Office of Mental Health

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14 NYCRR Part 589

Crisis Residence Program Guidance

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This document is intended to provide interpretative/implementation guidance with respect to certain provisions of 14 NYCRR Part 589. Because this guidance document only addresses selected portions of the regulation and does not include or reference the full text of the final regulation, 14 NYCRR Part 589, it should not be relied upon as a substitute for this regulation.

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A. PART 589 CRISIS RESIDENCE REGULATIONS

14 NYCRR Part 589 establishes standards for the operation of Crisis Residences which provide short term residential support to individuals who are exhibiting symptoms of mental illness and who are experiencing a psychiatric crisis. These regulations apply to providers that operate a Crisis Residence licensed by the Office of Mental Health (OMH). These programs include Residential Crisis Support, Intensive Crisis Residence, and Children's Crisis Residence.

B. PURPOSE OF GUIDANCE

The purpose of this document is to provide guidance for the implementation of Adult Crisis Residences through the following:

- Describing services
- Describing standards for the operation of Residential Crisis Support and Intensive Crisis Residences
- Describing guidelines for service delivery, documentation, and performance

This document describes both Residential Crisis Support and Intensive Crisis Residences. Language that does not specify and/or refers only to "Crisis Residences", is applicable to both programs.

C. CRISIS RESIDENCES

Crisis Residences are an integral part of the behavioral health continuum of care and coordinated crisis response system. They offer a safe place for the stabilization of mental health and psychiatric crisis symptoms and a range of services from support to treatment. Crisis Residences may avert the need for inpatient hospitalization or emergency room admission. Programs provide short-term voluntary support up to 28 days, 7 days a week. Programs can have from 3 to 16 beds and provide a home-like and welcoming environment. Crisis Residences are not a substitute for permanent housing. Services are recovery oriented, person centered, trauma informed, culturally and linguistically responsive, and aim to stabilize the presenting crisis by:

- Providing supportive and/or treatment services on-site
- Effectively engaging individuals in crisis intervention planning
- Integrating natural and other identified supports
- Coordinating with existing providers
- Supporting connections to community services and supports

Crisis Residences may be appropriate for individuals stepping down from a higher level of care such as inpatient hospitalization, emergency rooms, or a Comprehensive Psychiatric Emergency Program (CPEP) and unable to return to the community due to the risk of an escalation of symptoms.

1. Residential Crisis Support (RCS) Program Admission Criteria

Residential Crisis Support programs are voluntary, short-term programs that provide supportive crisis intervention services to individuals 18 years and older who:

- Are experiencing symptoms of mental illness
- May be experiencing challenges in daily life that create risk for an escalation of symptoms and/or are experiencing a period of acute stress that significantly impacts ability to cope with daily life

- Are experiencing symptoms of mental illness that cannot be managed in the individual's home and community environment without on-site supports
- Do not pose likelihood of serious harm to self or others as defined in section 9.01 of the Mental Hygiene Law
- Are medically stable
- Can safely participate in the program and community
- Are willing to participate voluntarily

2. Intensive Crisis Residence (ICR) Program Admission Criteria

Intensive Crisis Residences are intended for individuals that require a higher level of care than Residential Crisis Support. A primary mental health diagnosis is required for this program. A diagnosis should be obtained at admission or as close to the admission as possible. Providers are expected to provide necessary screenings and assessments to determine a diagnosis when needed.

ICR programs are voluntary, short-term programs that provide treatment and supportive crisis intervention services to individuals 18 and older who:

- Are experiencing symptoms of mental illness or a psychiatric crisis, which includes acute escalation of symptoms that cannot be managed without treatment by licensed mental health providers and medical professionals including counseling and medication therapy to evaluate, resolve, and/or stabilize the symptoms
- Do not pose likelihood of serious harm to self or others as defined in section 9.01 of the Mental Hygiene Law
- Are medically stable
- Can safely participate in the program and community
- Are willing to participate voluntarily

ICR programs provide close monitoring and observation. Staff will regularly monitor crisis symptoms, risk of harm, and mental health status and will facilitate crisis stabilization interventions. ICR programs are not intended to replace inpatient hospitalization. Individuals who are determined to be at serious risk of harm and/or require more services than are offered at an ICR should be referred to a higher level of care for evaluation.

3. Referrals

Crisis Residences should collaborate with crisis and emergency service providers in the community to inform them of referral processes and may create agreements that can expedite connection to the program. Crisis Residences will accept referrals 24/7 and may receive referrals by phone, email, fax, and in person. Crisis Residences accept referrals from anyone including but not limited to:

- Self-Referrals
- 988 Crisis Contact Centers
- Crisis Stabilization Centers (Intensive and Supportive)
- Mobile Crisis Providers
- Emergency Responders, including Law Enforcement
- Comprehensive Psychiatric Emergency Programs (CPEPs)
- Emergency Departments
- Community Partners
- Outpatient/Inpatient Behavioral Health Providers

- Primary Care and other Health Providers
- Health Home Care Managers
- OMH Licensed and Funded Housing Providers
- Homeless Shelter Providers
- Friends and Family

Crisis Residences will collect minimal information at referral to determine the appropriateness for admission. This information includes:

- Individual's name, age, and contact information
- Referral source name and contact information
- Preferred and primary language
- Presenting crisis or symptoms related to mental health or emotional distress causing significant challenges in daily life
- Screening for risk of harm to self and others
- Individual's voluntary interest or agreement to participate in the crisis residence program

(a) Admission Screening

After a referral is received, Crisis Residences will facilitate an admission screening process. The purpose of this process is to engage with the individual in crisis to confirm referral information as needed, determine the need for further evaluation, gather necessary information required to make an admission decision and facilitate a connection with appropriate services or interventions. This process includes:

- Collection of additional information regarding the mental health crisis and symptoms
- Screening and review of immediate needs
- Health information including allergies
- Screening for substance use, substance use disorder, and the risk of substance withdrawal
- Screening for risk of self-harm, suicide, and risk of harm to self and others
- Identification of treatment providers and supports including emergency contacts
- Determination of capacity to self-preserve and evacuate the building prior to admission as outlined in Part 589.15

Individuals may not be excluded solely based on:

- Unhoused status or no permanent discharge residence
- Criminal or legal systems involvement history
- History of aggression or destructive behavior
- Lack of insurance
- Absence of a mental health diagnosis
- Substance use history/substance use

Additional information can be obtained from providers with consent from the individual. However, this additional information is not required for admission. At admission, a discharge location should be identified by the guest. It does not have to be a permanent residence and may change during the stay.

In RCS programs, Crisis Intervention staff may gather information and conduct screenings to make admission determinations.

In ICR programs, assessments are conducted by Crisis Intervention Professionals.

The following is considered during the admission screening process to ensure that there are appropriate supports for people who present with any of the following risks:

- **Risk for suicide and self-harm.** If an individual self-discloses risk for suicide and self-harm, processes for determining the severity and next steps are necessary. Safety planning should be initiated whether or not a person is admitted to the Crisis Residence. Arrangements must be made to refer and connect them to an appropriate recommended level of care. When possible and safe to do so, efforts should be made to maintain individuals in the community.
- **Substance intoxication and/or withdrawal.** If an individual appears to be under the influence of a substance or admits to being under the influence, processes for determining the severity and next steps are necessary. If an individual cannot be admitted due to the severity of the substance use or withdrawal risk, arrangements must be made to refer and connect them to an appropriate recommended level of care.
- **Aggressive or destructive behavior.** If an individual is identified to exhibit aggression or destructive behavior, an assessment of the behavior in the context of the crisis and symptoms is necessary and efforts must be made to use de-escalation and non-violent intervention to prevent and/or decrease escalation of disruptive behaviors.

Programs will maintain policies and procedures which describe the admission process. Each admission must be determined on an individual basis. Programs must document all referrals, follow ups, admission decisions, and admission outcomes.

(b) Admission Decisions

After the receipt of the referral and the admission screening process, Crisis Residences will make every effort to communicate an admission decision to the individual and their referral source as soon as possible but no later than 24 hours from receipt of referral, and support admission as quickly as possible.

4. Licensed Practitioner of the Healing Arts Recommendation

Licensed Practitioner of the Healing Arts (LPHA) recommendations are required for individuals admitted to Crisis Residences. The purpose of this recommendation is to approve medical necessity for admission to the Crisis Residence.

The recommendation can be obtained at referral or during the admission. The LPHA recommendation is ***not*** required at referral; and the absence of a LPHA recommendation is ***not*** a reason to deny admission to the program. The LPHA making the recommendation may be employed by or contracted with the Crisis Residence, an existing provider of the guest, or a new provider.

LPHA recommendations are required for both Medicaid Managed Care and fee-for-service reimbursement. LPHA recommendations are expected for all Crisis Residence admissions despite the type of payor of services to ensure consistent medical necessity documentation.

All recommendations must be dated and signed whether handwritten or electronically by the LPHA and documented in both the Individual Service Plan and guest case record. Recommendations in the guest case record may be documented in a note or separate form including the Provider License # or NPI #. The recommendation may also be included with the admission notification or discharge note to the Medicaid Managed Care Plan (MMCP).

LPHAs include:

- Physician (MD/DO)
- Psychiatrist
- Addictionologist/Addiction Specialist
- Nurse Practitioner
- Registered Nurse
- Physician Assistant
- Licensed Psychologist
- Licensed Psychoanalyst
- Licensed Social Worker (LMSW or LCSW)
- Licensed Marriage and Family Therapist
- Licensed Creative Arts Therapist
- Licensed Mental Health Counselor
- Licensed Occupational Therapist

5. Service Planning

After program admission, Crisis Residences will engage guests in a service planning process to identify the services and supports that a guest will receive during their stay. The engagement and active involvement of the guest, their identified supports, and collaterals is required for a successful service planning process. Service planning incorporates information relevant to a guest's crisis stabilization, which may include:

- Treatment and/or community providers
- Housing and employment status
- Barriers and limitations to managing their crisis
- Identification of what has worked and not worked in the past

Service planning is an ongoing process that begins when a referral is received, continues at admission, and evolves throughout the duration of the stay in the Crisis Residence. The facilitation of mental health and/or substance use evaluations or other assessments, screenings, and clinical examinations to identify services, supports, interventions and/or treatments may be included as part of service planning.

Provider Qualifications: A Crisis Intervention (CI) Professional or CI Staff member supervised by a CI Professional

(a) Individual Service Plan

An Individual Service Plan (ISP) is a required component of the service planning process. A written plan based on the screening and/or assessment of the mental health status and needs of a guest, the ISP addresses the symptoms that led to their admission, establishing their stabilization and recovery goals and determining what services will be provided to assist the guest to accomplish these goals.

The ISP is unique to each guest and will incorporate their personal preferences, desired life roles, cultural, religious, linguistic, physical, medical, emotional, social, residential, recreational, vocational, and nutritional needs as appropriate.

The ISP must be implemented within 24 hours of the admission and updated routinely throughout the duration of the stay. The ISP must be developed and signed with the guest and a CI professional or CI staff under the supervision of a CI Professional.

The ISP includes but is not limited to:

- Services being provided by the Crisis Residence
- Services being provided in the community
- Guest strengths and identified needs that support the stabilization of the presenting crisis
- The roles of identified supports, which may include family
- Safety planning
- Goals for discharge planning and follow up/aftercare services
- Referrals and linkages to appropriate behavioral health and other community services
- Signature of the guest
- Signature of a CI professional or CI staff under the supervision of a CI Professional

(b) Incorporation of Community Treatment/Services in the ISP

Guests receiving services at Crisis Residences may participate in treatment and community-based programs. Examples of community services include but are not limited to:

- Outpatient clinic services
- Ambulatory detox
- Intensive outpatient
- Relapse prevention planning
- Wellness activities
- Vocational and employment services
- Education
- Recreation
- Case management
- Tobacco cessation services

D. CRISIS RESIDENCE SERVICES

1. Required Services at Crisis Residences

The following services are required to be provided in both RCS and ICR programs. One or more of these services must be incorporated in the ISP.

(a) Psychiatric Crisis Rehabilitation and Skills Training

Psychiatric Crisis Rehabilitation and Skills Training includes but is not limited to the following:

(i) Assistance in personal care and activities of daily living

Support for personal care and activities of daily living are rehabilitative and skills training support services that support guests to restore identified life skills impaired by crisis symptoms. Guests may be supported with self-care, self-advocacy, negotiating relationships, healthy communication skills, boundary setting, supporting the maintenance of social relationships that provide natural support, and the identification of supports to access appointments and treatment based on their self-identified needs. The goal of this service is to help guests proactively identify and develop therapeutic approaches to cope with internal and external stressors and to maintain crisis stabilization.

(ii) Wellness and skills development activities

Wellness and skills development activities include creating habits that reduce stress, minimize crisis symptoms, and promote well-being. Wellness activities may include meditation, journaling, listening to music, reading, drawing, writing, creating art, and exercise. Guests define wellness that are unique to their needs. Crisis Residences can:

- Support guests to maintain wellness lifestyle skills that can be incorporated in daily/regular routines
- Provide opportunities to practice and engage in group wellness activities
- Incorporate wellness activities in safety planning

(iii) Conflict resolution activities

Conflict resolution activities address interpersonal conflicts that can create or escalate mental health crisis symptoms. Crisis Residences may:

- Offer guests opportunities to practice conflict resolution skills in a safe place to support crisis stabilization
- Provide education and skill building for guests to learn and increase problem-solving techniques, boundary setting, self-advocacy, and self-determination
- Facilitate constructive meetings with the guest, their supports, and providers to address issues that are impacting recovery and mental health
- Identify resources, provide advocacy support, and strategies to address conflicts

Provider Qualifications: Crisis Intervention (CI) Professional(s) or CI Staff under the supervision of a CI Professional

(b) Peer Support

Peer support services include but are not limited to self-advocacy, recovery, and stepdown support, psychoeducation, person-centered goal planning, mutual engagement, information sharing, outreach, referrals, self-help, safety/crisis planning, and hospital diversion.

Peer support services are provided by staff with lived experience who actively engage with guests in crisis through a model of shared personal experience. Peers establish rapport and explain the services offered by the Crisis Residence.

Peers can facilitate support groups that promote relaxation, community living skills, health and wellness and model effective coping skills. Peers are expected to be included in the individual service and discharge planning process.

Provider Qualifications: Certified or provisionally certified Peer Specialists, certified or provisionally certified Recovery Peer Advocates, or credentialed or provisionally credentialled Family Peer Advocates and Youth Peer Advocates under supervision

(c) Safety Planning

Safety planning is a service to help guests experiencing a crisis with concrete ways to mitigate risk and increase safety. Safety planning includes the creation or modification of a safety/wellness plan that is led by the guest, which identifies early warning signs of worsening symptoms, triggers of suicidal thoughts and/or relapse and includes identifying coping strategies, preference for care in times of crisis, roles of provider(s), supports, and methods to maintain guest safety and stability. One example of a self-harm and suicide prevention plan is the Stanley-Brown Safety Plan.

Provider Qualifications: Crisis Intervention (CI) Professional or CI Staff supervised by a CI Professional

(i) Accessing and sharing wellness and safety plans:

PSYCKES, a web-based platform developed by the NYS Office of Mental Health, allows providers to upload and view Safety Plans. Existing safety plans located in PSYCKES may be accessed by providers and newly developed safety plans may be uploaded to PSYCKES with consent from guests. In addition, Crisis Residences should include relevant Safety Plan/s in the guest's case record with consent.

PSYCKES includes My Collaborative Health Outcomes Information System (MyCHOIS), an application for individuals receiving behavioral health services. MyCHOIS offers recovery and shared decision-making tools with an aim to promote health literacy, communication with doctors, and person-centered care.

Information can be found at PSYCKES Home (ny.gov).

(d) Care Coordination

Care coordination services emphasize continuity of care and discharge planning for the guest to facilitate a smooth transition to the community. Programs will coordinate with the guest, their existing case managers, and treatment providers and/or assist with linking the guest to services to ensure comprehensive care is available throughout the Crisis Residence stay. Care coordination activities include but are not limited to:

- Integration of direct care and support services
- Referral to and facilitation of engagement in outpatient behavioral health services, case management, physical health, or basic needs related to social determinants of health
- Confirmation of scheduled appointments with service providers during the stay and upon discharge

Additional services part of care coordination include:

(i) Supports for co-occurring substance use

Supports for co-occurring substance use are provided to guests who identify current or previous substance use crisis or a substance use disorder and are interested in working on recovery. Crisis Residences will provide referrals or linkages to community or inpatient services for substance use when needed. Crisis Residences should have Naloxone on-site and trained staff to administer.

The NYC Tobacco Cessation Technical Assistance Center (TAC) is a resource that providers may use to develop policies, procedures, and strategies to help guests who would like support with tobacco use disorders. Refer to https://nyctcttac.org/.

(ii) Engagement with identified supports

Engagement with identified supports is a service that facilitates and supports effective partnerships with the guest and their family support(s), natural supports, and service providers. Guests and staff will identify and make connections with individuals who can help support with the transition to the community.

Crisis Residences will make a concerted effort to assist and collaborate with the guest to determine preferences regarding the participation of identified supports. Crisis Residences

may engage identified supports regarding visits, attendance of group sessions, collaboration with service planning, review of discharge planning, etc.

Provider Qualifications: Crisis Intervention (CI) Professional(s) or CI Staff member under the supervision of a CI Professional

(e) Medication Management and Training

Medication management and training is a service to provide guests with psychoeducation on the appropriate use, role, and side effects of prescribed medications.

Crisis Intervention Staff in Crisis Residences may assist guests with medication reminders and observation with training and program approval. CI staff do not administer medications.

Provider Qualifications: Crisis Intervention (CI) Professional or CI Staff supervised by a CI Professional

(f) Medication Monitoring

Medication monitoring is a service that includes appropriate monitoring and supervision of the use of medication, including appropriate dosage and frequency. Prescribing medication is not an activity included under this service. Guests are expected to self-administer medications.

Provider Qualifications: Crisis Intervention Professional

2. Required Services at Intensive Crisis Residences

Intensive Crisis Residences must provide all services required at Residential Crisis Support, listed above. In addition, Intensive Crisis Residences must provide the following treatment services which include but are not limited to:

(a) Comprehensive Assessment

Crisis Intervention (CI) Professional staff in ICR programs conduct a comprehensive assessment after admission that informs the Individual Service plan. The purpose of this assessment is to assist in identifying crisis interventions and crisis stabilization treatments. This includes mental health and substance use assessments.

The information gathered from the referral and admission screening process should be included and expanded on in the comprehensive assessment. A comprehensive assessment includes but is not limited to the following:

- Identification of symptoms of the current crisis
- Assessment for risk of self-harm, suicide, and risk of violence/harm to others
- Identification of personal preferences and desired goals, including but not limited to, physical, medical, emotional, social, residential, recreational, cultural, language, religion/spiritual beliefs, vocational, and nutritional needs
- Identification of recent mental and physical health history and needs, including recent hospitalizations, medications, and/or co-occurring conditions
- Prescribed medications for medical, psychiatric, and substance use disorders
- Identification of social determinants of health, including access to primary and dental care, level of food security, living situation, support system, personal safety, and availability of heat, electricity, and potable water in the living environment
- Additional information with consent may be obtained from databases such as MYCHOIS, PSYCKES, EHRs, QE/RHIO, and/or other relevant databases

Provider Qualifications: Crisis Intervention (CI) Professional Staff in collaboration with other CI Staff, as appropriate

(b) Medication Therapy

Medication therapy services include prescribing and administering medications and monitoring the effects and side effects of the medication on mental and physical health. When treatment includes medication therapy, staff should ensure that the guest has a prescription for, or supply of, medication adequate to meet their needs until their next prescriber appointment.

Provider Qualifications: Prescribing medications, monitoring the effects of medications, and evaluating target symptom response to medications is provided by a Physician, nurse practitioner, or physician's assistant. Preparing, administering, and monitoring the injection of intramuscular medications are provided by a physician, nurse practitioner, physician's assistant, registered professional nurse or licensed practical nurse.

(c) Individual, Family and Group Counseling

This service includes psychotherapy, psychosocial rehabilitation, or counseling services to address crisis symptoms**.**

Provider Qualifications: A Crisis Intervention (CI) Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may provide Individual, Family and Group Counseling. CI Staff may assist a CI Professional providing Individual, Family and Group Counseling during and after a crisis.

3. Service Considerations for Young Adults

Young adults often can experience challenges receiving accessible age specific mental health services that are tailored to their developmental needs. For this reason, this guidance addresses supports specific to guests ages 18 to 25. When admitting young adults to Crisis Residences, consider the following:

- **Education.** Education includes whether the young adult is in high school, a trade school program or college and if they will need any assistance with getting to school and accessing school, General Education Development (GED), or college services. If a youth has an Individualized Education Plan (IEP) or a 504 plan, it may be helpful to engage the school district's Committee on Special Education (CSE) chair. Consider a referral to ACCESS-VR for vocational support during or after the Crisis Residence stay; if the individual is already connected with ACCESS-VR, their assigned vocational specialist can be a part of discharge planning.
- **Intellectual and developmental needs.** Intellectual and developmental needs may identify if the young adult needs support with increasing life skills, independence, and navigating transitions. Programs may also inquire about eligibility for services provided by the Office for People with Developmental Disabilities (OPWDD) when relevant.
- **Resource navigation.** Resource navigation includes supports to help the young adult access housing, preventative health and primary care resources, health insurance, public assistance, employment/workforce development resources, and local supports based on their age group and qualifying needs.
- **Health.** Health considerations include whether the young adult wants support to address current or chronic health issues, sexual/reproductive health, and/or pregnancy/parenting needs.

- **Family.** Family considerations include awareness of the young adult's living situation prior to admission, identification of any family conflicts, and their family and/or family of choice who will be able to support them during the admission and after the Crisis Residence stay. The young adult may or may not live with these individuals, but their support may be critical to a successful admission and discharge plan.
- **Confidentiality.** Confidentiality assures young adults that they can decide on who they want involved in their support system when engaging in the Crisis Residence program. Protected health Information should only be shared with family or family of choice with the young adult's consent.
- **Self-advocacy and empowerment.** Self-advocacy and empowerment mean that young people are adults who can make their own life choices and decisions about their mental health care. Providers may connect young adults with youth peer services and youth peer advocates.

Crisis Residences should consider young adult choice and comfort in the Crisis Residence setting. OMH has a list of information and resources for young people transitioning to adulthood, their families and service providers that can be found at https://omh.ny.gov/omhweb/consumer_affairs/transition_youth/resources/.

4. Telehealth Guidance

Crisis Residential services are designed to be provided on-site. For information related to telehealth guidance and Part 596 regulations refer to https://omh.ny.gov/omhweb/telehealth/.

5. Discharge Planning

Discharge planning is a fundamental component of service planning that starts at admission and continues throughout the guest's stay in the Crisis Residence. Discharge planning involves identification of discharge goals, discharge criteria, and ongoing services and supports in the community. The following is a list of considerations to determine discharge readiness:

- Guest ability and willingness to engage in the program services
- Whether guest needs can be addressed within the program scope of services
- Accomplishment of goals and objectives, as stated in the Individual Service Plan (ISP)
- The viability and accessibility of aftercare treatment, services, and supports

At the time of discharge, Crisis Residences will complete a discharge summary. The discharge summary is shared with the guests and their providers to enhance continuity of care following discharge from a Crisis Residence. A discharge summary will include all the components of the discharge plan and additionally include the following:

- Rationale for discharge
- Guest condition at discharge
- Summary of services received
- Summary of collateral involvement
- Safety or crisis intervention plan
- List of scheduled aftercare treatment, service, and supports including date, time, and location
- List of community resources relevant to the guest's culture, preferred language, and experience as requested
- Where a guest is staying after discharge

A discharge plan and summary should be signed by a staff member of the program and by the guest. If the guest refuses to sign, the refusal and reason should be documented. The guest must be given a copy of the discharge plan. Providers must notify the MMCP when the guest is discharged.

Discharge summaries and plans may be provided to their current providers, case managers, MMCP and collaterals. Crisis Residences will take necessary steps to follow policies regarding consent, information sharing and confirm all information shared is confidential. Refer to Confidentiality section for additional information.

E. Length of Stay

Length of stay (LOS) in Crisis Residences is based on the acuity of a guest's mental health crisis, their needs, and readiness for discharge. LOS varies from 1 up to 28 days. Crisis Residences are not exclusively 28-day programs and LOS determinations should be based on the length of time needed to stabilize the identified mental health symptoms that led to admission.

Crisis Residences must consider the following related to LOS:

- The admission notification to the MMCP should include the expected LOS
- Admissions should not exceed 28 days
- For LOS that may exceed 28 days, identification of potential barriers at the outset and coordination with discharge resources must be addressed throughout the guest's admission. Active discharge planning should be evident and documented
- For MMCP enrollees, if LOS exceeds 28 days, programs must coordinate continued service and discharge planning with the MMCP
- Discharge and immediate readmission at the end of a 28-day stay is discouraged
- There is no restriction on the maximum number of days per year for admissions
- LOS is contingent on the stabilization of crisis symptoms and medical necessity

F. Crisis Residence Documentation Requirements

Crisis Residences will maintain an electronic or physical case record for each guest. Physical case records must be maintained in one designated secure location. All program staff working directly with the guest must have access to the record. Each case record includes the following:

- Guest name, age, and contact information
- Date and time of admission
- Referral source name, contact information, and date of referral
- Presenting crisis or symptoms related to mental health or emotional distress causing significant challenges in daily life
- Admission note
- Screening for risk of harm to self and others
- Identified supports
- Preferred and primary language
- Rationale for admission
- Initial treatment and/or service needs
- Summary of mental, medical, emotional, social, residential, recreational, vocational, nutritional needs and medication needs
- Summary of relevant mental and physical health examinations including findings and conclusions, if available

- Summary of relevant clinical, psychological tests, etc., if available
- Documentation that upon admission the guest was educated in self-preservation procedures, regarding emergency evacuation and fire safety procedures and ability to exit premises
- LPHA recommendation
- The Individual Service Plan signed by a CI professional or CI staff under the supervision of a CI Professional, and the guest
- Daily progress notes include but are not limited to:
  - Services provided that are identified in the ISP
  - Relationship of services to the objectives and goals of the service plan
  - Progress toward objectives and goals
  - Occurrence of significant event(s) that affect or potentially affect the guest's condition
  - Signature of the staff member(s) who provided the service(s)
- Medication use during the admission, if applicable
- Communication with collaterals, including natural supports and care coordination
- Medication record if available
- A discharge summary and plan including length of stay
- Referrals and appointments

Intensive Crisis Residences will additionally include:

- Comprehensive assessment
- Mental health diagnosis/diagnostic impressions
- Treatment recommendations
- Prescription information
- Medication prescribed by the Program Physician, Psychiatrist or Nurse Practitioner, if applicable
- Medication treatment plan and medication administration, if applicable

Records must be retained for a minimum period of six years from the date of the last service provided. Case record policies and procedures will ensure confidentiality of guest records in accordance with section 33.13 of the Mental Hygiene Law.

G. CRISIS RESIDENCE PROGRAM OPERATIONS

1. Staffing

(a) Staffing Plans

Crisis Residences must have a written comprehensive staffing plan that is based on the population to be served, the number of approved beds, projected volume of guests to be served, and services to be provided. Staffing plans include a multidisciplinary team, rationale for staffing configurations and patterns, and the plan for appropriate supervision and training. Staffing plans are continuously reviewed and updated to ensure that the staff composition meets the needs of the Crisis Residence and the community.

Staffing Plans will include, but not be limited to the following:

- Identification of the number of staff necessary to operate a 24/7 program
- Staff positions by title, including FTEs for each position and qualifications
- Designations of full-time, part-time, and per diem staff in the staffing schedule

- Staff duties and responsibilities related to the delivery of required services
- Supervisory staff, and plan for assistance when a supervisor is not on-site
- Description of supervisory structures within the program

Staffing plans are approved through the licensing Prior Approval Review (PAR) process. Any changes to staffing plan must be reported to OMH. Guidance on the licensure process can be found at: https://omh.ny.gov/omhweb/par/.

(b) Staffing Standards

RCS and ICR programs will employ or contract with the following staff members:

- Program Director: a full-time employee of the agency and is responsible for the daily direction of the program
- Supervisory staff to oversee the provision of program services
- Crisis Intervention Professionals
- Crisis Intervention Staff including Qualified Peers

Refer to Definitions for a description of the credentials of Crisis Intervention Staff, Crisis Intervention Professionals, Peers, and Supervisors.

OMH recommends a minimum daily direct service staff ratio of 1:4 on-site Crisis Intervention staff to guests at all times. This includes awake overnight staff to ensure the safety of staff and the guests. Under certain circumstances the daily direct service ratio may be flexible. Request and approval of staff ratios will be reviewed and approved during the licensing process.

Crisis Intervention Staff included in the daily direct service staff ratio must be dedicated to that shift. Staff may not work in two programs at the same time during their shift. For example, a direct service staff cannot work for a community residence and the Crisis Residence during the same shift. For ICR programs, the Program Director and supervisory staff that are not dedicated to the shift should not be counted in the daily staff ratio.

Crisis Residences will adhere to the criminal background check requirements under the Justice Center in accordance with Mental Hygiene Law Sections 31.35 and 19.20, 14 NYCRR Parts 550 and 805, and clearance requirements under NYS Social Services Law Section 424 regarding the child abuse and neglect registry.

For more information regarding the Staff Exclusion List and Criminal Background Checks, visit https://www.justicecenter.ny.gov/pre-employment-checks.

Questions regarding submission may be sent to cbc@omh.ny.gov.

(c) Additional Intensive Crisis Residence Staffing

Intensive Crisis Residence guests must receive treatment services identified on the ISP. Due to the intensive nature of this service, it is expected that the staffing plan includes psychiatry, professional staff, peers, and other service providers available and accessible 24/7.

ICR programs will employ, contract, or consult with the following:

- Psychiatrist and/or Nurse Practitioner who can assess, diagnosis, provide medication therapy, and consultation services as needed

- An adequate volume of nursing staff with experience working with individuals with mental health conditions to ensure the continuous provision of treatment services in accordance with their scope of practice. This includes but is not limited to health screenings, and oversight, monitoring, and administering of medications. It is also

expected that nurses will be involved in care coordination for guests stepping down from hospitals and CPEPs. Nursing staff are physically present or on-call and able to come on-site immediately.

- Crisis Intervention Professionals such as LCSW, LMHC, and LMSW who can provide assessment, individual and group counseling, care coordination, and support to address mental health and co-occurring disorders

2. Supervision

Supervision is a collaborative activity between a supervisor and staff that provides guidance and support to promote competent and ethical delivery of services and supports. Supervision includes the oversight of direct services related to the treatment of mental health and substance use related conditions and the delegation of responsibilities for day-to-day management of program operations pursuant to the staffing plan approved by OMH.

Crisis Residences must employ or contract with an adequate number of CI professional staff who by their training and experience, are qualified to provide ongoing and emergency supervision to staff responsible for providing direct services to guests.

(a) Peer Supervision

Peers are integral staff in Crisis Residences. Peers offer hope through connection and engage with guests based on their needs and requests for support. Peers are included as part of a multidisciplinary team in Crisis Residences, adequately compensated for their qualifications and experience, and allowed opportunities to develop skills. Peer staff must have regular supervision and support to carry out their role. Supervision may include:

- Orient peer specialists to job duties and requirements
- Reinforce non-clinical nature of the peer support role with the peer specialists and colleagues
- Model a focus on strengths of peers and guests

Peer supervisors may use best practice resources such as National Practice Guidelines for Peer Specialists and Supervisors.

Peer support services can be supervised by competent mental health professionals including CI professionals, CASACs, other CI Staff with a master's degree in a human services field, and qualified peers with at least three years of direct experience providing peer or family peer services. Experienced family peer advocates may supervise youth peer advocates upon completion of State approved Youth Peer Support training.

3. Training

Training for all staff is critical to ensure staff understand their roles and have the skills to provide high quality care to all guests. Crisis Residences will ensure all staff are offered ongoing training opportunities for quality improvement, safety, and service delivery to increase staff confidence and guest satisfaction.

Crisis Residences must have policies and procedures for staff training including orientation, ongoing training, and staff development. It is important that staff trainings include best practices and approaches to serving diverse populations that are reflective of the cultural and ethnic groups within the service area. Trainings are expected to be regularly evaluated and updated.

Crisis Residences must verify and retain documentation of all staff training and experience and including professional licensures on file.

Crisis Residence staff are required to have training on the following:

- Administration of Naloxone
- Trauma-informed care
- De-escalation strategies
- Harm reduction
- Culturally and linguistically competent service provision
- Language Access/ Limited English Proficiency

In addition to the required trainings, it is recommended that Crisis Residence staff be offered, at minimum, the following training components as part of their employee orientation and continuing education opportunities. These trainings should take into consideration the program type and services delivered.

- Peer Support Services
- Behavioral Health and Racial Equity
- Supports for Individuals Identifying as LGBTQ+
- Supports for Individuals with Intellectual or Developmental Disabilities
- Wellness and Safety Planning
- Suicide Prevention
- Mental Health First Aid
- CPR and First Aid
- Safety and Crisis Intervention Planning
- Risk Assessment
- Domestic and Intimate Partner Violence
- Individual Service Planning
- Healthy Coping Strategies (Stress Reduction and Relaxation Techniques)
- Medication Management
- Overdose Prevention
- Co-occurring Disorders
- Substance Use/Substance Use Disorders
- Motivational Interviewing
- Psychosocial Rehabilitation and Skills Training
- Vicarious Trauma and Self-Care

Some OMH recommended training topics and resources can be found at the Center for Practice Innovations at https://practiceinnovations.org/ and the Academy of Peer Services at https://www.academyofpeerservices.org/.

4. Environment

Crisis Residences must maintain a home-like environment that promotes safety and comfort for guests. The environment of Crisis Residences includes:

- Single occupancy rooms
- Staffed and open 24 hours a day, seven days a week
- A smoke free environment
- A safe physical environment, as evidenced by compliance with relevant building safety standards

- Adherence to Life and Safety requirements for OMH Licensed Residential Settings outlined in 589.13. The Life and Safety requirements list will be available when applying for licensure.
- Accessibility and accommodations for guests with varying levels of disabilities and impairments

For guests who bring or use alcohol or drugs on the premises for recreational purposes, the program will discuss standards and expectations for a safe, recovery-focused, and rehabilitative environment.

(a) Co-location

A Crisis Residence may be co-located in a building with other programs, however; it must be within spaces that are physically and programmatically separate. In some instances, Crisis Residences may be co-located within a community residence. Programs may share a common entrance, kitchen, and laundry areas. Co-located programs must have separate and distinct direct service staff during each shift.

(b) Infection Control

Crisis Residences must follow relevant infection control guidance as published by NYS OMH including guidance issued during an emergency period.

5. Medication Procedures

Crisis Residences must have policies and procedures for the storage, record keeping, and oversight of prescribed medications brought into the program by guests receiving services. Controlled substances are subjected to state and federal requirements and restrictions and are to be secured. Guests may keep their own medications secured in a lock box in their room, or programs should provide secure storage space and secure access for guest medications in the staff office.

6. Coordination with Medicaid Managed Care Plans

Crisis Residences are expected to collaborate with the MMCP throughout the guest's stay for service and discharge planning. This may include case conferences. The frequency of communication should reasonably reflect the complexity of the guest's needs. It is an expectation that Crisis Residences work collaboratively and cooperatively with MMCPs as requested.

Crisis Residences must notify the MMCP within **two** business days of an enrollee's admission. OMH developed a suggested Crisis Residence Admission Notification Form. This form is not required; however, it contains the necessary information providers must submit to a MMCP within two business days of the guest's admission. MMCPs may use this form or develop their own but can only require providers to submit the information contained in the Crisis Residence Admission Notification Form which can be found here: https://omh.ny.gov/omhweb/bho/docs/adult-crisis-residence-admissions-notification-form.pdf.

When determined, Crisis Residences must notify the MMCP of the tentative and actual guest discharge date(s). Length of stay should not exceed 28 days per admission. Crisis Residences must work with MMCPs for admissions beyond 28 days.

Guests admitted to Crisis Residences may participate in community-based outpatient services or new outpatient services identified in their Individual Service Plan. MMCP authorization of these services cannot be restricted because of a Crisis Residence admission.

7. Organization and Administration

Crisis Residences will address the following areas to ensure the organization and administration of a Center is effective and suited to meet the needs of the community. Additionally, the organization and administration will ensure operations are fair and legally sound. These components are an important part of the overall experience for a guest while receiving services at a Crisis Residence.

(a) Governing Body

Crisis Residences will identify a Governing Body that will have overall responsibility for the operation of the program and may delegate responsibility for the day-to-day management of the program to appropriate staff in accordance with the organizational plan approved by OMH. The governing body meets on a regular basis, in no event less often than quarterly,and will maintain written minutes of all meetings as permanent record of the decisions made in relation to the operation of the program. The minutes will be reviewed and approved by the governing body.

The governing body approves a written plan or plans that, at a minimum, address the following aspects of the operation of each Crisis Residence program:

- The goals and objectives of the Crisis Residence program, including the admission and discharge criteria
- The plan of organization that clearly indicates lines of responsibility
- A written plan for services and staff composition which:
    - Includes the qualifications and duties of each staff position by title,and addresses all essential aspects of the operation of the Crisis Residence program, including clinical, administrative, supervision, fiscal, clerical, housekeeping, maintenance, dietetic, and recordkeeping and reporting functions and
    - Specifies all services available through the Crisis Residence program
- The written quality assurance plan
- The written utilization review plan

The governing body will approve the written policies and procedures of the Crisis Residence program.

(b) Guest Rights

Crisis Residences will maintain written policies to ensure the protection of guest rights that are in accordance with 14 NYCRR 527.5. These policies will include a guest grievance procedure. Crisis Residences will make a written statement of guest rights that is easily accessible within the program site and have copies available to for guests upon request. Crisis Residences will be responsible for ensuring the protection of guest rights. Guests must be informed of their rights at admission. A guest residing in a Crisis Residence has rights that include but are not limited to:

- A safe and sanitary environment
- Access to nutritious food
- Being treated with dignity and respect
- An environment that respects beliefs, religion, cultural diversity, and cultural identity
- Appropriate language access for limited English proficiency
- Shared decision making and right to self-determination (including daily schedule and

activities)
- A reasonable amount of safe storage space for clothing and other personal property
- A reasonable amount of privacy
- Contact with the people considered to be significant others and family and visitors at any time that is convenient and practical for the guest, as well as the operations of the Crisis Residence program
- Participation to the fullest extent in the establishment and revision of their Individual Service Plan
- Involvement and inclusion of individuals that are part of a natural support network (friends, family, significant others) in service planning, as determined by the guest
- Be informed of the grievance process

It is expected that all guests have access to 3 meals per day, personal care items, linens and emergency clothing as needed. In addition, Crisis Residences will allow guests to prepare and/or store their own meals as desired. Guests may provide their own meals if they choose.

(c) Guest Agreements

Guest agreements are written agreements between the guest and the Crisis Residence program and are considered a best practice. These agreements outline the expectations of the program and guest consent to these expectations. Agreements should be reviewed with the guest verbally and they should be provided with a written copy. The agreement should include the expectation that guests will participate in services outlined in their Individual Service Plans. Agreements provide a structure for conversation in the event a guest does not abide by their agreement and allows for the exploration of alternative arrangements that may relate to the current crisis and/or future planning.

(d) Confidentiality

Crisis Residences must deliver services in accordance with Mental Hygiene Law (MHL) 33.13 and The Health Insurance Portability and Accountability Act (HIPAA) regarding the confidentiality of protected health information (PHI). Crisis Residence providers should consult with their own legal counsel to create policies and procedures that will ensure the operating residence follows program guidelines, MHL 33.13, and HIPAA.

For more information, visit:

- https://omh.ny.gov/omhweb/hipaa/phi_protection.html
- https://omh.ny.gov/omhweb/guidance/hipaa-mhl-33-13-field-guidance.pdf
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/authorization/index.html

(e) Incident Reporting

The Protection of People with Special Needs Act, or PPSNA (Chapter 501 of the Laws of 2012) created the Justice Center for the Protection of People with Special Needs ("Justice Center"). The Justice Center is a State agency charged with the responsibility to track and prevent, as well as investigate and prosecute, reports of abuse and neglect of persons with disabilities or special needs (i.e., "vulnerable persons"). The PPSNA created a set of consistent safeguards for vulnerable persons served by systems under the jurisdiction of six state agencies, including OMH, to protect individuals against abuse, neglect, and other dangerous conduct, to aggressively investigate and address instances of neglect and abuse, and to provide fair treatment to employees upon whom vulnerable persons depend for their care.

Crisis Residences are required to comply with the incident reporting requirements of the PPSNA and 14 NYCRR Part 524.

Providers must report incidents using the New York State Incident Management and Reporting System (NIMRS). More information about NIMRS can be found at: https://www.omh.ny.gov/omhweb/dqm/bqi/nimrs/.

(f) Utilization Management

Crisis Residences will have an organized utilization management (UM) plan designed to monitor the appropriateness of admission and continued stay and to identify the over-utilization or under-utilization of services. If a waitlist is maintained, a process for managing the waitlist should be included in the program policies and procedures. The UM plan will be subject to approval by OMH.

(g) Billing and Reimbursement

Refer to Crisis Residence Benefit and Billing Guidance at the OMH Medicaid Managed Care Crisis Intervention Webpage, https://omh.ny.gov/omhweb/bho/crisis-intervention.html.

8. Data Collection and Reporting

Crisis Residences must report data metrics required by OMH for specific time frames. Data collection is used to:

- Improve quality of care for guests
- Improve guest satisfaction with services
- Identify trends to inform community planning
- Identify the effectiveness of crisis residential programs in the crisis continuum
- Ensure coordination and utilization of services within the crisis services system
- Inform policy decisions

Examples of data to be collected include but are not limited to:

- Demographic information
- Referral sources
- Length of stay
- Services provided
- Number of guests served
- Discharge location
- Diversion from Emergency departments, hospitals, etc.

(a) Quality Improvement

Crisis Residences may collect, analyze, and utilize information on a routine basis to improve service delivery in response to identified trends. In addition, Crisis Residences are expected to obtain feedback from guests, peers, and collaterals regarding services and integrate their feedback into program recommendations. Crisis Residences will ensure methods of obtaining guest feedback with the intention to monitor the guest perception of the services received.

(b) Consolidated Fiscal Reporting

Crisis Residences must complete an annual Consolidated Fiscal Report (CFR). Information can be found at https://omh.ny.gov/omhweb/finance/cfrs.htm.

The Adult Crisis Residences Program Codes are:

- 5030- Residential Crisis Support
- 5020-Intensive Crisis Residence

H. Advancing Behavioral Health Equity

Crisis Residences are expected to have written personnel policies which prohibit discrimination on the basis of race, color, creed, disability, sex, marital status, age or national origin, as well as written policies on ensuring a diversified workforce.

Crisis Residences must ensure efforts are made to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved, marginalized populations. Efforts may include outreach and education about services and access, linkages to advocacy organizations, and policies.

Underserved/unserved marginalized populations may include but are not limited to: Black, Indigenous, and other People of Color, members of the LGBTQ community, older adults, Veterans, individuals who are deaf and hard of hearing, individuals with limited English Proficiency (LEP), immigrants, and individuals re-entering communities from jails and prisons.

Crisis Residences will make an effort to hire and retain staff that mirrors the demographic profile of the community and persons that are served. The program should use available data to set workforce recruitment targets to meet this goal. Efforts to recruit a diverse workforce should include all levels of the organization's workforce, including management.

1. Utilization of Demographic Data

Crisis Residences will review demographic data for the program's catchment area to determine the cultural and linguistic needs of the population. Staff are trained to be aware and respond appropriately to the cultural and linguistic needs of the catchment area.
Crisis Residences will review available demographic data to identify disparities of access to treatment and implement policy and procedures to address such disparities.

2. Language Access

Crisis Residences must ensure provision of language assistance services to Limited English Proficient (LEP) Individuals and/or have other communication needs (e.g., Deaf or Hard of Hearing) at no cost to the individual to facilitate timely access to all health care and services. Language access services need to be made available in such a way that assessment or treatment activities will not be delayed. For more information about Limited English proficiency visit, https://www.lep.gov/.
In addition, Crisis Residences will:

- Make all necessary documents available in individual's preferred language (e.g., releases, documents pertaining to rights)
- Inform all individuals of their right to receive language assistance services clearly and in their preferred language, verbally and in writing
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area, with a focus on the varied reading levels among the service user population
- Make efforts to provide the individual's identified as collaterals with language assistance services in their preferred language, verbally and in writing
- Make efforts to employ staff that are proficient in the most prevalent languages spoken

by services users

- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

For more information regarding culturally and linguistically appropriate services refer to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) at https://thinkculturalhealth.hhs.gov/clas.

I. Local Government and Community Partnerships

Crisis Residences are encouraged to establish contractual and formal agreements, policies and procedures, referral protocols, and relationships with an array of program types and providers to facilitate access and linkages to services. These include:

- **Local governmental unit (LGU).** Relationships with LGUs to address provision of budgeting, community needs assessments, local priorities, and service delivery planning for the populations being served by the Crisis Residence. According to Article 41 of the Mental Hygiene Law, the LGU is the statutorily recognized planner for local mental hygiene services. OMH expects Crisis Residences to establish close consultation and collaboration with the LGU.
- **Community agencies.** Relationships with community agencies to have clear pathways for receiving, transitioning, and creating referral opportunities.
- **Local law enforcement.** Relationships with local law enforcement (i.e., sheriff departments, local police, and state police), emergency medical services (EMS), and other emergency services to increase awareness of Crisis Residences as a potential diversion from the hospital and emergency room.
- **Local inpatient and outpatient services.** Local inpatient and outpatient services, including but not limited to mobile crisis providers, crisis stabilization centers, hospitals, emergency departments, Comprehensive Psychiatric Emergency Programs, clinics, rehabilitation and detox services, harm reduction programs, PROS programs, ACT teams and other intensive outpatient programs to ensure prompt access and support for individuals with high acuity needs or emergencies.
- **Community partners, providers, and community programs.** Community partners, providers, and community programs, including but not limited to civil and criminal justice entities, insurance payors, Directors of Community Services, Department of Social Services (DSS), community support services, schools, and local agencies who offer specialized services to diverse populations (i.e., children and youth, LGBTQ+, people of color, people with disabilities, etc.

J. Definitions

Staffing definitions in this guidance have been updated to reflect required staffing qualifications for Medicaid Reimbursement. For additional definitions of terms included in this document refer to the OMH regulation Part 589 Crisis Residences.

Collaterals

Collateral means an individual who is a member of the guest's family or household, or other individual who interacts with the guest and is directly affected by or has the capability of affecting their condition and is identified in the Individual Service Plan as having a role in

treatment plan and/or is necessary for participation in the evaluation and assessment of the guest.

Crisis Intervention (CI) Professionals

Crisis Intervention Professionals are practitioners possessing a license authority under State licensure law by the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of behavioral health conditions within their scope of practice.

CI Professionals include the following individuals licensed or permitted in NYS:

- Physician (MD/DO)
- Psychiatrist
- Addictionologist/Addiction Specialist
- Nurse Practitioner
- Registered Nurse
- Physician Assistant
- Licensed Psychologist
- Licensed Psychoanalyst
- Licensed Social Worker (LMSW or LCSW)
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Licensed Creative Arts Therapist
- Licensed Behavioral Analyst
- Occupational Therapist who meets the qualifications set forth in 42 C.F.R. 440.110(b)(2)

A licensed psychologist is a professional who is currently licensed as a psychologist by the NYSED or possess a permit from the NYSED and who possess a doctoral degree in psychology and works in a Federal, State, county or municipally operated program or services. Master's degree-level psychologists may use the title "psychologist" and may be considered professional staff but may not be assigned supervisory responsibility. Master's level psychologists may not have supervisory oversight of Crisis Intervention services except for Peer services when applicable.

For services provided to individuals 21 and over, CI Professionals also include:

- Certified Psychiatric Rehabilitation Practitioners certified by the Psychiatric Rehabilitation Association
- Psychiatric Rehabilitation Practitioners certified by the Psychiatric Rehabilitation Association
- Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification, Therapeutic Recreation Therapists certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association
- Counselors certified by and currently registered with the National Board for Certified Counselors

Crisis Intervention (CI) Staff

CI Staff include para-professional, unlicensed, and peer staff who provide residential crisis services directly to guests. CI Staff are at least 18 year of age and have a bachelor's which may be substituted for a high school diploma, high school equivalency, or State Education Commencement Credential. Individuals without a bachelor's degree must meet one or more of the following qualifications:

- 1-3 years' experience working with individuals with serious mental illness or substance use disorders
- Students and interns within a DOH-approved NYS education department program
- Licensed Practical Nurse (LPN)
- Credentialed Alcoholism and Substance Counselor (CASAC)
- Qualified peer
- Lived experience with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders may have education requirement waived to provide services as CI Staff

Family

Family means those members of the guest's natural family, family or choice, or household who interact with the guest and are directly affected by, or have the capability of affecting, the guest's condition.

Guest

Guest means an individual 18 years and older who is receiving services at a Crisis Residence.

Qualified Peer

A qualified peer is an individual with lived experience as an individual with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who is provisionally certified or credentialed as a Peer Specialist, Family Peer Advocate, Certified Recovery Peer Advocate, or Youth Peer Advocate, and who has completed all required State approved trainings specific to their title.

Supervisors

Supervisors are CI Professionals qualified to supervise the delivery of program services within their applicable scope of practice and provide regularly scheduled supervision to staff.