

Comments and Responses on ARC 1554C Crisis Response Services

The following person/organization provided written comments, which are included in the summary below:

1. Diane Brecht, VP, Residential Treatment Services, Abbe, Inc.
2. Barb Gay, Foundation 2, Inc.
3. Karen Walters-Crammond, Executive Director, Polk County Health Services
4. Keri Neblett, Community Intervention Director, Crisis Center of Johnson County
5. Cynthia Steidl Bishop, COO, Eyerly Ball Community Mental Health Services
6. Michael Flaum, Director, Iowa Consortium for Mental Health, University of Iowa Carver College of Medicine, Psychiatry Research/MEB

The Department changed the format of the rule to reflect parallel construction and clarified synonymous terms for consistency. The style headings and numerical levels within the document are revised due to structural changes.

The Department changed the number and value of indicators to reflect the new construction of the rules. 24.26(3)c

Service	Number of Indicators	Value of Each Indicator
24-hour crisis response	19	3.9
Crisis evaluation	20	3.5
24-hour crisis line	23	3.0
Warm line	20	3.5
Mobile response	18	3.9
23-hour observation and holding	44	1.6
Crisis stabilization, community-based	39	1.8
Crisis stabilization, residential	50	1.4

The Department received 156 comments from six respondents on the proposed rules. The comments and corresponding responses from the Department are divided into 16 topic areas as follows:

A. Crisis Services in General.

1. One respondent commented the rules state the standards apply to providers not required to be licensed by DIA and asked if that means providers licensed by DIA for other services are excluded from these rules.

Department Response: The rules apply to all providers of the crisis stabilization services described herein. A provider of crisis stabilization services may or may not be licensed by DIA for the provision of other services.

2. One respondent commented in defining crisis services, it should be noted that effective crisis intervention and suicide prevention respect the autonomy of the individual and their need and right to be engaged in finding appropriate safety measures that do not require entering a hospital or other facility.

Department Response: The Department agrees with this statement and believes the rules are consistent; no change to the rules is needed.

3. One respondent commented crisis services should always include the assumption of highest level of risk and suicidal action. They noted training should be conducted, and ongoing monitoring in place, to ensure evidence based risk assessments of suicidal behavior are utilized for all clients in behavioral health crisis. The respondent also suggested that trainings, such as Applied Suicide Intervention Skills Training (ASIST) should be required for all crisis response staff.

Department Response: The rules require appropriate Department approved training for crisis response staff. ASIST is one example of a training program the Department would approve.

4. One respondent commented the rules do not seem to allow for people in crisis who do not meet criteria for a mental health disorder.

Department Response: The eligibility standard 441.24.25(1) does not require a mental health diagnosis for an individual to be eligible for a crisis stabilization service.

5. One respondent commented that training in regards to means restriction, as part of suicide response, should be required for all crisis response staff and training should also be provided for securing all environments for suicide safety.

Department Response: The rules require Department approved training for crisis response staff and the standards for organizational activities in Chapter 24 address any situation that poses a danger or threat to staff or individuals using the services for necessity appropriateness, effectiveness and prevention. 441-24.3 (b) (5).

6. One respondent commented trauma informed care training and practices should be required.

Department Response: The rules allow the organization to identify training appropriate for crisis response staff and trauma informed care training would be approved by the Department.

7. One respondent commented peer support services should be an integral part of each crisis stabilization service and each provider should be required to have the necessary supervision and support for peers who are providing direct stabilization service.

Department Response: The Department agrees and the rules include requirements for staff development, training and supervision for crisis response staff, which includes peer support specialists.

8. One respondent commented the use of a peer specialist who has made significant progress in their recovery to assist another individual with the same disorder is powerful and the intent should be to match a peer specialist with a crisis client that recognizes their situations as similar.

Department Response: The rules allow providers reasonable flexibility in staffing and in the assignment of peer support specialists.

9. Three respondents commented the services do not include crisis care management to ensure post-crisis linkage to other services, or stabilization has been achieved to prevent future similar crisis. One of the respondents also suggested online chat and text crisis services should be included in the rules.

Department Response: The Department's response is follow-up services are required to be addressed in the treatment summary and action plan. The rules do not limit how crisis stabilization services can be provided as long as the means of communication are sensitive to confidentiality of users and, when required, are HIPAA compliant.

10. One respondent commented the rules do not address crisis aversion services as an option for people on the verge of crisis who need support to get through a difficult time.

Department Response: Crisis aversion services were not included in Iowa Code 331.397 requirements for regional core services or additional core services and are beyond the scope of the rules.

11. One respondent noted the rules state crisis response services shall not be denied because of co-occurring conditions and asked if crisis response services can be denied if the individual is in a state of intoxication that presents a medical or behavioral safety issue? The respondent also asked what funding sources are anticipated.

Department Response: Provider policy and procedures should address appropriate crisis stabilization services to individuals with co-occurring conditions and should address actions to be taken for the safety of individuals and staff. The rules do not address funding sources.

B. Definitions.

1. One respondent commented the definition for Action Plan should be clarified to state it is developed collaboratively with the client and should include internal coping strategies as well as

professional providers and social supports, and identify environmental issues that assist the individual to be safe from self-harm.

Department Response: The Department has changed the definition of Action Plan in response to this comment. “*Action plan*” means a written plan developed for discharge in collaboration with the individual receiving crisis stabilization services to identify the problem, prevention strategies, and management tools for future crises. 441-24.20(225C).

Coping strategies, staffing qualifications, social supports, and environmental issues are all items to be addressed through the assessment requirement 24.32(2).

2. One respondent commented the rules include a definition of Clinical Supervisor, yet the term is not used in the rules.

Department Response: The Department agrees the term was not used in the rules and definition has been removed in response to this comment, 441-24.20(225C).

3. Two respondents commented the definition of Crisis Assessment does not include telephonic or other electronic methods of interview.

Department Response: Crisis assessment must be done utilizing face-to-face clinical interviewing as defined in this rule. The Department changed the definition of face-to-face. The new definition for “Face-to-face means services provided in person or utilizing Telehealth in conformance with the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy rules”.

4. One respondent commented the definition of Crisis Response Services seems to indicate either crisis screening or assessment must be done, but not both.

Department Response: Crisis stabilization services can occur after either a crisis screening or crisis assessment.

5. Three respondents commented the differences between the definition of Crisis Stabilization Community Based Services and Crisis Stabilization Residential Services are not clear enough to distinguish between the two service levels.

Department Response: The crisis stabilization service levels are the same with the difference being an individual receiving crisis stabilization residential services needs a short-term alternative living arrangement. The Department changed the definitions to clarify. “*Crisis stabilization community-based services*” or “*CSCBS*” means short term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis where the individual lives, works or recreates. 441-24.20(225C).

“*Crisis stabilization residential services CSRS*” Crisis Stabilization Residential Services” (CSRS) means a short-term alternative living arrangement other than a person’s primary residence, designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in organization arranged settings of less than 16 beds.

6. One respondent commented the definition of “stabilization plan” should say it is written by crisis response staff rather than mental health professional and in collaboration with the client rather than with the consent of the individual.

Department Response: The stabilization plan is to be written within 24 hours of admission to the crisis service. The Department feels the mental health professional should complete the plan through collaboration with Crisis response staff and the individual. The Department has changed the definition. "Stabilization plan means a written short-term strategy used to stabilize a crisis and developed by a mental health professional, in collaboration with the crisis response staff and the involvement and consent of the individual or their representative". 441-24.20(225C).

7. Two respondents commented the definition of Warm Line states it will be operated by peer counselors, and suggested crisis response staff or non-peer staff should also be included.

Department Response: The Department agrees the Warm Line intent was unclear and has changed the definition of “Warm line” to a telephone line staffed by individuals with lived experience who provide nonjudgmental, nondirective support to an individual who is experiencing a personal crisis. 441-24.20(225C). It is the Department’s intent that the Warm Line will be operated by peer support specialists and family support peer specialists. This would follow the national model of established warm lines.

8. One respondent commented the definitions do not provide for crisis response services to be provided by chat or text and suggested they be included.

Department Response: The definition does not limit how all crisis stabilization services can be provided as long as the means of communication are sensitive to confidentiality of users and, when required, are HIPAA compliant.

9. One respondent commented the terms peer support and peer counseling are used in the rules but are not defined.

Department Response: Definitions for peer support services, peer support specialists, and family support peer specialists have been added and the term peer counseling has been removed from the rule. “*Peer support services*” means a program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community. *Peer support specialist*” means the same as defined in 441.25.1(331). “*Family support peer specialist*” means the same as defined in 441.25.1(331)

10. One respondent asked if crisis incident reporting only applies to physical injury or death resulting from a medication error.

Department Response: The Department changed the definition to clarify crisis incident reporting applies to any one of the situations listed. The definition is “*Crisis incident* means an occurrence leading to physical injury or death, or an occurrence resulting from a prescription

medication error, or an occurrence triggering a report of child or dependent adult abuse”.
441-24.20(225C).

11. One respondent asked if the definition of Face-to-Face includes phone and online.

Department Response: The definition of face-to-face includes in person, Telehealth and web-based communications that are HIPAA Privacy rule compliant.

12. One respondent asked if the definition of “dispatch” includes rescue.

Department Response: The organization operating a crisis line is required to have a triage procedure to link to emergency services, mobile response and provider support services. If someone is screened for a life threatening situation, a call to 9-1-1 would be a part of the triage protocol.

13. One respondent commented the definition of “24 hour crisis line” should include online as well as in person crisis counseling.

Department Response: The definition does not limit the use of internet for the delivery of crisis stabilization services.

C. Organizational activities.

1. One respondent commented the rules say all toys and other materials used by children are clean and safe and asked if there are more clear guidelines for safety.

Department Response: There are no additional guidelines for safety. The rule includes the same standards for organizational environment contained in 24.23(1) through (5) and applies to all providers accredited under Chapter 24.

D. Standards for crisis response staff.

1. One respondent commented the rules state law enforcement and EMTs must be trained in crisis intervention and asked what the guidelines are for approval of courses.

Department Response: The Department will review and approve training programs submitted by providers to assure they address staff competencies for crisis stabilization services. Nationally recognized training will provide guidelines to fulfill the crisis response training requirement.

2. Two respondents commented the rules require Department approved crisis intervention training for all staff other than mental health professionals, and asked who will develop the training and administer the post training assessment of competency. The respondent also asked if the assessment of competency will be skill or knowledge based and if it will be similar to the training requirement for current Chapter 24 accreditation,

Department Response: The training requirement allows flexibility for providers and they can request Department recommendation for various training designs or programs that best fit the needs of the organization and the people they serve. Training will be arranged by the organization and will include post training assessment for competency. The assessment should reflect competencies in skill and knowledge necessary to the trainee’s job duties.

3. Five respondents commented the rules should not assume all licensed mental health professionals are skilled to respond with crisis stabilization services or complete suicide risk assessments based only on their licensure. The respondents suggested mental health professionals be required to have previous training in crisis and suicide intervention prior to working as crisis response staff.

Department Response: While specific training in crisis and suicide prevention is not required for mental health professionals, 24.3(4) (b) (5) requires training and education be provided to all staff relevant to their positions.

4. One respondent commented that accreditation through the American Associations of Suicidology (AAS) and one respondent commented that accreditation through Contact USA should be considered as an alternative to the trainings required by the Department.

Department Response: The Department changed the rule to allow deeming through the American Association of Suicidology and Contact USA. 441—24.27(225C)

5. One respondent commented the staff requirement for bachelor level accepts experience in “behavioral” or “mental” health, but the other categories only seem to accept “mental” health.

Department Response: The Department has changed the staffing requirements to include behavioral health. A bachelor’s degree with 30 semester hours or equivalent in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education) and at least one year of experience in behavioral or mental health services. 24.24(2) a (2). A registered nurse with two years of mental or behavioral health experience. 24.24(2) a (7).

6. Two respondents commented all crisis response staff should be required to receive Applied Suicide Intervention Skills Training (ASIST) and training in means restriction and securing environments for suicide safety, as well as Mental Health First Aid training.

Department Response: ASIST is an appropriate training the Department would approve and all staff are required to receive training relevant to their positions as required by 24.3(4)(b)(5).

7. One respondent asked if crisis response service staff shall meet all the qualifications listed or one of the following.

Department Response: This comment refers to a pre-publication draft of the rules and any issue of clarity has been addressed with the renumbering of the section.

8. One responder asked if the same training requirement applies to peer counselors in the warm line definition as to peer support specialists and suggested peer counselors be trained in ASIST.

Department Response: The term peer counselor has been removed from the rule as the term was causing confusion regarding intent of the warm line. ASIST is an appropriate training the Department would approve and all staff are required to receive training relevant to their positions as required by 24.3(4) (b) (5).

9. One responder asked if a registered nurse with three years of mental health experience means a Psychiatric Nurse.

Department Response: The Department has removed the definition for Psychiatric Nurse and ARNP is required to have two years of mental health experience.

10. One respondent commented the staff requirements for crisis response services seem to state all levels are equal and formal years of education should not be considered equal to training or certification in Mental Health First Aid. The responder further commented with the exception of the warm line, direct responders and first responders of crisis services should not be peer specialists alone.

Department Response: Each crisis stabilization service has specific staff requirements that relate to the particular level of crisis stabilization service to ensure all staff are appropriately trained and credentialed for the crisis stabilization services they provide.

11. One responder commented crisis services should be provided in addition to mental health evaluation and treatment, not as a replacement, which indicates the handoff to longer term treatment should be clarified. The responder further commented it is not a crucial requirement for at least one ARNP, physician assistant or psychiatrist to be available for consultation 24 hours per day for crisis services.

Department Response: Crisis stabilization services include eight services and access to clinical staff is important in crisis stabilization service provision. The Department feels it is important the crisis is assessed with the designated level of staff under each array of crisis stabilization services. No change was made in response to this comment.

E. Deemed status.

1. Two respondents commented each national accrediting body should have specific divisions related to crisis services if included as meeting division criteria and asked if this is accurate for the Council on Quality & Leadership in Supports for People with Disabilities.

Department Response: The Department agrees. The Department will review each accrediting organization's standard to assure they meet the rules. An organization may be one of these accredited organizations, but will be required to provide additional policies and procedures for the crisis stabilization service.

F. Crisis evaluation.

1. One respondent commented the rules provide for crisis screening by face-to-face service or telephone, and suggested electronic methods such as chat should be included.

Department Response: Methods such as chat, text, and Skype could be used for crisis screening if the provider's policy and procedures allow for this and meet all confidentiality applicable standards such as HIPAA.

2. One respondent commented a mental health assessment within 24 hours is not necessary for all clients who receive crisis services.

Department Response: The rules do not require an assessment. The screening process determines the next level of care which may or may not indicate a need for a mental health assessment.

3. One respondent commented 24.32(1)(b)(3) requires crisis screening be available 24 hours a day, 365 days a year, yet crisis screening can be a valuable service, even if not available at all hours.

Department Response: The Department believes the availability of crisis screening is important in crisis response. Crisis evaluation is required in Iowa code 331.397 for regional core services. Many of the crisis stabilization services are available 24 hours a day and require 24 hour screening capability. The Department deleted the performance indicator because the requirement for 24 hour screening is listed under each applicable service. The new wording under performance indicator is: "Crisis response staff are trained in crisis screening; a uniform process for crisis screening and referrals is outlined in policies and procedures; crisis screening records are kept in individual files". 24.32(1) (b).

4. One responder asked what is meant by including physical health in the assessment in addition to medical history. The respondent also asked how it is to be determined.

Department Response: The Department changed the definition to include physical health. The definition is "*Crisis assessment*" means a face-to-face clinical interview to ascertain an individual's current and previous level of functioning, potential for dangerousness, physical health, psychiatric and medical condition. The crisis assessment becomes part of the individual's action plan. Physical health means any chronic or acute health factors indicated in the crisis assessment that need to be addressed during crisis stabilization service delivery. 441-24.20(225C).

5. One respondent commented a licensed mental health professional is not necessary to conduct a crisis assessment within 24 hours of admission to a crisis stabilization service and should be done by crisis response staff or a crisis counselor.

Department Response: The Department feels the crisis assessment includes diagnosis and does need to be conducted by a mental health professional.

G. Twenty-four hour crisis response.

1. One respondent commented the requirement that at least one ARNP, physician assistant or psychiatrist be available for consultation 24 hours per day, 365 days per year will be a very costly and unnecessary requirement for 24 hour crisis response services.

Department Response: The Department feels clinical consultation is important to provide effective crisis stabilization services to the individual and support to all staff. The Department changed the requirement to “A mental health professional is available for crisis assessment and consultation 24 hours a day, 365 days a year. The mental health professional has access to a Qualified Prescriber for consultation” and deleted the wording “An advanced registered nurse practitioner, physician assistant or psychiatrist is available for consultation 24 hours a day, 365 days a year”. 24.33(2) (d).

Twenty-four hour crisis line.

1. One responder commented the twenty-four hour crisis line should be required to be answered by a live person, as is the warm line.

Department Response: The Department agrees the crisis line should be answered live which is required in the AAS and Contact USA accreditation (deeming) and the rule has been changed in response to the comment. The rule states “Policies are in place regarding how the crisis line is answered live, when to utilize the hold feature, the use of queue systems and triage of calls”. 24.34(2) (b)

2. One responder commented the 24 hour crisis line should provide crisis screening and crisis counseling which can stabilize the client and would not require further intervention.

Department Response: The Department agrees with this statement and the rules have been changed to include this requirement. The Twenty-four hour crisis line definition means a crisis line providing information and referral, counseling, crisis stabilization service coordination and linkages to screening and mental health services 24 hours a day, 365 days a year. 441-24.20 and 441-24.34. The performance benchmark has been changed to “Crisis screening, counseling, crisis stabilization service coordination and referrals are provided to individuals in crisis”. 24.34(2)

3. One responder commented 24 hour lines that do not have suicide prevention as a major component should be clearly distinguished from those crisis lines that do offer comprehensive crisis services.

Department Response: The Department agrees appropriate education and awareness will be necessary to market the crisis line. No change to the rule was necessary.

4. One responder commented the 24 hour crisis line should provide evidence based suicide risk assessment.

Department Response: The rules include a lethality assessment. No change was made.

5. One responder asked what call center software standardized to crisis services means.

Department Response: There are crisis call center software products available and each provider can determine which one meets their organization's needs. The Department is not mandating one software program over another. The crisis line software selected shall include a standardized capability to track usage.

6. One responder commented the triage procedure should include the ability to keep the caller on the phone line while dispatching services on another separate phone line.

Department Response: The Department agrees with this statement. Sub rule 24.34(2) (d) states "the organization shall have written policies and procedures describing a uniform process of screening and training for crisis line staff."

7. Three responders commented on the requirement for AAS required accreditation within two years, and recommended eliminating the requirement and allowing deeming through AAS accreditation.

Department Response: The Department eliminated the requirement of accreditation through the American Association of Suicidology and added requirements to meet the standards.

8. One respondent commented crisis lines located within the State of Iowa will generally have better knowledge of state resources, including regional services and have on-going relationships with emergency providers.

Department Response: The Department agrees with this statement. No change was made to the rule.

9. One responder commented AAS does not have a requirement to utilize peer support staff, nor any prohibition to using peers, as long as they meet the personal qualifications and demonstrate the requisite skills.

Department Response: The Department agrees with this statement. No change was made to the rule.

10. One responder commented the description of mobile response says 24 hour access to a mental health professional is required and suggested the same should apply to the 24 hour crisis lines that will be dispatching the mobile teams.

Department Response: The Department agrees and added the requirement for 24 hour access to a mental health professional to the crisis line in response to this comment. The new wording is "Twenty-four hour access to a mental health professional is required. 24.23(2) and 24.35(2) (h).

11. One responder asked if the number of contacts, including terminated and lost calls is tracked by the phone system or by software.

Department Response: The call center software has the capability to track number of contacts, and it would depend on the product the organization utilizes if it will also track terminated and lost calls. Arrangements can also be made with the telephone provider to gather this data.

H. Warm line.

1. One respondent asked if the requirement for the organization to document staff qualifications and training for peer support specialists, family support peer specialists and peer counselors is a minimum requirement.

Department Response: The documentation is a minimum requirement.

I. Mobile response.

1. One respondent commented AAS certification should be required for Mobile Response and indicated updated standards are scheduled to be released in September 2014.

Department Response: AAS certification is an option, not a requirement for mobile response.

2. One respondent commented mobile response should be dispatched after the provision of crisis phone counseling, and therefore should not be required to occur within 15 minutes from the initial call for assistance, and the decision to dispatch should be made by crisis counselor, with the client, based on the client's needs.

Department Response: The Department agrees with this comment and the language has been changed to say the organization shall dispatch mobile response staff immediately after screening has determined the appropriate level of care. The reference to a 15 minute dispatch time has been removed and replaced with immediately after screening. The wording is "Dispatch mobile response staff immediately after crisis screening has determined the appropriate level of care. If the mobile response staff already are responding to another call, explain to the caller there may be a delay in getting a mobile response and offer an alternative response". 24.36(2) (a)

3. Two responders commented it would not be possible to dispatch mobile response staff in less than 15 minutes if they are already responding to another call.

Department Response: The Department agrees with this comment and the language has been changed to say the organization shall dispatch mobile response staff immediately after screening has determined the appropriate level of care. The reference to a 15 minute dispatch time has been removed and replaced with immediately after screening. The wording is "Dispatch mobile response staff immediately after crisis screening has determined the appropriate level of

care. If the mobile response staff already are responding to another call, explain to the caller there may be a delay in getting a mobile response and offer an alternative response”. 24.36(2) (a) The language has also been changed regarding the requirement to track and trend data, response time and delays to “Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis stabilization services. 24.36(2) (c)

4. One responder commented organizations are required to track and trend data of response time for initial dispatch, response resulting in hospitalization, diversion from inpatient and jail and asked if diversions from hospitals should be tracked as well. Two responders further commented the standards may need to clarify what is meant by diversion and asked if the Department would want to track numbers of individuals who go to crisis residential or a hospital and the respondent suggested the data be shared with MHDS Regions.

Department Response: The Department changed the wording of the rule from inpatient to hospital to include both admissions and emergency room diversions. The new wording is “Data is collected to track and trend response time from initial dispatch, the time to respond to dispatch when a team is already in response; diversion from or admission to hospitals, correctional facilities and other crisis stabilization services”. 24.36 (2) (c). The Department is not specifying who the data can be shared with and agrees the data could be shared with MHDS Regions.

5. Two respondents commented the action plan should be copied and given to client as well as to service providers with proper consents.

Department Response: The Department has changed the rule to clarify a copy of the action plan is to be given to the individual and others with signed consent. The new wording is “When an action plan is developed, a copy is sent within 24 hours, with the individual’s signed consent, to service providers, the individual and other’s as appropriate”. 24.36(2) (d)

6. One respondent commented follow-up should occur with the client and others present during the crisis within at least 24 hours.

Department Response: The rule allows, but does not specifically require follow-up within 24 hours. Section 24.36(2)(f) of the rule does require a follow-up appointment with the individual’s preferred provider will be made and mobile response staff will maintain periodic contact with the individual until the appointment takes place.

7. One respondent commented traditional law enforcement response, including uniformed officers, sirens and other emergency vehicles, should be reserved for only those situations where there is a credible threat of violence.

Department Response: The Department agrees with this statement. No change was made to the rule.

8. One responder commented the standard requires mobile response staff to have face-to-face contact with individuals in crisis within 60 minutes from dispatch and expressed concern

response times may need to be longer after hours and on weekends and such constraints may cause responders to ignore safety issues so they do not exceed the time limit.

Department Response: The 60 minute response time will remain as the standard. The Department agrees there will be times when the response time will not be obtainable. The language has been changed to “mobile response staff have face-to-face contact with the individual in crisis within 60 minutes from dispatch. If the mobile response staff are responding to another request, there may be a delay in getting mobile response and an alternative response should be provided”. 24.36 (2)(b)

9. One respondent commented the organization should have documentation in the individual's service record on evaluation and criteria for admission to inpatient psychiatric hospital care. Only the designated psychiatric provider for a hospital's inpatient unit may direct orders for admission.

Department Response: The Department agrees with the comment. The rule has been changed to remove “Evaluation criteria for admission to inpatient psychiatric hospital care”. 24.36(2) (e) (5)

10. One respondent commented the mobile response description says staff shall respond in pairs to ensure the safety of both provider and individual served, and suggested adding unless there is a clear reason documented why one person would be safe, for example, responding to an emergency room setting.

Department Response: The Department believes the requirement for mobile response staff to work in pairs is necessary to insure the safety of the staff, the individual being served, and others. The language was clarified to allow for situations where another qualified person is available on site. “Staff work in pairs to ensure their safety and for the individual served. A single staff may respond if another person who meets one of the criteria listed in paragraph 24.24(2) (a) will be available on site”

11. One respondent commented the rules require an organization document contact with the individual at 10, 30, and 60 days post-discharge and suggested this requirement be changed

Department Response: The Department has changed the requirement wording to “A follow-up appointment with the individual’s preferred provider will be made and mobile response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place”. 24.36 (2) (f)

J. Twenty-three hour crisis observation and holding.

1. One responder commented staff are required to be on duty 24 hours a day and shall remain awake for the 24 hour schedule. The responder asked what staff to client ratio is required.

Department Response: No specific staff to client ratio is required. Organizations are expected to take a team approach to staffing and each organization will need to address staffing needs based upon the structure of the program they are operating.

2. One respondent commented the treatment summary is to include an assessment of the crisis with challenges and strengths and asked if a suicide risk level is included.

Department Response: The assessment is required to include a lethality assessment and the assessment is included in the treatment summary.

3. One respondent commented the 23 hour crisis observation and holding is primarily used as a diversion from inpatient level of care and asked if it is used to determine if further care is needed.

Department Response: The 23 hour observation time will determine if further care is needed and what level of care is appropriate.

4. One respondent commented the rules say the organization shall have a plan to demonstrate phone contact for parents and significant others and asked how that is different from contacting providers, family members, and natural supports within 23 hours of admission.

Department Response: The Department agrees the meaning of the two statements were similar and has changed the rule to “Individual’s give informed consent.” 24.37(4) (d) (1). The indicator “Treatment providers, family members and other natural supports as appropriate are contacted within 23-hours of the individual’s admission.” remains the same. 24.37 (4) (d) (2)

5. One respondent commented the rules say the organization shall track and trend data of an individual’s re-admission and asked if there are requirements for contact with the individual post discharge, similar to the follow-up requirement for mobile crisis response.

Department Response: The Department has added the same follow-up requirement to 23 hour observation and holding as is included in the mobile crisis response requirements: “A follow-up appointment with the individual’s preferred provider will be made and crisis response staff will maintain periodic contact with the individual until the appointment takes place”. 24.37 (4) (d) (8)

6. One respondent asked if there are requirements for suicide safety in the environment where 23 hour observation and holding services are provided.

Department Response: The environment is required to be safe accessible and supportive and the organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or others. If an assessment indicates an individual is at high risk or actively suicidal, a higher level of care is indicated.

K. Crisis stabilization community-based services.

1. One responder commented follow-up within 24 hours of discharge should be required for CSCBS.

Department Response: The Department agrees and the rules have been changed. The wording is “A follow-up appointment with the individual’s preferred provider will be made and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place”. 24.38 (6) (c) (4)

2. One responder commented requirements should be included to ensure facilities are evaluated for environmental risks for suicide attempts.

Department Response: This service is not facility based. The environment is required to be safe accessible, and supportive and the organization establishes intervention procedures for behavior that presents significant risk of harm to the individual using the service or others. If an assessment indicates an individual is at high risk or actively suicidal, a higher level of care is indicated.

3. One responder commented in addition to gender specific bathrooms, facilities should be equipped to address transgender individuals.

Department Response: This service is not facility based. The minimum standard is to provide privacy if a bathroom has multiple toilets. Facilities shall designate and have privacy in bathrooms for all individuals.

4. One responder asked, in the event an individual leaves the facility prior to discharge, what action will be taken to ensure safety of the individual.

Department Response: This service is not facility based. The service is voluntary. Staff would contact emergency services if necessary. Policies and procedures should address actions to be taken for the safety of individual and staff.

5. One respondent commented the rules do not clearly define the environments where crisis stabilization services can be provided and asked if the Department can provide examples of Community Based and Non-Community Based residential settings or environments where the services can be provided.

Department Response: The Department has changed the definitions of Crisis Stabilization Community Based Services (CSCBS) to “short term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in community based setting”. The goal of CSCBS is to stabilize the individual within the community. CSCBS is designed for voluntary services for individuals in need of a safe, secure location that are less intensive and restrictive than an inpatient hospital. Crisis Stabilization Residential Service (CSRS) “means a short-term alternative living arrangement other than a person’s primary residence, designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in organization arranged settings of less than 16 beds”. 24.20 (225C). The goal of CSRS is to stabilize and reintegrate the individual back into the community. CSRS is designed

for voluntary individuals who are in need of a safe, secure environment less intensive and restrictive than an inpatient hospital.

6. Two respondents commented the staffing requirement does not state 24/7 awake staffing.

Department Response: The Department changed the rule to “Crisis Response staff must be awake and attentive 24 hours a day”. 24.38(2) (f)

7. One respondent suggested re-wording the provision mental health services shall be provided by a mental health professional to add “with expertise appropriate to the individual's needs” and delete “to service individual's needs.”

Department Response: The Department agrees with this suggestion and changed the wording to “Mental health professionals provide services with expertise appropriate to the individual’s needs”. 24.38 (2) (c)

L. Crisis stabilization residential services.

1. One responder commented requiring documentation for stays beyond 3 to 5 days is confusing. The respondent suggested the Department look at the standards for Crisis Intervention and Crisis Stabilization from the Council on Accreditation of Rehabilitation Facilities for direction on the grouping of the services and level of specificity for the actual standards. The responder further suggested noting the absence of arbitrary time limits and other specifics could interfere with an organization's need to be flexible in meeting the needs of the area in which it is located. The responder suggested Crisis Stabilization standards would cover the Crisis Residential Services and the rest of the services could be organized under Crisis Intervention.

Department Response: The Department agrees with this suggestion and changed the wording to “require documentation for stays of more than 5 days”, rather than 3 to 5. No organizational changes to the rules were made in response to these comments. 24.39 (4) (e).

2. One responder commented there is a reference to programs or facilities of no more than 16 beds and asked if this excludes the use of existing infrastructure for crisis stabilization programs and if facilities currently licensed under DIA ineligible to provide these services even if accredited. The responder also asked if these services be provided in an unlicensed part of a building that also houses a licensed section and if facilities licensed by DIA for 16 beds or less would be eligible to provide these services.

Department Response: Crisis stabilization residential services can be provided in existing infrastructure, whether a stand-alone building or a part of a larger structure, as long as the facility is not over 16 beds. If a facility is licensed by DIA for other services, it would have to comply with the provisions of IAC 481-57.50(135C) for operating another business or activity in the facility.

M. Medication.

1. One respondent commented the rules say medication shall be administered by a qualified prescriber or an individual following instruction of a qualified prescriber and trained staff shall

observe an individual taking medication. The respondent asked if the Department would define what is meant by trained staff and what training would be required.

Department Response: Medication training for staff would be included in the requirement staff that receive appropriate Department approved training. The Department is not requiring a specific training program to allow providers more flexibility in choosing training programs that fit their organizational and client needs.