operates 24 hours a day, seven days per week.
Desired Individual Outcome	To be effectively treated with short-term intensive crisis intervention services resulting in stabilization and in being safely returned to a less intensive level of care within a brief time frame.
Admission guidelines	• Individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering to the extent that immediate stabilization is required. • Individual demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention. • Clinical evaluation of the individual's condition indicates dramatic and sudden decompensation with a potential for danger to self or others and the individual has no available supports to provide continuous monitoring. • Individual requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting. • The individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame. • A less intensive or restrictive level of care has been considered/tried or clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.
Continued stay guidelines	• The individual's condition continues to meet admission guidelines at this level of care. • The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate. • Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan. • Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. • All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. • Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident. • There is documented active discharge planning.