



# Best Practices for Emergency Mental Health Services in the Vermont System of Care

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## Introduction

In the fall of 2019, Designated Agency Emergency Services staff convened with the Vermont Department of Mental Health and Vermont Care Partners to develop a document that could articulate best practices for crisis assessments in the Vermont system of care to further guide clinicians, set a consistent practice expectation, and inform consumers and community partners about such practices. This document will offer several key principles and values of the work, with specific practices as subsets of each principle. Resources for this document include [APA Best Practices for Crisis Services](#), [Vermont's Emergency Services Standards](#), the Qualified Mental Health Professionals Manual, the ethics standards of our respective mental health professions, the work of [Shawn Shea](#), and the diverse professional perspectives and practice experiences of Emergency Services providers.

In addition to universal best practices, the document will make recommendations around organizational best practices and offer site-specific situations.

Regardless of the setting, Emergency Services teams strive to be respectful, responsive, collaborative and person-centered, and provide care for people with dignity. The culture of Emergency Services requires transparency, adaptability, and flexibility. To that end, crisis clinicians<sup>1</sup> have a responsibility to focus on the person at the center of concern, ensuring that individuals are aware of their rights. Emergency Services teams also have a responsibility to the community and/or others impacted by the person's actions, especially when in a public space.

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<sup>1</sup> The term "crisis clinicians" and "crisis assessments" will be used throughout this document. "Screeners" and "screenings" are also commonly used in communities. Not all Emergency Services crisis clinicians have master's degrees.

## Clinical Best Practices in Vermont

The following is a list of best practices that define the work of Vermont's Emergency services teams. Each set of practices flows from five principles of care:

1. A strong therapeutic relationship is necessary for an effective crisis assessment
2. For the person being assessed, privacy and confidentiality are critical
3. Crisis clinicians and people being assessed have access to and seek out relevant information
4. The person being assessed is empowered to make choices
5. Transparency in safety planning is important

### 1. A **Strong Therapeutic Relationship** is Necessary for an Effective Crisis Assessment

- Building rapport is critical. It happens in the first moments of interaction, including in the practices that lead up to contact.
- Crisis clinicians engage with the individual/family in a culturally competent and developmentally appropriate lens.
- Crisis clinicians take a stance of openness and curiosity about not knowing the presenting issues, concerns, and disposition even if the person has been known to the crisis clinician in the past.
- Crisis clinicians attempt to maintain effective therapeutic relationship throughout the assessment and throughout future crisis assessment/emergency services.
- While it is important to complete a thorough evaluation and any indicated/appropriate crisis assessment tools, crisis clinicians are responsive to the person's needs in the moment, stay attuned to the relationship, and adapt as needed.
- Crisis clinicians prioritize physical and psychological safety of the person, and are transparent with the person if there are concerns about the safety of others.
- Crisis clinicians encourage and support people in connecting to treatment, and/or reengagement in treatment, by including the person's existing physical and mental health treatment team as well as natural supports in the assessment process. When possible, crisis clinicians invite a member of the person's treatment team to join in a face-to-face contact; for example, a crisis clinician may invite the person's case manager to go to safety check.

### 2. For the Person Being Assessed, **Privacy and Confidentiality** are Critical

- Whenever possible and as age-appropriate, the person being assessed is offered a private location to speak to the crisis clinician.
- The rights of the person being assessed are protected. Receiving a mental health crisis assessment doesn't automatically take away a person's right to privacy. Crisis clinicians inform people being assessed about any limits of confidentiality or allowances for sharing of protected health information per HIPAA.
- The acuity of the person's symptoms can influence his or her right to privacy. Immediate safety concerns may limit rights to privacy.
- Crisis clinicians discuss the need for the presence of additional individuals for security if there are any concerns for safety.

- Crisis clinicians are transparent with the person regarding with disclosures of information. This includes informing individuals when their rights are compromised, when safe to do so.
- Continuous visual observation, a safety practice that is used most often in health care settings, can interfere with a person’s sense of psychological safety and right to privacy.<sup>2</sup>

### 3. Crisis Clinicians and People Being Assessed Have **Access to Relevant Information**

- Whenever possible, crisis clinicians review any existing crisis plans, WRAP plans, psychiatric advance directives if on file, collateral information, recent contact history if available, and documentation. This is true whether or not the person is a client of the agency.
- A crisis clinician does not go into a service “blind,” but rather uses available history and records to inform their assessment, and exercises due diligence to collect relevant information as necessary to obtain a full picture and understand the situation from multiple perspectives.
- Crisis clinicians are responsible for ensuring that the person’s participation in the crisis assessment has been made in the context of informed consent.
  - Individuals are informed of the details of the assessment process, and possible outcomes (e.g., placement, outpatient planning, referrals, etc.) and their legal rights as they might be limited by an involuntary process.
  - Crisis clinicians acknowledge to the person that they have choices about what information they share.
  - Crisis clinicians disclose their own credentials and experience.

### 4. The Person Being Assessed Is **Empowered to Make Choices**

- Whenever possible and safe to do so, the person being assessed is offered the least restrictive setting for the interview. for example, when possible, the person is offered a community-based mobile response rather than a response based in the Emergency Department.
- Crisis clinicians ask the person assessed about their preference for a second person present during the assessment. This may be the individual’s family, friend or another professional staff person.
  - This allows the individual to have a choice to be alone or not with the crisis clinician.
  - The preference of the individual is considered by the crisis clinician when possible and within reasonable limits.
  - At times a second person may be needed for safety reasons as indicated by level of acuity of presentation which poses danger to self or others.

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<sup>2</sup> The National Institute for Health and Care Excellence (NICE) guideline on the management of violence in healthcare settings recommends that staff should “use the least intrusive level of observation necessary, balancing the service user’s safety, dignity and privacy with the need to maintain the safety of those around them” (p. 215, National Institute for Health & Care Excellence, 2015).

- The person being assessed has input and choice about the content of their care plan and about who is involved in their plan.

## **5. Transparency in Safety Planning is Important**

- Crisis clinicians ensure that the person participates in and is aware of any safety plan. The crisis clinician reviews the safety plan and discusses what will happen if a safety plan isn't followed (example, follow-up calls, safety checks, if/when police would become involved, etc). Crisis clinicians are transparent with disclosures of any safety plan information when safe to do so.
- If treatment team members, community providers, or family members are part of the safety plan, all are made aware and best efforts are made to ensure that they are contacted and have an opportunity for input.

If the principles and practices above are not present during a crisis assessment, it is possible that the quality of the assessment may be compromised. Crisis clinicians make their best effort to acknowledge this during the informed consent process and in their documentation of the service.

## **Setting-Specific Considerations**

Many of the crisis assessments performed by Emergency Services teams occur outside an office setting. These circumstances create complex conditions not only for the person being assessed, but for crisis clinicians who may now be providing assessment and treatment in the context of another organization's responsibilities and culture, or in the community. Crisis clinicians may feel pulled between their mandate to meet the needs of the person being assessed and the expectations of the host organization (e.g. landlord, school, police department, hospital, etc). Conditions for crisis assessments can also be impacted by which partner initiated the crisis assessment; for example, a police department requesting that a crisis clinician join them in a crisis response creates a different dynamic than when a crisis clinician requests a police officer join them to respond to a crisis.

In some cases, Emergency Services teams are not the right entity to provide the needed service. When that is the case, crisis clinicians have a responsibility to connect the person or the organization to whomever can be of help whenever possible.

Consulting with partner agencies and organizations is an essential aspect of the work. In the context of the assessment, crisis clinicians may need to provide information or make modifications to the environment or apply protocols in order to establish safety before proceeding with the evaluation (either for themselves, the client, or other community members).

The following is a list of key setting-specific considerations. When crisis assessments need to be performed in the settings below, specific considerations influence the crisis assessment process. The nuances of difference settings must be taken into consideration to ensure a safe, effective response to the crisis.

## Community

- Crisis clinicians prioritize safety, taking into consideration location, exits, other parties, weapons, and animals.
- Mobile response requires preparedness: crisis clinicians need to ensure that they have materials on paper, informed consent, intake packets, client rights and professional disclosure forms, referral forms and information, and consider whether they will have cell reception.
- Best practice is to call ahead rather than arrive unannounced to do an assessment; crisis clinicians consider making a staging plan with police when necessary.
- Emergency Services teams consider paired staff response (e.g., crisis clinician with a peer, case manager or therapist, police) when resources allow and would improve or facilitate the assessment.
- Crisis clinicians inform other staff of initial departure time to location, arrival and provide periodic updates, especially in high-risk situations, as well as provide notification when the crisis assessment is complete and the crisis clinician has safely left.
- Emergency Services teams stay in regular communication with city, state, and town departments to improve collaboration.

## Law Enforcement

- Team Two trainings teach best practice around law enforcement collaboration.
- Law enforcement provides safety at the scene, both for the crisis clinician and for the person in crisis. Any mental health assessment is performed by the crisis clinician.
- HIPPA requires that crisis clinicians share protected health information using a “need to know”, minimum necessary rule of practice
- Law enforcement *can* share any information with crisis clinicians, and this is best practice (especially first-hand account, and names).
- Crisis clinicians identify and communicate with the officer in charge of the scene
- Either a Qualified Mental Health Professional [QMHP] or a law enforcement officer can write a mental health warrant. The preference is for the QMHP to write the warrant.
- Crisis clinicians document any conflict with law enforcement and notify a supervisor.
- Crisis clinicians do not personally transport clients who may pose a safety risk or who are involuntary for services.<sup>3</sup>

## Substance Use

- Crisis clinicians take each presentation seriously regardless of the presence of substance use because substance use –known or unknown – can impact mental status and impede the ability to conduct a thorough and valid assessment. At times, someone who is either

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<sup>3</sup> The Vermont Statute that covers warrants, emergency examinations, transportation, and more is 18 VSA 7504-7511: <https://legislature.vermont.gov/statutes/chapter/18/179>

intoxicated or incapacitated due to substances also presents with a suicidal or other mental health concern. When this is the case, a crisis clinician may start the evaluation, if requested, but cannot determine final psychiatric disposition until substances have cleared.

- In order for police to take a person into protective custody based on substance use, they first must meet criteria for incapacitation, defined as appearing to need medical care to assure his or her safety, or appearing to present a direct or passive threat to themselves or others.<sup>4</sup>
- A person cannot be held on an involuntary mental health Emergency Exam (EE) if substances are the primary driving factor for the concerning behavior.
  - It is critical for the crisis clinician to articulate risk specifically associated with the mental health presentation of the individual when preparing an involuntary mental health Emergency Exam (EE) for someone who has co-occurring substance use.
- Crisis clinicians must be alert for acute suicidality co-occurring with substance use, as this increases impulsivity and risk of harm.

## Schools

- Crisis clinicians are mindful and trauma-informed about the impact on the child/youth of being assessed at school, for example, finding a private location and discrete way to evaluate the youth without peers overhearing reason to meet with crisis clinician.
- Crisis clinicians make obtaining guardian consent and working collaboratively with all school, family, and other providers in setting the time and place for assessment and disposition planning a priority.
- Crisis clinicians are knowledgeable about FERPA vs. HIPPA, and ensure compliance to these standards; for example, crisis clinicians are aware of who is in the room during the crisis assessment and adhere to these regulations.
- During an assessment of a child in the school environment, crisis clinicians take into consideration the developmental stage of the child, the environment, social connections, social media and age-relevant factors that differ from an adult assessment.
- Whenever possible, crisis clinicians collect collateral information from different environments, such as home, school, extended family, caregivers and different people involved with the child/youth.
- Crisis clinicians provide education and support to school staff to keep the environment safe for the student.
- DCF reports are still needed if information is disclosed through an assessment to the crisis clinician even if the youth is evaluated at a school and teachers, who are also mandated reporters, are aware or have indicated making DCF reports of disclosures.
- If presented with a school requesting a threat assessment to determine if the student is able to re-enter the school and under what circumstances, the crisis clinician refers the

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<sup>4</sup> <https://legislature.vermont.gov/statutes/section/18/094/04802>

school to specialists of this domain whenever possible<sup>5</sup> Threat assessment and school safety resources may be accessed at the Vermont Department of Public Safety website here: <https://schoolsafety.vermont.gov/resources>

## Other DAs

Considerations below apply when the person being screened is a client of a designated agency that is not the Emergency Services designated agency or a resident of another designated agency catchment area.

- Emergency teams work collaboratively with other agency staff for crisis response and client specific ongoing treatment planning and coordination.
  - If the person is known to be a client of another agency before the crisis assessment occurs, the crisis clinician attempts to contact the agency in advance of the crisis assessment to gather collateral and input.
  - When possible, crisis clinicians invite a member of the person's treatment team to participate in the response (e.g., participate in safety check, allow the individual to communicate with their treatment providers, coordinate in making referrals, disposition and safety planning).
  - It may be appropriate to have follow-up conversations involving client supports or share crisis plans across agencies for cross-catchment response. Obtaining releases for such ongoing care coordination is best practice. It is also important to remember that the person receiving care in both catchment areas continues to have the right to make choices in their treatment providers without location driving their treatment decisions.
- Safety and providing an immediate, timely response are paramount, and may limit the considerations above.

## Emergency Departments [ED]

When possible, Emergency Services programs prioritize meeting with people in the community and the least restrictive setting possible. When people are assessed in the Emergency Department, the following elements should be considered:

- Crisis clinicians are aware of the various roles and decision making structures of the staff in the Emergency Department. Roles and expectations between hospital staff and designated agency staff are clear and includes mutual respect for the expertise that each organization brings to the person's care.
- Crisis clinicians are aware of the policy and procedures governing the Emergency Department.

- Crisis clinicians work collaboratively with Emergency Department staff.
- Crisis clinicians work to provide the assessment and crisis intervention in the least restrictive way possible
- Crisis clinicians conduct the assessment with maximum discretion to protect the individual's right to privacy.
- When observing violations of rights or ethics, crisis clinicians consult with leadership, advocate for the individual or address the discretion if appropriate and possible without affecting the crisis assessment process.
- Crisis clinicians understand that at times of acute suicidal or homicidal presentation may require the presence of a third party in the room to ensure safety.
  - Crisis clinicians can continue the assessment process if the third party is professional, does not interject in the crisis assessment process and if they are bound by confidentiality.
  - The person being assessed has the right to know why the third party is in the room and the additional risk of disclosure
  - If it is known or found to be that the third party is not professional, respectful or has had previous breaches of information, an alternate third party should be requested.
- Crisis clinicians communicate collaboratively with the person's health care team by sharing information and working to build a support plan throughout the person's stay in the ED. If a person has an acute physical health concern or presentation of acute intoxication, those health concerns should be addressed prior to the mental health crisis assessment.
- Crisis clinicians are transparent with people being assessed and their support systems about the limits of psychiatric consultation and prescription of medications in the ED setting.
- Peer supports are a valuable support for people being assessed and/or waiting for inpatient placements in EDs. Crisis clinicians can initiate this support.
- A person being assessed in an ED may experience vicarious trauma through observation of other ED activities. Crisis clinicians may also experience vicarious trauma.
  - Crisis clinicians advocate for assistance when situations arise in the Emergency Department that compromise the safety and exacerbate the individual's psychiatric stability.
- Crisis clinicians and their ED colleagues note if there are existing relationships or role conflicts and provide or suggest options when possible to protect confidentiality and give choice.

This list of settings and situations is not exhaustive. The document does not address best practices around threat assessments, the involvement of the Department for Children and Families and/or Adult Protective Services, parent/guardian refusals, telehealth, and conflict of interest situations, to name a few.

## Telehealth

Clinical judgment and interagency communication are important when determining whether or how to use of telehealth for crisis assessments across catchment areas, particularly when inpatient placement and/or Emergency Department referral is being considered.

- Crisis clinicians request the person's specific location and contact information at the start of the session in case emergency rescue is needed.
- When performing a crisis assessment over telehealth, it is important to consider the unique risks to privacy and confidentiality.
  - Whenever possible, assessments are performed using password protected and HIPAA-compliant telehealth technology.
  - Clinicians review with the client some of the inherent challenges to a confidential assessment when the person is at their home. For example, some people may not have access to private spaces and even if they, voices may travel and still be overheard. Some may have household members who may need of attention – children, elderly family members, etc. – that may require the person to be within earshot of them. Some people may need assistance from a household member with the technology in order to participate in a telehealth session. These challenges are acknowledged and mitigated where possible.
- Emergency Services programs ensure protocols so that crisis clinicians can provide informed consent documents and appropriate professional disclosures without being able to provide paper copies.
- Crisis clinicians acknowledge to the person being assessed that the telehealth format may impede their ability to perform a mental status exam, including the person's body and their movements. Their ability to assess the whole environment may also be impacted.
- Crisis clinicians may also acknowledge the benefits to the person of receiving the assessment via telehealth, such as a quicker response time or the ability for the person to stay in place.
- Crisis clinicians are trained in best practices for how to foster a therapeutic alliance with a person over telehealth.

### A. Organizational Best Practices

In addition to direct services best practices, there are system and organizational best practices that are key to delivering good care. These include:

- Organizations have a system to support and ensure quality and ethical integrity of assessments as measured through client satisfaction surveys and other evaluation tools.
  - Clinicians have training, ongoing support and regular supervision as well as access to consultation as needed to ensure quality crisis service and intervention.
- Designated agencies ensure that the process to access Emergency Services is clear to the public and for community partners (for example, schools and law enforcement).

- Agencies have a workflow to ensure that follow up calls, safety checks, and care coordination occur for anyone seen by the crisis team, in alignment with the principles of [Zero Suicide](#). For example, emphasizing the need for specific follow up and engagement with individuals presenting with suicide risk, ensuring timely transition of care tailored to their needs and preferences, and follow up with PCP and/or existing providers and referral sources.
- Providers have relationships with community partner organizations at all levels of care, from direct service staff to program directors to executive leadership.
- There is a clear process to resolve complaints, concerns, or barriers that emerge in the working relationship or practice between Emergency Service Programs and their partners.
- Emergency Services programs routinely engage with systems partners, such as the Department of Mental Health, Vermont Care Partners, and other designated agencies to support collaboration, innovation, and best practice.

## B. Training List

Above and beyond clinical and organizational trainings, the following trainings are resources to support best practice in Emergency Services.

- [Team Two](#)
- [Mental Health First Aid / Youth Mental Health First Aid](#)
- QMHP Training provided by the Vermont [Department](#) of Mental Health (3x/year)
- CAMS and CALM training coordinated by the Vermont Suicide Prevention Center
- Vermont Suicide Prevention Center: Zero Suicide: <https://vtspc.org/zero-suicide-page/>
- C-SSRS Columbia Crisis assessment training online: <http://cssrs.columbia.edu/>
- DCF and APS Mandated Reporter Trainings:  
<https://goto.webcasts.com/starthere.jsp?ei=1087433> and  
<https://www.youtube.com/watch?v=wQ9GCADGec>
- Statute References for Emergency Exam:  
<https://legislature.vermont.gov/statutes/section/18/179/07504>

## Conclusion

This guidance document was developed by Vermont Care Partners' Emergency Services Directors Group with input from their teams and consultation from the Vermont Department of Mental Health. It is designed to reflect a shared understanding of best practice by clinicians in Vermont and to communicate these practices to community and systems partners. As with any system of care, as practices evolve and new findings in the field emerge, this document will need to be updated to reflect changes in principles and practice. Emergency Services programs will always remain committed to providing respectful, responsive, collaborative and person-centered care, while treating people with dignity.