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**New York State Office of Mental Health
New York State Office of Addiction Services and Supports
14 NYCRR Part 600
“Crisis Stabilization Centers”
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This document is intended to provide interpretative/implementation guidance with respect to certain provisions of 14 NYCRR Part 600. Because this guidance document addresses only selected portions of the regulation and does not include or reference the full text of the final regulation, 14 NYCRR Part 600, it should not be relied upon as a substitute for this regulation.

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A. Part 600 Crisis Stabilization Center Regulations

The New York State Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) (hereafter collectively referred to as the “Offices”) published Crisis Stabilization Center regulations, 14 NYCRR Part 600 on March 9th, 2022. The purpose of this guidance document is to establish standards for Crisis Stabilization Centers which provides voluntary crisis stabilization services to individuals experiencing mental health and substance use crisis symptoms.

B. Purpose of this Guidance

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

- a. Describing services.
- b. Describing standards for the operation of Crisis Stabilization Center services.
- c. Describing the Offices expectations for documentation, performance, and service delivery of Crisis Stabilization Centers.

This document is intended to provide guidance for both Supportive Crisis Stabilization Centers and Intensive Crisis Stabilization Centers. Language that does not specify and/or refers only to “Crisis Stabilization Center(s)” or “Center(s)”, is applicable to for both Supportive and Intensive models.

C. Crisis Stabilization Centers

Crisis Stabilization Centers (CSCs) provide voluntary support, assistance, and urgent treatment to individuals across the lifespan. The development of Crisis Stabilization Centers is founded on the recovery-oriented care provided and led by Peers and Peer Advocates. CSCs are categorized as either a Supportive Crisis Stabilization Center or an Intensive Crisis Stabilization Center.

1. Supportive Crisis Stabilization Center

Supportive Crisis Stabilization Center (SCSC) means a center that provides support and assistance to individuals with mental health and/or substance use crisis symptoms. Services are for recipients experiencing challenges in daily life that do not pose the likelihood of serious harm to self or others. Such challenges may also create risk for an escalation of behavioral health symptoms that cannot reasonably be managed in the recipient’s home and/or community environment without on-site supports. The Center provides voluntary services with an emphasis on peer and recovery support. SCSCs will provide, or contract to provide, all SCSC services on-site, twenty-four hours per day, seven days per week. Recipients may receive services in a Supportive Crisis Stabilization Center for up to twenty-four hours.

Services provided to recipients at a SCSC include, but are not limited to, the following:

- Assistance with coping skills to help manage urges to use substances.
- Assistance with emotional self-regulation, including the use of coping strategies and grounding techniques.

- Providing support for emotional distress that does not require medication management.
- Providing psychoeducation.
- Delivering support and assistance when feeling overwhelmed and unaware of how to connect to treatment.
- Providing collaborative assistance in developing or revising safety plans and/or providing support for the use of existing safety plans when the recipient's provider is not available.
- Linking recipients with referrals for emergency housing, healthcare, food, disability services, substance use, and mental health services.

2. Intensive Crisis Stabilization Center

Intensive Crisis Stabilization Center (ICSC) means a center that provides urgent response and/or treatment services to recipients experiencing an acute mental health and/or substance use crisis. **ICSCs offer all services provided at an SCSC including an emphasis on peer and recovery support**, while also providing rapid access to services for acute symptoms, assisting in diversion from a higher level of care, and prescribing or administering medications to manage substance use and mental health symptoms. Like an SCSC, the ICSC provides voluntary crisis treatment services with an emphasis on peer and recovery support in a safe and therapeutic environment. ICSCs will provide stabilization and referral services twenty-four hours per day, seven days per week on site. Recipients may receive services in an ICSC for up to twenty-four hours.

Services provided at ICSCs include the examples described above for SCSCs. Additional services provided at an ICSC include the following:

- Behavioral interventions and medication management for mental health, substance use, and co-occurring disorders
- Management of mild to moderate substance withdrawal and intoxication
- Psychosocial assessments

3. Services

(a) Services Provided at Supportive and Intensive Crisis Stabilization Centers

All CSCs are required to provide the following services for the purposes of assessment and stabilization of mental health and/or substance use crisis symptoms:

(i) Triage and Screening

Triage and screening are services that begin upon presentation at the CSC and are performed by a registered nurse (RN), in collaboration with other staff as appropriate. The goal of triage and screening services is to understand the reason for, complexity of, and urgency of a recipient's presentation and determine the most appropriate type of care to best meet their needs. The Offices recommend using standardized, evidence-based, risk screening instruments to inform clinical decision-making. For recommended screening instruments please refer to [Appendix F](#).

As part of triage and screening, all presenting recipients should receive the following:

- Identification of a recipient's preferred and/or primary language, including sign language, to ensure services are provided in a manner that meets their language access needs.

- Collaboration between the staff and the individuals identified as collaterals by the recipient, as applicable.
- Screening for personal identity preferences, including but not limited to gender identity, religion, and race/ethnicity to ensure services are provided in a culturally affirming manner.
- Screening for needed accommodations or modifications regarding physical disabilities, fall risk, and the recipient’s ability to manage their activities of daily living.
- Screening for risk of self-harm, suicide, and risk of violence/harm to others.
 - The level of risk will be determined by the utilization of screening instruments. For recommended screening instruments please refer to [Appendix F](#).
- Screening for substance use, substance use disorder, and the risk of substance withdrawal. For recommended screening instruments please refer to [Appendix F](#).
- Determination of the appropriate level of care for a recipient who uses substances, made by utilizing the most recent version of the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR).
 - When a crisis assessment and/or LOCADTR indicates that a recipient requires a higher level of care, Centers will make every attempt to engage the recipient until a direct connection to the appropriate service provider is complete.
 - Further information about the LOCADTR can be found at <https://oasas.ny.gov/locadtr>.
- All recipients will receive a basic health screening and vital signs measurement. Additional tools such as fingerstick, urine toxicology, and/or breathalyzer may be utilized as needed and if available at the center.
 - Centers will be responsible for obtaining appropriate license/certification from the NYS Department of Health to conduct such testing on site.
- Centers will be equipped to deliver basic health services. The type of available basic health services will be determined by the scope of practice, training, and experience of the medical staff at the Center.

A triage and screening must be conducted on every presenting recipient to ensure that the Center is adequately equipped to meet their needs. For recipients who are determined to require a higher level of care, the Center must ensure the recipient is linked to the appropriate level of care. This shall include making the referral; communicating with the receiving provider, program, facility and/or hospital; and arranging transportation of the recipient to the receiving provider to ensure a warm handoff. Centers must develop contracts or Memorandums of Understanding (MOUs) to establish clear pathways for referrals, communications, and collaborations with such higher levels of care. For more guidance on partnerships and linkages, please refer to the [Community Partnerships](#) section below.

(ii) Assessment

Assessment is a service to assist in identifying interventions and/or treatments that may be used to address the recipient's needs. Assessments are performed by a Registered Nurse in collaboration with other staff, as appropriate, after the completion of triage and screening. Assessments must be strength-based, person-centered, trauma-informed, and reflect the cultural and linguistic needs of the recipient.

An assessment should include the following:

- Identification of symptoms and factors contributing to a recipient's crisis (i.e., psychiatric substance use, social, familial and/or legal factors).
- A thorough assessment of risk for recipients who screen positive for risk of harm to self or others. The risk assessment should include static and dynamic factors, such as mental status, supports, protective factors, and access to means, including access to weapons.
 - Prior to discharge, the Center must document the steps it has taken to develop or revise a safety plan for recipients determined to be at moderate or high risk of harm to self or others.
- A review of the recipient's health history, including recent hospitalizations, medications, and/or comorbid conditions.
- An assessment of the recipient's physical health needs.
- An assessment of social determinants of health (i.e., access to primary and dental care, level of food security, living situation, personal safety, and availability of heat, electricity, and potable water in the home).
- An assessment should include additional [information gathering](#) obtained from databases such as PSYCKES, local Electronic Health Records (EHRs), QE/RHIO, and/or other relevant database(s).

From the assessment, an individual service plan should be developed that will guide the therapeutic interventions most helpful in determining appropriate level of care and observation. This should be performed collaboratively with recipients identified supports or care providers. For recipients who are determined to require a higher level of care, the Center must ensure the recipient is linked to the appropriate level of care. For more information, refer to the [Presentation at the Center](#) section.

(iii) Therapeutic Interventions

Therapeutic interventions are required to relieve presenting symptoms and concerns including, but not limited to, identifying stressors, emotions, thought patterns, and urges to use substances. Interventions should be person-centered, trauma-informed, and comprehensive. They include, but are not limited to, crisis counseling, psychoeducation, and crisis de-escalation.

(1) Crisis counseling

Crisis counseling incorporates various models and techniques of crisis intervention. Individuals presenting to a CSC experiencing a crisis may feel overwhelmed and have difficulty utilizing coping strategies. Crisis counseling includes but is not limited to providing support and guidance for reducing psychological stressors, providing a comforting environment, educating recipients about common stress and trauma reactions, and empowering recipients by promoting their strengths and existing coping strategies.

(2) Psychoeducation

Psychoeducation (PE) is provided by professional staff to recipients and/or collaterals. PE may be utilized at various stages of treatment. The goal of PE is to increase knowledge and clarity about various facets of a recipient's illness and/or symptomology. PE may include, but is not limited to, providing education to promote a healthy lifestyle, increasing communication skills, reducing stigma, and assisting in the management and prevention of symptom recurrence for both mental health and substance use disorders.

(3) De-escalation/Intervention Strategies

De-escalation is a non-violent intervention strategy to prevent and/or decrease escalation of disruptive behaviors and severe emotional disturbance. Effective de-escalation techniques involve both verbal and non-verbal communication skills as well as listening skills. Staff will be aware of physical and verbal signs of escalated behavior such as fidgeting, pacing, rocking, and verbal communication of discomfort. Staff will be respectful of the recipient's personal space and strive to provide a comfortable environment and supportive response.

(iv) Peer Support

Peer support is at the heart of the CSC model, with peers and peer advocates functioning as important members of the multidisciplinary team as professionals with lived experience who help support and provide services to individuals in crisis. Peers have many titles and specialties, including certified peer specialists, certified recovery peer advocates, credentialed family peer advocates, and credentialed youth peer advocates.

When individuals present to a CSC, peers should be the ones to greet and orient them to the Center when available. Peers are to act as advocates for recipients and help them to understand the array of services offered by the Center. In addition, peers and peer advocates are an important part of discharge planning and may work with the recipient and multidisciplinary team to broker resources and identify supports within the community.

Peers and peer advocates serve a wide range of populations across the lifespan, providing individual advocacy, empowerment, recovery support services, prevention, outreach, engagement, hospital diversion, information and referral, self-help, safety/crisis planning, planning for prevention of setbacks, assisting in the development of psychiatric advance directives, relaxation, resource brokering, as well as health and wellness coaching.

When working with adolescents, peer support may include parenting skills development, empowering families, coaching, engagement, bridging and transition support, self-advocacy, self-efficacy, community connections, and natural supports related to family support and engagement.

Centers must connect recipients with community peer programs if ongoing support is needed and if a peer who specializes in the recipients' needs is not available on-site. CSCs should post notices displaying the availability of on-site peer services and self-help resources, along with contact information of local off-site peer services and self-help resources.

(v) Ongoing observation

Ongoing observation is the process of monitoring recipients throughout their stay to ensure safety, and that interventions and/or treatments provided by staff meet the recipient's needs. Ongoing observation allows CSC staff to identify any symptoms that may indicate the need for a higher level of care. Center policies and procedures will address ongoing observation via established observation guidelines, minimum staffing contact requirements, and specific interventions/procedures for adults and youth.

Level of observation will be based on an assessment of acuity and agreement between the recipient and CSC staff. Staff will work with the recipient to accommodate requests for privacy.

Refer to the [Premises](#) section for more information on CSC environment, including privacy options.

(vi) Care Collaboration with a Recipient’s Friends, Family, and/or Care Providers

Care collaboration involves communication with the recipient’s designated collaterals who fulfill an important role in supporting the recipient’s treatment, service coordination, and recovery. Staff will work with the recipient to clearly identify the frequency and scope of communication with the recipient’s identified supports and collaborate with to assist in the recipient’s recovery process, treatment, wellness and safety care planning, as well as discharge/aftercare planning.

Staff will ensure proper written authorization has been obtained from the recipient prior to contacting collaterals, in accordance with federal Health Insurance Portability and Accountability (HIPAA) privacy rules, the State’s mental hygiene laws and Title 42, Part 2 of the Code of Federal Regulations (Part 2).

(vii) Discharge and Aftercare Planning

Discharge planning is a fundamental service that is discussed throughout the recipient’s stay to ensure their needs will be met following discharge. Discharge planning involves creating clear pathways to continuity of care in collaboration with the recipient. Continuity of care is critical to ongoing stabilization of the recipient. All efforts will be made to ensure recipients are connected to referred services and supports.

Prior to a recipient’s discharge, the following activities should be performed:

- Identifying previously established services and provider(s) of the recipient, including:
 - Notifying the recipient’s Health Home Care manager if the recipient is enrolled, or referral to a Health Home if the recipient is not enrolled, if appropriate.
 - Collaborating with the recipient’s residential team, ACT team, and/or case manager if applicable and with the recipient’s consent.
- Asking the recipient’s preference for additional community-based services following discharge.
- Determining if the recipient’s health insurance is accepted by their preferred service providers.
- Contacting the recipient’s insurance company to identify services in the recipient’s network, when applicable.
- Collaborating with referral sources or other involved collaterals as part of the discharge planning process.
- Planning to address social determinants of health that were identified in the assessment (i.e., access to primary and dental care, level of food security, living situation, personal safety, and availability of heat, electricity, and potable water in the home).
- If treatment includes medication management, ensuring the recipient has a prescription for, or supply of, medication adequate to meet their needs until their next prescriber appointment.
- Providing the recipient with written discharge instructions and reviewing them with the recipient.
- Providing a child’s discharge instructions to their family or guardian and reviewing them with the child and family or guardian.

- Providing the recipient with their Wellness and Safety Plan and reviewing it with the recipient.
- Providing a child with their Wellness and Safety Plan and reviewing it with the child and family or guardian.
- Utilizing peer specialists and advocates as an important part of discharge planning to broker resources and identify supports in the community.

Once the recipient is determined to be ready for discharge, the CSC must assure the following:

- Determine the most appropriate level of care.
- Provide and review:
 - written discharge instructions with the recipient;
 - a minor's written discharge instructions with their family or guardian;
 - a Wellness and Safety Plan with the recipient; and
 - a child's Wellness and Safety Plan with the child and family or guardian.
- Secure an appointment and connect the recipient to the appropriate provider or service. Develop clinical or other risk-based protocols to determine which recipient will receive follow-up and the necessary extent of such follow-up.
- Verify contact information for the recipient and collaterals if appropriate so the CSC may conduct follow-up contacts.
- Connect the recipient to the appropriate provider, with an in-person hand off whenever possible.
- Facilitate direct connection to follow up care, including the provision of transportation with possible options such as agency vehicles, ride share programs, Medicaid transport, or agreement with other transportation services.

CSCs will make every effort to verify that aftercare appointment(s) have occurred. Centers will follow up with the next provider (including housing or shelter provider), care coordinator, and other collaterals to provide warm-handoffs and ensure all efforts are made to connect the recipient with care and resources in the community. Referrals to crisis outreach services, crisis residential services, Health Homes, Centers of Treatment Innovation (COTIs), or Open Access Centers may be used to connect with the recipient, review the discharge plan, and facilitate linkages to care.

Follow-up care provides the recipient with additional support, ensures that referrals meet the recipient's needs, increases the likelihood of outpatient engagement, and may decrease the frequency of crisis and/or future visits to the Center. CSCs will establish policies and procedures to support and strengthen the ability of staff to identify and provide follow-up services that are in line with a recipient's aftercare planning. To promote continuity of care, it is required that providers make appropriate, person-centered referrals to services that can provide follow-up in the community. Crisis services are transitional in nature and will not be used as a substitution for ongoing treatment and support services in the community.

In cases where no additional appointments were made due to either lack of clinical necessity or refusal of services, decisions about the need for follow-up contact with the recipient will be made based on clinical considerations and in collaboration with the recipient.

Until linkage to care is completed, or for other clinically indicated reasons, the CSC will make a reasonable effort to do the following:

- Ensure recipients are safe and stable in the community.
- Provide support, care, and assistance with linkage to follow up care.
- Refer to crisis outreach services to support a recipient's stability in the community.
- Provide resources for local recovery centers and/or harm reduction services, when appropriate.
- Best practice is that follow-up contacts should be made within 24-hours of discharge.

Note: Supportive Crisis Stabilization Centers do not need to provide the additional on-site services required to be provided at Intensive Crisis Stabilization Centers (see below). However, SCSCs must have agreements and/or demonstrate linkages to providers who offer those services.

(b) Additional Services Provided at Intensive Crisis Stabilization Centers

In addition to the services described above, the Intensive Crisis Stabilization Centers must provide the following services:

(i) Psychiatric Diagnostic Evaluation and Plan:

Psychiatric Diagnostic Evaluation and Plan is a service that determines diagnostic impressions and helps to guide next steps in treatment.

A psychiatric evaluation includes information about the recipient's presenting concerns, current symptoms, medical history, psychiatric history, substance use history, current medications, allergies, medication history, risk assessment, and mental status examination. The psychiatric evaluation will be completed by the psychiatric provider.

When appropriate, collateral information may also be obtained, with the recipient's consent, to help inform the evaluation and plan.

This service is performed by a psychiatrist or a psychiatric nurse practitioner, and will be performed as soon as possible following triage, screening, and assessment.

(ii) Psychosocial Assessment

A psychosocial assessment is an evaluation of a recipient's health and well-being. It can include the following: medical history, family history, psychological history, substance use history, social history, living situation, recreational interests, cultural needs, language preference, religious and spiritual preferences, vocational and nutritional needs, and desired life roles.

When appropriate, collateral information may also be obtained, with the recipient's consent, to help inform the recipient's psychosocial assessment.

A psychosocial assessment may be performed by any licensed professional working within their scope of practice.

(iii) Medication Management and Training:

Medication management and training are activities which provide information to the recipient to ensure appropriate management of medication through understanding the role and effects of medication in treatment, identification of side effects of medication, and discussion of potential effects of substances, including food and other medications, to the recipient when they are taking the medication. Training in medication self-administration is also an appropriate activity, when clinically indicated.

Recipients who are started on medications by an ICSC provider will be directly linked to the clinically appropriate level of care to ensure ongoing access to the medications.

Medication management can be performed by prescribers and nursing staff working within their scope of practice.

(iv) Medication Therapy

Medication therapy is the process of determining which medications will be prescribed and/or utilized during the course of treatment; assessing the effectiveness of the recipient's existing medication regimen by reviewing the recipient's medication record and consulting with the recipient and, as appropriate, their family or guardian; prescribing and/or administering medication; and monitoring the effects and side effects of the medication on the recipient's mental and physical health.

Medication therapy may be performed by a licensed professional working within their scope of practice.

(v) Mild to Moderate Detoxification Services

Mild to moderate detoxification services are for recipients experiencing non-acute physical and/or psychological symptoms associated with the cessation or reduction in use of a substance to which they have a physiological dependence. These symptoms may be coupled with situational crises such as an unstable living environment. Recipients who are unable to tolerate detoxification on their own without withdrawal complications may also receive these services. Withdrawal severity, measured as mild, moderate, or severe, is typically determined by a validated scale for withdrawal for that substance. For information regarding validated scales see [Appendix F](#).

(vi) Medication for Addiction Treatment (MAT).

Medication for Addiction Treatment (MAT) involves prescribing medications to treat the physical and psychological symptoms associated with substance use, such as craving, and may or may not include counseling or behavioral therapies. MAT will be provided in a person-centered manner where the medication, dose, and frequency of administration are tailored to the needs of each recipient. All medical practitioners can prescribe MAT for substance use disorders such as alcohol and tobacco use disorders without restriction.

Buprenorphine may be prescribed for the treatment of opioid use disorder. Qualified practitioners including physicians, physician assistants (PAs), and nurse practitioners (NPs) can prescribe buprenorphine after they obtain a buprenorphine waiver from the United States Drug Enforcement Administration (DEA). This waiver is commonly called an X-waiver or a DEA X number. In accordance with federal rules, practitioners who want to prescribe buprenorphine for up to thirty (30) patients no longer need to complete previously required trainings before applying for an X-waiver. For more information about becoming a buprenorphine waived practitioner, visit the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) website. Methadone can be dispensed only by OASAS and federally certified opioid treatment programs (OTPs).

(c) Service Consideration for Minors

Minors who present to a CSC will be served by staff with training in child and adolescent developmental and behavioral health. The presence of these staff on-duty 24 hours per day, 7 days per week will ensure developmentally appropriate, high-quality care.

The following may be considered when providing services to minors at a CSC:

- Working collaboratively with schools, pediatricians, and other systems in the community that serve minors (child welfare, juvenile justice, etc.) to provide comprehensive behavioral health services.
- Collaborating with child and adolescent peer organizations to identify supports and/or psychoeducational materials that are specifically engaging to children, youth, and adolescents.
- Creating separate waiting areas and private spaces for minors and families/guardians (see Premises section) to increase safety and reduce stigma.
- Allowing families/guardians to engage and collaborate with the staff and minors as partners in all stages of decision-making.
- Identifying and engaging with the behavioral health needs of the parents/guardians, caregivers' other family members, and collaterals of the minor.
- Screenings and assessments specific to minors, such as Adverse Childhood Experiences (ACEs).

(i) Mandated Reporting

CSCs will comply with the provisions governing the reporting of suspected child abuse or maltreatment, as set forth in sections 413-416 and 418 of the NYS Social Services Law.

(ii) Consent for Minors

If a minor under the age of 18 presents to the Crisis Stabilization Center without a parent or legal guardian present, every effort will be made to reach the parent/legal guardian to obtain consent and attempt to locate collaterals to support unaccompanied minors while receiving CSC services. If consent cannot be obtained, the minor will undergo an evaluation to determine the reason for their visit, the minor's level of risk of harm to self and/or others, and any other immediate concerns.

If the minor is voluntarily seeking evaluation and/or treatment for mental health or substance use and the physician determines that parent/legal guardian involvement would have a detrimental effect on the course of the treatment, or the parent/legal guardian refuses to provide consent, and treatment is necessary for the best interests of the minor, treatment may be provided by a licensed physician or other staff operating under the physician's supervision. In circumstances where mental health or substance use treatment is provided without the consent of a parent/legal guardian the clinician shall document the reasons why in the medical record, along with a written statement by the minor indicating that he or she is voluntarily seeking services.

If the CSC cannot locate a minor's parent(s) or guardian(s) or such parent(s) or guardian(s) refuse or fail to communicate within a reasonable time with the CSC regarding the provision of services for a minor voluntarily seeking substance use services, the program director may consent to the provision of services to the minor. An explanation of the reasons to support treatment and the efforts to contact the minor's parent(s) or guardian(s) shall be documented in the medical record.

The provisions regarding substance use or mental health treatment for a minor without parental or guardian consent are consistent with mental hygiene law sections 22.11 and 33.21.

4. Telehealth

Telehealth is the use of audio and/or video telecommunication. Telehealth is an allowable mode of service delivery with proper approvals from the Offices.

To apply for approval to deliver services via Telehealth, the CSC must submit the Telehealth Provider Attestation of Compliance for Telehealth Services and relevant policies and procedures for proposed telehealth use. The CSC will review and comply with the applicable telehealth regulation and accompanying guidance issued by the Offices to ensure compliance.

CSC Providers are required to develop and implement appropriate policies and procedures in accordance with all regulations and rules issued by the Offices. Services may only be delivered via telehealth by appropriate staff, as referenced in Article 29G of the public health law and associated regulations issued by the Department of Health, acting within their scope of practice, and the service(s) must be appropriate to be delivered via telehealth.

5. Wellness and Safety Planning

OMH and OASAS strongly recommend that CSCs use, update, and share Wellness and Safety Plans consistent with recipient consent. “Wellness and Safety Plan” is a blanket term referring to a range of tools which can be helpful in engaging individuals in care and preventing future negative outcomes. A Wellness and Safety Plan can refer to a suicide prevention plan, a recovery support plan, a violence prevention plan, psychiatric advanced directives, a harm reduction plan, a Wellness and Recovery Action Plan (WRAP[®]), and a variety of other specific plans. These plans typically have common elements, including recipient’s self-identified and preferred ways of coping with events in their lives. These preferred ways of coping can include coping mechanisms, calming techniques, preferred crisis stabilization strategies (e.g., oral versus injectable as needed medications, preferred medications, use of calming techniques), contact information for people who will be involved in decisions about care, preferred harm reduction techniques, etc. A recipient’s Wellness and Safety Plan will be attached to their discharge plan and provided to the recipient.

(a) Accessing and Sharing Wellness and Safety Plans

For the last several years, PSYCKES has included a section where providers can upload Safety Plans and can view and download such plans that have been uploaded by other providers. CSCs should routinely look for and utilize these existing plans and should upload all Safety Plans developed at the CSC to PSYCKES so other providers can access them. In addition, CSCs should review their own internal information systems to review the recipient’s uploaded Wellness and Safety Plan where included.

D. Crisis Stabilization Center Operations

1. Community Partnerships

(a) Both Supportive and Intensive Crisis Stabilization Centers

CSCs are required to develop policies and procedures describing partnerships and linkages to services. Each Center must obtain a Memorandum of Understanding (MOU) with the following program types to facilitate rapid access and linkages to follow-up services:

- OASAS inpatient withdrawal and stabilization programs certified pursuant to Part 816.
- OASAS residential treatment consisting of, at a minimum, stabilization services, certified pursuant to Part 820.
- Emergency Department and/or Comprehensive Psychiatric Emergency Services (CPEP).
- OMH Licensed Crisis Residential Services.
- OASAS and OMH certified and licensed outpatient programs.
- Transportation services.

Working relationships with community agencies allow the Centers to have clear pathways for receiving, transitioning, and creating bilateral referral opportunities. Protocols must be established with partnered entities to ensure a streamlined, person-centered approach that will ensure continuity of care.

Centers will also establish partnerships with local law enforcement (i.e., sheriff departments, local police, and state police), emergency medical services (EMS), and other emergency services throughout the development and implementation of the CSC. Protocols will be established to not only maintain partnerships and continuous collaboration, but to increase the likelihood of positive recipient engagement within the community. Outcomes of these relationships may result in the following scenarios:

- Law enforcement will have the ability and resources to contact Center staff when they have questions regarding a potential recipient. For example, an officer may ask the Center if their services are appropriate for a potential recipient's symptoms and presenting concerns. If so, an officer may provide an estimated time of arrival to allow Center staff to prepare for the potential recipient's arrival. If not, Center staff may provide the officer with resources for the appropriate response and level of care based on presenting concerns.
- Law enforcement will have the ability and resources to contact the Center about a hesitant recipient to inquire about their services and discuss transportation options in order to reduce stigma.
- The CSC, law enforcement, and EMS may collaborate to establish a transportation plan that will ensure all attempts are made to safely connect an individual with appropriate services using trauma-informed and person-centered approaches.

Centers will be expected to establish partnerships within the crisis response continuum and local inpatient and outpatient services, including but not limited to mobile crisis providers, crisis residences, hospitals, emergency departments, CPEPs, clinics and other outpatient providers, rehabilitation and detox services, harm reduction programs, PROS programs, ACT teams and other intensive outpatient programs. Outcomes of these relationships may result in the following scenarios:

- Centers have close referral relationships with Mobile Crisis Teams and will accept referrals promptly.
- A Center may have the ability to arrange intake appointments for recipients prior to discharge from the CSC by holding contractual linkages with affiliated programs and providers.
- Center staff may have a point of contact to review referrals received by the CSC in order to directly connect the recipient with care in a timely manner.

- Centers may have agreements with local clinics, PROS programs, and ACT teams to ensure communication is open and accessible when a recipient receives services at the Center.

Additionally, Centers will be best served by establishing partnerships with other community partners entities, 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.).

The following are examples of a CSC using partnerships and technology to facilitate linkage to care:

- Establishment of a point of contact at the local Department of Social Services (DSS) and with local housing facilities to assist with emergency housing when needed.
- Establishing MOUs with partners to allow access to shared calendars for appointments to provide the date/time of an appointment before the recipient is discharged.
- Awareness of local pharmacies' hours of operations and informing pharmacies ahead of time about common medications that would be prescribed to ensure pharmacies have sufficient stock.
- Establishing a point of contact or direct messaging system for law enforcement to ask questions related to transportation and the appropriateness of CSC services.

(b) Supportive Crisis Stabilization Centers

SCSCs must have agreements and/or demonstrate linkages to services that are required to be provided on-site at Intensive Crisis Stabilization Centers. These services include the following:

- Psychiatric Diagnostic Evaluation and Plan
- Psychosocial Assessment
- Medication Management
- Medication for Addiction Treatment (MAT)
- Medication Administration and Monitoring
- Mild to Moderate Detoxification Services

2. Presentation at the Center

Individuals may present to the Center in a variety of ways including, but not limited to, walk-ins, referrals from providers, emergency medical services transport, or police transport. The staff will make a reasonable effort to obtain as much information from whomever brought or referred the recipient to the Center to best understand their reason for presentation.

CSC staff will ensure that discussions take place with the presenting recipient and transporting entity to reinforce that all services offered at the CSC are voluntary. CSC staff should ensure recipients are aware of their right to ask questions and state their preferences at any time. As long as CSC staff have no acute clinical or safety concerns, the recipient may choose to stop services at any time. If staff have acute safety concerns but the client would like to stop services and/or leave the Center, staff will do their best to continue to engage the recipient to discuss person-centered safety options, including next level of care. If a recipient presents to a CSC and their needs are not deemed appropriate for this level of intervention, the CSC will make necessary arrangements to ensure the recipient is directly linked with the appropriate level of care.

CSCs must have procedures in place to inform what staff will do if acute safety concerns arise that prioritizes the safety and needs of all recipients and staff (i.e., suggesting a recipient move to a quiet area, providing immediate support, calling for an ambulance, security, and/or 911 for assistance).

3. Information Gathering

In order to obtain a comprehensive understanding of the presenting recipient, gathering information from multiple sources is a key aspect of informing treatment decisions. In addition to the recipient's self-report, the CSC will obtain information about a recipient's history from accessible databases including PSYCKES, local EHRs, QE/RHIO, and/or other relevant database(s) after obtaining any required consents.

In addition to the search of databases, CSCs will also make concerted efforts to obtain information from professional collaterals (i.e., providers, care managers, etc.), identified by the recipient, who are involved in the recipient's care. Information obtained will include but not be limited to information regarding the recipient's involvement with providers and other community services. This information will clarify clinical characteristics including current and history of medication use, mental health treatment, substance use treatment, medical issues, as well as successes and challenges with treatment engagement.

Efforts must be made to identify and contact personal collaterals (i.e., family members, friends, etc.) to better understand the recipient's current living situation, history, and treatment preferences. The CSC may utilize a consent process that complies with all relevant state and federal confidentiality requirements, including 42 CFR Part 2 to allow the recipient to designate which collaterals the CSC can contact to obtain additional information and support the recipient's care, coordination, and recovery. Multiple sources will be pursued to obtain information and input from collaterals. When serving children and adolescents input from schools, caretakers and social services agencies will be pursued, as appropriate.

4. Confidentiality

Services must be delivered in accordance with Mental Hygiene Law (MHL) 33.13, the Health Insurance Portability and Accountability Act (HIPAA), and the Code of Federal Regulations (CFR) Title 42, Part 2 requirements regarding the confidentiality of protected health information (PHI) for all patients and service recipients. Centers should consult with their own legal counsel to create policies and procedures that will ensure the practicing Center is in compliance with program guidelines, MHL 33.13, HIPAA, and 42 CFR Part 2.

For more information please visit:

- https://omh.ny.gov/omhweb/hipaa/phi_protection.html
- <https://www.lac.org/resource/the-fundamentals-of-42-cfr-part-2>
- https://oasas.ny.gov/search/provider_forms
- <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/authorization/index.html>

5. Staffing

(a) Staffing at Both Supportive and Intensive Crisis Stabilization Centers

CSCs are required to continuously employ or contract with an adequate number of staff, comprised of a multidisciplinary team on-duty and capable of meeting the needs of presenting individuals. The CSC staff

will provide voluntary services and urgent treatment to individuals experiencing symptoms related to a crisis.

The multidisciplinary team will include, but not be limited to:

- (1) A registered nurse, who is onsite twenty-four hours a day, seven days a week, to ensure adequate screening, assessment and care for all recipients.
- (2) A Psychiatrist or Psychiatric Nurse Practitioner.*
- (3) A Credentialed Alcoholism and Substance Abuse Counselor.
- (4) A Certified Peer Specialist.

**Because SCSCs are not expected to provide medication management services on-site, SCSCs may utilize the Psychiatrist or Psychiatric Nurse Practitioner as a supervisory and/or consultation role.*

In addition to the above referenced staff, all CSCs will have:

- A Program Director who is responsible for the CSCs overall administrative direction. Program directors are responsible for oversight of day-to-day operations and administrative direction. A program director must have at least two years of full-time work experience in the mental health or substance use disorder field and at least one year of supervisory experience.
- An on-duty staff member who, by virtue of training or experience, is competent to engage or treat children and adolescents. The individual(s) will preferably have more than 2 years of direct care experience working with children and families.
- Other clinical, professional and support staff to ensure adequate provision of services. This may include but not be limited to social workers, LPNs, psychologists, mental health aides, mental health counselors, marriage and family therapists, family peer advocates, and other staff as indicated.

It is critical that the Centers ensure access to supervision and training of all staff, including peer and peer advocates. Refer to the [Supervision](#) and [Training](#) sections for more information.

(b) Staffing Requirements at Intensive Crisis Stabilization Centers

ICSCs have additional staffing needs and requirements in addition to the staffing requirements for both SCSCs and ICSCs described above.

ICSCs must have the following staff disciplines on-duty* 24-7:

- (1) A Psychiatrist or Psychiatric Nurse Practitioner
- (2) A Credentialed Alcoholism and Substance Abuse Counselor
- (3) A Certified Peer Specialist

**On-duty means the individual is physically present or on-call and available which includes the ability to come on-site as needed.*

A medical director must be designated to oversee the ICSC. The medical director may serve as medical director of more than one program certified by the Offices.

The medical director must have the following:

- A license and active registration as a physician by the NYS Education Department.
- At least one year of education, training, and/or experience in mental health and substance use disorder treatment.

The medical director has overall responsibility for the following:

- Medical services provided by the ICSC.
- Oversight of the development and revision of policies, procedures and ongoing training for matters, including but not limited to, routine medical care, specialized services, specialized medications, and medical and psychiatric emergency care, screening for, and reporting of communicable diseases and infection in accordance with law, and public health education including prevention and harm reduction.
- Collaborative supervision with the program director of non-medical staff in the provision of mental health and substance use services.
- Supervision of medical staff in the performance of medical services.
- Assisting in the development of necessary referral and linkage relationships with other institutions and agencies including, but not limited to, general or specialty hospitals and nursing homes, health-related facilities, home health agencies, hospital outpatient departments, diagnostic and treatment facilities, laboratories, and related resources.
- Ensuring program compliance with all federal, state, and local laws and regulations.

To ensure the availability of buprenorphine, the ICSC will have prescribing professionals on-duty or on-call at all times who can prescribe approved medications, including buprenorphine, consistent with state and federal rules. CSCs will be mindful of potential changes to federal rules pertaining to the provision of controlled substances shall deliver services in compliance with state and federal rules and guidance issued by OASAS. ICSCs may enter into contracts with appropriate practitioners to ensure the availability of buprenorphine 24/7.

ICSCs are strongly encouraged to have a minimum on-site presence of a psychiatrist or psychiatric nurse practitioner for the day shift, 7 days per week. To provide sufficient services to recipients, ICSCs may also require access to physicians trained in disciplines other than psychiatry, or to more intensive medical supervision when certain medical disciplines or services are not on-site or available.

(c) Staffing Plan – All Crisis Stabilization Centers

CSCs must have a comprehensive staffing plan, which is continuously reviewed and updated to ensure staff composition meets the needs of the CSC and community. All CSC staff will be oriented in and have ongoing access to all relevant policies and OMH/OASAS regulations.

The staffing plan will include, but not be limited to, the following:

- Identification of the number of staff necessary to operate a 24/7 facility, including staff coverage for peak and non-peak hours.
- Justification for projected number of staff based on compiled demographic data.
- Descriptions of various disciplines of clinical and professional staff including managerial and supervisory staff.
- Descriptions of the staff's designated role within the CSC.
- Designations of full-time, part-time, and per diem staff.
- Descriptions distinguishing between onsite staff, on-duty, and on-call and available staff coverage.

- Policies to ensure timeliness of on-site/in-person response time by on-call staff.
- Plans to address staffing needs in the event of emergencies that may cause high volume/capacity issues.

6. Supervision

Supervision is a professional and collaborative activity between a supervisor and staff that provides guidance and support to promote competent and ethical delivery of services and supports. Crisis Stabilization Centers must be adequately staffed with individuals who are qualified to provide ongoing and emergency supervision. Supervision may entail oversight of direct services related to the treatment of a mental health and/or substance use related condition and/or delegation of responsibilities for day-to-day management of the CSC pursuant to a staffing plan approved by the Offices.

Clinical supervision is a formal and continuous process of professional support and learning to ensure quality of recipient care. Clinical supervision may be provided in an individual and/or group format. Clinical supervisors observe, mentor, evaluate, and inspire to create an environment that promotes learning, professional development, and ethical delivery of practice. CSCs are expected to employ or contract an adequate number of licensed staff, who by their training and experience, are qualified to provide formal clinical supervision to staff who are responsible for direct care of recipients pursuant to the staffing plan approved by the Offices. All supervisors and clinical supervisors will only provide services which are in their scope of practice and level of competence.

- The Program Director must ensure all staff are knowledgeable of supervisory staff and their primary responsibilities.
- Staffing plans must describe all supervisory structures, including but not limited to, medical staff, clinical staff, and peers.
- A professional and/or certified staff member who functions in a supervisory role must have working knowledge of the staff disciplines they supervise and experience (e.g., a licensed social worker who supervises certified peers and peer specialists must be knowledgeable of peer roles and practice).

7. Training

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. CSCs will ensure all staff are offered ongoing training opportunities for quality improvement, risk management, safety, and service delivery in order to increase staff confidence and recipient satisfaction.

Training components will include principles of crisis intervention, recovery, 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 the CSC, based on data obtained from the service area.

It is recommended that all CSC 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 +
- Overdose Prevention
- Harm Reduction
- How to Assess for Risk to self and others
- Psychiatric Disorders
- Substance Use/Substance Use Disorders
- Co-occurring Disorders
- Wellness and Safety Planning
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Youth and Family Engagement
- Domestic Violence
- Peer Engagement
- 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
 - Justice Center Reporting
 - HIPAA and Confidentiality
 - Mandated Reporting
 - Language Access
 - Infection Control

Crisis settings are unique environments that pose challenging situations unique to the behavioral health system; therefore, CSC staff will require various levels of trainings and skill sets to work safely, effectively, and efficiently. CSCs will create policies and procedures to provide and monitor staff training. Trainings will be regularly evaluated and updated. CSCs must retain documentation that each staff have completed the minimum training requirements. For clinical staff, the CSC must have documentation of professional licensure on file.

CSC staff must be competent in the identification of risk factors of harm to self and others. Center staff must provide services within their defined scopes of practice. Additionally, all staff should be cross trained to acquire base knowledge of the various disciplines provided at the CSCs, including but not limited to, peer engagement and working with children and adolescents. Staff trainings shall reflect the populations being served and services to be provided.

Peer and peer advocate support is crucial to the quality and service delivery of CSCs, as well as to the implementation of a strong recovery-oriented training curriculum. Peers and peer advocates will be provided training and supports as needed to strengthen their role in the crisis response system.

8. Background Checks

The CSC will ensure staff complete necessary background checks as part of the hiring process. OASAS and OMH have established a joint process to streamline the background check process, in keeping with

the provisions of MHL Article 36, including submission of a criminal background check (CBC) request and review of background check results. Background checks are required to work in a program authorized under the NYS Mental Hygiene Law. They include a criminal background check through the NYS Division of Criminal Justice Services (DCJS), a check of the NYS Office of Children and Family Services (OCFS) Statewide Central Registry (SCR), and a check of Staff Exclusion List (SEL) maintained by the NYS Justice Center for the Protection of People with Special Needs (Justice Center). Pre-employment checks will be required for all employees, volunteers, and contractors who will have regular and substantial unsupervised or unrestricted physical contact with recipients receiving services. Staff at the respective OMH Field Office or OASAS Regional Office will ensure the provider's ability to perform the required checks.

CSCs shall 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, please visit <https://www.justicecenter.ny.gov/pre-employment-checks>. Questions regarding submission may be sent to cbc@omh.ny.gov.

9. Medication Procedures

(a) Both Supportive and Intensive Crisis Stabilization Centers

CSCs will create procedures to monitor, store, review, and access home medications brought into the Center by recipients while receiving services. Procedures should include appropriate recordkeeping and supervision associated with the use of home medications while at the Center.

(b) Intensive Crisis Stabilization Centers

Intensive Crisis Stabilization Centers have the ability to provide medication, when indicated, to stabilize a recipient's mental health or substance use crisis. In some circumstances, a recipient may be experiencing acute distress, discomfort, or agitation, and timely access to medications to treat the underlying symptoms or conditions will be of great benefit.

Several medications that assist with stabilization are controlled substances which are subject to strict state and federal requirements to obtain and provide to the recipient. Medications specifically used to treat opioid use disorder, opioid withdrawal or stabilization are subject to additional state and federal restrictions. Each Intensive Stabilization Center will evaluate their staffing, program needs, and available community resources to determine the best model to use to ensure access to medications. Below are the currently available options.

(i) Drug Enforcement Administration (DEA) Registered Prescriber – Drug Enforcement Administration (DEA) Registrant

An individual licensed within NYS who has the ability to prescribe within their scope of practice and is registered with DEA to dispense controlled substances (administer and dispense) at the Center location can order a stock of controlled substance medications from a DEA registered distributor for administration of medication to recipients while on site. Follow up medication can be prescribed to the recipient and obtained from an area pharmacy. Administration can be

done by other staff under the supervision of the individual with State and Federal authorization. The NYS Licensed DEA Registrant is the sole individual responsible for the safe storage, use, and disposal of the controlled substances and must have policies and procedures in place which cover storage, administration, ordering, supervision, documentation in medical record, security for safe keeping of the medication, and safe disposal of unused medication.

(ii) Contractual Agreement with a Community Pharmacy for Delivery of Medications

A Center develops an agreement with a Community Pharmacy open 24/7 to deliver controlled substances within a specified period of time to the recipient at the Center. The recipient then self-administers medication under the supervision of Center Staff. At a minimum, CSCs will develop appropriate policies and procedures regarding medication storage and staff oversight of recipient self-administration.

(iii) Hospital Affiliated Program

A hospital affiliated program located on hospital grounds which utilizes the hospitals' on-site pharmacy to obtain recipient specific medications through a prescriber's order to be administered on site to a Center recipient. CSC staff can administer to the recipient consistent with prescriber's order.

10. Case Records

CSCs will have a complete case record for each recipient that is maintained electronically or physically. If a CSC maintains physical case records, all records that cover each recipient's complete case must be maintained in one designated location. Each case record will include the following:

(i) Both Supportive and Intensive CSCs will record:

- Identifying information about the recipient and identified collaterals.
- Documentation of triage, risk screening, substance use screening and assessment.
- A note upon presentation indicating
 - source of referral
 - date and time of services
 - reason why the person came to the crisis Center (chief complaint)
 - initial treatment needs
 - individualized service plan
 - date service commenced
 - medical history, allergies, current medications.
- A summary of presenting concerns (medical, emotional, and social needs).
- Safety or wellness plan, when indicated.
- A discharge summary, which includes disposition and recommendations for follow up.
- Referrals and appointments.

(ii) Intensive Crisis Stabilizations will additionally record:

- Documentation of the psychiatric evaluation and plan.
- Documentation of psychosocial assessment.
- Medication treatment if applicable, including MAT if MAT can be initiated at the ICSC.
- Diagnostic impression.

- Recommendations and referrals for MAT, if MAT is clinically indicated but cannot be initiated at the ICSC.
- A summary of treatment, including medication management and training.
- A summary of notable symptoms that emerged.

The case record will additionally explain any circumstance in which the recipient declines or is not able to participate in the discharge planning process.

Staff will ensure proper written authorization has been obtained from the recipient prior to contacting collaterals, in accordance with HIPAA privacy rules, the mental hygiene laws, and Title 42, Part 2 of the Code of Federal Regulations.

Records must be retained for a minimum period of ten years from the date of the last service provided to the recipient or, in the case of a minor, for at least ten years after the last date of service or three years after they reach majority, whichever time period is longer.

In circumstances where substance use or mental health treatment is provided without the consent of a parent/legal guardian, the following items will be documented in the minor's record:

- Attempts to contact the parent/legal guardian.
- The capacity of the minor to make such determinations regarding their treatment.
- The treatment provided.

(a) Individual Service Plans

An Individual Service Plan is a written plan developed by CSC staff in collaboration with the recipient. The individual service plan assists in identifying and guiding the services provided based on screening and assessments. Individual services plans will be included in the case records to document interventions. Individual services plans are developed on a person-centered basis and may minimally include the following:

(i) Both Supportive and Intensive CSCs will include recommendations for:

- Peer services.
- Non-pharmacological interventions such as individual or group counseling.
- Family meetings or other collateral involvement.
- An individualized plan to address risk of harm to self or others.
- Level of observation and frequency of reassessments.
- Involvement of a Certified Alcoholism and Substance Abuse Counselor (CASAC) and/or activity or other therapies as available.

(ii) Intensive Crisis Stabilization Centers will additionally include:

- Detoxification services if applicable.
- Standing and/or PRN medications provided to the recipient if applicable.
- Plans for medical care, including vital signs.

(b) Discharge Summary

At time of discharge, CSCs will complete a discharge summary. The discharge summary is shared with the recipients' providers and/or receiving facilities to enhance continuity of care following discharge

from a CSC. A recipient's discharge summary will include all the components of the [Discharge Instructions](#) and additionally include the following:

(i) Both Supportive and Intensive CSCs will document:

- A summary of all services received in the Center.
- A summary of notable events, including notable medical events.
- A general health summary.
- A summary of collateral involvement.
- The recipient's condition at discharge.
- A summary of therapeutic interventions.

(ii) Intensive Crisis Stabilization Centers will additionally document:

- Notable vital signs, medical interventions, and medical events.
- A summary of treatment for substance withdrawal if applicable.
- The recipient's condition at discharge, including the results of a recent mental status examination and risk assessment.
- A diagnostic impression.

A copy of the discharge summary will remain as part of the recipient's case record. The discharge summary will be shared with a recipient's current treatment and housing providers, Health Home care coordinators, managed care organizations, and to others per a recipient's written consent and approval. Discharge summaries are shared prior to the recipient's first community appointment after discharge. Centers will take all necessary steps to follow policies regarding the sharing of information and confirm all information sent is secure and confidential.

(c) Discharge Instructions

Discharge instructions (also known as discharge plan or an after-visit summary) must be completed prior to a recipient's discharge and provided to each recipient upon discharge from the CSC. A recipient must have the opportunity to participate in the development of their discharge plan.

The discharge instructions must be written in person-centered, age and developmentally appropriate language. The instructions will include follow-up services and supports that have been discussed collaboratively between the staff and recipient, including additional services that may assist the recipient post discharge. The discharge instructions must minimally include the following:

(i) Both Supportive and Intensive CSCs:

- A summary of findings.
- A wellness and safety plan, if applicable.
- A psychiatric Advanced Directive, if applicable.
- Recommendations for or referrals to community services including peer services, educational vocational programs, and social supports.
- Information regarding follow-up including dates, times, addresses and additional contact information for follow-up appointments with outpatient providers and/or programs.
- Telephone numbers for the CSC to allow the recipient opportunities to ask questions.
 - If a recipient is transferred to a higher level of care, information about the crisis unit/facility, inpatient hospital, or residential program where the recipient will be transferred for ongoing care, including address and contact information.

(ii) Intensive Crisis Stabilization will additionally include:

- Treatment recommendations.
- Prescription information.
- Information regarding follow-up, including prescriber appointments if medications are a part of the discharge plan, as well as outpatient providers or programs that dispense or prescribe MAT for SUDs.

The discharge instructions will be reviewed with the recipient and family, if applicable, prior to their exit from the CSC. The discharge instructions will be signed by the recipient and family if applicable. A copy will also remain as part of the recipient's case record.

The discharge instructions will also be promptly provided to current providers including housing providers, appropriate Health Home care coordinators and managed care organizations, prior to the recipient's next appointment.

11. Organization and Administration

All CSCs 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 recipient while receiving services at a CSC.

(a) Governing Body or Sponsor

A CSC will identify a Governing Body or Sponsor that will have overall responsibility for the operation of the Center.

(b) Advisory Board or Committee

The Offices recommend CSCs have an advisory board or committee that incorporates stakeholders, including representatives of family, consumers across the lifespan, and other relevant advocacy and/or community organizations.

(c) Recipient's Rights

The CSCs written policies ensure the protection of recipient's rights. These policies establish and describe a recipient grievance procedure. The CSC must post a statement of recipients' rights in a conspicuous location easily accessible to the public and provide a copy to recipients upon service provision in accordance 14 NYCRR 527.5.

(d) Incident Reporting

The CSC must ensure the timely reporting, investigation, review, monitoring, and documentation of incidents. Such records and any related information must be made available to the Offices at their request. CSC providers are required to adhere to the incident reporting requirements in accordance with 14 NYCRR Part 524 and 836. See OMH [Office of Quality Improvement](https://omh.ny.gov/omhweb/dqm/bqi/resources.html) website for more information <https://omh.ny.gov/omhweb/dqm/bqi/resources.html>.

CSCs will:

- Ensure all staff receive training regarding the definition of incidents and reporting procedures at time of hire and annually.
- Ensure reportable incidents (i.e., allegations of abuse and neglect and significant incidents), are reported to the Justice Center.

- Utilize NYS Incident Management Reporting System (NIMRS) for incident reporting.
- Ensure implementation of recommended corrective actions.
- Utilize NIMRS reports, or other available incident/data analysis reports, to compile and analyze incident data for the purpose of identifying and addressing patterns and trends.

(e) Advancing Behavioral Health Equity

CSCs will have a designated staff member, preferably in a managerial position, who is responsible for planning, initiating, and updating the CSCs equity initiatives. Equity initiatives include the creation and implementation of a diversity, inclusion, equity, and cultural/linguistic competence plan that is to be reviewed and updated on an ongoing basis. Additionally, the CSC will have written personnel policies that 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 and inclusive workforce.

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

Underserved, marginalized, and unserved populations may include but are not limited to people of color, members of the LGBTQ+ community, older adults, Veterans, individuals who are deaf and hard of hearing, individuals who are visually impaired, individuals with limited English proficiency (LEP), immigrants, and individuals re-entering communities from jails and prisons.

(i) Staffing Demographics

CSCs must make efforts to recruit, hire, and retain staff that reflect the diverse demographic profile of the community. The CSC must 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. CSCs will utilize various outreach and recruitment strategies to promote employment opportunities to all populations, encouraging diverse individuals to apply. Outreach and recruitment strategies may include sharing open positions with diversity-focused community organizations, encouraging language in the proposed job descriptions that reflects the importance of having an inclusive and diverse workforce, and including questions regarding serving diverse populations during the interview process.

(ii) Utilization of Demographic Data

CSCs must review demographic data for the Center’s area of service to determine the cultural and linguistic needs of the population. Staff will be trained to be aware and respond appropriately to the cultural and linguistic needs of the service area. Trainings will reflect the prevalent cultural groups being served, as identified by collected data of the service area. Cultural trainings should be regularly re-evaluated and updated based on additional needs that arise in the community (See [Training](#) section for reference). CSCs must review available demographic data to identify disparities in access to treatment and should implement policies and procedures to address such disparities.

(iii) Language Access

CSCs must ensure the provision of language assistance services to recipients with limited English proficiency (LEP) and/or other communication needs (e.g., deaf or hard of hearing) at no cost to the recipient to facilitate timely access to all health care and services. All staff will be trained on the Center’s process of connecting recipients with language access services. CSCs will ensure

staff, including but not limited to managerial staff, are available to assist all staff with language access services. Language access services must be made available in such a way that assessment, intervention, and/or treatment services will not be delayed. For more information about Limited English proficiency please see www.lep.gov.

In addition, CSCs must:

- Make all necessary documents available in the recipient's preferred language (i.e., releases, documents pertaining to rights).
- Inform all recipients of their right to receive language assistance services 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 individuals identified as collaterals with language assistance services in their preferred language, verbally and in writing.
- Make efforts to employ or contract staff that are proficient in the most prevalent languages spoken by those receiving CSC services.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters will be avoided.

For more information regarding culturally and linguistically appropriate services please visit <https://thinkculturalhealth.hhs.gov/clas>.

(f) Local Government and Community Planning

The CSC must collaborate with the local governmental unit (LGU) and relevant community stakeholders, such as schools, law enforcement, treatment providers, housing providers, peers, and family support organizations. At a minimum, such participation must include:

- Provision of budgeting and planning data as requested by the local governmental unit.
- Identification of the population being served by the CSC.
- Identification of the geographic area being served by the CSC.
- Description of the CSCs relationship to other providers of service.
- Invitations to the Director(s) of Community Services (DCS) for the regional catchment area to attend inspection reviews for the purpose of local review and monitoring.
- Provision of any inspection reports and corrective action plans to the DCS.
- Review of fiscal by the Offices and the relevant DCS.

It is important to note that, through Article 41 of the Mental Hygiene Law, the LGU is the statutorily-recognized planner for local mental hygiene services. In this capacity, the LGU identifies local priorities, needs and outcomes and the metrics used to measure such outcomes. The mental hygiene planning process includes an electronic format, through the County Planning System (CPS), which allows local planners to access relevant and timely data resources to conduct needs assessments and planning using one standardized format for OMH, OASAS, and The Office of Persons with Developmental Disabilities (OPWDD). As such, the Offices expect the development of CSCs to include close consultation and collaboration with the LGU.

(g) Data Collection

Consistent with Part 600.14, CSCs must report data to the Offices on a regular basis according to data metrics required by the Offices.

CSCs will use collected data to:

- Improve the quality of care provided.
- Improve recipient satisfaction.
- Identify trends to inform community planning.
- Identify the effectiveness of crisis stabilization in the crisis continuum.
- Inform future policy decisions.
- Ensure coordination and utilization of services within the crisis services system.

The CSCs will report data in a designated format set forth by the Offices.

(i) Quality Improvement

CSCs will collect, analyze, and utilize information on a routine basis to change and improve services in response to identified trends. In addition, the CSCs will seek feedback from recipients, peers, and collaterals regarding services and integrate their feedback into program recommendations.

(ii) Recipient Satisfaction

The CSC will ensure methods of obtaining recipient feedback with the intention to monitor the recipient's perception of the services received. Various methods can be used to obtain feedback including but not limited to survey tools, mailings, touch screen kiosks.

(h) Diversion

CSCs will be required to have plans in place to address surge capacity, with the ability to respond accordingly with sufficient and appropriate staffing. CSC participation in local services planning with hospitals and LGUs will help to mitigate future CSC volume and capacity issues.

Similarly, CSC collaboration with local hospitals and other community providers assist in creating safe pathways for individuals experiencing crisis stabilization needs in the event CPEPs and 9.39 hospitals experience the need to be placed on diversion. CSCs will continue to offer their core services and refer recipients who require a higher level of service that the CSC is not staffed to handle.

In the event that a CSC faces circumstances which may necessitate diversion from the Center, the appropriate OMH/OASAS Field Office must be notified according to a mutually developed and agreed upon plan.

(i) Consolidated Fiscal Reporting

CSCs must complete an annual Consolidated Fiscal Report (CFR) as a licensed program. Further information regarding the CFR will be released at a future date.

12. Premises

CSCs must maintain an environment that promotes safe and effective operation of the Center. The premises must be reasonably maintained to ensure access to services. The physical space will accommodate all recipients, including but not limited to, recipients with developmental and intellectual disabilities, physical disabilities, communication needs, and visual impairment and blindness.

In an effort to provide space for healing, the CSC will offer a welcoming and comfortable environment. To achieve this, recipients should be greeted by peers or peer advocates upon presentation to a CSC in order to help them feel safe and comfortable. Other members of the multidisciplinary team will engage recipients throughout the care process. Staff should communicate all treatment and intervention options clearly and offer information about the CSC and CSC services in writing to the recipient in their preferred language whenever possible. Staff will also provide continuous contact and support to recipients throughout their stay, promote a person-centered care approach, and attend to recipients in a way that preserves their dignity by cordially engaging with them to discuss their needs, comfortability, and participation in services.

The CSC will protect the safety and privacy of minors who present by having separate areas, including waiting areas and group counseling spaces from those areas that serve adults. Minors will always be in the presence of a custodial adult when appropriate.

The CSC environment will include the following:

- Reflect a home-like atmosphere.
- Ensure the availability of comfortable seating including but not limited to observations chairs, health care recliners, etc.
- Ensure recipients are greeted by CSC staff (preferably a peer specialist) and provided ongoing engagement throughout service delivery.
- Adequate staffing and support staff (i.e., aids or technicians) to attend promptly to recipients' needs, including the comfort of those both waiting for and receiving services.
 - This may include but is not limited to providing food, snacks, beverages, blankets, adjustable lighting, tissues, therapeutic/comforting items, and comfortable seating.
- Ensuring all spaces, including the waiting areas and treatment areas, are set-up to reflect a therapeutic, trauma-informed environment that is conducive to stabilizing mental health and substance use crisis.
- Creation of an engaging and supportive environment with minimal barriers to enhance safety and promote engagement.
 - This may include replacing Plexiglas barriers with curtains or moveable barriers to support stronger connections and provide additional privacy when needed.
 - Options for maintaining privacy during interviews and intervention/treatment.
- Options to provide additional privacy or personal space to recipients when needed. This may include providing recliners are available with privacy curtains for recipients who may be experiencing symptoms that require further privacy.
- Creation of spaces for the recipient's belongings, including medications (i.e., lockers).
- Accommodation of routine activities and regularly used equipment.
- Adequate controls for medications and controlled substances.
- Controlled access to, and maintenance of, case records.
- Monitoring of the entrance and exit to the CSC to ensure safety of all recipients.
- A group observation room that will have the option to provide privacy based on assessment and need. For example, a group observation room may be used for monitoring withdrawal symptoms, medication administration, and observing effects of medications. A CSC staff person will always be present in the group observation room.

(a) Co-location

CSCs may be co-located with existing facilities and service providers, consistent with any applicable CMS requirements. CSCs may be co-located or adjoined with existing facilities and service providers, including but not limited to crisis residential services, mobile crisis services, outpatient clinics, inpatient rehabilitation or residential programs, OTPs, and Open Access Centers. Co-location of CSCs with existing facilities, providers, and programs that provide additional crisis services may be an appropriate method to enhance the services offered at the Center. Additionally, co-location is an opportunity to establish and strengthen partnerships and linkages within the service area.

For additional guidance related to shared space please visit:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/2016-09-14_shared_space_guide.htm

13. Billing

Standards pertaining to reimbursement:

Only Crisis Stabilization Centers certified jointly by the Offices may submit claims and be reimbursed for Crisis Stabilization Center services.

Claims for Crisis Stabilization Center services must be submitted using the appropriate combination of rate codes, procedure codes, and modifiers. Please see the [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual](#) for details on MCO claiming and encounter reporting processes.

- Crisis Stabilization Centers may bill for either a half-day or per diem visit in a twenty-four-hour period.
- Crisis Stabilization Centers should submit one claim per visit. The date of service on the claim should be the date the individual arrived at the Center.
- To bill for brief, the Crisis Stabilization Center must have provided services up to three hours.
- To bill for full, the Crisis Stabilization Center must have provided services for more than three hours.

E. Definitions

For definitions of terms included in this document please see the OMH/OASAS regulation Part 600 Crisis Stabilization Centers.

F. Appendix

Forms:

- To order forms please email: DesignCenter@omh.ny.gov

Recommended Violence Screening and Assessments Tools:

- Behavior Activity Rating School (BARS)

- Brøset Violence Checklist
- Dynamic Appraisal of Situational Aggression – Inpatient Version
- Historical Clinical Risk-20
- Overt Aggression Scale
- Staff Observation Aggression Scale/Revised
- Short Term Assessment of Risk and Treatability (START)

Recommended Screening Tools for Suicidality:

- Ask Suicide Screening Questions (ASQ)
- PHQ 9
- ED -Safe patient Safety Screener
- Columbia Suicide Severity Rating Scale – Triage Version (C-SSRS)
- Suicide Behavior Questionnaire Revised (SBQ-R)

Recommended Assessment Tools for Suicidality:

- Suicide Assessment 5-step Eval. And Triage
- Scale for suicide ideation
- Beck Scale for suicide ideation
- Child suicide potential scale
- Decision Support tool
- Behavioral Health Screening- ED

Levels of Care Determinations:

- LOCADTR
- LOCUS
- CALOCUS

Recommended Screens for Substance Use:

- National Institute of Drug Abuse (NIDA) Quick Screen
- NIDA Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST).
- The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)
- The Drug Abuse Screening Test-10 Item (DAST-10)

Recommended Assessments for Substance Withdrawal:

- The Clinical Institute Withdrawal Assessment of Alcohol - Revised (CIWA-Ar)
- The Clinical Institute Withdrawal Assessment Scale - Benzodiazepines (CIWA-B)
- The Clinical Opioid Withdrawal Scale (COWS)