



Home Based Crisis Intervention (HBCI)

Program Guidance Document

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Home Based Crisis Intervention

Program Overview

The New York State Office of Mental Health (OMH) established Home Based Crisis Intervention (HBCI) as a short term, intensive service to avert unnecessary psychiatric hospitalizations of children and youth. This goal is accomplished via clinical interventions with the child/youth and their family, and case management services such as referrals to longer term services. HBCI is based on the Homebuilders Model, an evidence-based family preservation program.¹ Some critical components of this model which are to be incorporated into the policies and procedures of each agency providing HBCI services are:

- Acceptance of only those children/youth who are at imminent risk of psychiatric hospitalization or residential treatment. A short-term, crisis oriented, and intensive intervention process which is provided as soon as possible, but no later than 48 hours after referral to the program;
- Flexible staff hours, including 24 hour response capability;
- An intake and assessment process designed to ensure that no family is left in a dangerous situation;
- An approach to intervention that focuses on the family, both its strengths and its needs;
- An approach that is multi-faceted including skill building, counseling, and concrete services;
- A small caseload with each Interventionist working with only 2-3 families at a time;
- A brief duration of services, typically 4 to 6 weeks;
 - For those programs serving solely clients with mental health diagnoses and intellectual/developmental disabilities, the expected duration of services is 6 to 9 weeks
- Linkage to ongoing community supports, i.e.: Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS), Health Home Care Management, Child and Family Treatment Supports and Services
- Follow up with families at 1 and 3 month intervals to assess progress and to evaluate the program's success

1.1 Target Population

The target population for the HBCI service is children/ youth ages 5 to 20 years 11 months of age who are experiencing a psychiatric crisis so severe that unless immediate effective intervention is provided, the child/youth will likely be admitted to a psychiatric hospital or placed in a treatment residence.

- More specifically, acute psychiatric crisis is defined by the presence of at least two of the following criteria:
 - current, persistent, and severe major symptoms and/or behaviors (e.g., affective, psychotic, suicidal or significant impulse control issues) that are contributing to a current state of crisis for the child;
 - child and/or family has not adequately engaged or responded to treatment in more traditional settings;
 - home environment and/or community unable to provide necessary support for developmentally appropriate growth required to adequately address mental health needs in current crisis;
 - high use of acute psychiatric hospitals;
 - high use of psychiatric emergency or crisis services;
 - clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence, Residential Treatment Facility (RTF); acute inpatient psychiatric treatment/state operated psychiatric hospital – including rapid readmission to a hospital) without intensive community services.

- When determining the need for HBCI services for a young person aged 18 years to 20 years, 11 months of age, the following criteria will be met in addition to the criteria above:
 - The youth resides full time with at least one caregiver who is either a legal guardian OR who fulfills a primary caretaking role, is financially dependent on a caregiver (without the finances of the caregiver the young adult would not be able to provide for their own basic needs);
 - The caregiver is willing to provide the bulk of emotional support to the young adult during HBCI treatment and immediately after, agrees to participate in HBCI treatment with the youth, and agrees to facilitate attendance in ongoing treatment after discharge;
 - The young adult is willing to have the caregiver fulfill the duties above and will sign a Release of Information between the caregiver and HBCI;
 - If a youth has a court-appointed guardian, the Release of Information signed by the youth is not required, but obtaining assent from the youth will be considered

Families referred to the service are anticipated to be the highest needs families, those who may be multi-system involved, and/or have had frequent mobile crisis and/or ED visits.

1.2 Access to the Service

HBCI services are accessed via referrals from their outpatient mental health provider, mobile crisis or local Emergency Department, Comprehensive Psychiatric Emergency Program (CPEP), or another individual who is aware of the family's need for immediate, intensive crisis support. Families may also self-refer to the program.

1.3 Goal and Objectives

The goal of the HBCI service is to avert unnecessary psychiatric hospitalization and residential placement.

- The objectives that have been established to meet this goal are:
- Crisis de-escalation and safety planning;
- Stabilization of children within their family setting;
- Provision of services that are culturally competent, evidence-based or promising, and collaborative with the family and community;
- Coordination and collaboration with already established providers such as care managers, therapists and psychiatric providers.
 - It is expected that outpatient mental health treatment will continue while HBCI is working with the child/youth and family, in order to maintain therapeutic engagement and to provide adequate mental health support during a mental health crisis
- Improvement in family functioning, communication and co-regulation;
- Securing all needed services for which the family and child are eligible;
- Reduction in the probability of violence toward self, others or property;
- Improvement in problems identified at intake;
- Transition to services needed at discharge.

1.4 Guiding Principles

Home Based Crisis Intervention must be provided in accordance with these guiding principles:

- **Intervention at crisis:** Interventionists work with families when they are in crisis and begin safety planning with the family within 48 hours of referral. Each family will collaborate in creating and receive a written copy of a written safety plan outlining triggers, warning signs, supports, and steps to ensure the safety of the physical environment.
- **Accessible and Flexible:** Services are provided in the family's home and community (e.g., school) at times convenient to families, including evenings. Interventionists are available 24 hours a day, 7 days a week, for crisis intervention. This accessibility allows close monitoring of potentially dangerous situations. Services are flexible and adapt to the specific and changing needs of each child/family, and may include up to daily intervention; Interventionists provide a wide range of services, such as helping families

meet the basic needs of food, clothing, and shelter; transportation, and budgeting.

- **Time limited and low caseload:** Families receive 4 to 6 weeks of intensive intervention. Interventionists typically serve 2- 3 families at a time and provide up to daily meetings with the child/youth and family, that are typically at least one hour in length.
- **Collaborative and strength based:** Interventionists help clients identify and prioritize goals, strengths, and values and help them use and enhance strengths and resources to achieve their goals. Assessments of family strengths, problems, and barriers to service/treatment, and outcome-based goals in treatment plans are completed collaboratively with each family.
- **Culturally and Linguistically Competent:** Services are respectful of and responsive to the values and needs of the family and contain a range of expertise in treating and assisting families in a manner responsive to cultural and linguistic diversity. Services are delivered in a manner that recognizes and respects the culture and practices of the child/youth and family, including the awareness and understanding of different cultural groups' experiences. Such experiences include but are not limited to oppression and social diversity with respect to race, ethnicity, sex, sexual orientation, gender identity or expression, disability, religion, immigration status and their impact on engagement and perception of care.
- **Evidence-Based/Promising Practices:** Services utilize or apply core components of evidence-based and promising practices, supported by continuing education activities for staff to promote learning and implementation. Interventionists use practices such as motivational interviewing, behavioral parent training, and trauma-informed cognitive-behavior therapy strategies.

2. Home Based Crisis Intervention Team

2.1 Staff Roles and Qualifications

HBCI teams will consist of a Master's level licensed supervisor and clinical staff (subsequently referred to as Interventionists). Teams may include a Peer Advocate, a consulting Psychiatrist or consulting Psychiatric Nurse Practitioner and clerical support, if the program feels that these additional positions are beneficial to the development of the team and service to their clients. Each Interventionist must have a Master's degree or a Bachelor's degree with relevant experience.

Staffing ratios require a minimum of a .5 FTE Supervisor, and a minimum of 2.5 FTE total per core team (Supervisor and Interventionists). The two standard staffing ratios

are .5 FTE Supervisor and 2.0 FTE Interventionists, and a 1.0 FTE Supervisor and 4.0 FTE Interventionists. Most teams are comprised of 1.0 FTE Supervisor and 4.0 FTE Interventionists. A program may not have more than 15.0 total FTE.

Some examples of possible staffing models within these ratios are:

Supervisor	Interventionist	Total FTE
.5 FTE	2 FTE	2.5
.75 FTE	3 FTE	3.75
1 FTE	4 FTE	5
1.5 FTE	6 FTE	7.5
2 FTE	8 FTE	10

Programs may determine the most appropriate staffing model for their catchment area based upon, but not limited to: the population they intend to serve, the number of HBCI programs in the county(ies), the ability to hire Interventionists, etc.

Supervisor – A full-time licensed mental health professional (LMHP) professional staff member who directs and supervises staff activities, leads team organizational and clinical meetings, provides clinical direction to staff regarding individual cases, conducts side-by-side contacts with staff and regularly conducts individual supervision meetings. The Supervisor may provide case coverage for short periods due to staffing needs such as Interventionist time off. LMHP’s are expected to be licensed by the New York State Education Department and operate within the practitioner’s scope of practice as defined in NYS law. These include, but are not limited to: Licensed Psychologists, Licensed Clinical/Masters Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, or Licensed Creative Arts Therapist.

Interventionist – MA preferred, BA with experience considered – The Interventionist is responsible for providing treatment to the child and their family/caregivers to address the clinical needs of the child and the complex needs of the family unit. The Interventionist will provide crisis intervention and stabilization with the child/youth and family, and case management services such as referrals to other services and ensuring the structural home environment is safe. Treatment interventions are to be individualized to the child/family and evidence-based practices should be used to address identified clinical and family system needs. Expected to be licensed by the New York State Education Department and operate within the practitioner’s scope of practice as defined in NYS law. Licensed mental health providers (LMHP’s) include: Licensed Psychologists, Licensed Clinical/Masters Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, and Licensed Creative Arts Therapist. BA staff and unlicensed MA staff with at least one year of relevant experience in community-based mental health or case management will be considered if MA licensed staff are not available for hire.

Psychiatrist – The Psychiatrist provides clinical consultation to the HBCI team. The Psychiatrist must be currently licensed as a physician by the NYS Education Department and certified by, or be eligible to be certified by, the American Board of Psychiatry and Neurology. In lieu of a Psychiatrist, the HBCI team may also use a NYS licensed Physician with significant experience prescribing psychotropic medications for children and youth.

Psychiatric Nurse Practitioner – The Psychiatric Nurse Practitioner (PNP) provides clinical consultation to the HBCI team. The PNP must be currently licensed as a Psychiatric Nurse Practitioner by the NYS Education Department.

Peer Advocate – Peer specialists are in a unique position to serve as role models, educate recipients about self-help techniques and self-help group processes, and support effective coping strategies based on personal lived experience...

- Family Peer Advocates (FPA) are parents or caregivers who are raising or have raised a child with serious mental health concerns and are personally familiar with the associated challenges and available community resources for children and families. The FPA must possess a credential recognized by the Office of Mental Health, or be provisionally credentialed, and receive specialized training and supervision.
- Youth Peer Advocates (YPA) are individuals, age 18 to 30 years old, who self-identify as a person who has first-hand experience with mental health and/or co-occurring behavioral health challenges. At a minimum a youth peer must, have a high school diploma, high school equivalency or a State Education Commencement Credential and possess a credential recognized by the Office of Mental Health, or be provisionally credentialed, and receive specialized training and supervision.

Program Assistant - Typically, a non-clinical staff member who is responsible for managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for recipient and program expenditures; and performing reception activities (e.g., triaging calls and coordinating communication between the program and the recipients).

Core Competencies Expected of Staff:

All HBCI Interventionists, Supervisors and Clinical Consultants will demonstrate basic core competencies in designated areas of practice, including crisis de-escalation, screening and assessment, system of care/multi-system work, and family psychoeducation.

Screening and Assessment:

- Screening for social determinants of health; understanding of ACES; knowledge of and linkage with the larger community and service system through which to address needs
- Mental Health screenings for issues such as Depression, Anxiety, ADHD

- Trauma screens (e.g. UCLA PTSD Reaction Index scale; ACES) or other diagnostic tools where appropriate
- Risk screening and assessment (e.g. Columbia Suicide Severity Rating Scale, Stanley-Brown Safety Plan)
- Substance use screening and assessment (e.g. Screening, Brief Intervention, and Referral to Treatment - SBIRT)

Clinical approaches/treatment models that may include evidence based and promising practices such as:

- Motivational Interviewing for ongoing engagement of youth and families with complex needs
- System of care; multi-systems approach to involve the active coordination of care of the child/youth and family with multidisciplinary providers, agencies, community resources and supports
- Family therapy/family systems approaches consistent with the range of developmental stages of the children/youth to be served
- Behavioral interventions for severe behavior disorders, co-occurring learning disorders or limited cognitive functioning
- CBT, DBT core competencies to treat symptoms of anxiety, depression, dangerous and self-harming behaviors, hyperactivity, impulsivity/dysregulation, trauma
- Integrated treatment for co-occurring substance use disorders (SUD); stage-wise treatment approaches (e.g. Stages of Change) using Motivational Interviewing practice techniques
- Family Psychoeducation model for families to gain greater knowledge of mental illnesses and emotional or behavioral disorders in order to reduce stress, confusion, and isolation
- Evidence-based parenting programs (e.g. Parent Management Training; Strengthening Families) for children with moderate to severe behavioral difficulties

2.2 Team Function and Communication

Consistent with the Homebuilders model, one Interventionist is assigned to the family, and is supported by the entire clinical team. The single-Interventionist approach is favored over a team of two professionals because it is considered less intrusive in an already intense situation. The deployment of one Interventionist demands, however, that the staff possess a high range of assessment and intervention skills and that they are comfortable facing varied situations while in the community. Supervisors and staff must be able to work well as members of a team, including the ability to solicit and receive feedback and support. Moreover, selected staff will need the flexibility and endurance that is required in a crisis-oriented, 24 hour on-call work environment.

The single-Interventionist approach also demands that the Interventionist and their supervisor complete a thorough safety assessment of the home and community at first

contact with the family and on an ongoing basis (see Section 2.3). It is expected that each Interventionist carry a caseload of 2-3 families in order to ensure that families have regular and routine access to their assigned Interventionist. The assigned Interventionist should be whom the family has regular and consistent visits with throughout their enrollment in HBCI. Alternate Interventionists and/or the Supervisor may visit the family in the instance of vacations or extended leaves. The team should have a clear procedure for communication with each other during times of case coverage.

Clinical staff should be culturally competent and sensitive to the cultural variability in communication style, language, value systems and the degree to which the children and families have assimilated into the majority culture. Staff should be able to meet the linguistic needs of ethnically, culturally and linguistically diverse children and families.

Due to the intense nature of the cases, the Supervisor should ensure that Interventionists receive both individual and group supervision on at least a weekly basis. It is imperative that the Interventionists feel supported in their work, have ability to access community-based resources on behalf of the families they serve, and are encouraged to enhance their clinical knowledge and skill.

In many ways the Supervisor is the key ingredient to the success of an HBCI program. Each Supervisor must fully understand and endorse short-term, in-home crisis services, be skillful in building and maintaining a supportive team, and have clinical expertise in case consultation and supervision. The Supervisor will be available to the Interventionists for as needed support and consultation during and outside of regular operating hours. If the Supervisor is unavailable, the Supervisor will arrange coverage for this role with a Master's level or higher licensed professional and will communicate needed information to this interim Supervisor. The Supervisor is not expected to carry an ongoing caseload, but will cover cases on a short term basis if staffing needs indicate this.

2.3 Assessment

An Interventionist enters the home as soon as possible, but no later than 48 hours after the referral has been received and accepted.

It is expected that all referred families whose child meet the criteria outlined in Section 1.1 are given the opportunity to participate in the program. Given the commitment needed to participate in the program, it is critical that the families are given an in-depth overview of the HBCI program's scope and structure. Possible causes for denial of HBCI services include:

- The child/youth does not meet the crisis criteria outlined in Section 1.1;
- The program does not have an opening;
- The family or youth of consenting age decline services;
- The child/youth is assessed to need a higher level of care.

The family will then be provided options for other services.

A determination of the referral's acceptance or denial will be made within two (2) business days of the receipt of the referral. As a crisis program designed to serve children and youth at immediate risk of psychiatric hospitalization or placement in a treatment residence, HBCI does not maintain a waitlist.

In order to assess the home environment for safety of the child/youth, family, and staff, the first contact with the family will include an evaluation of the home environment. This will include, but is not limited to: the presence and security of firearms and other weapons; recent history of homicidal intent and plan; recent history of impulsive and aggressive behavior; availability of cellular phone service; the presence and temperament of pets and other animals.

If it is determined that the youth is in crisis and is in imminent risk of hospitalization, and if the family agrees to HBCI services, an Interventionist is assigned to the youth and family. It is expected that the Interventionist will be present in the home to address the current crisis within 48 hours of referral. Families should receive a program brochure and written literature in their preferred language. All forms for participation in the program including, but not limited to, releases of information, treatment plans, and consent forms should be developed in family friendly language. A safety plan is created with the family at first contact with HBCI. The Stanley-Brown Safety Plan is strongly recommended for use by HBCI. A written copy of the Safety Plan should be provided to the child/youth and family by the end of the first in-home visit.

2.4 Treatment Planning

After the immediate crisis has abated, the Interventionist, the youth, and family develop a psychosocial assessment and a treatment plan with treatment goals, treatment objectives and discharge criteria. This treatment plan will be reviewed with the supervisor. The treatment plan should be created in collaboration with already established providers and community supports, such as care managers, therapists, psychiatric providers, primary care providers and school staff. The treatment goal should address averting unnecessary psychiatric hospitalizations and increasing the youth's ability to remain safe in the community. The objectives should address the Interventionist's role in the family's development of support networks, and strategies to increase the youth's safety in the home and community. The objectives should include teaching supportive adults in home and school strategies to reduce triggering events and de-escalation. There should be an objective identifying needed supports and referrals to be made during the course of HBCI involvement.

Given the Local Government Unit's (LGU) statutory role in managing the county's mental health service system, the LGU may request the names of children/youth admitted to HBCI. If this information is requested, the HBCI program should alert the Children's Single Point of Access (CSPOA) of the children/youth admitted to HBCI. Pursuant to MHL 33.13 (c)(12), written consent is not required for the release of this information. The parent/guardian/individual should be given the opportunity to sign a

Release of Information for CSPOA, which would allow for further discussion with the CSPOA and the CSPOA Committee regarding ongoing supports and treatment. Please note that a Release of Information for the CSPOA is not required for a child/youth's admission to HBCI.

The Interventionist will utilize a strength-based and trauma-informed approach. A variety of age-appropriate interventions using the guiding principles noted above will be used. Techniques may include rational emotive therapies, modeling active listening, and demonstrating de-escalation strategies. The treatment plan may also include referrals to needed services following the termination of HBCI services. Discharge criteria will include a reduction in the behaviors leading to the need for HBCI services. During the course of treatment, the Interventionist will summarize the progress made toward treatment goals on a weekly basis, and establish goals for the following week.

2.5 Discharge Planning

The family's enrollment in HBCI is complete when the immediate threat of out of home placement or psychiatric hospitalization has passed, if further services are no longer needed, or if less intensive services will safely maintain the child/youth in the community. The expected length of service is 4-6 weeks. For children/youth dual diagnosed with a mental health diagnosis and an Intellectual/Developmental Disorder the expected length of service is 6-9 weeks. Services can be extended beyond the expected length of service; this is decided on a case by case basis by the Supervisor if it is assessed that discharge is contraindicated for the child/youth and the child/youth and family are able to continue in the intensive program.

During the last session, the Interventionist informs the family that program staff will follow up with them in 3 months and at 6 months. Upon discharge a letter is sent to other service providers, detailing the date and time of referral to HBCI, intake and termination dates, goals established for intervention, and progress made towards those goals.

2.6 Telehealth

Definition of telehealth: The use of telephone or video to provide therapeutic services over a distance. Telehealth does not include an electronic mail message, text message, or facsimile transmission between a provider and a recipient. All telehealth provided over video will be over a HIPPA-secure platform.

The HBCI provider will develop a telehealth policy and procedure that includes the particular risks and benefits of telehealth, strategies to maintain confidentiality, safety planning for a telehealth session, and documentation.

As per OMH Telehealth Guidance [\[link\]](#) HBCI is designed to be delivered in the natural environment, specifically the home and community-based settings where individuals, live, work, learn and attend school, and socialize or participate in their community. Additionally, HBCI services are specifically designed to serve individuals and families

that experience challenges or barriers that limit or impede their capacity to receive services in an office-based setting, and reduce disparities in access and care across NYS and in underserved/underrepresented communities.

Therefore, providers should prioritize in-person service delivery. An entire episode of care cannot be conducted by Telehealth Services only. At least one Intake & Evaluation session must be completed in-person to promote engagement and facilitate informed choice prior to finalization of the treatment plan. Telehealth must not replace in-person program requirements by restricting or denying in-person access by service, catchment area, community setting, or individualized need.

Telehealth may be used as an adjunct to in-person operations where appropriate. Telehealth may be used to supplement in-person services, to optimize engagement (e.g. for screening so that the individual can learn about choices in services), to temporarily provide care in circumstances where in-person engagement is not possible (e.g., risk of infection).

Where services are provided using telehealth, audio-visual telehealth modalities are strongly encouraged. It is always preferable to employ audio-visual telehealth to allow practitioners to visualize the individual and their environment. Only when audiovisual telehealth is not an option due to technology, cost, or participant refusal, the provider should assess whether audio-only telehealth is clinically appropriate in place of in-person services. Such an assessment must include considerations specific to the services and interventions that can be provided through audio-only telehealth. In these situations, practitioners should make every effort to understand and address the barriers a recipient faces to engagement in audio-visual Telehealth Services. Due to the nature of HBCI's intensity of services and crisis intervention, there are significant limitations to the type and quality of interventions that can be delivered via audio-only telehealth.

The rationale for utilizing any form of telehealth must be documented in a progress note. If an individual or family expresses a preference for ongoing or long-term clinical services via telehealth, HBCI may not be the appropriate level of service for that individual and family. The provider may need to support the individual and family in transitioning their services to an outpatient clinical treatment provider and/or care management.

If telehealth is provided to an individual/family in any setting, the following safety precautions are met and documented: the current location of the child/youth is confirmed; the contact information for the child/youth and caregiver is confirmed; the privacy of the child/youth's location is confirmed; the consent of the caregiver for the child/youth to participate in telehealth is confirmed

The final decision on the use of telehealth will be made by the HBCI Supervisor. The child/youth or any member of the family at home is physically ill and it is assessed that for infection control reasons it is best if visitors to the home are limited;

2.7 Documentation

Assessment documents, treatment planning, session notes, contact notes, discharge plans, consent for treatment, and releases of information will be maintained in a confidential manner that is readily accessible by all members of the treatment team.

- All clients and caregivers will receive a written safety plan (recommend Stanley and Brown, 2008) at the end of the first visit
- Treatment plans will be completed within the first 7 days of treatment, and will document the client's and caregiver's participation
- Session notes will be completed within two business days of the visit and will include topics covered, client/caregiver response, and next steps in treatment.
- Collateral contacts will be documented within two business days of the contact
- Discharge plans will be completed within 7 days of discharge, and will document the participation of the client and caregiver in the plan

2.8 Staff Training and Supervision

Training for all staff is critical to ensure staff are comfortable in their roles and have the ability to provide high quality care to all recipients. HBCI programs will ensure all staff are offered ongoing training opportunities for quality improvement, risk management, safety, and service delivery in order to increase staff confidence, recipient satisfaction, and outcomes. Training components will include principles of crisis intervention, trauma-informed care, and person-centered approaches. Trainings on best practices and approaches to serving diverse populations should include the cultural groups being served by HBCI, based on data obtained from the service area. It is recommended that all HBCI staff should be offered, at minimum, the following suggested training components as part of their employee orientation and continuing education opportunities.

- Trauma Informed Care
- Vicarious Trauma and Self- Care
- Crisis management and de-escalation techniques
- Behavioral Health Equity
- Specific issues in working with individuals identifying as LGBTQ +
- Harm Reduction
- How to Assess for Risk to self and others
- Psychiatric Disorders
- Co-occurring Disorders
- Wellness and Safety Planning
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Youth and Family Engagement
- Domestic Violence

- Engagement of youth in the treatment planning process
- Information Sharing

An overview of the organization's Policy and Procedures, including:

- Safety and Organization
- Incident Management
- Incident Reporting to Justice Center Reporting
- HIPAA and Confidentiality
- Mandated Reporting
- Language Access
- Infection Control

HBCI programs will create policies and procedures to provide and monitor staff training. Trainings will be regularly evaluated and updated and HBCI programs must retain documentation that each staff have completed the minimum training requirements. For clinical staff, the HBCI program must have documentation of professional licensure on file.

3. Program Operations

3.1 Eligibility

Children and youth aged 5 years to 20 years, 11 months who are at imminent risk for psychiatric hospitalization, and who reside within the catchment area of the HBCI program, are eligible for HBCI services. See section 1.1 for detailed eligibility criteria.

3.2 Admission Process

Following the initial phone screen within two (2) business days of receipt of the referral. The Interventionist will meet with the youth and family accepted to the program (see Section 2.3) to complete necessary documentation and admit the client to the program. The Interventionist will be present in the home within 48 hours of receipt of the referral. Necessary documentation includes, but is not limited to, a safety plan, confirmation of receipt of privacy practices, consent to treat the youth, releases of information for involved individuals and agencies and a treatment plan.

3.3 Discharge Process

The family's enrollment in the HBCI program is complete when the immediate threat of out-of-home placement has passed, services are no longer needed, or if less intensive services or resources can suffice.

As stated above, the expected length of enrollment in the program is 4-6 weeks; the length of enrollment for youth in HBCI programs specializing in the treatment of youth

dually-diagnosed with Intellectual or Developmental Disabilities is 6-9 weeks. However, families can be enrolled beyond 6 (or 9) weeks if the supervisor and Interventionist deem it to be necessary and the family is willing to participate. Services may continue if the immediate risk of hospitalization is still imminent, if there are no other community services or resources available to help reach specified goals, or if it is agreed that termination will cause a deterioration of accomplishment up to that point.

4. Required Data Collection

The Child and Adult Integrated Reporting System (CAIRS) should be used to collect the following data: demographic, child strengths and needs, family strengths and needs, discharge plan and status, and hospitalizations and placements. CAIRS data for each treated child/youth will be completed by HBCI program staff at admission, at discharge, at one month post-discharge and three months post-discharge. This data will be reviewed on a monthly basis by OMH staff. The data collected from HBCI programs, the software that is used, and the frequency with which it is collected is subject to change by OMH.