Interpretive Guidelines
Mental Health Community Services Standards, Chapter 412, Subchapter G
Governing Crisis Services (§§412.310 and 412.314)

Standard	Criteria	Interpretive Guide, Surveyor Guide & Technical Assistance
DIVISION 2— ORGANIZATIONAL STANDARDS **§412.310. Access to Mental Health Community Services.** 412.310(f) Time frames. The LMHA and MMCO must arrange mental health services for consumers within the following time frames. (1) Crisis services: (A) Emergency care services — immediately. (B) Urgent care services — within 24 hours of request. (2) Routine care services — within 14 calendar days of request.	1) Crisis services: (A) Emergency care services — immediately. (B) Urgent care services — within 24 hours of request. 2) Routine care services — within 14 calendar days of request.	**Interpretive Guide:** The LMHA and MMCO must implement a system to assure individuals receive the mental health community services in timeframes that meet the needs of individuals in their local service area and these minimum requirements: • Immediately means no longer than 15 minutes for telephone contact with a QMHP-CS and no longer than an hour for face-to-face contact with a QMHP-CS. • The provider sees the individual face-to-face within 24 hours of requesting services. This may occur at any location agreeable to both parties, though usually at a clinic site. • The provider sees the individual face-to-face within 14 calendar days of request. This may occur at any location agreeable to both parties, though usually at a clinic site. **Surveyor Guide**: As in Section 412.304 (a), The LMHA and MMCO must monitor providers for compliance with these applicable subsections contained in Divisions 2 and 3. The Local Authority should have a means of collecting, aggregating, and analyzing data regarding compliance by all providers with these time frames. Begin with this data and with the Utilization Management system, if any. If not, the surveyor will select a random sample of clinical records from a range of providers, both internal and external, to determine the level of compliance of providers with this standard. If the Local Authority has no systems for ensuring compliance with required time frames and for Utilization Management, even if the LA's providers meet this standard, the LA is out of compliance with requirements in 412.034, as above, and with 412.313 (b) related to Utilization Management. **Technical Assistance:** Most IS systems currently in use or development have the capacity to collect this data. If not, there should be a specific plan for how the Local Authority will collect this data, such as review of clinical records and/or having providers or supervisors maintain this data for each unit through which they provide services.
412.310(g) Crisis	1) The 24-hour telephone	**Interpretive Guide:** Literature and postings should describe the hotline number as toll

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screening and response system. The LMHA and MMCO must have a crisis screening and response system in operation 24 hours a day, 365 days a year, that is available to consumers throughout its contracted service delivery area. A telephone system to access the crisis screening and response system must include a toll-free number and be easily accessible and well publicized. Calls to the telephone system must be answered by an individual trained in the crisis screening and response system's procedures who has 24-hour accessibility to QMHP-CS staff to perform clinical crisis screening and assessment. Consumers who are deaf or hard of hearing must be able to access the telephone system through TDD/TDY capabilities.	response system is staffed by trained personnel 24 hours a day. 2) The telephone response system is available in all areas served by the LMHA. 3) The telephone response system is available at no charge. 4) The telephone response system is well publicized.	free, and service area-wide. There should be no "gaps," or dead spaces in the service area. Minimum: The crisis hotline number should be in the phone book, on all LMHA and MMCO postings and literature, and periodically in local news advertisements. **Surveyor Guide**: These criteria are measured throughout the review process, the crisis hotline test calls, contact notes, and the clinical record review. The more linkages that occur from the initial telephone call to the point of face-to-face intervention, the greater the possibility for gaps in service or communication. The surveyor needs to understand the system well enough presite to identify possible lapses. For LMHAs and MMCOs with few community support services (Rehabilitation, ACT, Supported Employment and Housing), the constant crisis availability required by the standards seems very draining. This is because the fewer community supports available and the less assertive the LMHA's and MMCO's service philosophy, the more "crisis" business they will have. TDMHMR has determined that gatekeeping is an authority function, as opposed to a provider function. Therefore, it is potentially problematic, but not forbidden, for LMHA's to outsource pieces of the crisis and assessment functions. When a LMHA buys their crisis interventions (and resolutions) from someone else, especially hospitals, they almost certainly give away certain gatekeeping functions. Pay attention to the quality and thoroughness of provider training, LMHA or MMCO contract monitoring activities, and coordination between the LMHA or MMCO and their providers. Test call at a variety of times to the hotline for the local service area. Expect to reach within 15 minutes all QMHP-CSs on call at the time, plus review of clinical records. The hotline must work 100% of the time for the LMHA and MMCO to meet this standard. **Technical Assistance:** Depending on the configuration of services provided by the LMHA/MMCO or their contractors, the rural versus urban character of the service area, and other community resources available in the service area, many kinds of coverage of this function may be applicable and acceptable. Some crisis systems are centralized, some decentralized, and others a combination. For discussion of options for configuration of a crisis system, contact the State Authority Quality Management or Behavioral Health Services divisions.
412.310(h) Coordinating provision of crisis services in compliance with the Mental Health Code. The LMHA and MMCO must develop and implement policies and procedures governing the provision of crisis services that: (1) comply with the Texas Mental Health Code	1) The Local Authority advocates for and provides the least restrictive appropriate setting as defined in **§571.004.**	**Interpretive Guide:** The LMHA must provide advocacy or ensure that a contract entity provides advocacy in their stead for determining treatment in the Least Restrictive Treatment Alternative for all individuals presenting for assessment during psychiatric crisis. There should be evidence of a systemic policy emphasis on community integration and cooperation, with the LMHA taking the lead in clinical and rights related matters. The LMHA must evidence, through written policy and observed practice, an understanding of its role as "advocate" for persons with Mental Illness. The LMHA should be particularly proactive in it's advocacy role in situations in which hospitals provide screening services as part of their responsibilities under EMTALA (see section 412.314).It remains the responsibility of the LMHA to coordinate the

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(Texas Health and Safety Code, Subtitle C, §571.001 et seq.); (2) identify providers' role and responsibilities in responding to crisis; (3) describe the coordination of crisis services among providers of crisis services; and (4) describe the facilitation of the coordination of crisis services among law enforcement, the judicial system, and other community entities.		provision of crisis services in it's service area and to ensure that individuals with mental illness receive treatment in the least restrictive, most appropriate and available setting. **Surveyor Guide**: The surveyor presite or onsite should interview by telephone at least a sample of local police departments, sheriff's departments, local hospital emergency rooms, jails, and county judges or their clerks to determine the community's view of the LMHA's crisis response system. Because most law enforcement entities do not like to transport individuals and wait for screenings to be performed, the surveyor must take care to weigh answers from these entities. The LMHA should not be judged on anecdotal information. However, this feedback from the community agencies involved may help identify problem areas for the surveyor to follow-up. The surveyor must assess and make a judgement on how rigorously the LMHA adheres to the principle of "least restrictive treatment alternative." Has the LMHA developed true community based crisis alternatives (residential, intensive interventions, CSU)? Do the written and practiced procedures for screening and crisis intervention emphasize a non-coercive approach? Is there a clear emphasis on keeping consumers in their community? If the agency deals with crises by defaulting to law enforcement and commitment procedures, they cannot meet these criteria. **Technical Assistance:** The most descriptive and relevant document governing this area of service is the current Texas Mental Health Code. In some places across the state, local law enforcement entities are not aware of their responsibilities as designated by the code. In fewer cases, but still existing, are judges and justices who do not know the code. The LMHA may need to provide on-going education regarding responsibilities of all entities during the commitment process.
	2) The Local Authority advocates for and protects consumer rights with regard to apprehension by Peace Officers without warrant (001). 3) Applications for Emergency Detention (002) and Applications for Magistrate's Orders (Warrants) for Emergency Detention (011).	**Surveyor Guide**: The law provides for Peace Officers to apprehend individuals **without** warrants if the specified criteria are met. Does the LMHA try to assess these individuals in a local setting (i.e., the Clinic), or are they driven straight to a locked or state facility? If so, are consumers seen at the locked facility by LMHA staff? The LMHA should not default their role as advocates to law enforcement or ER staff. If contract staff or facilities are providing emergency evaluation, there must be documentation of active contract monitoring**,** to include training by the LMHA in crisis intervention and advocacy, as well as applicable standards and rules. Does the LMHA have a good working relationship with the local judiciary and law enforcement agencies? Do they make good faith efforts to participate in the process of involuntary commitment by advocating for the least restrictive alternative? Do they assume responsibility for consumers in the service area at all hours? Do they offer any assistance/advocacy/education to families applying for Emergency Detentions? Or do they default automatically to the local law and judiciary in any situations where consumers are not voluntary and compliant?
	4) Application for Court-	**Interpretive Guide:** There must be evidence that the LMHA makes recommendations

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	ordered Mental Health Services (574.012) Recommendations for Treatment	to the court for the least restrictive, most appropriate treatment available to meet the needs of the individual. **Surveyor Guide:** Do hospital and court liaisons (or other LMHA staff) file recommendations for the most appropriate treatment, in a timely manner, for each individual? How are the recommendations weighted? Do they follow the principle of least restrictive alternative? If these documents are last minute hurry-ups, or predominantly advocating continued inpatient care, then the standard cannot be met.
	5) Individual cases requiring law enforcement participation evidence proper service coordination. 6) The MHA documents on-going service coordination activities with law enforcement and other community entities.	**Interpretive Guide:** There must be evidence of scheduled meetings, seminars, or workshops with local law enforcement and judiciary. **Surveyor Guide:** In a random record sample selected on-site from crisis logs, there must be documentation of cooperative communication and coordination between the provider and other pertinent authorities. The documentation should have a routine appearance, as if the entities are accustomed to working with each other. Give extra compliments for a memorandum of understanding between community stakeholders and the LMHA/provider, or documented minutes of interagency councils/task forces on crisis intervention, screening, commitment procedures, mental health code interpretation.
412.310(i) Access to emergency medical and crisis services. The LMHA and MMCO must develop for providers' use, procedures to access emergency medical and crisis services for consumers.	1) The MHA demonstrates the ability to access emergency medical services 24 hours a day, 365 days a year. 2) The MHA can access emergency psychiatric services 24 hours a day, 365 days a year.	**Interpretive Guide:** All staff are aware of procedures for accessing emergency medical and psychiatric services at all times. If there is access to 911 emergency response, and the staff demonstrate awareness of this, then it is sufficient to meet the standard. Telephone hotline test calls, emergency/crisis contact notes, clinical records, interviews with family members and other local stakeholders all evidence that emergency psychiatric services are available and accessible 24 hours a day, 365 days a year. **Surveyor Guide:** LMHA policies and procedures for crisis services and medical emergencies should describe what staff are supposed to do in these crises. While on-site ask randomly selected staff at several different levels of the organization what they would do in either sort of crisis. If they do not know to call 911, the usual procedure in most places, the LMHA does not meet this standard. **Technical Assistance:** None.
DIVISION 3—STANDARDS OF CARE **§412.314. Crisis Services.** 412.314(a) Immediate screening and assessment. The provider of crisis services must be available 24 hours a day, 365 days a year, to perform immediate screenings and assessments	1) Individuals experiencing acute psychiatric crises are assessed face-to-face by a QMHP—CS. 2) Face-to-face assessments are provided immediately,	**Interpretive Guide:** All personnel designated to perform emergency face-to-face assessments are at minimum QMHP-CS qualified. Immediately means that the individual must be able to speak to a QMHP-CS within 15 minutes and should be able to be seen face-to-face by a QMHP-CS within one hour. The assessment may take place at a designated "safe place" in the community, in homes, jails, clinics, emergency rooms, or wherever local law enforcement and other local agencies and entities agree. If a LMHA covers a very large geographic area, they may need to have enough mobile

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of consumers in crisis using any designated assessment instruments as required or approved under a contract between the LMHA or MMCO and a state agency. Consumers experiencing a crisis that may require emergency care services, as determined by a QMHP-CS screening must be immediately assessed face-to-face by a QMHP-CS.	and are available 24-hours a day.	QMHP-CSs on-call to be able to provide a face-to-face assessment within one hour for all areas served. According to the Federal Emergency Medical Treatment and Active Labor Act, individuals who arrive at a hospital emergency room must be screened by qualified **hospital** staff to determine if the person has an Emergency Medical Condition, which may include a psychiatric emergency. If such an emergency condition is found to exist, then the hospital cannot discharge the person unless the condition is stabilized, nor can it transfer the person in an unstabilized condition except per EMTALA regulations. In such cases, the screening and stabilization responsibilities are clearly maintained by the hospital. However, the LMHA continues to have the responsibility to ensure that mental health services are provided in the Least Restrictive, most appropriate and available setting to meet the individual's needs. This may include the need to provide consultation to the hospital, or to assist the hospital with performing an adequate assessment. Under no circumstances can the LMHA/MMCO require that the hospital discharge or transfer the person in order to perform an assessment if this would be a violation of EMTALA. **Surveyor Guide:** Compliance with the QMHP-CS requirement should be evaluated by comparing the Crisis Services' competency list to the LMHA, MMCO or provider's list of credentialed QMHP-CSs. The surveyor should read all curricula used for training staff to perform this function, preferably presite, to ensure that it addresses all the basic elements. Telephone interviews with other agencies interfacing with the LMHA/provider of crisis screenings may reveal problem areas. Often most of a system will work well, while some stakeholders or communities are not satisfied or the service is not working well in that particular community. Any questions raised by input from other stakeholders should be considered, though judiciously, and answered to the surveyor's satisfaction during the survey process. Procedures do not allow for any lapse in the provision of immediate, face-to-face assessment except for situations where the person presents at a hospital emergency room as described above. Review of crisis contacts (hotline, walk-ins, referrals from community agencies and stakeholders) reveals that immediate face-to-face assessments are provided in 100% of cases where indicated. **Technical Assistance:** Much information exists regarding suicidalogy, conflict resolution, intervention with substance abusers, crisis resolution, and other related clinical interventions. However, much of the literature does not address intervention for individuals with major psychotic disorders. The well-prepared worker will be familiar with literature regarding practice in all of these areas, with all populations. EMTALA regulations should be reviewed to thoroughly understand the unusual exceptions secondary to this Federal statute.
412.314(b) Physician	In cases of confirmed acute	**Interpretive Guide**: In cases of confirmed acute psychiatric crisis, the QMHP—CS

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assessment. If the consumer requires emergency care services, as determined by the QMHP-CS assessment (as described in subsection (a) of this section), then the provider of crisis services must have a physician, preferably a psychiatrist, perform a face-to-face assessment of the consumer as soon as possible, but within 24 hours. The QMHP-CS must provide ongoing crisis services (e.g., interventions for the crisis and/or monitoring of the consumer) until the crisis is resolved or the consumer is placed in a clinically appropriate environment.	psychiatric crisis: 1) the QMHP—CS provides ongoing interventions and/or monitoring, until...; 2) the person is assessed face-to-face by a physician who is preferably a psychiatrist; and 3) ASAP and within 24 hours.	provides on-going interventions and/or monitoring. This may involve actually physically staying with the individual until they can be assessed face-to-face by a physician. The person must be assessed face-to-face by a physician who is preferably a LMHA/contract psychiatrist. However, a medical physician can see an individual, determine the need for treatment, and initiate certificates for involuntary commitment, if necessary. The face-to-face assessment by a physician must be available within 24 hours. Unless a screening service or facility provides inpatient treatment, it is not required to have a physician onsite, but rather only available within 24 hours. Best Practice in this area is for QMHP-CS staff providing face-to-face screenings after hours to have a psychiatrist available for telephone consultation, at a minimum. **Surveyor Guide:** Providing face-to-face crisis intervention and support is best wherever appropriate. The minimum would be to provide periodic telephone checks or communication with Mental Health Deputy, other law enforcement, EMS, documenting that safety and care are ensured. The service provided must measure up to the clinical and customer service demands of the situation. How do they address the psychiatric piece of the crisis response? Is the medical service responsive to the customer and the situation? Or is it the same for everybody? Does the psychiatric assessment always occur during business hours the next day? The service must not only be within the time frame, but also be appropriate to the nature of the crisis. **Technical Assistance:** Long waits for face-to-face assessments by a physician are possibly the major problem negatively effecting the LMHA's relationship with the community in which they work. Stakeholders, including individuals in crisis, families, law enforcement, and emergency rooms become particularly disgruntled and complain to whomever they can when asked to wait for several hours. The extended use of LPHAs and QMHP-CSs on-call for crisis screenings can help alleviate such long waits for the individual in crisis and reduce complaints about the system.
412.314(c) Documentation of crisis services. The provider of crisis services must maintain documentation of the crisis services, including:	The provider of crisis services must maintain documentation of the crisis services.	**Interpretive Guide:** The provider must document their interventions and the clinical justification for them, as well as the customer's or individual's input, preferences, and response to them. **Surveyor Guide:** The reviewer must see evidence that documentation of crisis events consistently meets requirements. The reviewer may evaluate reviews by supervisors or contract monitors that have monitored whether or not the providers document their interventions and the clinical justification for them, as well as the customer's or individual's input, preferences, and response to them. In some situations the surveyor will be able to review a large number of records and total them up for a pass/fail score based on close examination; however, interviews with provider staff and consumers, satisfaction survey data, internal communications, responses to QI , Consumer Rights, and client care monitoring findings, reveal the overall presentation of the LMHA (or

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		provider) in this area. **Technical Assistance:** Though most clinicians document adequately, the use of forms which clearly call for the required information are most successful. Best Practice in this area includes close oversight of crisis documentation by a clinical supervisor on a daily basis, to ensure that all information is complete. Particularly for a clinician who is very busy, close and timely oversight helps the clinician complete any missed information while their memory is fresh. Documentation of these crisis events must be adequate to help the LMHA/provider defend themselves in a court of law in this very risky and often litigated service.
412.314(c)(1) date, time, name of consumer (if given);	Document the date and time of the contact and the consumer's name	**Interpretive Guide**: Date includes day, month, and year. Time includes the exact time to the minute and AM or PM. Note the consumer's name if they give it. **Surveyor Guide:** Review of clinical documentation onsite will give a good sense of the consistency and completeness of this requirement. **Technical Assistance:** None.
412.314(c)(2) presenting problem;	Document a description of the presenting problem from the consumer's perspective and from the perspective of other informants, if different	**Interpretive Guide**: Presenting problem refers to the current event or circumstances which brought the consumer in for assessment and the way in which they appear, speak, and behave at the time. If the consumer gives signed consent, the presenting problem as described by a collateral informant such as a family member may prove informative and valuable as well. **Surveyor Guide:** During the review of clinical documentation onsite, the surveyor should attend especially to any documentation indicating behaviors which have been or might be dangerous to self or others, and follow-up to determine if appropriate resolution took place. **Technical Assistance:** None
412.314(c)(3) services requested by the consumer (or LAR on the consumer's behalf);	Document the services requested by the consumer;	**Interpretive Guide**: The clinician will usually need to ask the consumer which services they are requesting. The consumer may need to have the clinician explain what services exist and are available, in order for the consumer to know what to request. **Surveyor Guide:** The surveyor will determine compliance through the review of clinical documentation of crisis events, in records, logs, or any other format. **Technical Assistance:** None
412.314(c)(4) disposition of the crisis;	Document the disposition of the crisis	**Interpretive Guide**: Complete disposition should be documented, including the immediate plan and a long-term plan, if possible. Documentation must describe all efforts taken by the LMHA/provider to ensure the person's immediate safety, treatments available in the least restrictive alternative, and attempts to provide or arrange services.

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		Surveyor Guide: This documentation is the single most important element, so should be perfectly discernable and clear. These are legal documents and require oversight to ensure completeness. Look for reviews of crisis documentation by clinical supervisors, clinical record reviews by quality management staff or other auditors, and any reports that summarize data regarding the consistency of this documentation. Even one record that mentions dangerous behavior as an issue, but does not clearly describe the disposition of the case, may be cited as a sentinel event, depending on the severity of the behavior. **Technical Assistance:** Oversight is the key to ensuring complete documentation.
412.314(c)(5) names and titles of staff involved;	Document the staff involved; either directly or through consultation	**Interpretive Guide**: Use names and titles which are clearly identifiable. **Surveyor Guide:** If it is not signed, it does not count. **Technical Assistance:** None
412.314(c)(6) all actions (including referrals to other agencies) used by the provider to address the problems presented and the dates and time of such actions; and	Document actions used by provider to address the problems presented and the dates and time of such actions	**Interpretive Guide**: Use specific names of people and agencies, so that someone else having to follow-up on a case with which they are unfamiliar has all the information they need. **Surveyor Guide:** Adequacy will be determined through review of crisis documentation. **Technical Assistance:** None
412.314(c)(7) the response of the consumer, and if appropriate the response of the LAR and family members.	Document the response of the individual to the interventions and recommendations of the provider. If the family, significant other or LAR are involved in the interaction, document their response as well.	**Interpretive Guide**: Response means how the person reacted and behaved as a result of intervention. **Surveyor Guide**: The supervisor, reviewer, or contract monitor must make a determination as to whether or not the providers document their interventions and the clinical justification for them, as well as the customer's or individual's input, preferences, and response to them. **Technical Assistance:** A suggestion for the LMHA's gathering of satisfaction information is to ask the person and the family if they are satisfied with the intervention and to record the answer.
412.314(d) Communication of crisis contacts. If a consumer currently receiving mental health community services from an LMHA or MMCO has experienced a crisis and been	1) Crisis contacts are communicated to the person's Continuity of Services Staff Person (CSSP). 2) The CSSP notifies all	**Interpretive Guide**: Crisis contacts are communicated to the person's CSSP. The CSSP notifies all pertinent staff, to include the physician, the service coordinator, and all staff providing other services. The purposes are for sound clinical practice and for the efficient use of staff time, so that staff know to cancel other appointments for the consumer who has entered inpatient treatment. **Surveyor Guide**: Look for a clearly stated policy about this; this requirement has been

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assessed in accordance with subsection (a) of this section, then the provider of crisis services must communicate that crisis contact to the LMHA or MMCO as soon as possible, but no later than the next working day, in order for the LMHA or MMCO to ensure the consumer's continuity of services.	pertinent staff. 3) Knowledge of the crisis incident is disseminated within one workday.	in the standards long enough that it should be imbedded in every provider's training protocol, and any CSSP should be able to recite it and show you how and where this is documented. Systems: Outpatient services should function more smoothly as a result of this. Consumers have coordinated responsive interventions that change as a result of crisis calls or events. Physician or other appointments are not missed due to consumers being in Hospital or crisis residential unit without knowledge of pertinent staff. Appointment scheduling is flexible enough to accommodate pre-crisis and post-crisis interventions. Case by case: 90% of clinical records reviewed evidence the communication of crisis-related events; shared information informs and impacts the providers' relationship with the consumer. **Technical Assistance:** None.