Crisis Team

REQUIRED POLICIES AND PROCEDURES

- ☐ Crisis Intervention
- ☐ Crisis Response for Back up
- ☐ Emergency Medical Conditions and Post-Stabilization Care Services
- ☐ Forced Medication Hearings
- ☐ Involuntary Commitment Procedure
- ☐ Off Site Emergencies
- ☐ Post Stabilization
- ☐ Substance Abuse Admission and Treatment

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical
PAGE:	1 of 2
SUBJECT:	Crisis Intervention
EFFECTIVE DATE:	7/2010
REVISION DATE:	10/2015

Crisis Intervention

POLICY
Davis Behavioral Health will provide crisis assessment and crisis intervention services for all persons who phone in or walk in to any DBH facility and who is in an emergent, psychiatrically unstable condition. This service will be provided 24 hours a day, seven days a week. Emergency services are available without preauthorization.

PURPOSE
Professional ethics require licensed mental health professionals to provide services to persons who are in an emergent situation irrespective of funding considerations if that professional is the first contact.

DEFINITION
DBH defines Crisis (Emergency) Services as inpatient or outpatient covered services furnished by a master's level (or higher) clinician who is qualified to furnish services required to evaluate and/or stabilize an emergency medical condition.

PROCEDURE
1. At least one DBH mental health professional will be identified as the crisis contact at all times of day, everyday of the year.

    a. These mental health professionals will be licensed to conduct psychotherapy, and will have knowledge of:

        i. Appropriate use of community services.

        ii. Crisis intervention techniques.

        iii. Risk assessment.

        iv. Procedures for involuntary hospitalization.

    b. During the daytime office hours, a crisis back-up will be identified from the available professionals on staff to provide crisis services when the primary responder is unavailable or responding to other crises.

2. A DBH physician will be designated to be available to the crisis workers at all times for psychiatric consultation or hospital inpatient admission decisions.

3. The crisis service will provide, based on need, either telephone intervention services or face-to-face assessments. Face-to-face evaluations can occur at any DBH facility or can occur in the community depending on circumstances, including the needs of the client, the needs of the community, and various safety considerations. The determination

will prioritize the best interest of the client. If a face-to-face assessment is indicated, the assessment will include:

a. An assessment of risk of harm to self or others.

b. Crisis intervention.

c. A crisis stabilization plan.

d. Appropriate referral for

i. Medical screening (if necessary)

ii. Follow-up services

iii. Inpatient services

4. During non-office hours, a crisis line will be operated by the adult residential unit to make certain that live answering capability is maintained around the clock.

a. The phone number of this crisis line will be given to all clients at the time of orientation to services.

b. The residential unit personnel answering the crisis line will refer any emergency to the on-call crisis worker.

c. The on-call crisis worker will contact the client within thirty minutes of the referral.

5. When the crisis evaluation indicates that hospitalization may be necessary, the crisis therapist is authorized to authorize up to the first 72 hours in the hospital. Any hospital that is desired by or most convenient for the consumer will be considered as a service provider.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Crisis Intervention Procedure
EFFECTIVE DATE:	1/2015
REVISION DATE:	

Crisis Intervention Procedure
Response for Backup

In session, a client is having thoughts of harming themselves or others, or having other behaviors that are concerning the therapist:

Will the client commit to safety?

Yes

1. Complete Safety Plan (be sure to include removing any potentially dangerous objects from the individual's access).
2. Discuss the Safety Plan with family member or parent (if the client is a minor).
3. Encourage line of sight observation.
4. Discuss using the DBH crisis line in the evening if needed. You may also contact the evening crisis worker and request an outreach (support staff have the schedule of on-call crisis workers).

No

Ask support staff to contact crisis worker or you can try to contact him/her directly, however for logging purposes, it is beneficial to go through support staff.

DBH crisis worker will complete the risk assessment. The following are dispositions that may result from a risk assessment:
Provide in home support
More immediate or additional appointments by DBH providers
Archway (children and adolescent behavior issues)
DBH Receiving Center (ages 5-17)
CRU (adults)
Wellness Check
Hospitalization

Phone Calls

If a medical evaluation or possible hospitalization is needed, refer the client to the nearest hospital emergency room (ER). Each ER has its own crisis team and the respective crisis worker will complete their own evaluation. Key questions to ask: Does the client have transportation to the ER? Are family members or parents able and willing to safely transport the client to the hospital ER? If so, the family and/or client will take the individual to the hospital and ask to meet with a crisis worker in the ER.

If the client is unwilling, or cannot be transported safely, contact the local law enforcement agency and request a wellness check. When law enforcement arrives at the home, a "pink sheet" may be completed, which is the initiation of involuntary treatment and possible involuntary hospitalization.

*****<u>As a general rule, DBH is not responsible to find a psychiatric bed in a hospital. All hospitalizations go through the hospital ER</u>*****

1. **Walk-In Crisis or Mobile Outreach**
   Even if the client has a therapist, support staff will contact the on-call crisis worker. During business hours, the primary daytime crisis worker is Ainsley Wall. If the daytime crisis worker is unavailable, the call will need to be handled by the backup crisis worker. The expectation is that the backup crisis worker will interrupt his/her activities (even if in session) to address the call. If the backup crisis worker does not respond appropriately, that person's supervisor will be asked to handle the call. If this does not resolve the situation, contact Todd Soutor, Jan Pendley, Marty Hood, or Kristen Reisig to assist the client.

2. **Not a DBH Client**
   If a non-DBH client walk-in crisis presents, support staff takes the same steps described above to contact a crisis worker. DBH responds in the same manner, regardless of the client's address, funding source, or county of residence. The crisis worker is to assess the situation and determine the possible need for hospitalization. If hospitalization is not needed, determine if the client can/should go to a different agency (i.e., if the client is a Weber County resident, refer him/her to Weber Human Services or if the client has private insurance and DBH is not an in-network provider, refer him/her to insurance provider panel). Regardless of the referral, gather the client's information including name, DOB, address, phone number, and insurance information (if face-to-face crisis) and ask an intake worker to open them in Credible. Document your note.

3. **Referral Options**
   If Davis County Medicaid, refer to DBH for ongoing services. If out of county Medicaid, refer to the respective mental health center. If the client is uninsured, some services may be offered through the DBH Living Well Clinic—contact David McKay at extension 429. If the client has private insurance, he/she may be eligible for the after hours clinic or the client may contact their insurance company to see what benefits, services, and providers are available.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical Policies
PAGE:	1 of 3
SUBJECT:	Emergency Medical Conditions and Post-Stabilization Care Services
EFFECTIVE DATE:	1/2009
REVISION DATE:	10/2015

Emergency Medical Conditions and Post-Stabilization Care Services

POLICY STATEMENT

Davis Behavioral Health will adhere to provision of Emergency Medical Conditions and Post Stabilization Care Services as found in the Medicaid Contract with the Utah State Department of Health and in accordance with 42 CFR. DBH will assume financial responsibility for PMHP enrollees as outlined in said contract. Utah Medicaid members will be charged only applicable co-pays for hospitalizations in accordance with Utah Medicaid's copayment policy. Out-of-network hospitals may not bill members more than the member would pay an in-network hospital.

EMERGENCY MEDICAL CONDITIONS

a. An Emergency Medical Condition is a psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of behavioral health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
   - Placing the health of the client (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
   - Placing the health or safety of other individuals in serious jeopardy
   - Serious impairment to bodily functions
   - Serious dysfunction of any bodily organ or part.

b. With respect to clients who have Medicaid insurance, DBH pays for Emergency Medical Conditions. The attending emergency physician or the provider actually treating the client is responsible for determining when the client is sufficiently stabilized for discharge or transfer to an inpatient unit or other facility.

c. DBH will not deny payment for treatment obtained when a client with Medicaid has an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition.

d. DBH will not
   - Deny payment for emergency services when a client is instructed to access such services by DBH or another healthcare provider (without regard to whether the client meets the prudent layperson standard).
   - Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms
   - Refuse to cover emergency services as a result of anyone's failure to notify DBH within 10 days of the client's presentation for emergency services.
   - Hold the client who has an emergency medical condition responsible for screening and treatments needed to diagnose the specific condition or stabilize the client.

- Deny payment for emergency services furnished by psychiatrists.

POST-STABILIZATION CARE SERVICES (PCS)

a. Generally, Post-stabilization Care Services begin upon admission to the inpatient psychiatric unit after Emergency Services to evaluate or stabilize the Emergency Medical Condition have been provided in the Emergency Room.

b. However, in situations where the hospital demonstrates the client received Emergency Services related to an Emergency Medical Condition during the inpatient psychiatric admission, DBH will reimburse the hospital in accordance with regulations governing Emergency Services.

PRE-APPROVED POST-STABILIZATION CARE SERVICES

a. DBH will pay for Post-stabilization Care Services that are pre-approved by DBH
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POST-STABILIZATION CARE SERVICES NOT PRE-APPROVED

a. DBH will pay for Post-stabilization Care Services that are not pre-approved, but are administered to maintain the client's stabilized condition, within one hour of a request for pre-approval of further Post-stabilization Care Services.
b. DBH will pay for Post-stabilization Care Services obtained that are not pre-approved but are administered to maintain, improve or resolve the Enrollee's stabilized condition if:
    i. DBH does not respond to a request for pre-approval within one hour (of the request);
    ii. DBH cannot be contacted; or
    iii. DBH's representative and the treating physician cannot reach an agreement concerning the client's care and a DBH physician is not available for consultation.
        a. In this situation, DBH will give the treating physician the opportunity to consult with a DBH physician and the treating physician may continue with the care of the client until a DBH physician is reached; or one of the criteria outlined in 42 CFR 422.113(c)(3) is met:
            i. a DBH physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
            ii. a DBH physician assumes responsibility for the client's care through transfer
            iii. a DBH representative and the treating physician reach an agreement concerning the client's care; or
            iv. the client is discharged

c. DBH is not responsible for Post-stabilization Care Services provided prior to the request from a hospital for pre-approval of further PCS. However, there may be extenuating circumstances that precluded the hospital from requesting pre-approval for PCS immediately upon admission to the hospital. In such instances DBH may reimburse the provider for the entire inpatient psychiatric admission when it is determined it would be clinically appropriate to do so.

d. If a hospital requests pre-approval of a specific number of days, and DBH authorizes less than the number of days requested, this constitutes an Action and triggers a Notice of Action (see Article XI, B), unless:

    i. Authorizing fewer days and conducting periodic continued stay reviews (e.g., every 24 hours, etc.) to ensure clients are discharged timely are standard procedure.

FORCED MEDICATION HEARING

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical Policies
PAGE:	1 of 2
SUBJECT:	Forced Medication Hearing
EFFECTIVE DATE:	12/2005
REVISION DATE:	8/2012

Policy

Adult consumers (18 years of age and older) who are under civil commitment to the local mental health authority are entitled to certain due process proceedings prior to being administered medication treatment against their will.

Purpose

Davis Behavioral Health is intent upon balancing the interests of the consumer in freedom from unnecessary medical treatment against the legitimate and medically necessary treatment needs for those consumers the court has deemed unable to make his/her own treatment decisions.

Procedure

1. If a consumer is able to give informed consent to medication treatment, but refuses to do so, or if the consumer is unable to give consent, the treating physician may request a Medication Hearing be held to determine if the medication treatment is medically necessary and authorized.
2. With the exception of exigent (STAT) circumstances, no involuntary treatment occurs prior to the consumer being afforded a hearing with a decision on that hearing in accordance with the procedures outlined in this policy.
3. The DBH designee contacts committee members (at least 1 non-treating psychiatrist and 2 non-treating designated examiners) and sets a date and time for the hearing. The DBH designee forwards a *Notice to Convene a Medication Hearing* form to the attending physician for completion which advises the consumer of the diagnosis, the factual basis for the diagnosis, and why the treating physician believes medication treatment is necessary. The consumer receives a copy of the notice at least 24 hours prior to the scheduled hearing.
4. If the consumer refuses to attend the hearing or otherwise waives his/her right to attend the hearing, the hearing is held in the absence of the consumer. The consumer's absence from the hearing does not alter the decision reached with respect to whether or not to proceed with the proposed course of treatment.
5. Prior to the hearing, the treating physician (or designee) provides the Hearing Committee access to documentation regarding the consumer's mental condition, including medical records, doctor's orders, nursing notes and any other documents available which are pertinent to the determination of whether to proceed with the course of treatment. The consumer has the right to examine these documents, unless releasing the information would be detrimental to the consumer's health or safety of any individual.

THE MEDICATION HEARING

1. Medication hearings are conducted on the treatment units and are conducted in an informal, non-adversarial manner so as not to have a harmful effect upon the consumer.
2. The consumer has the following rights at the hearing:
    a. to attend the hearing
    b. to present evidence on his/her behalf
    c. to call witnesses; and
    d. to question witnesses called by committee members. Neither physician nor consumer has the right to legal representation; however, should the consumer choose, he/she may be represented by a lay advisor.
        i. d.1. If the consumer has a previously appointed legal guardian, the legal guardian is notified of the hearing and permitted to attend
3. One committee member chairs and conducts the hearing. The chair begins each hearing by informing the consumer and others present of the purpose of the hearing and the manner in which the hearing will proceed.
4. The treating physician attends the hearing and presents the physician's finding and recommendations with respect to the consumer's treatment. The committee members and consumer may question the treating physician and any other members who present information.
5. The consumer has the right to present information, which may include witnesses. The committee may question any witnesses called by the consumer.
6. If any person becomes disruptive during the proceedings, the chair may have that person removed and the hearing continues in the absence of said person.
7. Following the presentation of the information, the consumer, the treating psychiatrist, and others leave the room while the committee deliberates. Upon reaching a decision, the consumer and others are permitted to return to the room to hear the committee's decision.
8. The committee signs the Involuntary Medication Treatment Form which specifies the criteria for involuntary commitment as well as
    a. The proposed medical treatment is in accordance with prevailing standards of accepted medical practice;
    b. The proposed medical treatment is in the medical best interest of the consumer, taking into account the possible side effects of the treatment as well as the potential benefits of the treatment.

RIGHT TO APPEAL

1. The consumer has the right to appeal the committee's decision to the Medical Director or designee of the Local Mental Health Authority within 24 hours of the committee's decision by signing an Appeal of Involuntary Treatment Hearing Decision Form.
2. The consumer will receive a written decision from the Medical Director or designee within two business days of appeal.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

INVOLUNTARY COMMITMENT PROCEDURE

SECTION:	Clinical Policies
PAGE:	1 of 3
SUBJECT:	Involuntary Commitment Procedure
EFFECTIVE DATE:	12/2005
REVISION DATE:	10/2017

Policy

Clients involuntarily committed to the local mental health authority will be treated by Davis Behavioral Health in the most appropriate and least restrictive level of care. DBH will have a centralized record-keeping process that retains current documentation of the commitment status of all involuntarily committed DBH clients. All clients under commitment will have regular contact with DBH clinical staff who will consistently assess the appropriateness of the commitment and the treatment.

Purpose

The purpose civil commitment is to provide treatment to individuals who meet commitment criterion as established by Utah commitment law. DBH will make every attempt to manage this process in a respectful and client friendly manner. Utah commitment law assigns responsibility for involuntarily committed clients to the local mental health authority. The mental health agency (under the auspices of the local mental health authority) determines the optimal level of care for involuntarily committed clients. DBH has the responsibility to assure that committed clients are, at all times, in a level of care that is both sufficient for their individual treatment needs and in the least restrictive environment. The goal is to ensure optimal treatment and to acknowledge and protect the civil liberties of the client.

Procedure

A. Utah commitment law allows for clients to be admitted to a behavioral inpatient unit on an involuntary basis for a 24 hour period. During the initial 24 hours of the admission, the client is evaluated by the relative hospital's psychiatric provider. After this evaluation, a decision is made to either discharge the client; change the client's status from involuntary to voluntary; or to file an Application for Order of Involuntary Commitment (for adult clients) with the District Court,

B. Records of current commitment orders

1. An appointed DBH staff member will serve as the commitment coordinator. This person will maintain a current list of involuntarily committed adults and a copy of the judicial order.
2. DBH staff with an appropriate need-to-know may access these records by contacting:

   a. The Utilization Management Specialist;
   b. The Director of Intensive Services;
   c. The Clinical Director;
   d. The Administrator on Call (AOC).

C. Assignment of Treatment Coordinator of Committed Clients
DBH will assign responsibility for treatment coordination of involuntarily committed clients according to level of acuity and treatment needs. If the client is being treated in:

1. the Utah State Hospital, the DBH hospital liaison is the commitment service coordinator;
2. an acute inpatient unit or in a non-DBH residential/outpatient program, the DBH utilization management specialist under the direction of the director of intensive services or the DBH compliance officer is the commitment service coordinator. The client is assessed by an Assisted Outpatient Treatment (AOT) clinician while in the hospital for the appropriate level of outpatient care;
3. a DBH outpatient program, the outpatient therapist is the commitment service coordinator;
4. a DBH residential program, the program director is the commitment service coordinator;

D. Responsibilities of the Commitment Service Coordinator

1. The commitment service coordinator will "as frequently as practicable, examine or cause to be examined every person" (Utah Code 62A-12-240) to determine if they continue to meet commitment criteria.

    a. The frequency of contact with the committed client will be determined by clinical indications.

2. During the professional contacts with the client, family and/or treatment staff, the AOT clinician will assess whether the client:

    a. continues to meet commitment criteria;
    b. is cooperating with treatment;
    c. requires a change in level of treatment to a greater or lesser level of restrictiveness.

E. If <u>at any time during the commitment</u> the client is assessed to no longer meet commitment criteria:

1. The client will be informed that they are being placed on voluntary status;
2. The discharge from involuntary commitment will be reported to the court.

G. Arrangements for referral to and coordination with the Utah State Hospital:

1. All civilly committed clients who are considered appropriate for referral to the Utah State Hospital by DBH are processed through the adult and children/youth liaisons to the Utah State Hospital. These liaisons facilitates all admissions to the Utah State Hospital ensuring that all appropriate paperwork is processed and families are oriented to the services offered through the USH.

2. The liaison staff from DBH make regular visits to the Utah State Hospital to meet with clients and coordinate with State Hospital staff to promote continuity of care and disposition and transition planning for clients to return to the care of DBH post discharge from the State Hospital.

3. Clients received back into the local community after discharge from the State Hospital are integrated into the DBH continuum of care as their individual needs may require. Commitment status is transferred from the third to the second district court and will be monitored as described in this policy.

4. The DBH staff work cooperatively with the patients' family, support system, or legal guardians, local school district, and other agencies to ensure a smooth transition back into the community.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

OFF SITE EMERGENCIES

SECTION:	Clinical Policies
PAGE:	1 of 1
SUBJECT:	Off Site Emergencies
EFFECTIVE DATE:	12/2005
REVISION DATE:	6/2013

Policy

It is the policy of DBH to respond to emergencies in all DBH locations and in the community for active clients of DBH; for Davis County Medicaid recipients; for calls initiated by local law enforcement; and for all Davis County residents under the age of 18 (whether or not they are DBH clients). DBH's ability to respond to all Davis County residents under the age of 18 is based on the continuation of available funding and may be discontinued if such funding is no longer available. The DBH crisis worker will respond to all mental health emergencies at the Davis County Jail.

It is the policy of DBH that the safety of its clinicians is top priority. Consequently, such providers reserve the right not to respond to community based emergencies if they feel that their safety is compromised.

Emergencies at Davis County hospitals involving unfunded persons or insured persons will be the responsibility of the hospitals to manage.

Purpose

It is the purpose of this policy to provide a full continuum of care for DBH clients; to provide emergency services in the least restrictive environment; to participate as a cooperative community partner; and to fulfill contractual obligations.

Procedure

I. Crisis Team Response
   a. When a call comes in requesting DBH crisis team assistance, the individual receiving the call will immediately activate the DBH on-call crisis worker.
   b. The DBH on-call crisis worker will respond within the standards established by the current Medicaid contract (at a minimum).
   c. The DBH crisis worker will make contact with the caller and address the situation based on the clinical needs of the identified client.
   d. The DBH crisis worker will document all calls in DBH's electronic medical record if possible. There are times when the caller is unwilling to give any identifying information, thereby making clinically identifiable documentation impossible.
   e. DBH will respond to all emergencies at the Davis County Jail by contacting the medical unit in the jail and consulting with the jail RN.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical Policies
PAGE:	1 of 1
SUBJECT:	Post-Stabilization Policy
EFFECTIVE DATE:	1/2009
REVISION DATE:	2/2015

Post Stabilization Policy

Policy Statement:

Davis Behavioral Health will adhere to provisions of Post Stabilization Services found in Medicaid Contract with the Utah State Department of Health Article III Section F Items 1-5

Procedures:

After a client has been discharged from an inpatient behavioral unit, Davis Behavioral Health will assume follow-up care based on the clinical needs of the client. If the client is not considered suitable for outpatient care and needs some type of transitional treatment, the client may be transitioned from inpatient care to residential, respite, or other type of intensive care environment. If the client is suitable for outpatient care, DBH will make a reasonable effort to schedule an outpatient appointment within five business days of discharge.

If DBH is unable to schedule a current client with their primary treatment provider within five business days, the utilization management specialist will contact the respective supervisor to schedule an appointment within the five day standard.

If the client does not show for the initial follow-up appointment, the utilization management specialist will notify the director of intensive services, the director of the FAST team and hospital liaison specialist to request follow up contact.

If the recently hospitalized client is not in active services at DBH; will be starting services at DBH; or does not have in-home services with DBH, the hospital liaison specialist will offer to visit the home and complete a Daily Living Activities (DLA) assessment as part of post-hospitalization care.

Financial Responsibility

Davis Behavioral Health will assume financial responsibility for post stabilization services either at DBH or within its network of contracted providers for all PMHP enrollees. Post stabilization services must be pre-approved by Davis Behavioral Health within one hour of an organizations request. In the event that DBH does not respond, or cannot be contacted for a request for pre-approval within one hour of the request, or an agreement on treatment cannot be reached concerning the enrollee's care, then DBH must give the treating physician the opportunity to consult with a DBH physician, and the treating provider may continue with care of the patient until a DBH physician is reached, or DBH assumes responsibility for the enrollee's care through transfer, DBH and the treating physician reach an agreement on care, the enrollee is discharged. DBH must limit charges to enrollees for post stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through DBH.

Policies & Procedures

DAVIS BEHAVIORAL HEALTH

SECTION:	Clinical
PAGE:	1 of 3
SUBJECT:	Substance Abuse – Admission & Treatment
EFFECTIVE DATE:	2007
REVISION DATE:	9/2011

SUBSTANCE ABUSE: ADMISSION and TREATMENT

POLICY

Substance abuse admissions will be based on severity of treatment need within a context of limited financial resources. Priority will be given to pregnant women, women with dependent children, intravenous drug users, and county residents. Contractual obligations will also be honored. Federally mandated set asides and requirements of the State Division of Substance Abuse will be followed. Assessment procedures will be utilized to determine severity of need and hence generate a waiting list, if necessary.

PURPOSE

The policy insures reasonable fairness, compliance with regulations, requirements, contractual obligations, and sets the stage for quality assessments and delivery of care. The policy addresses the screening / assessment of non-specified consumers as well as special populations. This allows for prioritization of admissions based on mandated set aside requirements as well as establishing medical necessity for an episode of care.

ASSESSMENT POLICY

Substance abuse assessments will be comprehensive and include science-based elements, which drive placement and treatment decisions. Assessments will be population sensitive and reflect the special needs of the developmentally disabled, children and youth, and adults. Co-morbidity with other mental disorders will be evaluated and also drive placement and treatment decisions. Special assessment questions required by the State Division of Substance Abuse and Mental Health will be addressed and reflected in the assessment document.

PROCEDURES

I. Screening: Screening is the process that determines the need for a comprehensive assessment and/or other referral. A screening may be forgone if the need for comprehensive assessment is obvious. A screening should include the following:
   A. The completed screening form including recommendations.

B. The completed pre-admission ASAM worksheet indicating the level of care at which comprehensive assessment and admission should occur; and
C. Indication of whether a priority admission per Federal and State set aside requirements is needed (may be part of the narrative).

II. Comprehensive Assessment: A Bio-Psycho-Social-Cultural assessment is the process that establishes medical necessity for an episode of care, results in a DSM multi-axial diagnosis, and generates alcohol and drug data that is required by the State Division of Substance Abuse and Mental Health. It elucidates problem areas and life circumstances that will translate into a treatment plan and must be completed for every treatment admission. Information is compiled in the Davis Behavioral Health Substance Abuse Initial Evaluation form, which reflects the State Divisions Substance Abuse Preferred Practice Guidelines.

III. Required items specific to substance abuse assessment are as follows:

A. Completion of the Substance Abuse Assessment Form. (Bio-Psycho-Social-Cultural).
B. Special attention to the alcohol and drug use profile with all attendant data completed in that section, which must be entered in the computer to produce quarterly reports to the State Division of Substance Abuse and Mental Health.
C. In the medical section, indication that clients at risk for HIV/AIDS have had the issue discussed with them.
D. Data is collected, reviewed, and diagnosed based on a face-to-face client interview by a Licensed Mental Health Therapist.

The initial assessment must be completed within 2 days for Day Treatment admissions and within 7 days for outpatient admissions. Specific assessment forms or procedures may change, but required essentials must continue to be assessed.

POLICY: SUBSTANCE ABUSE TREATMENT

Substance abuse treatment will be determined by initial placement and/ transfer decisions based on American Society of Addictive Medicine (ASAM) criteria. ASAM criteria define medical necessity for a specified level of care. Sensitivity to individual client needs and circumstances will also be considered in placement / transfer decisions, as well as externally based requirements (i.e. from Corrections, Courts, and contractual obligations). Principles of effective science based treatments and preferred practices will also guide treatment. Recognition that recovery from addiction can be long-term process with multiple relapses and multiple episodes of care, results in a commitment to adequate time for recovery in treatment within a context of limited fiscal resources.

PURPOSE

The policy combines emphasis on medical necessity, individualized treatment planning, externally based forces, and improving treatment strategies. It provides a framework from which programmatic and individualized treatment decisions can be made.

PROCEDURES

Substance Abuse treatment procedures will follow preferred practice treatment procedures and requirements. Stand out procedures and requirements are as follows:

A. Each program within the Substance Abuse continuum of care will follow DBH referral / transfer and discharge policy and ASAM guidelines for client level of care placement.
B. Special requirements that are program specific, (i.e. day-treatment, intensive outpatient, outpatient) program requirements, and contractual obligations, will be monitored and documented.
C. Transfer from a mental health therapist resulting in an episode of substance abuse treatment requires the addition at transfer of the Substance Abuse Assessment Form, ASAM criteria, and substance abuse treatment plan.
D. Co-morbid mental disorders may require concomitant or sequential treatment depending on the needs of the client and the other pragmatic and clinical considerations.
E. Disorders of sufficient severity to require medication should receive medication / referral services concomitant with substance abuse treatment;
F. Documentation of family involvement is encouraged and should be recorded in the clinical record.
G. Case management services should be added when needed; particularly for pregnant women and women with dependent children, where contracts specify extra care, and otherwise where indicated.
H. Treatment plans for day-treatment admissions adhere to a maximum 2-day time line for the initial plan and must be updated as required. Treatment plans for outpatient and intensive outpatient admissions adhere to a maximum 7-day time line for the initial plan and must be updated as required. Time lines for updates that are specified by the Division of Substance Abuse are followed.
   Treatment services should not be provided until a treatment plan is completed.
I. ASAM updates defining level of care must accompany each treatment plan update.

Treatment related forms and even procedures may change, but essentials referred to above must continue to be addressed in an identifiable way.