

## DDD-PI-007

TO: Regional DD Program Administrators  
DD Service Providers  
North Dakota Developmental Center

FROM: Gene Hysjulien, Director  
Disability Services Division

SUBJECT: Crisis Intervention including referral to the North Dakota  
Developmental Center and the North Dakota State Hospital

DATE: February 11, 2004

EFFECTIVE DATE OF POLICY: Immediately

### Purpose

This policy replaces DDD-PI-007 dated April 3, 1993 and DDD-PI-035 dated April 1, 1993 and has been updated to include a process to assure that all community alternatives and resources have been exhausted prior to referral to the North Dakota Developmental Center or the North Dakota State Hospital.

### Policy

The following is a description of the process to be implemented in the event of a crisis, which requires an individual to be placed in an alternative environment. Some examples of a crisis situation may include: death or disabling illness of the primary caregiver, natural disasters affecting the living situation of an individual, behaviors injurious to self or to others that affect the safety of other others in the living environment or community, acute medical or psychiatric concerns, and abuse or neglect affecting the health and safety of the individual.

It is critical that the principle of least restrictive environment be implemented in time of crisis. Consideration will be given to enhancing supports within the individual's current living environment to enable continuity whenever possible. This may be accomplished through addition of temporary enhanced staff in the home, enhanced behavioral consultation and intervention, skilled nursing through Home Health where appropriate, or modification of the individual's program plan to address the specific needs of the individual.

In the event all interventions in the individual's current living situation have been exhausted and the individual's needs cannot be addressed, alternative arrangements will be made with a plan to return the individual to their home environment whenever possible. Depending on the nature of the crisis situation, return to the home environment may not be feasible or in the best interest of the individual. In such situations, long-term alternative living situations and services will be considered and planned for.

### **Process**

1. The assigned DD Case Manager will immediately report the crisis situation to the Regional DD Program Administrator.
2. The DD Case Manager will arrange for, and conduct a Case Plan/ISP meeting as soon as possible with the individual's team to include as appropriate: the individual, the parent or legal guardian, representatives of the agency or agencies providing services, the Protection and Advocacy Project if requested by the individual, and other consultants as necessary.

The team will identify the supports needed to resolve the crisis situation. First priority will be to maintain the individual in their current living environment. If alternative placement is needed, the team will identify options that meet the individual's needs. In the event the nature of the emergency demands immediate removal of the individual from the current situation such as acute hospitalization, the Case Plan/ISP team will be convened as soon as possible after the event, in order to plan services in a timely manner.

3. If the team meeting results in a recommendation that the individual be referred to another community provider agency, the DD Case Manager will initiate the referral. If the individual is a child, requiring placement out of the family home, the DD Case Manager will present the referral to the Regional Review Team for Children.
4. During the course of the crisis intervention and transition, the DD Case Manager and the individual plan team will maintain involvement in ongoing monitoring and planning to assure a smooth transition.

DD licensed providers are required to follow the 1990 Council Accreditation Standards (per DD licensure requirements) in regard to discharge and transfer. The provider must:

- a) Participate in the discharge planning process and development of alternative services and provide mechanisms for follow-up or follow-along.
- b) If the provider makes a decision to discharge the individual, the provider must provide written notification of the intent to discharge or transfer the individual 30 days prior to the proposed date of discharge or transfer to: the individual and/or the individual's guardian and DD Case Manager. The provider must provide notification 30 days prior unless it is an extreme emergency in which the individual and/or others are in immediate danger of injury or death.
- c) Prepare written discharge summary with copies provided to DD Case Management and the individual and/or their legal representative.

Every effort must be made to exhaust all options and resources in the community. Options to be considered include, but are not limited to:

- Return to parental or relative's home
- Authorization of Family Support Services (in home supports)
- Authorization of Family Support Services (Family Care Option home)
- Authorization of Family Support Services (Family Care Option III living arrangement)
- Placement in a foster home
- Placement in another group home
- Placement in an Individualized Supported Living Arrangement
- Placement in a long-term care facility (Basic Care, Nursing Facility)

- Placement in the regional crisis unit.
- Placement in local acute hospital or psychiatric unit.

For children with co-occurring mental retardation and mental illness needs, a referral to the State Review Team may be appropriate. Contact the Program Administrator for Family Support Programs in the State DD Unit to arrange the review.

If it appears that the individual's support needs exceed services and resources in the community, a referral to the North Dakota State Hospital or the North Dakota Developmental Center may be considered to meet the health and safety needs of the individual.

#### **Referrals to the North Dakota Developmental Center and State Hospital**

All referrals to the two state institutions for individuals receiving DD Case Management must be initiated by the appropriate Regional DD Program Administrator or assigned DD Case Manager.

In order to ensure that timely and appropriate intervention and planning occurs for the individual, Regional DD Case Management will initiate contact with staff from the:

1. State DD Unit and
2. ND Developmental Center

to inform them of the potential crisis. This should be done as soon as case management is aware that it may be necessary for the region and/or current service provider to explore alternative placement and that institutional placement may be needed.

Effective August 28, 2003 the Superintendent of the ND Developmental Center and State Hospital has indicated that all referrals to the state institutions (NDDC and NDSH) involving an individual receiving DD Case Management Services, should be directed to staff at the Developmental Center. Developmental Center staff will then consult with staff at the State Hospital and internally a decision will be made as to which institution will be accessed.

**Before a formal referral is made to either institution, the Regional DD Program Administrator will schedule a conference call to review the case, identify possible community options for alternative placement, and assure that all community services, supports and resources have been exhausted statewide. Conference call participants will include:**

- ◆ **All Regional DD Program Administrators or their designee**
- ◆ **Staff from the State DD Unit**
- ◆ **Staff from the North Dakota Developmental Center at Grafton (contact the Social Service Director to coordinate the call.)**
- ◆ **Other Regional Human Service Center or DHS staff as appropriate**

It is expected that this staffing will take place before referral is made, unless it is an extreme emergency that could not have been predicted or prevented.

If after the conference call it is determined that a referral to either the Developmental Center or State Hospital is necessary, the assigned DD Case Manager will assist the individual and/or the legal guardian to initiate the admission process.

The DD Case Manager will participate in the admission plan meeting, and in any other team meetings as requested. In order to provide for maximum continuity of services for the individual, the DD Case Manager will invite the QMRP/program coordinator from the community provider agency or other involved staff from which the individual is being admitted to attend or participate in the admission meeting by conference phone. The DD Case Manager will also invite/involve other relevant provider staff and other involved agencies e.g., county, education, juvenile services, foster care etc. to participate in the admission meeting and planning.

The goal is to have the individual return to the community as soon as possible. Obviously timelines will depend upon each individual situation, based on the individual's needs. However, discharge planning should be addressed as part of the individual planning process so that the person can return to appropriate community services as soon as it is feasible.