DRAFT- FOR REVIEW

Guidance for Outpatient Treatment, Residential, Residential Treatment Facility, Care Management Programs on Collaborating with Hospitals on Admissions and Discharges

March 2024

The goal of this document is to offer guidance to all community-based treatment, rehabilitative, care management, residential, and Residential Treatment Facility (RTF) programs that are licensed, designated, or funded by the Office of Mental Health on best practices and expectations for collaborating with hospital Emergency Departments (EDs), Comprehensive Psychiatric Emergency Programs (CPEPs), and Inpatient Psychiatric Units and each other regarding admissions and discharges for individuals with behavioral health presentations. Please refer to the appendix for applicable programs.

The Office of Mental Health and Department of Health recently released Guidance on Evaluation, Admission, and Discharge Practices for individuals who present with behavioral health conditions. A critical component of successful implementation of such guidance is ensuring a person-centered, trauma-informed, and recovery-oriented approach and increased coordination with community-based programs who are responsible for warm hand-offs when individuals step up to and down from higher levels of care. A collaborative community system can ensure successful post-discharge community tenure and help individuals, including those with the most complex needs, achieve personally meaningful and individually driven improved outcomes.

All the recommended activities outlined below are to always be considered in a person-centered context. Providers should always strive to establish the individual's wishes and views and construct plans of care based upon the individual's perspective. There will be rare extenuating circumstances when specific recommended practices should not be used, and there will be circumstances when individuals clearly state they do not want the provider to pursue specific recommended practices. Providers must always balance individual needs and preferences with recommended standards of care and pursue plans of care centered around the individual's wishes whenever possible.

This guidance is applicable broadly to all OMH licensed, designated, and funded treatment and rehabilitative, residential, RTF, and care coordination programs. Aspects of the guidance that are applicable only to certain programs are delineated below. The appendix categorizes programs.

All community-based programs must keep their contact information up to date in CONCERTS using the Mental Health Provider Data Exchange (MHPD) to ensure that hospitals and other providers can locate accurate contact information through the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to obtain timely collateral information.

For the purposes of this guidance, collateral source of information means anyone that has direct knowledge of the individual's pre-crisis baseline, events that led to the presentation, recent history,

prior psychiatric and medical history, strengths, support networks, and/or risk factors. Collateral sources help with comprehensive mental health care consistent with person focused recovery-oriented care.

This could be:

1) People, as designated by the individual receiving services (or their legal guardian), considered a member of their family, friends, caregiver/guardian, member of their household;
2) Staff member(s) of a treatment, residential, RTF, or other community-based program; and/or
3) People, as designated by the individual receiving services (or their legal guardian), who otherwise interact regularly with the individual receiving services.

OMH providers should always make reasonable attempts to obtain consent from patients (or their legal guardian) to facilitate communication with other service providers and collaterals, where clinically appropriate. As a reminder, the Federal Health Insurance Portability and Accountability Act (HIPAA) allows information sharing for the purposes of treatment and care coordination, with or without patient consent. This applies to Article 28 hospital programs, including emergency departments. OMH providers meeting certain criteria are allowed under both HIPAA and subdivision (d) of section 33.13 of the MHL to use or disclose PHI for treatment or care coordination purposes with other parties without a signed consent form. Further guidance is forthcoming on information sharing.

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Section I: Guidance for Community-Based Providers for Individuals Currently Enrolled in the Service/Program

Section IA: Communication and Collaboration with Hospital Providers

Outpatient Treatment, Rehabilitative, and Care Management Providers

1) Programs must develop a protocol for identifying staff who are responsible for communicating information from the records of individuals served to hospital staff seeking information. This function must be available during regular business hours for all programs.
    a. For programs responsible to respond to crises after hours, it is expected that this function is available for hospital staff in the evening, overnight, and weekends/holidays. These programs should have a system to allow hospitals to contact a staff member who can access and provide clinical information when an individual presents to an ED or CPEP outside of standard business hours.
2) Programs are expected to transmit the following to acute hospital programs:
    a. Current safety plans, psychiatric advance directives, and/or relapse prevention plans, if available. PSYCKES MyChois allows uploading of safety and other plans.
    b. List of family and other supports and their contact information, as well as any limitations on consent to share information;
    c. List of all community service providers and their contact information, as available, as well as any limitations on consent to share information;
    d. Pertinent critical clinical information, including but not limited to, current condition (status), active (or current) problem list, accurate medication list, estimate of individual's adherence to treatment, and diagnoses;
    e. Presentation within the last 12 months to mobile crisis and other crisis services, EDs, CPEPs, or inpatient units;
    f. Current suicide and violence risk assessment, if available;
2) As a suggested practice, programs should develop summaries or face sheets (in hardcopy or electronic) with the above information to have available as a reference for the staff member(s) communicating with hospitals as well as for rapid transmission to the hospital team.
3) Intensive and wrap-around programs (e.g., Assertive Community Treatment (ACT) Teams, SOS Teams, Specialty Mental Health Care Management/HFW HHSC, CTI teams, INSET teams, OnTrackNY Coordinated Specialty Care, etc.) are expected, unless there is a rare extenuating circumstance, to join in the ED/CPEP individuals who require emergency hospital evaluation and, where possible and as appropriate, remain with them, to speak with the hospital team, as necessary, and provide current collateral information. In the rare circumstance that despite assertive engagement, the individual declines accompaniment, the staff member should ensure that information is transmitted to the hospital within the timeframe of arrival to the hospital.

4) Community providers and ED/CPEPs are expected to develop collaborative communication protocols for circumstances when programs send individuals requiring emergency hospital evaluation to the ED/ CPEP. They should ensure close communication with the ED/CPEP by:
   a. Proactively transmitting the summary information described above, when available, to the ED/CPEP based on procedures, timing and contacts collaboratively developed by hospital and community partners.
   b. Developing communication protocols whereby program staff who send the individual to the ED/CPEP should call the ED/CPEP and speak with ED/CPEP staff to provide collateral information. This may include the evaluating social worker (if a primary social worker is assigned), the ED physician, or psychiatrist. If a direct conversation is not possible or is declined by the hospital, this should be clearly documented.
   c. Developing a system for sharing contact information for the community staff member who can be available to answer questions - during business hours for all programs and during all hours for programs responsible to respond to crisis after hours.
   d. Developing communication protocols for outpatient programs that initiate an involuntary removal from the community pursuant to MHL §9.41, 9.45, 9.58, or 9.60 to directly communicate exactly what prompted the removal to ED/CPEP staff, that include the evaluating hospital psychiatrist or emergency physician determining if the individual meets criteria for an involuntary or emergency inpatient admission. The communication should be clearly documented. If a direct conversation is not possible or is declined, this should also be clearly documented.
   e. Ensuring that legal guardians are contacted by the outpatient provider as soon as possible when minors are transported to the hospital.

Residential Providers and Residential Treatment Facilities (Community-Based Inpatient Psychiatric Providers for Children and Youth)

1) Programs must develop a protocol for identifying staff who are responsible for communicating information from the records of individuals served to hospital staff seeking information. This function must be available during regular business hours for all programs.
   a. In RTFs and residential programs with evening, overnight, and/or weekend/holiday staffing, it is expected that this function is available for hospital staff whenever a staff member is on duty.
   b. RTFs and residential programs should develop local communication protocols with hospital and other community partners, including how hospitals can contact on-duty staff members who can provide information when an individual presents to an ED or CPEP outside of standard business hours.
   c. RTFs and residential programs should have a protocol to ensure that after-hours staff are kept up to date of circumstances that may result in individuals being referred to the hospital or Emergency Room/CPEP.
2) RTFs and residential programs must have a protocol to ensure that on-call supervisors are notified within 1 hour or as required by their agency expectations if shorter than 1 hour any time an individual is sent to a hospital.
3) Programs are expected to transmit the following to acute hospital programs:
   a. Current safety plans, psychiatric advance directives, and/or relapse prevention plans, if available. PSYCKES MyChois allows uploading of safety and other plans;

b. List of family and other supports and their contact information, as well as any limitations on consent to share information;
c. If applicable, a list of all community service providers and their contact information, as available, as well as any limitations on consent to share information;
d. Pertinent critical clinical information, including but limited to, current condition (status), active (or current) problem list, accurate medication list, estimate of individual's adherence to treatment, and diagnoses;
e. Recent presentations to mobile crisis and other crisis services, EDs, CPEPs, or inpatient units;
f. Current suicide and violence risk assessment, if available;
g. DSS 3074 Status of Bed Reservation form for Residential Treatment Facilities (RTFs) recipients.

4) As a suggested practice, programs should develop summaries or face sheets (in hardcopy or electronic) with the above information to have available as a reference for the staff member(s) communicating with hospitals as well as for rapid transmission to the hospital team.
5) RTFs and residential programs with 24/7 staffing plans (See Appendix for required Residential Programs or specify) are expected to, unless there is a rare extenuating circumstance, join in the ED/CPEP individuals who require emergency hospital evaluation and remain with them as appropriate including to speak with hospital staff and provide current collateral information. In the rare circumstance that despite assertive engagement, an individual over 18 declines accompaniment, the staff member should ensure that information is transmitted to the hospital within the timeframe of arrival to the hospital.
6) RTFs and residential providers and ED/CPEPs are expected to develop collaborative communication protocols for circumstances when programs send individuals requiring emergency hospital evaluation to the ED/ CPEP. They should ensure close communication with the ED/CPEP by:
   a. Proactively transmitting the summary described above, when available, to the ED/CPEP based on procedures, timing and contacts collaboratively developed by hospital and community providers.
   b. Program staff who sent the individual to the ED/CPEP should call the ED/CPEP and speak with ED/CPEP staff to provide collateral information according to communication protocols developed locally by hospital and community partners. This may include the evaluating social worker (if a primary social worker is assigned), the ED physician, or psychiatrist. If a direct conversation is not possible or is declined by the hospital, this should be clearly documented.
   c. When minors are transported to the hospital, the RTF or residential program must notify their legal guardian as soon as possible.
   d. For RTF recipients kept overnight, the program staff need to provide the ED/CPEP with the DSS 3074 Status of Bed Reservation form.

Section IB: Coordinated After-care and Discharge Planning

Care Coordination Providers

1) When an individual is admitted to an inpatient psychiatric unit, the care coordinator assigned to work with the individual and with whom they are engaged, or a back-up staff member who is familiar with the individual's recent history, should remain engaged with the hospital treatment team to follow the individual's progress and give input to discharge and aftercare planning. Hospital acute programs are directed to develop discharge plans in conjunction with the individual receiving

services. Care Coordination Providers should assist hospital staff in coordinating with all other community-based service providers.

   a. CTI Teams, OMH Designated Specialty Mental Health Care Management Agencies (SMH CMAs), OMH-funded Pathway Home, and High-Fidelity Wraparound (HFW) programs should visit the individual while in the hospital setting prior to discharge if possible and be present on day of discharge to accompany the individual back into the community.

2) Care Coordination programs must connect with individuals being discharged from EDs, CPEPs, and inpatient units within seven days of discharge.

   a. SOS Teams, CTI Teams, SMH CMAs, HFW, and Pathway Home programs and other high intensity care coordination programs must see the individual within 72 hours of discharge from the ED, CPEP, or Inpatient Psychiatric Unit.

3) Post-discharge, staff are expected to check-in frequently, ideally daily, until the first follow-up outpatient treatment appointment.

4) Ideally, a staff member should accompany the individual to the first post-discharge follow-up appointment. In the rare circumstance that despite assertive engagement, the individual declines accompaniment, the staff member should ensure that necessary information is transmitted to the treating provider.

5) On the first contact post-discharge, care coordination programs should provide psychoeducation on crisis resources, including 988, and the program's own crisis capabilities. When programs meet with individuals while still inpatient, information should be shared then, and reviewed at the first discharge appointment.

6) On the first contact post-discharge, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection, and engagement. If peer support services are not currently provided through the program; information about any available community-based peer services should be offered.

7) The inpatient unit is directed to forward a comprehensive discharge summary within seven days of discharge. Care coordination programs should ensure that all the discharge summary has been distributed to all applicable parties supporting the individual, within the legal requirements for confidentiality.

8) For any individual attending primary or secondary school, and within legal requirements of consent, the community-based care coordination team should contact the minor's school and ensure the school team is aware of the recent hospital discharge and to be prepared to help integrate the minor back into normal routines.

9) For individuals with complex needs and repeated admissions, the care coordination program should initiate, as applicable, a meeting with other service systems involved in the care of the recently discharged individual, including, but not limited to the LGU, the school, other outpatient treatment programs, residential programs, and social services to plan on how to decrease the individual's risk for readmission. The family should be included in meetings involving discharged adolescents and children. The community-based treatment providers must participate in this meeting.

Outpatient Treatment and Rehabilitative Providers

1) When an individual is admitted to an inpatient psychiatric unit, staff familiar with the individual should remain engaged with them and the hospital treatment team to follow the individual's

progress and give input to discharge and aftercare planning. Hospital acute programs are directed to develop discharge plans in conjunction with the individual receiving services.

a. ACT Teams should visit the individual while in the hospital setting prior to discharge, if possible, and be present on day of discharge, as appropriate, to accompany the individual back into the community.

2) Outpatient Treatment and Rehabilitative programs must offer follow-up scheduled appointments to individuals being discharged from EDs, CPEPs, and inpatient units within seven days of discharge. A referral to an unscheduled walk-in intake clinic is not sufficient. However, offering an appointment with a specific time within walk-in hours is acceptable provided there is a staff member who is expecting the individual and will follow up if they do not show up.

a. Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS) and Certified Community Behavioral Health Clinics (CCBHCs) must offer individuals who are currently enrolled in the service or program a follow-up appointment within five business days of discharge from an acute setting.

b. ACT Teams, in addition to contact on the day of discharge, should additionally have a scheduled appointment to see the individual within 72 hours of discharge.

c. If the individual does not come to their scheduled appointment, the outpatient treatment provider must attempt to engage the individual. Programs can offer different modalities, off site outreach and engagement services, and others, as available. This communication must be documented.

d. If the individual does not come to their scheduled appointment and is enrolled in care coordination services, the outpatient treatment provider must notify the care coordination provider.

e. If the individual does not come to their scheduled appointment, the outpatient provider may notify the hospital, in accordance with locally developed communication protocols, so that the hospital can ensure more discharge supports if the individual presents again.

3) On the first post-hospital discharge visit, outpatient programs must provide psychoeducation on crisis resources, including 988, and the program's own crisis capabilities.

a. If the first post-hospital discharge visit is not within 72 hours of discharge, the program should reach out to the discharged individual no later than 72 hours of discharge to offer an appointment reminder and provide information on crisis resources.

4) On the first post-hospital discharge visit, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection, and engagement. Peer Support is an evidence-based practice; when an individual or family receives support from a peer with relative lived experience, individual self-efficacy, and autonomy as well as improved communication, connections, support and involvement. If peer support services are not currently provided by the program; information about any available community-based peer services should be offered.

5) For individuals with complex needs and repeated admissions, the hospital is directed to provide several communications to the receiving outpatient programs. The programs should have staff familiar with the individual available to receive and review the communications.

a. The hospital is directed to provide a verbal clinical update within legal requirements for consent to the receiving outpatient treatment program as close as possible to the time of discharge.

b. The CPEP/ED is directed to forward a written discharge note that includes lab results and pharmacological interventions to the outpatient providers within two business days. Outpatient treatment programs should have a protocol in place to receive the summary and ensure that the assigned psychiatrist or psychiatric nurse practitioner reviews it within 24 hours of receipt to ensure that critical-time tasks, including but not limited to completing a medication reconciliation, are not missed.

c. The inpatient unit is directed to forward a comprehensive discharge summary within seven days of discharge. Outpatient treatment programs should have a protocol in place to receive the summary and ensure that the assigned psychiatrist or psychiatric nurse practitioner reviews it within 24 hours of receipt to ensure that critical-time tasks, including but not limited to ordering labs for continuing clozapine, are not missed.

6) For any individual attending primary or secondary school, and within legal requirements of consent, the outpatient treatment team should contact the minor's school and ensure the school team is aware of the recent hospital discharge and to be prepared to help integrate the minor back into normal routines.
7) If an individual with complex needs and repeated admissions is enrolled in a care coordination program, the care coordination program should initiate, as applicable, a meeting with other service systems involved in the care of the recently discharged individual, including, but not limited to the LGU, the school, other outpatient treatment programs, residential programs, peer support services, and social services to plan on how to decrease the individual's risk for readmission. The family should be included in meetings involving discharged adolescents and children. The community-based treatment providers must participate in this meeting.

Residential Providers and Residential Treatment Facilities (Community-Based Inpatient Psychiatric Providers for Children and Youth)

1) When an individual is admitted to an inpatient psychiatric unit, staff familiar with the individual should remain engaged with the individual and the hospital treatment team to follow the individual's progress and give input to discharge and aftercare planning.
2) Post-discharge, RTF or residential program staff should check-in daily until the first post-discharge follow-up treatment appointment. Program staff should alert a supervisor if there are any concerns.
3) As applicable, if the individual does not go to their scheduled post-discharge outpatient treatment appointment, the RTF or residential program must attempt to engage the individual and facilitate their re-engagement in outpatient care. If unsuccessful, the RTF or residential program should reach out to the outpatient treatment provider, care management programs, and other community supports to strategize next steps.
4) RTFs and residential programs should provide psychoeducation on crisis resources, including 988, and the agency's own crisis capabilities, as applicable.
5) If possible, RTFs and residential programs should provide information and connection to peer support services for outreach, connection, and engagement. If peer support services are not currently provided by the RTF or residential program; information about community-based peer services should be offered.

6) For individuals with complex needs and repeated admissions, the hospital is directed to provide several communications to the receiving RTF or residential program. The programs should have staff familiar with the individual available to receive and review the communications.
    a. For individuals with complex needs and repeated admissions, the hospital is directed to provide a verbal clinical update within legal requirements for consent to the receiving RTF or residential program as close as possible to the time of discharge. Programs should have staff familiar with the individual available to receive the verbal sign-out.
    b. The CPEP/ED is directed to forward a written discharge note that includes lab results and pharmacological interventions to community providers within two business days. RTFs and residential programs should have a protocol in place to ensure the supervisor review the summary within 24 hours of receipt to ensure program staff are aware of critical time-sensitive appointments, such as lab appointments.
    c. The inpatient unit is directed to forward a comprehensive discharge summary within seven days of discharge but sooner where possible, and ideally on date of discharge. RTFs and residential programs should have a protocol in place to ensure the supervisor review the summary within 24 hours of receipt to ensure time-critical interventions, medication titrations, and appointments are understood and followed.

Section II: Referrals of New Individuals from Hospitals to Community Providers

Outpatient Treatment and Rehabilitative Providers

1) Upon accepting a referral for a new individual, outpatient treatment programs should make every effort to contact the individual while they are still in the hospital, including via telehealth to help improve engagement post-discharge.
2) New referrals from hospital EDs, CPEPs, and inpatient units must be seen within seven calendar days of discharge from the hospital. A referral to an unscheduled walk-in intake clinic is not sufficient. However, offering an appointment with a specific time within walk-in hours is acceptable provided there is a staff member who is expecting the individual and will follow up if they do not show up. Community-based treatment programs should prioritize individuals being discharged from the hospital for any available intake appointment.
    a) As per, 14 NYCRR Part 599.6, Mental Health Outpatient Treatment and Rehabilitative Service (MHOTRS) programs must assure that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those determined to be in urgent need by the Director of Community Services (DCS) receive services within five business days.
    b) If the scheduled follow-up appointment is not within 72 hours of discharge, the program should reach out to the discharged individual no later than 72 hours of discharge to offer an appointment reminder and provide information on crisis resources.
    c) During the initial appointment, programs should provide psychoeducation on crisis resources, including 988, and the program's own crisis capabilities.
    d) If the individual does not come to their scheduled appointment, the outpatient treatment provider must attempt to engage the individual. Programs can offer different modalities, off site outreach and engagement services, and others, as available. This communication must be documented.

e) If the individual does not come to their scheduled appointment, the outpatient provider must engage with all other post-hospital discharge referrals, including but not limited to, care coordination programs, CTI or SOS Teams, to inform them and coordinate a strategy to re-engage the individual. The outpatient program should also contact the discharging hospital program and ask for the hospital discharge staff for help in re-engaging the individual.

3) On the initial visit, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection and engagement. Peer Support is an evidence-based practice; when an individual or family receives support from a peer with relative lived experience, individual self-efficacy, and autonomy as well as improved communication, connections, support and involvement. If peer support services are not currently provided by the program; information about any available community-based peer services should be offered.

Care Coordination Programs

1) Care coordination programs should rapidly enroll referred eligible individuals who are currently hospitalized and engage them in the hospital before discharge.
2) Upon hospital discharge, care coordination staff should check-in frequently, ideally daily, until the first post-discharge outpatient treatment appointment. Ideally, such staff from care coordination programs should accompany the individual to the first follow-up appointment.
3) Upon enrollment, programs should provide psychoeducation on crisis resources, including 988, and the program's own crisis capabilities.
4) On the first contact post-discharge, if the individual is not already connected to peer support services and if available, programs should provide information and connection to peer support services for outreach, connection and engagement. If peer support services are not currently provided through the program; information about any available community-based peer services should be offered.
5) If the individual does not come to their scheduled appointment, the care coordination provider must attempt to engage the individual. Programs can offer different modalities, off site outreach and engagement services, and others, as available. This communication must be documented.

Appendix – Classification of Programs

****Please note these program classifications apply to this guidance only.**

Outpatient Treatment and Rehabilitative Programs

- Adult BH HCBS - Habilitation, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Education Support Services
- Assertive Community Treatment (ACT) - Adult, Young Adult and Youth
- Certified Community Behavioral Health Clinic (CCBHC)
- CFTSS: Children's Mental Health Rehabilitation Services Program (CMHRS)
- Children's Crisis Residence
- Children's Day Treatment
- Continuing Day Treatment
- CORE – Community Psychiatric Support and Treatment (CPST)
- CORE – Empowerment Services – Peer Supports
- CORE – Psychosocial Rehabilitation (PSR)

- Crisis Residential Support
- Home-Based Crisis Intervention Team
- Intensive and Sustained Engagement Teams (INSET)
- Intensive and Supportive Crisis Stabilization
- Intensive Crisis Residence
- Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS)
- Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS) Intensive Outpatient Program
- OnTrack Coordinated Specialty Care
- Partial Hospitalization Program (PHP)
- Personalized Recovery-Oriented Services (PROS)
- Residential Treatment Facility (RTF) - Children & Youth*

Outpatient Care Management Programs

- Assertive Community Treatment (ACT) – Adult, Young Adult, and Youth
- Certified Community Behavioral Health Clinic (CCBHC) Care Management
- Critical Time Intervention Teams
- High Fidelity Wraparound designated Health Homes Serving Children
- Intensive and Sustained Engagement Teams (INSET)
- OnTrackNY Coordinated Specialty Care
- Pathway Home
- Safe Options Support (SOS)
- Specialty Mental Health Care Management

Residential Programs

- Apartment/Support
- Apartment/Treatment
- Children's Community Residence
- Community Residence for Eating Disorder Integrated Treatment
- Congregate/Support
- Congregate/Treatment
- Family Care
- SRO Community Residence
- Supportive Housing
- Supportive Single Room Occupancy Housing

Residential Treatment Facility

- Residential Treatment Facility – Children and Youth

Programs Responsible for Responding to Crises in Evenings, Nights, Weekends, and Holidays

- Assertive Community Treatment (ACT) – Adult, Young Adult, and Youth
- Certified Community Behavioral Health Clinic (CCBHC)
- Children's Crisis Residence

- Children's Day Treatment
- Community Residence for Eating Disorder Integrated Treatment
- Congregate/Support
- Congregate/Treatment
- Continuing Day Treatment
- Crisis Residential Support
- Home-Based Crisis Intervention
- Intensive and Supportive Crisis Stabilization
- Intensive Crisis Residence
- Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS)
- Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS) Intensive Outpatient Program
- OnTrack New York
- Partial Hospitalization Program (PHP)
- Personalized Recovery-Oriented Services (PROS)
- Residential Treatment Facility – Children and Youth
- SRO Community Residence