## CONTENTS

**Introduction** ............................................................................................................... 1

**Accreditation Policies and Procedures** ................................................................. 5
- Accreditation Conditions ................................................................................................. 5
- Accreditation Decisions .................................................................................................. 6
- Overview of the Steps to Accreditation ........................................................................ 8
- CARF Events .................................................................................................................... 11
- Steps to Accreditation .................................................................................................... 11
- Falsification of Documents .............................................................................................. 18
- Public Information .......................................................................................................... 18
- Subsequent Surveys ........................................................................................................ 19
- Extension of Accreditation ............................................................................................. 20
- Allegations, Suspensions, and Stipulations .................................................................... 21
- Disputed Accreditation Decisions ................................................................................. 21

**Changes in the 2019 Manual** ................................................................................. 25

**Section 1. ASPIRE to Excellence®** ................................................................. 29
- *Assess the Environment* ................................................................................................. 31
  - A. Leadership .................................................................................................................. 31
  - B. Governance (Optional) .............................................................................................. 41
- *Set Strategy* .................................................................................................................... 49
  - C. Strategic Planning ..................................................................................................... 49
- *Persons Served and Other Stakeholders—Obtain Input* ................................................... 53
  - D. Input from Persons Served and Other Stakeholders ................................................. 53
- *Implement the Plan* ......................................................................................................... 55
  - E. Legal Requirements .................................................................................................. 55
  - F. Financial Planning and Management ....................................................................... 57
  - G. Risk Management ...................................................................................................... 63
  - H. Health and Safety ...................................................................................................... 65
  - I. Workforce Development and Management ............................................................. 80
  - J. Technology .................................................................................................................. 88
  - K. Rights of Persons Served .......................................................................................... 96
  - L. Accessibility ................................................................................................................ 99
- *Review Results* ............................................................................................................. 103
  - M. Performance Measurement and Management ...................................................... 103
- *Effect Change* ............................................................................................................... 111
  - N. Performance Improvement ....................................................................................... 111
## Section 2. General Program Standards ....................................................115
- A. Program/Service Structure .................................................................117
- B. Screening and Access to Services .......................................................130
- C. Person-Centered Plan ........................................................................139
- D. Transition/Discharge ..........................................................................143
- E. Medication Use ..................................................................................147
- F. Promoting Nonviolent Practices .........................................................155
- G. Records of the Persons Served .............................................................164
- H. Quality Records Management ............................................................166

## Section 3. Core Treatment Program Standards .....................................171
- A. Assertive Community Treatment (ACT) ...............................................173
- B. Case Management/Services Coordination (CM) .................................180
- C. Community Integration (COI) ...............................................................183
- D. Court Treatment (CT) ........................................................................185
- E. Crisis Intervention (CI) ........................................................................190
- F. Crisis Stabilization (CS) ......................................................................192
- G. Day Treatment (DT) ...........................................................................194
- H. Detoxification/Withdrawal Management (DTX) .................................196
- I. Health Home (HH) ..............................................................................205
- J. Inpatient Treatment (IT) ........................................................................212
- K. Integrated Behavioral Health/Primary Care (IBHPC) ..........................216
- L. Intensive Family-Based Services (IFB) ................................................221
- M. Intensive Outpatient Treatment (IOP) ................................................223
- N. Office-Based Opioid Treatment Program (OBOT) ...............................225
- O. Outpatient Treatment (OT) ................................................................230
- P. Partial Hospitalization (PH) ................................................................232
- Q. Residential Treatment (RT) .................................................................235
- R. Specialized or Treatment Foster Care (STFC) ....................................240
- S. Student Counseling (SC) .....................................................................245
- T. Therapeutic Communities (TC) ............................................................247

## Section 4. Core Support Program Standards ........................................253
- A. Assessment and Referral (AR) .............................................................255
- B. Community Housing (CH) ................................................................256
- C. Comprehensive Suicide Prevention Program (CSPP) ..........................260
- D. Call Centers (CC) ...............................................................................265
  - Crisis Call Center .................................................................................267
  - Information Call Center ........................................................................268
- E. Diversion/Intervention (DVN) ..............................................................269
- F. Employee Assistance (EA) .................................................................271
- G. Prevention (P) ...................................................................................276
- H. Supported Living (SL) .......................................................................279
## Section 5. Specific Population Designation Standards

| A. Adults with Autism Spectrum Disorder (ASD:A) | 284 |
| B. Children/Adolescents with Autism Spectrum Disorder (ASD:C) | 293 |
| C. Children and Adolescents (CA) | 301 |
| D. Consumer-Run (CR) | 304 |
| E. Criminal Justice (CJ) | 309 |
| F. Eating Disorders (ED) | 313 |
| G. Juvenile Justice (JJ) | 317 |
| H. Medically Complex (MC) | 322 |
| I. Older Adults (OA) | 329 |

---

### Appendix A. Required Written Documentation

235

### Appendix B. Operational Timelines

351

### Appendix C. Required Training

359

### Glossary

369

### Index

385
CARF International is a private, nonprofit organization that is financed by fees from accreditation surveys, workshops, and conferences; sales of publications; and grants from public entities.

The CARF International group of companies includes:
- CARF
- CARF Canada
- CARF Europe

Since its inception in 1966, CARF has benefited from organizations joining together in support of the goals of accreditation. These organizations, representing a broad range of expertise, sponsor CARF by providing input on standards and other related matters through membership in CARF’s International Advisory Council (IAC). A list of current IAC members is available on the CARF website, www.carf.org/members.

Mission

The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of the persons served.

Vision

Through responsiveness to a dynamic and diverse environment, CARF serves as a catalyst for improving the quality of life of the persons served.

Moral Ownership

The CARF Board of Directors has identified that the persons served, as defined below, shall be the moral owners of CARF.

*Persons served* are the primary consumers of services. When these persons are unable to exercise self-representation at any point in the decision-making process, *persons served* is interpreted to also refer to those persons willing, able, and legally authorized to make decisions on behalf of the primary consumer.

Values

CARF believes in the following core values:
- All people have the right to be treated with dignity and respect.
- All people should have access to needed services that achieve optimal outcomes.
- All people should be empowered to exercise informed choice.

CARF’s accreditation, research, continuous improvement services, and educational activities are conducted in accordance with these core values and with the utmost integrity.

In addition, CARF is committed to:
- The continuous improvement of both organizational management and service delivery.
- Diversity and cultural competence in all CARF activities and associations.
- Enhancing the involvement of persons served in all of CARF’s activities.
- Persons served being active participants in the development and application of standards of accreditation.
- Enhancing the meaning, value, and relevance of accreditation to persons served.
**Introduction**

**Purposes**

In support of our mission, vision, and values, CARF’s purposes are:

- To develop and maintain current, field-driven standards that improve the value and responsiveness of the programs and services delivered to people in need of life enhancement services.

- To recognize organizations that achieve accreditation through a consultative peer-review process and demonstrate their commitment to the continuous improvement of their programs and services with a focus on the needs and outcomes of the persons served.

- To conduct accreditation research emphasizing outcomes measurement and management and to provide information on common program strengths as well as areas needing improvement.

- To provide consultation, education, training, and publications that support organizations in achieving and maintaining accreditation of their programs and services.

- To provide information and education to persons served and other stakeholders on the value of accreditation.

- To seek input and to be responsive to persons served and other stakeholders.

- To provide continuous improvement services to improve the outcomes for organizations and the persons served and their community of influence.

**Development of the Standards**

The CARF standards have evolved and been refined over 50 years with the active support and involvement of providers, consumers, and purchasers of services. The standards are maintained as international consensus standards. The standards define the expected input, processes, and outcomes of programs for persons served. CARF recognizes and accepts its responsibility to assess and review the continuing applicability and relevance of its standards. CARF convenes its International Advisory Council; advisory committees; and regional, national, and international focus groups to systematically review and revise CARF’s standards and develop standards for new accreditation opportunities. Composed of individuals with acknowledged expertise and experience, these committees and groups, including persons served, make recommendations to CARF concerning the adequacy and appropriateness of the standards.

This work is viewed as a starting point in the process of standards development and revision. Recommendations from this input are used to develop proposed new and revised standards, which are then made available for review by the public, persons served, organizations, surveyors, national professional groups, advocacy groups, third-party purchasers, and other stakeholders. This input from the field is carefully scrutinized by CARF and results in changes to the standards.
Applying the Standards

The organization is expected to demonstrate conformance to the applicable standards during the site survey so that the survey team can determine the organization’s survey findings and, ultimately, allow CARF to determine the accreditation decision. On subsequent surveys, the organization is expected to demonstrate continuous conformance from any previous period of CARF accreditation.

Some sections of the standards, such as the ASPIRE to Excellence® section which relates to the overall business practices of the organization, are applicable regardless of the programs or services for which the organization is seeking accreditation. The standards in other sections are applicable in accordance with instructions in those sections.

Some standards have intent statements that help to explain, clarify, and provide additional information about the standard. When there is an intent statement, it immediately follows the standard to which it relates.

Some intent statements are followed by examples that illustrate potential ways an organization may demonstrate conformance to the standard.

Some standards may suggest resources that an organization may find helpful in implementing or conforming to the standards. Resources may include references to websites, organizations, or publications that provide information or assistance relevant to topics or areas included in the standard.

**Note:** Before initiating the self-evaluation process or applying for a survey, an organization should contact CARF to discuss the programs and services it intends to include in the accreditation process. This step helps determine which standards will be applicable. If an organization provides a program or service that is not listed in this manual, the organization should also contact CARF for more information.

Blended Surveys

Some organizations may want to become accredited for programs or services included in different standards manuals. This is possible using what CARF terms a “blended” survey.

Blending allows an organization to seek accreditation through one survey for programs or services with applicable standards in more than one manual. For example, services found in the Employment and Community Services Standards Manual can be blended into a survey using the Medical Rehabilitation Standards Manual. The primary manual (i.e., the one into which other standards are blended) is determined by the predominant focus of the programs or services for which the organization is seeking accreditation. Factors that CARF considers when blending programs include the integrity of the programs and services and whether to incorporate standards from a related program or service section, such as the rehabilitation process or quality services for the persons served.

For more information please contact CARF, as specific guidelines are used for blended surveys. It is important to make this contact early in the accreditation preparation process.
CARF Publications

CARF offers publications and products through the online store at [www.carf.org/catalog](http://www.carf.org/catalog). Publications are available in alternative formats to accommodate persons with disabilities. Please contact CARF’s Publications department at (888) 281-6531 for assistance.

Organizations are encouraged to call CARF toll free with any questions regarding which manual to use, which standards apply, interpretation of the standards, and clarification of the survey process. It is important to access CARF resources throughout the preparation process. Following is a list of CARF’s customer service units (CSUs) and the publications related to each.

<table>
<thead>
<tr>
<th>Customer Service Unit</th>
<th>Standards Manuals and Related Publications</th>
</tr>
</thead>
</table>
| Aging Services                         | ■ Aging Services Standards Manual  
■ Aging Services Survey Preparation Workbook*  
■ Continuing Care Retirement Community Standards Manual  
■ Continuing Care Retirement Community Survey Preparation Workbook*  
■ Standards Manual Supplement for Networks** |
| Behavioral Health                      | ■ Behavioral Health Standards Manual  
■ Behavioral Health Survey Preparation Workbook*  
■ Opioid Treatment Program Standards Manual  
■ Opioid Treatment Program Survey Preparation Workbook*  
■ Standards Manual Supplement for Networks** |
| Child and Youth Services               | ■ Child and Youth Services Standards Manual  
■ Child and Youth Services Survey Preparation Workbook*  
■ Standards Manual Supplement for Networks** |
| Employment and Community Services      | ■ Employment and Community Services Standards Manual  
■ Employment and Community Services Survey Preparation Workbook*  
■ Standards Manual Supplement for Employment Service Centres in Canada**  
■ Standards Manual Supplement for Networks** |
| Medical Rehabilitation                 | ■ Medical Rehabilitation Standards Manual  
■ Medical Rehabilitation Survey Preparation Workbook*  
■ Standards Manual Supplement for Networks** |
| Vision Rehabilitation Services         | ■ Vision Rehabilitation Services Standards Manual with Survey Preparation Questions  
■ Standards Manual Supplement for Networks** |

*CARF recommends using the companion survey preparation workbook for your standards manual. The workbook assists in conducting a self-evaluation in preparation for the accreditation survey.  
**Supplements for the standards manuals are available for download at: [www.carf.org/Accreditation/QualityStandards/OnlineStandards](http://www.carf.org/Accreditation/QualityStandards/OnlineStandards).

**NOTE:** Standards manuals become effective on July 1, 2019, to allow organizations sufficient time to incorporate changes into their operations.
ACCREDITATION
POLICIES AND PROCEDURES

These accreditation policies and procedures relate to the site survey, accreditation process, and continuation of accreditation. Because all aspects of the accreditation process are reviewed regularly for appropriateness, these policies and procedures may be changed between standards manual publication dates. Notification of changes, additional information, and clarification can be obtained at the CARF website, www.carf.org, or by contacting CARF. Organizations that are currently accredited or have begun the process of becoming accredited and have obtained access to Customer Connect can obtain current accreditation policies and procedures at the Customer Connect website (customerconnect.carf.org).

NOTE: Customer Connect is CARF’s secure, dedicated website for accredited organizations and organizations seeking accreditation. Customer Connect is the primary means of transmitting certain documents, such as the survey fee invoice and quality improvement plan. These documents are posted to Customer Connect and an email is sent to the individual identified as the organization’s Survey Key Contact. Organizations should use Customer Connect regularly to view accreditation- and survey-related documents and to keep CARF informed of any changes in the name or email address of the key contact person.

The submission of a survey application constitutes the organization’s agreement to adhere to the CARF policies and procedures that are in effect on the date on which the survey application is submitted to CARF and to all subsequent changes as they become effective. The review and appeal process set forth in these policies and procedures, as amended from time to time, shall be the organization’s sole remedy with respect to the survey, accreditation decision, and continuation or termination of accreditation. By submitting the survey application, the organization expressly waives and releases CARF from any and all claims, demands, actions, lawsuits, and damages that may arise from or relate to, directly or indirectly, the survey, accreditation decision, and continuation or termination of accreditation.

Accreditation Conditions

The following Accreditation Conditions must be satisfied in order for an organization to achieve or maintain accreditation by CARF:

1. For a minimum of six months prior to the site survey, each program/service for which the organization is seeking accreditation must demonstrate:
   a. The use and implementation of CARF’s organizational and service standards applicable to the program/service.
   b. The direct provision of services to the persons served.

Intent Statements

This timeframe is required to ensure that the CARF survey process is not merely a paper review, but that the service seeking accreditation is actually having an impact on the persons served. In addition, this timeframe allows for the collection of sufficient historical data, information, and documentation to assess the organization’s conformance to the standards.

It is also expected that services will have been provided for at least six months prior to the site survey. This condition applies to organizations that have newly initiated program(s)/service(s) and to those that have ongoing program(s)/service(s) that are provided sporadically. Therefore, in the six months prior to the survey, the organization should have served at least one person in each service seeking accreditation. In a network, direct services are provided by its participants.
2. The organization must provide such records, reports, and other information as requested by CARF.

Intent Statements
It is the responsibility of the organization to provide evidence to the survey team to demonstrate conformance to the standards.

This condition also applies to information requested by CARF prior to, during, and after the site survey. The intent of this condition is for CARF to have access to all information deemed necessary to assess conformance to the standards. Access to stakeholders, including persons served, is also covered by this condition, as is access to all documents, including but not limited to files of persons served (active and closed), human resource files, strategic plans and reports, and financial statements. In certain circumstances, unavailability of key organizational staff necessary to demonstrate conformance to standards at the on-site survey may be grounds for Nonaccreditation.

3. A Quality Improvement Plan (QIP) must be submitted within 90 days following notice of accreditation. This plan shall address all recommendations identified in the report.

Intent Statements
CARF will provide the organization with the format to use for this plan with its notification of the accreditation decision.

If consultation in completing the QIP is needed, the organization is encouraged to contact CARF.

If an organization requests a review of a Nonaccreditation decision and the outcome of that review is a One-Year, Provisional, or Three-Year Accreditation decision, the QIP must be submitted to CARF within 45 days of notice of the outcome of that review or appeal.

4. An organization that achieves a Three-Year Accreditation must submit a signed Annual Conformance to Quality Report (ACQR). The report is submitted in each of the two years following the Three-Year Accreditation.

Intent Statements
In order to maintain accreditation, organizations are expected to operate in conformance to CARF’s standards and comply with CARF’s policies and procedures on an ongoing basis. They must incorporate changes to the standards, accreditation conditions, and policies and procedures as they are published and made effective by CARF.

CARF will provide the organization with the format for this report, which must be completed and returned.

NOTE: If any of these conditions are not met, CARF will determine the appropriate course of action, which may include denial or withdrawal of accreditation.

Accreditation Decisions
To be accredited by CARF, an organization must satisfy each of the CARF Accreditation Conditions and demonstrate through a site survey that it meets the standards established by CARF. While an organization may not be in full conformance to every applicable standard, the accreditation decision will be based on the balance of its strengths with those areas in which it needs improvement.

CARF uses the following guidelines to determine each accreditation decision:

Three-Year Accreditation
The organization satisfies each of the CARF Accreditation Conditions and demonstrates substantial conformance to the standards. It is designed and operated to benefit the persons served. Its current method of operation appears likely to be maintained and/or improved in the foreseeable future. The organization demonstrates ongoing quality improvement and continuous conformance from any previous period of CARF accreditation.

One-Year Accreditation
The organization satisfies each of the CARF Accreditation Conditions and demonstrates conformance to many of the standards. Although there are significant areas for improvement in relation to the standards, there is evidence of
the organization's capability to improve and commitment to progress toward their improvement. On balance, the services benefit those served, and the organization appears to protect their health, welfare, and safety.

An organization may be functioning between the level of a Three-Year Accreditation and that of a One-Year Accreditation. In this instance, accreditation will be issued for one year. An organization will not be issued a second consecutive One-Year Accreditation.

Provisional Accreditation

Following the expiration of a One-Year Accreditation, Provisional Accreditation is issued to an organization that is still functioning at the level of a One-Year Accreditation. A Provisional Accreditation is issued for a period of one year. An organization with a Provisional Accreditation must be functioning at the level of a Three-Year Accreditation at its next survey or it will receive an accreditation decision of Nonaccreditation.

Nonaccreditation

The organization has major areas for improvement in several areas of the standards; there are serious questions as to the benefits of services or the health, welfare, or safety of those served; the organization has failed over time to bring itself into substantial conformance to the standards; or the organization has failed to satisfy one or more of the CARF Accreditation Conditions.

Preliminary Accreditation

Prior to the direct provision of services to persons served, the organization demonstrates substantial conformance to applicable standards. There is evidence of processes and systems for service and program delivery designed to provide a reasonable likelihood that the program(s)/service(s) will benefit the persons served. A Preliminary Accreditation is issued to allow new organizations to establish demonstrated use and implementation of standards.

A full follow-up survey is conducted approximately six months following the initiation of services to persons served, at which time a Three-Year Accreditation, One-Year Accreditation, or Nonaccreditation decision is issued. If this follow-up survey has not been applied for and scheduled within six months of the first survey, the Preliminary Accreditation will expire.

**NOTE:** Some of the accreditation policies and procedures are supplemented, revised, or not applicable for organizations seeking Preliminary Accreditation. Please contact CARF for details.
## Overview of the Steps to Accreditation

The table below provides an overview of the steps to accreditation. These steps are explained in more detail in the sections following the table.

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>Consult with a designated CARF resource specialist.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An organization contacts CARF, and a resource specialist is designated to provide guidance and technical assistance.</td>
</tr>
<tr>
<td></td>
<td>■ For an organization preparing for its first survey, it is important to make this contact early in the process. The resource specialist is available to answer questions in preparation for a survey and throughout the term of the accreditation.</td>
</tr>
<tr>
<td></td>
<td>■ For an organization preparing for a resurvey, the designated resource specialist may already be known. It is suggested that contact still be made early in the reaccreditation process to verify relevant organizational or program/service information.</td>
</tr>
<tr>
<td></td>
<td>■ The resource specialist provides the organization access to Customer Connect (<a href="http://customerconnect.carf.org">customerconnect.carf.org</a>), CARF’s secure website for transmitting documents and maintaining ongoing communication with accredited organizations and organizations seeking accreditation.</td>
</tr>
<tr>
<td></td>
<td>■ The organization orders the standards manual in which its program(s)/service(s) best fit. Visit <a href="http://www.carf.org/catalog">www.carf.org/catalog</a>.</td>
</tr>
<tr>
<td></td>
<td>■ The CARF Accreditation Sourcebook, which explains the accreditation process, and other publications are also available to assist the organization in the preparation process.</td>
</tr>
<tr>
<td></td>
<td>■ The organization maintains ongoing contact with CARF for assistance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 2</th>
<th>Conduct a self-evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The organization conducts a self-study and evaluation of its conformance to the standards using the standards manual and its companion publication, the survey preparation workbook.</td>
</tr>
<tr>
<td></td>
<td>The self-evaluation is part of the organization’s internal preparation process and is not submitted to CARF.</td>
</tr>
<tr>
<td>STEP 3</td>
<td>Submit the survey application.</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td></td>
<td>The organization submits the survey application via Customer Connect, customerconnect.carf.org.</td>
</tr>
<tr>
<td></td>
<td>- The survey application requests detailed information about leadership, program(s)/service(s) that the organization is seeking to accredit, and the service delivery location(s).</td>
</tr>
<tr>
<td></td>
<td>- The organization submits the completed survey application, required supporting documents, and a nonrefundable application fee at least three full calendar months before the two-month timeframe in which it is requesting a survey. Organizations undergoing resurvey submit their survey application on the date that corresponds with their accreditation expiration month (see page 12).</td>
</tr>
<tr>
<td></td>
<td>- The submission of the completed survey application indicates the organization's desire for the survey and its agreement to all terms and conditions contained therein.</td>
</tr>
<tr>
<td></td>
<td>- If any information in the survey application changes after submission, the organization should notify CARF immediately.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 4</th>
<th>CARF invoices for the survey fee.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After reviewing all information in the survey application, CARF invoices the organization for the survey fee. The survey fee invoice is posted to the Customer Connect website and an email notification is sent to the organization's key contact person. Scheduling of the survey begins immediately upon invoicing. Any changes in problem dates must be communicated in writing to CARF by this time. The fee is based on the number of surveyors and days needed to complete the survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 5</th>
<th>CARF selects the survey team.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CARF selects a survey team with the appropriate expertise.</td>
</tr>
<tr>
<td></td>
<td>- Surveyors are selected by matching their program or administrative expertise and relevant field experience with the organization's unique requirements.</td>
</tr>
<tr>
<td></td>
<td>- CARF notifies the organization of the names of team members and the dates of the survey at least 30 days before the survey.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 6</th>
<th>The survey team conducts the survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The survey team determines the organization's conformance to all applicable standards on site through the observation of services, interviews with persons served and other stakeholders, and review of documentation.</td>
</tr>
<tr>
<td></td>
<td>- Surveyors also provide consultation to organization personnel.</td>
</tr>
<tr>
<td></td>
<td>- The organization is informed of the survey team's findings related to the standards at an exit conference before the team leaves the site. The survey team submits its findings to CARF, but the team does not determine the accreditation decision.</td>
</tr>
<tr>
<td>STEP 7</td>
<td>CARF issues the accreditation decision.</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>CARF reviews the survey findings and issues one of the following accreditation decisions:</td>
</tr>
<tr>
<td></td>
<td>- Three-Year Accreditation</td>
</tr>
<tr>
<td></td>
<td>- One-Year Accreditation</td>
</tr>
<tr>
<td></td>
<td>- Provisional Accreditation</td>
</tr>
<tr>
<td></td>
<td>- Nonaccreditation</td>
</tr>
<tr>
<td></td>
<td>Approximately six to eight weeks after the survey, the organization is notified of the accreditation decision and receives a written report. The organization is also provided with a certificate of accreditation that lists the program(s)/service(s) included in the accreditation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 8</th>
<th>Submit a Quality Improvement Plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within 90 days after notification of accreditation, the organization fulfills an accreditation condition by submitting to CARF a Quality Improvement Plan (QIP) outlining the actions that have been or will be taken in response to all recommendations identified in the report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 9</th>
<th>Submit the Annual Conformance to Quality Reports.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An organization that achieves a Three-Year Accreditation submits a signed Annual Conformance to Quality Report (ACQR) to CARF on the accreditation anniversary date each year during the term of accreditation. This is a condition of accreditation.</td>
</tr>
<tr>
<td></td>
<td>- CARF sends the organization the form for this report approximately ten weeks before it is due.</td>
</tr>
<tr>
<td></td>
<td>- The ACQR reaffirms the organization’s ongoing conformance to the CARF standards.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 10</th>
<th>CARF maintains contact with the organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CARF maintains contact with the organization during the term of accreditation. Organizations should also contact CARF as needed to help maintain conformance to the standards and keep CARF informed of administrative or other items.</td>
</tr>
<tr>
<td></td>
<td>- CARF offers publications to help organizations provide quality program(s)/service(s).</td>
</tr>
<tr>
<td></td>
<td>- CARF’s public website, <a href="http://www.carf.org">www.carf.org</a>, and its secure customer website, Customer Connect (<a href="http://customerconnect.carf.org">customerconnect.carf.org</a>), provide news, information, and resources.</td>
</tr>
<tr>
<td></td>
<td>- CARF seminars and conferences are excellent ways to receive updates and other information about the accreditation process and the standards.</td>
</tr>
</tbody>
</table>
CARF Events

CARF sponsors a series of educational and training sessions to assist organizations to prepare for CARF accreditation, help them remain current with changes in the standards, present new standards, and discuss field practices. CARF also offers web-based educational events. To obtain the dates and locations of all events, visit www.carf.org/events or contact the Education and Training Department at (888) 281-6531, ext. 7114.

Steps to Accreditation

Step 1. Consult with a designated CARF Resource Specialist

The first step in the accreditation process is to contact CARF. When an organization contacts CARF, a dedicated resource specialist is assigned to provide guidance and technical assistance regarding the appropriate standards manual, program(s)/service(s) to be accredited, interpretation and application of standards, and accreditation process. The resource specialist is available to answer questions both in preparation for a survey and throughout the entire term of accreditation.

After initial contact with a resource specialist, the organization orders the standards manual in which its program(s)/service(s) best fit. The CARF Accreditation Sourcebook, which explains the accreditation process in detail, and other publications are also available to assist the organization in the preparation process. The manual and other publications can be ordered at www.carf.org/catalog.

Step 2. Conduct a self-evaluation

To earn accreditation, an organization must meet Accreditation Conditions 1 and 2 and demonstrate that it meets the applicable CARF standards. The starting point is an assessment by the organization of its current practices against the applicable standards set forth in the appropriate standards manual. The organization conducts a self-study and evaluation of its conformance to the standards using the appropriate standards manual and its companion publication, the survey preparation workbook. Depending on the level at which the organization initially assesses its conformance, a number of successive assessments may be appropriate. The organization’s designated resource specialist is available to provide free technical assistance during the self-evaluation process.

The self-evaluation is part of the organization’s internal preparation process, and there is no requirement for it to be submitted to CARF or shared with the surveyors. However, some organizations find it useful to share the self-evaluation with the survey team during the on-site survey.

Step 3. Submit the survey application

The survey application is completed and submitted online via Customer Connect. After preparing under the appropriate standards manual, an organization seeking accreditation for the first time requests access to the survey application for completion and submission to CARF. Resurvey organizations are notified of the survey application automatically.

The survey application is submitted with the nonrefundable application fee when the organization is ready for survey dates to be established in accordance with the accompanying chart. It generally takes two to three months for a survey to be scheduled after the survey application has been received.
Accreditation Policies and Procedures

Survey Timeframe At a Glance
An organization seeking accreditation for the first time uses the due date corresponding to its preferred timeframe. Resurvey organizations use the due date corresponding to expiration month, not preferred timeframe. This lead time is needed for timely scheduling and issuing of a new decision before expiration of the current accreditation.

<table>
<thead>
<tr>
<th>Preferred Timeframe</th>
<th><strong>Survey application due to CARF no later than</strong></th>
<th><em>Expiration Month</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Jul/Aug</em></td>
<td>Feb 28</td>
<td>Aug</td>
</tr>
<tr>
<td><em>Jul/Aug</em></td>
<td>Feb 28</td>
<td>Sept</td>
</tr>
<tr>
<td>Aug/Sept</td>
<td>Apr 30</td>
<td>Oct</td>
</tr>
<tr>
<td>Sept/Oct</td>
<td>May 31</td>
<td>Nov</td>
</tr>
<tr>
<td>Oct/Nov</td>
<td>Jun 30</td>
<td>Dec</td>
</tr>
<tr>
<td>Nov/Dec</td>
<td>Jul 31</td>
<td>Jan</td>
</tr>
<tr>
<td>Dec/Jan</td>
<td>Aug 31</td>
<td>Feb</td>
</tr>
<tr>
<td>Jan/Feb</td>
<td>Sept 30</td>
<td>Mar</td>
</tr>
<tr>
<td>Feb/Mar</td>
<td>Oct 31</td>
<td>Apr</td>
</tr>
<tr>
<td>Mar/Apr</td>
<td>Nov 30</td>
<td>May</td>
</tr>
<tr>
<td>Apr/May</td>
<td>Dec 31</td>
<td>Jun</td>
</tr>
</tbody>
</table>

*CARF does not issue July expirations as the standards manuals become effective on July 1 of each year.
**CARF may request organizations with large surveys to submit their applications early.

**NOTE:** Actual survey timeframes are assigned by CARF based upon surveyor availability.

Please note that a survey application received after the due date is at risk for a delay in survey timeframe. Organizations are encouraged to submit their survey application at least ten business days before the indicated due date. Submission of the completed survey application confirms the organization's agreement to all terms and conditions contained therein. If any information in the survey application changes after submission, CARF should be notified in writing immediately.

Selection of Program(s)/Service(s) to be Surveyed
In the survey application, the organization identifies the program(s)/service(s) it desires to have surveyed by CARF and the site(s) where they are provided, including administrative locations. The number and expertise of surveyors and the length of survey required are based on information in the survey application and will be determined at CARF’s sole discretion. Additional information, such as the organization's budget, brochures, and other materials, must be sent to CARF when the survey application is submitted.

An organization has the right and responsibility to choose the program(s)/service(s) to be accredited. However, all locations that offer any of the program(s)/service(s) must be included in the accreditation. CARF will not accredit a program or service if only a portion of it is submitted for accreditation.

CARF does not consider the funding or referral entities as differentiating a program/service so as to exclude portions of it from being included in the accreditation. If the organization needs assistance in interpreting or applying this policy, it should contact CARF.

CARF may change the size and/or scope of any accreditation survey or decision as it deems appropriate.

Organizations with Multiple Program(s)/Service(s)
If one survey includes multiple program(s)/service(s) or sites for accreditation, and any one program/service or site is operating at a lower level of conformance to the standards than the others, the level of accreditation issued for that survey will be the level of the lowest-conforming program, service, or site.

An organization may submit more than one survey application if it wants to have separate surveys for different program(s)/service(s) or sites that it operates. In separate surveys, each accreditation decision is independent and based solely on the individual survey and the level of conformance demonstrated by the organization.
and the program(s)/service(s) that are part of that survey. In this case, different decisions may be issued as appropriate.

**Step 4. CARF invoices for the survey fee**

After reviewing the survey application and other materials to determine the number of surveyors and days needed to conduct the survey, CARF invoices the organization for the survey fee.

CARF’s survey fee applies to any type of site survey conducted by CARF—an initial survey, resurvey, or special visit (e.g., a supplemental survey or a One-Year, Provisional, or Nonaccreditation review). Any part of a day that a surveyor spends at any site of the organization, including the last day, is billed as a whole day.

The survey fee must be paid in full within 30 calendar days of the invoice date. Any public agency for which advance payment of the survey fee is not legally permissible must submit, at least 30 days prior to the survey, a binding purchase order for the full amount of the survey fee.

CARF reserves the right to cancel any scheduled survey, or change the survey timeframe for any unscheduled survey, if the fee is not paid by the survey fee due date.

Once the surveyors are in transit to a survey site, the survey fee is not refundable in whole or in part. Thus, if a survey is terminated on site or is shortened for any reason, no portion of the survey fee will be refunded.

Please contact CARF for current fees.

**Outstanding Debt**

All survey and other fees referenced in this manual shall be paid when due. CARF will not accept a survey application from any organization that has an outstanding past due debt to CARF until that debt has been paid. CARF also reserves the right to withhold an accreditation decision or issue a Nonaccreditation if an outstanding debt remains. CARF may modify an organization’s existing accreditation, up to and including termination of accreditation, in the event any fees are not paid in a timely manner.

**Step 5. CARF selects the survey team**

Surveyors are assigned to surveys based on a number of factors, the most important of which is the surveyors’ experience with the types of program(s)/service(s) being surveyed. Other considerations include the availability of surveyors, language, and the need to avoid conflicts of interest.

The organization may request a change of any surveyor assigned to conduct the survey in the event of a bona fide conflict of interest. CARF must receive the request for a surveyor change in writing within 14 calendar days of the date on which CARF transmits notification of surveyor assignment. A change in surveyor assignment is made when just cause, as determined by CARF, has been presented.

Subject to surveyor availability, the organization may be required to provide language interpreters at its expense to assist the surveyors; please contact CARF for details.

**Scheduling the Survey Dates**

Survey dates are established by CARF based on the survey application and in consultation with surveyors. A timeframe of no fewer than four weeks within a specific period of two consecutive months is required for scheduling. CARF must be advised at the time of submission of the survey application if there are days during the designated timeframe that will pose problems for the organization. Examples of such days may include community events, religious holidays, and vacation plans. A survey is scheduled during the organization’s workweek and hours of operation. The use of Saturdays and Sundays as survey days is limited to organizations that provide services on those days and only with prior approval from the organization.

**Cancellation and Rescheduling**

The organization is notified of the specific survey dates at least 30 calendar days prior to the survey. An organization is considered scheduled for a site visit on the date the notification is sent. The dates established by CARF are final. A cancellation/rescheduling fee, plus all related nonrefundable travel cancellation expenses, will be assessed if
an organization requests any change affecting the scheduled dates or configuration of its survey, whether cancellation, postponement, or other date change, or if the survey is cancelled by CARF due to survey fees not timely paid. It should be noted that CARF does not wait for receipt of the survey fee to schedule the survey. Therefore, to avoid a cancellation/rescheduling fee, the organization must notify CARF in writing of any changes in available survey dates prior to CARF’s notice of established dates. When CARF is unable to schedule a survey in the designated timeframe, the organization’s current accreditation will not lapse but will be extended until notification of the next accreditation decision.

Before the Survey

Preparation

In conjunction with the appropriate standards manual, the organization should use CARF’s other publications to adequately prepare for the site survey. Many of these publications have been written to help an organization prepare for a survey. CARF may be contacted by telephone or email to answer questions that the organization may have regarding the survey process or interpretation of the standards. Inquiries about the standards or survey process can be made as frequently as needed by an organization seeking accreditation, and there is no charge for this support.

During an original survey, the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey. During a resurvey, the organization is expected to demonstrate conformance to all applicable standards throughout the entire period since its last survey.

If an organization is a unit or department within a larger entity that develops and/or controls any policies, procedures, plans, or practices relevant to the survey, the organization should be prepared to demonstrate to the survey team how it and its program(s)/service(s) seeking accreditation implement such policies, procedures, plans, and practices.

The survey poster

At least 30 days prior to the survey, the organization must display a poster announcing the pending survey and the survey dates. This poster can be downloaded in various languages from the Resources section of Customer Connect (customerconnect.carf.org) in an editable format so that organizations may make adjustments (such as font, color, and size) to ensure the poster is accessible for all persons served. This poster must remain conspicuously posted at all locations until the survey concludes. Information on the poster includes a description of CARF as a review organization and instructions for...
interested persons to contact CARF to submit comments about the organization’s performance and their satisfaction with services. These comments can be submitted through a toll-free phone number or via email, fax, or letter. Information received by CARF may be sent to the surveyors. The survey team may interview persons who have submitted comments or contacted CARF prior to the survey when on site. All interviews are confidential.

**Pre-survey contact**

Approximately three weeks before the visit, the survey team coordinator will contact the organization to discuss logistics and answer questions the organization may have regarding scheduling interviews and other items. The survey team may request that additional information that is not confidential be made available at the hotel the night before the survey or otherwise in advance. While provision of such information in advance of the survey is at the discretion of the organization, it can help facilitate an efficient and consultative on-site survey.

**Assemble or arrange access to records**

Records needed to substantiate conformance to the CARF standards should be assembled in one room of the organization to be available for surveyor use throughout the survey, or arrangements should be made for surveyor access to electronic records. Many of these items are listed as documentation examples in the survey preparation workbook.

**Third-party representatives**

Each organization is required to have at least one representative of a major purchaser or user of its services available, either in person or by phone, to be interviewed by the survey team. CARF also routinely requests information prior to the survey about an organization from the governmental oversight agency and funding or referral sources. Although the organization generally chooses the individuals to be interviewed during the survey, the survey team may select other stakeholders to interview. An organization has the option of inviting third-party representatives to observe the orientation and exit conferences. Observations of interviews and survey team meetings, however, are prohibited because of the confidential nature of the matters discussed.

**The Survey**

*Note:* The daily schedule of a survey will vary for each organization. The following is only a sample.

**First Day**

**Opening of business**

The survey team arrives at the organization and conducts an orientation conference with the leadership, personnel, and others invited by the organization. The orientation conference provides the opportunity for the surveyors to clarify the purpose of the site survey, how the team will conduct the survey, and verify the program(s)/service(s) and sites to be surveyed. The organization should be prepared to provide the team with a brief overview of its operations, including the population served, the program(s)/service(s) provided, the programmatic objectives of the organization, and other important areas.

**After the orientation conference**

The survey team is given a brief tour of the physical facilities. Some team members may proceed directly to community sites that are a part of the survey rather than participate in the tour.

**Mid-morning to late afternoon**

The survey team meets to coordinate efforts and proceed with survey activities. The organization is asked to schedule interviews with any persons identified, based on their availability. Every effort is made to minimize disruption to ongoing operations. If the organization has any question about the scheduling of interviews, these should be addressed with the survey team coordinator.

With a short lunch break, the team spends the rest of the day observing the program(s)/service(s) being surveyed; interviewing various personnel, persons served, leadership, funding source representatives, community members, and others; and reviewing documents such as records of the persons served, fiscal reports, administrative records, and other materials. Records for review shall be selected by the survey
team. A responsible person from the organization should be on the premises at all times to facilitate the process and answer questions for the team; however, this person should not attend individual interviews or survey team meetings.

**Evening**

The survey team reviews findings relative to conformance to the standards. The surveyors may request permission to remove nonconfidential documents from the survey site for review in the evening. Approval of this is at the discretion of the organization. If the organization offers residential programs, community housing, or supported living services, evening hours may also be used to visit sites.

The work that the survey team must do in the evenings prior to the last day of the survey is quite extensive. Therefore, the organization should never schedule any social activity that would involve surveyors.

**Second or Last Day**

If the survey involves more than two days, the following schedule applies to the last survey day. The other day(s) will be used for further observation, interviews, and documentation review. It should be noted that the last day of the survey typically ends not later than 3:00 pm.

**Opening of business**

The survey team returns to the organization to obtain additional information, continue its interviews, review documents, and perform other survey activities. The organization’s personnel may be asked for assistance in locating information to show conformance in specific areas.

**Late Morning**

The survey team meets to compile its findings and prepare for the exit conference. A pre-exit meeting may be requested with or by the personnel in charge to summarize the findings and/or discuss any areas still to be resolved.

**Early Afternoon**

The exit conference, which is approximately one hour in length, is conducted by the survey team with those invited by the organization. The organization may record the exit conference. The purpose of the conference is for the survey team to provide feedback concerning the strengths of the program(s)/service(s) and operations in relation to the standards, identify areas for improvement, and offer suggestions and consultation.

The organization may question any areas identified for improvement by the survey team at the exit conference, or immediately after the exit conference, and present further evidence of conformance to the standards before the surveyors leave the site. Once the survey team has left the site, the organization may not contribute any further information to demonstrate conformance to the standards.

**NOTE:** If any issues or questions arise before or during the survey that the organization cannot resolve with the surveyors, the organization is encouraged to call CARF for guidance and resolution prior to completion of the survey.

**After the Survey**

After the survey has ended, all questions or concerns should be directed to the CARF office rather than to members of the survey team.

**Step 7. CARF issues the accreditation decision**

The survey team reports its findings to CARF for review and determination of the accreditation decision. After the accreditation decision has been made, a written accreditation report is sent to the organization. The length of time from the site survey to the organization’s notification of the decision is approximately six to eight weeks.

The report contains the accreditation decision and identifies recommendations for standards that were not fully met. When the organization is resurveyed, it is held accountable for follow up on the recommendations in the previous report and for evidence of conformance to standards throughout the term of accreditation, and for all applicable standards in the current standards manual.

**NOTE:** CARF personnel, acting during the course and within the scope of their employment, are the only persons authorized to officially represent CARF in...
Step 8. Submit a Quality Improvement Plan
Within 90 days of notification of the accreditation decision, the organization submits to CARF a Quality Improvement Plan (QIP) in which it outlines the actions that have been or will be taken in response to the recommendations identified in the accreditation report. The QIP form with instructions is posted on Customer Connect (customerconnect.carf.org) at the time of the accreditation decision. CARF may be contacted for assistance if any recommendations require further explanation or if the organization needs assistance in determining whether its planned action is adequate to demonstrate conformance to the CARF standards. Submission of the completed QIP is required by Accreditation Condition 3 in order to maintain accreditation.

If an organization requests a review of a One-Year or Provisional Accreditation decision, the QIP must be submitted to CARF within 45 days following notice of the outcome of the review.

Step 9. Submit the Annual Conformance to Quality Reports
As part of the commitment to ongoing performance excellence that all CARF-accredited organizations are expected to demonstrate, each organization that achieves a Three-Year Accreditation must submit an Annual Conformance to Quality Report (ACQR) in a format supplied by CARF for each year of its accreditation. The report is due on the first and second anniversary dates. Through the ACQR, the organization certifies that it at all times conforms to the standards, satisfies the Accreditation Conditions, and complies with CARF’s policies and procedures as changes are published and made effective from time to time.

Submission of the completed ACQR is required by Accreditation Condition 4 in order to maintain accreditation.

Step 10. CARF maintains contact with the organization
Ongoing Communication of Administrative Items and Significant Events
During the term of accreditation, the organization must provide timely information to CARF about certain events that occur within or affect the organization or its accredited program(s)/service(s). Some situations may require further actions to be taken. (e.g., see the “Supplemental Surveys” and “Allegations, Suspensions, and Stipulations” sections.) Information about the events listed below must be communicated to CARF within 30 days of their occurrence:
- Change in leadership.
- Change in ownership, acquisition, consolidation, joint venture, or merger.
- Change in organization name.
- Change in mail and/or email address(es).
- Relocation, expansion, or elimination of an accredited program or location.
- Financial distress.
- Investigation.
- Material litigation.
- Catastrophe.
- Sentinel event.
- Governmental sanctions, bans on admission, fines, penalties, loss of programs, or *CMS survey deficiency (*CCRCs and U.S. PCLTCCs only).

Changes in ownership and/or leadership, the addition of a site to an existing accreditation, mergers, consolidations, joint ventures, and acquisitions involving accredited program(s)/service(s) may require the payment of an administrative fee or a supplemental survey.

Forms for reporting administrative items and significant events
Forms for reporting administrative items and significant events are available on the CARF website at www.carf.org/Accreditation/
Accreditation Process/Ongoing Communication

Accreditation Process/Ongoing Communication and in the Resources section of Customer Connect (customerconnect.carf.org). Please contact CARF for more details.

Falsification of Documents

The information provided by an organization seeking CARF accreditation is a critical element in the accreditation process and in determining the organization’s conformance to the standards. Such information may be obtained via interviews or direct observation by surveyors or may be provided through documents reviewed by the survey team or submitted to CARF.

CARF presumes that each organization seeking accreditation is doing so in good faith and that all information is accurate, truthful, and complete. Failure to participate in good faith, including CARF’s reasonable belief that any information used to determine conformance to CARF’s standards during or subsequent to the survey has been falsified, may be grounds for Nonaccreditation or a decision to modify or withdraw the existing accreditation.

In the event that an organization loses accreditation or is not accredited because of CARF’s reasonable belief that any falsification of documents or information, CARF will not accept a survey application from the organization for a period of at least twelve months. CARF may also notify the appropriate governmental agencies.

Public Information

Identification of Accreditation by the Organization

CARF accreditation is issued to an organization for identified program(s)/service(s). An organization that has achieved accreditation should identify this achievement publicly, and use of the CARF logo by an accredited organization for this purpose is encouraged. The CARF logo is available online in the Resources section of Customer Connect (customerconnect.carf.org) and on the CARF website at www.carf.org/logo. All references to CARF accreditation by the organization must clearly identify the accredited program(s)/service(s), unless all program(s)/service(s) offered by the organization are accredited by CARF.

CARF personnel and surveyors may not be referred to or quoted in any public release involving accreditation without prior approval from CARF. An organization may, however, disseminate or quote from the accreditation report.

Certificate of Accreditation

An organization is provided with one certificate of accreditation, which is suitable for framing. Additional certificates are available for purchase. This certificate identifies the organization that submitted the survey application, the level of accreditation, the program(s)/service(s) for which the organization is accredited, and the month and year in which the accreditation expires. For each year that an organization meets the annual requirements for continuing conformance, CARF will provide a seal to affix to the certificate indicating continued accreditation.

An organization may use or display its certificate of accreditation to demonstrate conformance to the CARF standards, but it may not use or display the certificate in any manner that is inconsistent with the purposes of CARF and its accreditation function or that misrepresents the availability or quality of the program(s)/service(s) offered by the organization. The certificate should never be used either explicitly or implicitly as a claim, promise, or guarantee of successful service. Accreditation indicates an organization’s demonstrated use of professionally approved standards and practices in connection with particular program(s)/service(s), and the certificate is regarded as providing information and guidance for the public at large and for persons considering services.

An accreditation applies only to the organization’s specific program(s)/service(s) surveyed by CARF. The certificate may be displayed only by that organization. If an organization closes one or more of its accredited program(s)/service(s) and other program(s)/service(s) remain accredited, the certificate should be
returned to CARF and a revised certificate will be issued free of charge.

Upon dissolution of the organization or loss of accreditation for any reason, each unexpired certificate must be returned to CARF and the organization must refrain from representing itself or its program(s)/service(s) as accredited and must cease to use or display the certificate or the CARF logo in any manner. Similarly, if accreditation is suspended, the organization must not represent itself or its program(s)/service(s) as accredited or use or display the certificate or the CARF logo until and unless accreditation is restored.

Release of Information by CARF

To enhance the value of accreditation to persons served and other stakeholders, CARF may release information related to an organization and its accreditation to the extent that it is not confidential or protected by law, including, but not limited to:

1. Whether CARF has received a survey application from a specific organization.
2. Scheduled survey dates for a specific organization.
3. Whether a survey has been completed.
4. The date of expiration of accreditation of a particular organization.
5. An organization's accredited program(s)/service(s).
6. An organization's accreditation decision and status.
7. Whether an organization has requested review of a One-Year Accreditation, Provisional Accreditation, or Nonaccreditation decision.
8. Whether an organization is involved in appealing or may still appeal a Nonaccreditation decision.
9. As required by law or contract.

For convenient access to information, CARF includes on its website a searchable list of organizations with accredited program(s)/service(s), including identifying information such as name, address, and telephone number. This posting allows the public to review the accreditation status of an organization's accredited programs at any time.

Subsequent Surveys

Depending on the circumstances, CARF may conduct three types of surveys of the organization’s programs following the initial survey. These survey types are described below.

Resurveys

To maintain accreditation beyond the expiration date of its current accreditation, an organization’s program(s)/service(s) must be resurveyed or be in the process of a resurvey by the expiration date. CARF notifies an organization of the need for a resurvey approximately seven months before expiration of its accreditation.

The resurvey process is the same as the initial survey process in that a completed survey application is required and all applicable standards are applied. During a resurvey, however, the organization is expected to be able to demonstrate conformance during the entire period since its last survey. Also, special attention is given to implementation of changes made in response to the Quality Improvement Plan from the previous survey.

If new program(s)/service(s) are being added or the mission and focus of the organization or its program(s)/service(s) or locations have changed since the previous survey, it is suggested that the organization contact its CARF resource specialist.

Supplemental Surveys

The main objective of a supplemental survey is to recognize the dynamic status of organizations and permit changes in accreditation between surveys. Supplemental surveys may be required under two circumstances:

1. When an organization changes its leadership or ownership or engages in a merger, consolidation, joint venture, or acquisition transaction.
When an organization’s leadership or ownership changes after the survey is conducted, it may be necessary to conduct a supplemental survey of conformance to the standards applicable to the organization’s administration and program(s)/service(s). For the same reasons, a supplemental survey may also be required when an organization is party to a merger, consolidation, joint venture, or acquisition involving accredited program(s)/service(s).

2. When an organization wishes to add a new program, service, or location to an existing accreditation.

An organization with currently accredited program(s)/service(s) may be required to have a supplemental survey for the purpose of adding a new location to its existing accreditation. CARF will determine the need for a supplemental survey once the organization notifies CARF, in writing, of the changes in the organization. CARF will contact a representative of the organization to get more details, if required.

A supplemental survey is always required if an organization wants to add a new program or service that is not currently accredited.

If a supplemental survey is required, the organization must submit a completed survey application to CARF with a nonrefundable application fee. A survey fee for a supplemental survey is assessed for the number of days and surveyors required.

The maximum term of the accreditation of the new program, service, or location added will be the remaining term of the current accreditation. If during the supplemental survey the program, service, or new location is found to be functioning at a lower level of accreditation than the program(s)/service(s) currently accredited, the result will be a reduction in the level and term of the entire accreditation decision.

A supplemental survey focuses on the program, service, or location being added. The standards that are applied may vary in accordance with the length of time since the previous survey. Organizations seeking to add a program, service, or location to their current accreditation should contact CARF for instructions regarding the applicable standards.

Monitoring Visits

CARF may conduct announced or unannounced monitoring visits of organizations with accredited programs/services. A monitoring visit may be conducted any time CARF receives information that an organization may no longer be conforming to the standards. The organization’s accreditation may be modified as a result of a monitoring visit, and submission of a new Quality Improvement Plan may be required. A monitoring visit may consist of a partial or full survey team depending on the nature of the information received. The cost of a monitoring visit is covered by CARF.

Extension of Accreditation

Extensions of up to three months for extenuating circumstances may be granted by CARF, at its sole discretion, for an organization with a current Three-Year Accreditation. The organization must request this extension in writing when submitting the completed survey application at least five months before its expiration date. CARF will review the request and determine whether the extension will be approved. Although the request for extension will not be approved prior to the submission of the survey application, an organization may contact CARF to seek prior authorization to request an extension.

An extension will not be considered or granted for an organization with a One-Year, Provisional, or Preliminary Accreditation.

If an organization with a Three-Year Accreditation intends to request an extension greater than three months, additional information must be submitted for consideration. The organization must submit written information with the completed survey application and application fee that details demographic and program/service changes since the last survey and an update on the performance of each accredited program/service. The organization should also send the
following items and/or information to CARF at least five months prior to the expiration month:

- A letter from the organization's leadership explaining the reasons that the extension is being requested.
- A copy of the most recent performance analysis, as specified in Standard 1.N.1. in this manual.
- An update of the Quality Improvement Plan.

All information will be reviewed before CARF renders a decision on the extension request. In no case will an organization be granted more than a six-month extension.

If an organization is granted an extension, the survey will be conducted using the standards manual that is current on the date of the survey. After the survey, the expiration date will revert to the original month of expiration.

If an extension is granted, only those program(s)/service(s) that are currently accredited and that the organization intends to have resurveyed will be included in the extension.

Organizations that submit their survey application and request for an extension after the date the survey application was due risk a lapse in their accredited status.

### Allegations, Suspensions, and Stipulations

Upon being informed by any source of a change in an organization’s conformance to the CARF Accreditation Conditions, standards, or policies and procedures, CARF, at its sole discretion, may review and modify the organization’s accreditation status up to and including revocation of accreditation. CARF may also suspend or place stipulations on continued accreditation. During suspension, the organization is not accredited and may not communicate to third parties that it is CARF accredited.

CARF’s review may involve a request for an immediate response from the organization, the submission of documents and other information, solicitation of information from external organizations and individuals, and/or the undertaking of an announced or unannounced monitoring visit. Refusal to respond or unsatisfactory response to a CARF inquiry concerning an allegation may result in modification of accreditation status. When a change in status is deemed warranted, CARF will notify the organization of this action.

If an extension is received after a survey but before the accreditation report and accreditation decision are released, CARF may withhold the release of the report and decision until such time as CARF may determine.

### Disputed Accreditation Decisions

An organization issued a One-Year or Provisional Accreditation or Nonaccreditation from an original survey, resurvey, or supplemental survey (“Survey”) may request an on-site review (“Review”). *Any Review is subject to the process set forth below for either Review of One-Year or Provisional Accreditation Decisions or Review and Appeal of Nonaccreditation Decisions, as applicable.

*If the accreditation decision is based on failure to satisfy one or more of the CARF Accreditation Conditions or unavailability of key organizational staff during the Survey, as determined in CARF’s sole discretion, the accreditation decision is final and the review and appeal processes do not apply.

### Review of One-Year or Provisional Accreditation Decisions

1. Request for Review. CARF must receive a written request for a Review from the organization (“Request”) within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey. The Request must clearly identify each specific recommendation disputed by the organization (“Disputed Recommendation”) and a detailed explanation of the rationale for the dispute with respect to each Disputed Recommendation.

2. Review Fee. CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review
fee, which is equal to CARF’s current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.

3. Scheduling. Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.

4. On-Site Review. The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review (“Findings”); however, it is the responsibility of the organization to provide information to the survey team that demonstrates conformance to the applicable standards. While the Disputed Recommendations are the focus of the Review, any standard applied on the Survey may be applied on the Review.

5. Accreditation Decision. CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings and any recommendations from the Survey not identified in the Request.

6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization's knowing and intentional waiver of this review process. All CARF Accreditation Policies and Procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation decision, and all other matters related to the Review are final. All decisions and determinations related to and interpretations of this review process shall be determined at CARF’s sole and binding discretion.

Review and Appeal of Nonaccreditation Decisions

Review

1. Request for Review. CARF must receive a written request for a Review from the organization (“Request”) within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey.

2. Review Fee. CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review fee, which is equal to CARF’s current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.

3. Scheduling. Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.

4. On-Site Review. The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review (“Findings”); however, it is the responsibility of the organization to provide information to the survey team that demonstrates conformance to the applicable standards. A Review is intended to be a full survey; accordingly, all standards applied on the Survey may be applied on the Review.

5. Accreditation Decision. CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings.

6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization’s knowing and intentional waiver of this review process. All CARF Accreditation Policies and Procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation
decision, and all other matters related to the Review, are final; provided, however, that if the result of the Review is Nonaccreditation, the organization may be entitled to appeal pursuant to the process set forth below. All decisions and determinations related to and interpretations of this review process shall be determined at CARF’s sole and binding discretion.

Appeal

1. Notice of Appeal. An organization issued a Nonaccreditation from a Nonaccreditation Review is entitled to a hearing before an appeal panel (“Panel”) if CARF receives written notice of appeal from the organization (“Notice”) within ten calendar days of the date of the letter that communicates the accreditation decision from the Review. The sole issue on appeal shall be whether the Review was conducted in a manner consistent with CARF’s published review process; that is, whether the Review survey team conducted interviews, reviewed documents, and otherwise gathered information to determine Findings (“Issue”).

2. Materials and Election. CARF must receive from the organization within ten calendar days of the Notice date: (a) all written materials it shall present at the hearing (“Materials”) or a written statement that no materials shall be presented (“Statement”); and (b) a written election to conduct the hearing either by telephone or in person at CARF headquarters in Tucson, Arizona, U.S.A. (“Election”).

3. Scheduling. Following receipt of the Materials or Statement and the Election, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the hearing within 60 calendar days of receipt of the Materials or Statement and the Election. Once scheduled, CARF shall notify the organization of the date of the hearing and the designated Panel.

4. Appeal Hearing. During the hearing, the organization shall have up to one hour to present the previously submitted Materials, if any, and any unwritten information it believes support a determination that the Review survey team did not conduct interviews, review documents, and otherwise gather information to determine Findings. Thereafter, the Panel may pose questions to the organization and to the Review survey team. Finally, the organization shall have up to 20 minutes to provide any concluding remarks. The organization and survey team shall not question each other.

5. Irrelevant Information. Any information deemed irrelevant to the Issue may be excluded from the hearing and/or not considered by the Panel. The Panel shall under no circumstances consider the Findings.

6. Accreditation Decision. CARF shall affirm the Nonaccreditation or issue another accreditation decision, with or without stipulations, based on consideration of the relevant information received by the Panel at the hearing.

7. Miscellaneous. If CARF does not timely receive Notice, the Materials or Statement, or the Election, or if the organization fails to present relevant information at the scheduled hearing, such shall constitute the organization’s knowing and intentional waiver of this appeal process. The accreditation decision and all other matters related to the appeal are final and not subject to review or appeal. All decisions and determinations related to and interpretations of this appeal process shall be determined at CARF’s sole and binding discretion.
The purpose of this section is to identify notable changes that have been made in the standards included in this manual compared to the previous year’s manual. Please be aware that in addition to the changes noted here, some standards may have minor revisions that do not change the requirements of the standard and are not listed here.

In addition to the changes noted in this section, throughout the manual the Intent Statements, Examples, Resource listings, and other supporting content have been revised and updated to remain current and/or to clarify the intent or requirements of the standards. Changes in the Accreditation Policies and Procedures, program descriptions, applicable standards information, and reference materials are also not listed here.

**Note:** CARF makes every effort to list all significant changes in the standards; however, not all changes are included. All sections that are applicable to an organization should be thoroughly reviewed to ensure that the current standards are implemented in the organization’s accredited programs and services and those seeking accreditation.

**Section 1. ASPIRE to Excellence®**

1.A. Leadership

- In Standard 1.A.3., element o. *Technology planning* is new.
- In Standard 1.A.6., element a.(9) has been modified slightly for clarity; the words *if applicable* were added.

1.C. Strategic Planning

- Standard 1.C.2. has been revised slightly for clarity; requirements are not changed.

1.E. Legal Requirements

- The stem of Standard 1.E.3. has been modified slightly for clarity; requirements are not changed.

1.F. Financial Planning and Management

- Standard 1.F.7. has been revised and expanded to add a requirement that the review of bills be documented, and the items listed under element b. have been modified and include new requirements related to the review.
- In Standard 1.F.9., element a. is new and subsequent elements were renumbered accordingly; and element h. is new.
- Standard 1.F.10. has been revised to incorporate requirements from previous Standard 1.F.11.
- Previous Standard 1.F.11. has been deleted and combined into revised Standard 1.F.10.

1.H. Health and Safety

- Standard 1.H.4. has been reworded slightly and restructured for clarity; requirements are not changed.
- Standard 1.H.7. has been revised for clarity; requirements are not changed.
- Standard 1.H.8. has been reworded slightly for clarity.
- In Standard 1.H.9., the stem has been reworded slightly for clarity, and element f. was revised to delete the words “if appropriate.”

1.I. Workforce Development and Management


1.J. Technology

- This section has been significantly revised and expanded based on input from the field. Previous Standard 1.J.1. has been replaced with new Standards 1.J.1.–5., and previous Standards 1.J.2.–8., related to service delivery using information and communication technologies, have been renumbered to 1.J.6.–12.
Changes in the 2019 Manual

Section 2. General Program Standards

2.A. Program/Service Structure

- In Standard 2.A.1., element a.(6) has been modified to add funding sources.
- Standard 2.A.4. has been modified slightly for clarity; requirements are not changed.
- Previous Standard 2.A.5. has been deleted; subsequent standards have been renumbered accordingly.
- Standard 2.A.25. (previously 2.A.26.) has been revised and restructured, and includes new elements and requirements.

2.B. Screening and Access to Services

- In Standard 2.B.12., element d. is new and addresses assessment for suicide risk; subsequent elements were renumbered accordingly.

2.C. Person-Centered Plan

- In Standard 2.C.4., elements b.(4)(a) and b.(4)(b) are new and specify additional requirements related to personal safety plans for persons served.
- Previous Standard 2.C.6. has been deleted; subsequent standards have been renumbered accordingly.

2.D. Transition/Discharge

- Standard 2.D.5. is new and requires programs to implement procedures for effective referrals and transitions; subsequent standards were renumbered accordingly.

2.G. Records of the Persons Served

- In Standard 2.G.1., element c. is new.

Section 3. Core Treatment Program Standards

3.A. Assertive Community Treatment (ACT)

- The Intent Statements for Standard 3.A.7. has been modified to clarify the allowable providers for medical services.

3.N. Office-Based Opioid Treatment Program (OBOT)

- This section is new in the 2019 manual.
- Previous Section 3.N. Out-of-Home Treatment has been deleted.

3.P. Partial Hospitalization (PH)

- Previous Standard 3.P.9. has been deleted; subsequent standards have been renumbered accordingly.
- In Standard 3.P.18., element a. has been reworded slightly for clarity.

Section 4. Core Support Program Standards

4.D. Call Centers (CC)

- This section has been renamed and revised to clarify specific standards that are applicable to the two types of call center programs that may seek accreditation: Crisis Call Centers and Information Call Centers.
- Standard 4.D.7. has been restructured and revised, and adds a new requirement for procedures to be in writing.

4.F. Employee Assistance (EA)

- In Standard 4.F.1., elements a., c., and e. have been modified slightly for clarity.
- In Standard 4.F.2., element a. has been modified slightly for clarity.
- In Standard 4.F.3., the stem and elements a. and l. have been modified slightly for clarity.
- In Standard 4.F.4., the stem and elements b.(1) and e. have been modified slightly for clarity.
- Previous Standard 4.F.14. has been deleted.
Section 5. Specific Population Designation Standards

- Previous Section 5.A. Addictions Pharmacotherapy has been deleted; subsequent sections have been renumbered accordingly.

Glossary

- The definition for the term *Individual plan* was revised slightly to add the word *written* for clarity.
SECTION 1

ASPIRE to Excellence®
Assess the Environment

To be relevant and responsive in a rapidly changing environment, the organization must be vigilant of the context in which it conducts its business affairs. Environmental assessments provide the foundation for development and implementation of organizational strategy. Assessments should be conducted within the context of the organization’s purpose, location, and sphere of influence, and relate to the vision and mission of the organization and how both fit into the social, economic, competitive, legal, regulatory, and political environments in which the organization operates. Collection and analysis of information regarding these factors provide the basis for the creative thought necessary to guide all organizational planning and action toward a future of service and business excellence. The role of leadership is critical to environmental assessment.

A. Leadership

Description
CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization’s stated mission. The leadership demonstrates corporate social responsibility.

1.A. The organization identifies:
   a. Its leadership structure.
   b. The responsibilities of each level of leadership.

Examples
The leadership structure can be documented in the form of an organizational chart, table of organization, or narrative description of the positions and lines of authority within the organization. For very small organizations it is common to see a narrative description of positions, responsibilities, and lines of authority as there are typically so few staff members covering all areas of responsibility.

The survey team verifies that whomever is identified fulfills the responsibilities of leadership.

1.A. 2. A person-centered philosophy:
   a. Is demonstrated by:
      (1) Leadership.
      (2) Personnel.
   b. Guides the service delivery.
   c. Is communicated to stakeholders in an understandable manner.

Intent Statements
The organization’s person-centered philosophy should be evident in the development and delivery of services, systems, approaches, and interventions. Implementation of this philosophy from the unique perspectives of the leadership,
personnel, and persons served is addressed during the survey process. See the Glossary for the definition of stakeholders.

Examples

2.c. The person-centered philosophy could be communicated a number of ways, including:

- Posting it on the walls or website of the organization.
- Incorporating it into materials that are distributed to stakeholders, such as orientation handbooks for the persons served and their families, personnel, volunteers, and advisory and governing boards; fact sheets, plans, and performance reports; and marketing brochures and pamphlets.
- Articulating it during tours of the organization; presentations such as orientation and training for personnel, volunteers, and advisory and governing boards; community education sessions; meetings and forums to seek input from stakeholders; recorded messages such as the voice response system.

1.A.3. The identified leadership guides the following:

a. Establishment of the:
   (1) Mission of the organization.
   (2) Direction of the organization.

b. Promotion of value in the programs and services offered.

c. Achievement of outcomes in the programs and services offered.

d. Balancing the expectations of the persons served and other stakeholders.

e. Financial solvency.

f. Risk management.

g. Ongoing performance improvement.

h. Development of corporate responsibilities.

i. Implementation of corporate responsibilities.

j. Compliance with:
   (1) All legal requirements.
   (2) All regulatory requirements.

k. Review of the organization's policies at least annually.

l. Health and safety.

m. Succession planning.

n. Strategic planning.

o. Technology planning.

Intent Statements

3.k. Review of the organization’s policies at least annually addresses all policies specific to the program(s) seeking accreditation and policies that directly relate to or impact the program(s). Through a systematic review of its policies an organization can address the relevance, pertinence, and necessity of existing policies as well as the need for updates or new policies to guide its operations and practices.

3.m. Succession planning identifies actions to be taken by the organization should key personnel be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization. See Standards 1.I.3.g. and 1.I.11. in Section 1.I. Workforce Development and Management.

3.o. The leadership is actively engaged in planning related to the organization’s implementation of technology systems and solutions that support and enhance its business and service delivery practices.

Examples

As the mission impacts service delivery, the achievement of outcomes, and strategic planning activities, a regular review of the mission statement assesses and reinforces the values of personnel and board members (when applicable) regarding the persons served and ensures that everyone is in agreement regarding the direction of the organization.

Input from the persons served and other stakeholders can influence the mission, as their needs, desired outcomes, and other factors change over time. The leadership ensures that specific activities are conducted to enhance its ability to guide the organization ethically, effectively, and efficiently.

3.c. The leadership works together to achieve and improve identified outcomes. Information
on outcomes is used to guide performance improvement efforts such as strategic planning. These efforts and achievements are documented. The organization is responsive to its environment and conducts planning to position itself strategically. In strategic planning, the organization may begin by doing an environmental scan and asking all of its stakeholders for input.

3.h.–i. These standard elements establish the organization’s responsibility to be prepared to respond to questions from the public regarding its accredited services. Questions that might be expected include, but are not limited to, those about its CARF survey results and the accreditation report, the quality and effectiveness of services, descriptions of services and persons served, performance outcomes of the services, consumer and customer satisfaction with services, and other information that persons may use to make informed choices about services and service providers.

The organization informs the public of its policy and procedure for responding to requests for information through such means as a brochure, newsletter, public service announcement, newspaper article, or information posted on its website.

The organization demonstrates its knowledge and implementation of applicable laws and regulations. The organization has a system that ensures that it stays informed of changes and remains current.

3.k. Leadership may delegate responsibility for review as it chooses.

Systemwide policies that directly impact the programs seeking accreditation may be reviewed by the program leadership and suggestions for revisions forwarded for consideration to the departments responsible for the specific policies.

3.m. Succession planning might identify which employees within the organization could move into key positions, consider how to develop employees to fill leadership positions, and highlight the need or opportunity to identify potential leaders external to the organization or even external to the field.

1.A. 4. The leadership of the organization is accessible to:
   a. The persons served.
   b. Personnel.
   c. Other stakeholders.

1.A. 5. The organization implements a cultural competency and diversity plan that:
   a. Addresses:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   b. Is based on the consideration of the following areas:
      (1) Culture.
      (2) Age.
      (3) Gender.
      (4) Sexual orientation.
      (5) Spiritual beliefs.
      (6) Socioeconomic status.
      (7) Language.
   c. Is reviewed at least annually for relevance.
   d. Is updated as needed.

Intent Statements

The organization demonstrates an awareness of, respect for, and attention to the diversity of the people with whom it interacts (persons served, personnel, families/caregivers, and other stakeholders) that are reflected in attitudes, organizational structures, policies, and services.

The organization’s cultural competency and diversity plan addresses how it will respond to the diversity of its stakeholders as well as how the knowledge, skills, and behaviors will enable personnel to work effectively cross culturally by understanding, appreciating, and respecting differences and similarities in beliefs, values, and practices within and between cultures.

Examples

The organization assesses and has awareness and knowledge of the diversity of a variety of stakeholders. Examples of diversity awareness and knowledge include areas such as spiritual beliefs,
holidays, dietary regulations or preferences, clothing, attitudes toward impairments, language, and how and when to use interpreters. The organization should be prepared to discuss what has resulted from the knowledge gained; e.g., modified service delivery, consideration of diversity in treatment plans, personnel training, increased satisfaction of stakeholders.

Cultural competency can be demonstrated by hiring persons who are representative of the persons served; by designing and delivering service in a manner that will be most effective given the cultures served; and by providing settings that promote comfort, trust, and familiarity.

Training and education in diversity and cultural competency may be offered directly by the organization or by community resources. Diversity in terms of culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language would be addressed. Training might focus on the cultures and spiritual beliefs of the countries of origin, especially their views of health, wellness, disability and its causes, and the influence of culture on the choice of service outcomes and methods.

Training related to cultural competency is directed toward personnel working with ethnically or otherwise diverse populations. It is suggested that the training attended by each employee be documented, generally in the personnel file and/or training records.

5.b.(3) Gender may include both gender identity and gender expression.

Resources

The Society for Human Resource Management has information about diversity training on its website at www.shrm.org that might be helpful, including views of disability and its causes, and the influence of culture on service delivery and predicted outcomes.

Many other professional, educational and advocacy organization websites provide information related to diversity and cultural competency. These include:

- National Center for Cultural Competence: nccc.georgetown.edu
- U.S. Department of Health and Human Services Think Cultural Health: www.thinkculturalhealth.hhs.gov
- Human Rights Campaign: www.hrc.org/resources
- Indigenous Cultural Safety Collaborative Learning Series: www.icscollaborative.com

1.A. 6. Corporate responsibility efforts include, at a minimum, the following:

a. Written ethical codes of conduct in at least the following areas:
   (1) Business.
   (2) Marketing.
   (3) Contractual relationships.
   (4) Conflicts of interest.
   (5) Use of social media.
   (6) Service delivery, including:
      (a) Exchange of:
         (i) Gifts.
         (ii) Money.
         (iii) Gratuities.
      (b) Personal fundraising.
      (c) Personal property.
      (d) Setting boundaries.
      (e) Witnessing of legal documents.
   (7) Professional responsibilities.
   (8) Human resources.
(9) Organizational fundraising, if applicable.

(10) Prohibition of:
   (a) Waste.
   (b) Fraud.
   (c) Abuse.
   (d) Other wrongdoing.

b. Written procedures to deal with allegations of violations of ethical codes, including:
   (1) A no-reprisal approach for personnel reporting.
   (2) Timeframes that:
       (a) Are adequate for prompt consideration.
       (b) Result in timely decisions.

c. Education on ethical codes of conduct for:
   (1) Personnel.
   (2) Other stakeholders.

d. Advocacy efforts for the persons served.

e. Corporate citizenship.

Intent Statements

Corporate responsibility demonstrates what an organization stands for including its ethical, social, and environmental values. It involves creating, communicating, and balancing value for all stakeholders.

Corporate responsibility assists in:
- Advocating for the persons served.
- Promoting ethical business practices.
- Developing efficiency as an organization.
- Considering the impact of organizational activities on persons served, personnel, other stakeholders, and the environment.

Examples

The organization identifies, develops, and documents its required ethical practices and values. Although these codes may be found in various written materials such as personnel policies and operations manuals, many organizations find it helpful to include this information in one set of documents, which makes it easier to use in staff and board member training. An organization might find information from professional organizations and associations useful as a reference in developing its codes of ethical conduct.

Values are the core beliefs that guide attitudes and actions. A written ethics code states the major philosophical beliefs, principles, and values of an organization. Codes should be designed to promote the kind of relationship within which services can best be carried out and to give guidance in decision-making situations. The policies concerning ethical conduct could be developed using information from such sources as state practice acts for the various disciplines/professions involved in services; the ethical codes of professional associations for the various disciplines/professions involved in services; the ethical codes of business, marketing, and human resource management associations; and the organization’s own mission and core values statements.

The staff and members of the governance authority are knowledgeable of and follow the organization’s required codes of ethical practices and values. This is evident in its daily operations. The organization has a mechanism in place to follow up and address all allegations of violations of its ethical codes. An organization could use a mechanism such as an ethics committee to investigate and act on allegations of violations of ethical conduct. It could also use the same or a similar mechanism to address both allegations of violations of ethical conduct and allegations of infringements of the rights of the persons served.

A no reprisal system is developed for use by the staff in reporting suspected incidents of waste, fraud, abuse, and other questionable activities and practices. Written procedures for investigating allegations of wrongdoing are available for guidance. In addition, there should be some evidence that employees are aware that the system exists and know how to use it.

Examples of advocacy and corporate citizenship efforts could be:
- Positions on local boards that address accessibility, housing, leisure pursuits,
Section 1.A. Leadership

and employment for persons in need of human services.

- Educational events for communities on caregiver issues.
- Educational events for schools on safety issues, such as wearing helmets while riding bikes.
- Drug and alcohol programs.
- Education on health issues.
- Employment opportunities.
- Active involvement in community organizations and service groups, such as chambers of commerce, rotary clubs, governor councils, provincial advisory committees, and meals on wheels.
- Providing reasonable accommodations to promote equal opportunities for participation throughout all levels of the organization.
- Providing access or referral to social, legal, or economic advocacy resources.
- Involvement in projects and programs to inform, educate, protect and promote a healthy environment such as recycling, use of environmentally friendly products, reduction of consumptions in the areas of water and energy, or reduction of greenhouse gas emissions.

6.a. The codes of ethical conduct could be developed using information from such sources as state practice acts for the various disciplines/professions involved in services; the ethical codes of professional associations for the various disciplines/professions involved in services; the ethical codes of business, marketing, human resource management associations and organizations that evaluate charities; and the organization's own mission and core values statements and corporate compliance programs.

6.a.(4) Examples of conflicts of interest might include:

- Referral fees, self-referrals, and fee splitting.
- Accepting gifts or money from a vendor who does or is trying to secure business with the organization.
- Preferential treatment of an individual or entity due to a personal relationship with someone in the organization.
- Use of confidential information for one's own advantage.
- Employment by more than one organization resulting in competing interests.
- A board member who also serves on the board of a competitor organization.

6.a.(5) This standard relates to Standard 1.G.3. on media relations and social media in the context of risk management. With the ubiquity of social media, it is increasingly important that organizations address related risks and ethical considerations as part of their codes of conduct. Topics an organization might address include acceptable use of social media by personnel as it relates to the organization, such as posts that positively reflect on the organization and its activities; privacy and confidentiality considerations, such as seeking permission from persons served for posts or pictures that include them and not sharing information about persons served in personal posts; how an organization's social media will be monitored for adherence to its expectations and how violations will be dealt with; and engagement on social media during work hours. Additionally, the organization may address how it uses social media searches as part of its applicant vetting process.

6.a.(6)(b) Examples of personal fundraising that may be addressed in an organization's written code of ethical conduct include personnel soliciting funds on behalf of a personal cause, selling cookies for a daughter in girl scouts, selling candy or wrapping paper for a child's school, having persons served selling items on behalf of the organization, and allowing persons served to raise funds by appeals to personnel or other persons served.

6.a.(6)(c) Ethical conduct might include respect for and safeguarding of the personal property of the persons served, visitors, and personnel and property owned by the organization.

6.a.(6)(d) The code of ethical conduct might address relationship issues such as personnel dating other personnel at the organization or persons served, sexuality, and boundaries in the
relationships between providers and the persons served.

6.a.(6)(e) Examples of legal documents that personnel may be asked to witness include powers of attorney, guardianship, and advance directives.

6.d. Advocacy efforts for the person served could include the organization conducting or participating in public education or activities that promote the elimination of discrimination and stigma for the persons served.

Activities that demonstrate promotion of the reduction of stigma could include participation in a variety of public education efforts, community boards and committees, newspaper articles, and radio and television presentations. The organization can directly provide these sessions or actively participate in them. Maintaining a log or file of the activities in which the organization is involved can be helpful in demonstrating conformance. A method of demonstrating internal conformance to this standard would be the use of “people first” language in the organization’s publications, operations, and activities.

7. An organization in the United States receiving federal funding demonstrates corporate compliance through:
   a. Implementation of a policy on corporate compliance that has been adopted by the organization’s leadership.
   b. Implementation of written procedures that address exclusion of individuals and entities from federally funded healthcare programs.
   c. Designation of a staff member to serve as the organization’s compliance officer:
      (1) That is documented.
      (2) Who:
         (a) Monitors matters pertaining to corporate compliance.
         (b) Conducts corporate compliance risk assessments.
         (c) Reports on matters pertaining to corporate compliance.
   d. Training of personnel on corporate compliance, including:
      (1) Role of the compliance officer.
      (2) The organization’s procedures for allegations of fraud, waste, abuse, and other wrongdoing.
   e. Internal auditing activities.

Intent Statements
The acceptance of federal funding requires acceptance of the responsibility and accountability for tracking the funds and determining and overseeing how funds are being used and reported. Receiving federal funding includes direct and indirect federal funding. The receipt of federal funding may occur in a variety of ways, including the direct receipt of Medicaid or Medicare funding, funding through another entity (such as a block grant or funds received through a vocational rehabilitation or other state agency contract), or funding through being a federally funded network.

7.b. Office of the Inspector General has the authority to exclude individuals and entities from federally funded healthcare programs. Hiring an individual or entity on the List of Excluded Individuals and Entities (LEIE) may subject an organization to monetary penalties. Written procedures address the organization’s process and timeframes for verifying that personnel are not on the LEIE and actions to be taken in response to the information received. For further information, see https://oig.hhs.gov/exclusions/index.asp.

7.e. Internal auditing activities include audits that would reasonably uncover improper conduct and/or billing errors.

Examples
Under corporate compliance systems, organizations develop and implement processes to assess compliance issues, take corrective measures, and continually monitor compliance in all areas including administration and service provision. These systems should be guided by regulations provided by the Centers for Medicaid and Medicare (CMS), and consistent with Section 6401 of the Patient Protection and Affordable Care Act of 2010.
Generally speaking, the term **compliance** is used to describe the act of complying with or acting in accordance with a set of standards or expectations mandated by an outside entity and is frequently used in conjunction with regulatory reviews, licensing audits, etc.

The organization, by assigning an individual to ensure that these business practices are followed, demonstrates that it can be a responsible agent. With these responsibilities, the organization is committed to protecting its personnel when actions of the organization are being put under scrutiny. Personnel will be given assistance during any investigative process.

A corporate compliance program must be “effective” as defined by the U.S. sentencing guidelines and be “...reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct.” Perhaps the most practical benefit of having an effective corporate compliance program in place is the mandatory reduction in any monetary fines and penalties ordered by a judge who imposes a sentence on an organization. The implementation of a corporate compliance program establishes an atmosphere that prompts early detection of any wrongdoing before it becomes too serious and/or before it is detected through a regulatory or governmental audit or survey. Additional benefits of an effective corporate compliance program are:

- Reducing the likelihood of a violation occurring.
- Reducing the likelihood of civil liability, which comes chiefly in the form of demands for return of overpayments, civil money penalties, and whistle-blower lawsuits.
- Providing management with a different and generally more accurate view of the organization.
- Establishing a structure of information relevant to the compliance program;
- Establishing a structure to maximize the right of confidentiality under the attorney-client privilege.

7.a. A policy on corporate compliance typically articulates the organization’s strong ethical culture and commitment to compliance with all applicable laws, regulations, and requirements. The role of the compliance officer may be defined, including the compliance officer's access to top-level leadership and/or the governing board.

7.c.(2)(a) The compliance officer may perform compliance related activities or monitor activities delegated to other personnel.

7.c.(2)(b) Compliance risk assessment activities can be included in the organization’s risk management activities.

7.c.(2)(c) The compliance officer reports to top-level leadership regarding compliance related activities, results of internal auditing activities, and results of investigations from reports of suspected fraud, waste, and abuse from organizational personnel.

7.e. The internal auditing activities should be designed to evaluate the organization’s compliance with federal requirements as well as determining the effectiveness of the compliance program.

1.A. 8. **Leadership provides resources and education for personnel to stay current in the field in order to demonstrate program strategies and interventions that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**

**Intent Statements**

Leadership support is critical to the ability of personnel to learn and implement current strategies and interventions.

**Examples**

Examples of resources that leadership might provide include journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resource or education efforts with other area providers of services, financial support and/or time off to
participate in special interest groups or to attend conferences.

Applicable Standards

Standard 1.A.9. applies to organizations that directly solicit charitable financial support in connection with any program seeking accreditation. It does not apply to organizations whose fundraising is conducted by a foundation, third party, or other separate legal entity, or in connection with programs not seeking accreditation.

1.A.9 To demonstrate accountability, an organization that engages in fundraising:

a. Implements written procedures that address, at a minimum:
   (1) Oversight.
   (2) Donor:
      (a) Solicitation.
      (b) Communication.
      (c) Recognition.
      (d) Confidentiality.
   (3) Valuing of donations.
   (4) Use of donations in accordance with donor intent.
   (5) Documentation and recordkeeping.
   (6) Use of volunteers in fundraising efforts, if applicable.

b. Provides training related to fundraising written procedures to appropriate personnel, including:
   (1) Initial training.
   (2) Ongoing training.

Examples

9.a.(1) Written procedures might address which individual, committee, or department has authority and responsibility for the organization’s fundraising activities; how the individual, committee, or department responsible for oversight fits into the larger organizational structure; and requirements for reporting.

9.a.(2)(a) Written procedures might address the mechanism(s) for and frequency of donor solicitation; what groups or individuals, e.g., persons currently participating in a program, can or cannot be solicited; and any state/provincial or other type of registration required to conduct certain charitable solicitations.

9.a.(2)(b) Written procedures might address how the organization will communicate with donors, e.g., in person or by mail, email, telephone, or social media channels; at what frequency; and what information will be exchanged. Written procedures might also include how the organization will handle requests to discontinue or restart communication with a donor and how it will maintain the currency of its records used for communication, e.g., relocation or death of a donor.

9.a.(2)(c) Written procedures might address the recognition of donors by name, donation amounts or other descriptors, and matching donations.

9.a.(2)(d) Written procedures might address how the organization will maintain the confidentiality of...
of donors in accordance with applicable laws and regulations, such as HIPPA or PIPEDA, and donor wishes; e.g., a donor who wants to remain anonymous.

9.a.(3) Written procedures might address how the fair market value of noncash donations such as clothing, electronics, furniture, and other goods or services is determined and who may make such determinations; and what to do if a donor requests a receipt for a higher value than the donation is worth.

9.a.(4) Written procedures might address how funds or other donations will be applied in accordance with donor intent; e.g., a capital campaign to fund a new building or renovations; a golf tournament, casino night, or auction to fund the purchase of a vehicle to transport persons served or new equipment that will be used by persons served; or ongoing efforts to raise funds to support services for persons who would otherwise be unable to participate in the organization’s programs/services.

9.a.(5) Written procedures might address what documentation is required to comply with legal and regulatory requirements and/or to satisfy the organization’s requirements, how long documentation is retained, how documentation regarding fundraising and donors is kept separate from other administrative recordkeeping, and whether information such as credit card and bank account numbers is kept on file.

9.a.(6) Written procedures might address in what capacity volunteers may be involved in fundraising activities and what the expectations are of those roles, recruitment of volunteers, training and supervision of volunteers, dismissal of volunteers, and background checks if necessary.

9.b.(2) Ongoing training may be provided when there is a change in fundraising procedures or practices, a change in the scope of an organization’s fundraising efforts, or a change in the legal or regulatory requirements related to fundraising to which the organization is subject.

Resources
- Charity Watch: www.charitywatch.org/home
- Charity Review Council: www.smartgivers.org
- Charity Navigator: www.charitynavigator.org
- CFRE International: www.cfre.org
- Association of Fundraising Professionals: www.afpnet.org
- IRS Charitable Solicitation—State Requirements: www.charitiesinstituteireland.ie/guidelines
- Charities Institute Ireland: www.charitiesinstituteireland.ie

9.a.(3) Resources related to valuing of donations include:
- Goodwill: www.amazinggoodwill.com/donating/IRS-guidelines
- Salvation Army Donation Value Guide: satruck.org/Home/DonationValueGuide
- Internal Revenue Service: www.irs.gov/uac/about-publication-561


Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Organizational chart
- Policy on corporate compliance, if applicable
B. Governance (Optional)

Description
The governing board should provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability. The board is responsible for ensuring that the organization is managed effectively, efficiently, and ethically by the organization's executive leadership through defined governance accountability mechanisms. These mechanisms include, but are not limited to, an adopted governance framework defined by written governance policies and demonstrated practices; active and timely review of organizational performance and that of the executive leadership; and the demarcation of duties between the board and executive leadership to ensure that organizational strategies, plans, decisions, and actions are delegated to the resource that would best advance the interests and performance of the organization over the long term and manage the organization's inherent risks. The board has additional responsibilities under the domain of public trust, and as such, it understands its corporate responsibility to the organization's employees, providers, suppliers, and the communities it serves.

Applicable Standards
These governance standards may be applied, at the option of the organization, if the organization has a corporate governing board. The organization must indicate on its survey application that it wishes to have the governance standards applied.

When elected, these standards apply only to the board vested with legal authority to direct the business and affairs of the organization's corporate entity. These standards may not be applied to bodies lacking governance authority granted by state or provincial corporation laws, such as advisory and community relations boards and management committees.
For example, if a hospital is seeking accreditation at the level of its brain injury program, and the hospital requested that these standards be applied as an effort to review the governance practices in the organization, the standards would be applied to the hospital's governing board and not to the program's leadership (unless the program is separately incorporated, in which case they would apply to the program's board if it has the vested authority). For more information, please contact your customer service unit.

1.B. 1. The board implements governance policies that:
   a. Facilitate ethical governance practices.
   b. Assure stakeholders that governance is:
      (1) Active in the organization.
      (2) Accountable in the organization.
   c. Meet the legal requirements of governance.

Intent Statements
The board should clearly document its approach and duties related to governance including its compliance with applicable statutes and provisions of articles of incorporation and bylaws. Board members are subject to three basic legal duties in performing their responsibilities: duty of care, duty of loyalty, and duty of obedience. Accountability requires that oversight mechanisms be in place, such as meetings, reports, and timely reviews of corporate performance.

Examples
Examples could include:
- Documented governance policies.
- Annual review of bylaws (legal requirements).
- Delegation of authority to executive leadership with defined limits, such as financial limits.
- Assurance that internal control and risk management systems, delegated to executive leadership, are in place.
- Timely reviews of corporate performance (e.g., quarterly).

- Annual reports to stakeholders.
- Input meetings with stakeholders.
- How board members understand the organization's fundraising goals and strategies, identify prospective donors, and engage with donors.

1.B. 2. Governance policies address:
   a. The selection of the board, including:
      (1) Board membership criteria.
      (2) Selection process.
      (3) Exit process.
   b. Board member orientation.
   c. Board development.
   d. Board education.
   e. Board leadership, including selection of:
      (1) Board chair.
      (2) Committee chairs.
   f. Board structure, including:
      (1) Board size.
      (2) Board composition.
      (3) Definition of independent, unrelated board representation.
      (4) Duration of board membership.
   g. Board performance, including:
      (1) Financial matters, if any, between the organization and individual board members, including:
         (a) Compensation.
         (b) Loans.
         (c) Expense reimbursement.
         (d) Stock ownership.
         (e) Other matters of financial interest.
      (2) Use of external resources, including, as applicable:
         (a) External auditors.
         (b) Executive compensation advisors.
         (c) Other advisors, as needed.
      (3) Self-assessment of the entire board at least annually.
Section 1.B. Governance (Optional)

(4) Periodic self-assessment of individual members.

(5) Written conflict-of-interest declaration that is signed at least annually.

(6) Written ethical code of conduct declaration that is signed at least annually.

(7) External interactions.

Intent Statements

2.a. The board has sole responsibility to determine appropriate skills and characteristics required for a competent and contributing board member. Each organization and its board must consider and identify its own member criteria (such as skills, diversity, representation of person served) and follow a selection process that accounts for the perceived needs of the board at the time of selection, attracting board members who have the time to devote to board activities to advance the organization's purpose. Establishing membership criteria and defining a selection process should attract board members with the necessary skills and knowledge to do their job well.

The board should also manage its own governance performance by reviewing the collective board and individual members. In the event that performance issues arise with any specific board member (such as not attending meetings or lack of meaningful participation) the board must clearly identify its protocol to discharge a board member in a defined exit process.

2.b. Board member orientation usually requires that both the board and executive leadership conduct a comprehensive orientation process to ensure that the board member becomes familiar with the organization's vision, mission, strategic direction, values, ethics, financial matters, governance practice, and policies in keeping with legal and/or other reporting requirements (e.g., annual tax filings).

2.c.–d. The organization should continually make efforts to build governance capacity through ongoing education. Rather than specifically relying on the individual expertise of a particular board member, the organization should make a concerted effort to advance the skills of the entire board, as the whole board is ultimately accountable, speaking with one voice.

2.e. The board should act freely to select a chair who is best for the board and organization at a given time. With respect to selecting the board chair or specific committee chairs, the organization should identify those criteria and selection processes.

2.f.(1)–(4) Good governance means performing effectively in clearly defined roles and functions. The structure of governance—board size, mix, and terms—are all decisions unique and specific to each organization.

Each organization should assess the optimum number of board members it needs with the requisite skills to thoroughly exercise governance oversight. It is the board's responsibility to decide how it should strike a balance between the broad-based skills and experiences necessary for the board, with the pragmatic consideration of managing the structure and process of a larger board. Although larger boards may bring diverse skills, they do not necessarily bring better governance.

The approach an organization takes regarding the term of board membership is also subject to board deliberation and decision. No term limits, with acceptable board performance, ensures continuity in knowledge and community relationships. Natural attrition and term limits bring renewal and new vigilance by virtue of new skills and experiences of new members. Boards that frequently turn over tend to create organizational instability as both knowledge and experience is lost to the organization. The board must determine its approach in the context of the organization.

Board member independence and unrelatedness to executive leadership allows the board to act without undue influence from management. Further, when selecting a qualified candidate for board membership, a mix of members who have no ties or relationships to the organization is one way of ensuring independence. This effort can be satisfied through at-large members who can balance the varied interests of board members. Independent and unrelated board members may sometimes lead the governance management or executive compensation committees to enhance accountability.
2.g.(1) The board must set the ethical tone in the organization and model integrity in its conduct. In the case of publicly traded or other for-profit organizations, the board may receive compensation and other forms of financial incentives. In not-for-profit organizations, there may be other financial links not directly apparent. Board policy should address these issues, supported by signed conflict of interest and ethical code of conduct declarations.

2.g.(2) Many governance decisions are complex and significant; therefore, the board should seek expert advice. Although expert advice can be provided through the organization’s internal experts, the board should seek external professional advice on complex legal and financial issues as necessary. Access to external expert advice can be coordinated and supported by the organization’s executive leadership.

2.g.(3)–(4) The board as a whole should continuously assess its performance in an effort to determine its effectiveness in governing the organization. This assessment ensures that the board is fulfilling its duties and evolving within the context of challenges the organization may face. Assessing board achievement and opportunity to improve will facilitate an evolving governance model to ensure that its activities remain relevant and effective on behalf of owners/stakeholders. This concept also applies to individual board members.

2.g.(7) Outside parties may include advisors, regulators, investors, press, consumers, and customers.

Examples

2.e. A selection criterion for the finance/audit committee chair could ideally be a board member with a finance background.

2.g.(2) Examples of situations in which the use of external advisors or resources would be appropriate could include:

- Seeking financial or legal advice on a merger or acquisition.
- Getting advice from an expert on corporate risk management.
- Getting advice from a financial expert on organization investment policies.

2.g.(3) Whole board assessment strategies can include:

- Completing meeting questionnaires (e.g., questions rated strongly agree, agree, neutral, disagree, or strongly disagree).
  - We (the board) spent our time on the most important governance topics.
  - We used our time effectively.
  - The meeting was chaired effectively.

- Discussing the board’s effectiveness at the conclusion of each board meeting, rolled into a year-end review documented in board minutes.

- Completing a year-end questionnaire tallied for board discussion. The following are sample questions, which can be rated by board members as Excellent, Good, Fair, Poor, or N/A:
  - Legal Frameworks:
    - Statements in the governing documents (e.g., bylaws, policies) setting forth the board’s function and duties are:
  - Board Structure:
    - The board’s size in relation to the organization’s needs is:
    - The board’s spread and balance in regard to expertise, age, diversity, interest, and points of view are:
  - Board Comprehension:
    - The board’s comprehension of the interests of various constituencies (funders, persons served, and advocates) with which the organization deals is:
  - Board Practices:
    - The board’s orientation to the organization is:
    - The frequency of board meetings in relation to organizational needs is:
    - The board’s practices with regard to amendments of bylaws are:
    - The board’s practices with regard to election of officers are:
    - The board’s practices with regard to establishing committees and their mandates are:
– Board Performance:
- The board’s performance in formulating the organization’s long-term goals is:
- The board’s ability to monitor its own accomplishments and progress is:
- Performance standards expected by the board for attending all regularly scheduled meetings are:
- Performance standards expected by the board for committee participation are:
- Performance standards expected by the board for referral of prospective board members are:

– Relations with Executive Leadership:
- The board’s working relationship with the chief executive officer is:
- The definitions of the roles of the chief executive officer and board are:

2.g.(4) Individual board self-assessment can include:

■ A yearly self-assessment questionnaire and resulting discussion with the board chair. The following are sample questions, which can be rated by board members as Excellent, Good, Fair, Poor, or N/A:
  – My understanding of the organization’s mission, vision, and core values is:
  – My understanding of the legal requirements and stipulations under which the board acts is:
  – When outside auditors present the financial statements, my understanding of those documents is:
  – My attendance at board meetings is:
  – My preparedness for board and committee meetings is:
  – My working relationship with other board members is:

1.B. 3. The board’s relationship with executive leadership includes:

a. Delegation of:
   (1) Authority to executive leadership.
   (2) Responsibility to executive leadership.

b. As appropriate, access to personnel.

c. Support of governance by the organization.

Intent Statements
See the Glossary for the definition of executive leadership.

3.a. Determining the relationship between the board and the organization’s executive leadership requires significant thoughtfulness and diligence to be clear about the functions of governance versus the duties delegated appropriately to the organization’s management. Although each organization determines appropriate roles, generally boards ensure that the organization has a vision for its future via goals, aims, missions, or ends and that management work is conducted legally, ethically, and with integrity to achieve those goals. The board’s accountability to its stakeholders is achieved by holding the organization’s management accountable for performance. The board delegates authority to management to conduct business via resource use (e.g., money, people, technology) and ensures that executive leadership develops plans and acts to achieve organizational goals. This delegation and review process is a continuous oversight mechanism, culminating in a review at least annually of the organization’s (and therefore, the executive leadership’s) success.

This delegation of authority differentiates between the authority of the executive leadership and the authority of the board.

3.b. From time to time, the board may need access to varied management and staff in carrying out its governing duties. So as not to cross into management authority, the board should be clear on when and how it may consult with other management/staff to enhance its governance duties. This relationship is established between the board and executive leadership so that managerial operations are maintained as a priority for
those assigned to that responsibility. The organization should ensure that the board has appropriate administrative support.

Examples
3.c. The organization may show support of the governing body by how it shares information with members of the governing body; how time and space are provided in support of governance-related work; the types of resources made available to the board for educational purposes such as orientation to the organization, memberships in professional associations in the field, or membership in an organization such as Boardsource (www.boardsource.org) which promotes effective governance practices.

1.B. 4. Board processes include:
   a. Agenda planning.
   b. Developing meeting materials.
   c. Distributing meeting materials.
   d. Overseeing the following committee work, as applicable:
      (1) Governance development.
      (2) Governance management.
      (3) Financial audit.
      (4) Executive compensation.
      (5) Other pertinent activities, as defined by the board.

1.B. 5. Governance policies address executive leadership development and evaluation, including:
   a. At least annually, a formal written review of executive leadership performance in relation to:
      (1) Overall corporate performance versus target.
      (2) Individual performance versus target, if applicable.
      (3) Professional development.
      (4) Professional accomplishments.
      (5) Professional opportunities.

b. An executive leadership succession plan that is reviewed at least annually.

Intent Statements
Evaluation of executive leadership is an essential part of performance management and should include opportunities for continued growth and development.

5.b. Succession planning for executive leadership ensures continuity of leadership due to the planned or unplanned departure of the chief executive. To manage associated risks of unplanned leadership vacancies, the board should have a plan for this. Details of such a plan vary by organization and often the current executive leadership is charged with providing this plan to the board annually.

Examples
5.b. The succession plan for review may include a letter from the executive leadership to the board identifying two internal candidates who can fill the position on a temporary or permanent basis. Often, this leads the board into a joint discussion with executive leadership on the skills, capacity, and depth of leadership potential in the organization.

A thorough competency-based succession program should assess competencies necessary for organizational leadership positions, match against a 360 review of potential internal candidates, and identify promotion or development opportunities.

1.B. 6. Governance policies address executive compensation, including:
   a. A written statement of total executive compensation philosophy.
   b. Review by an authorized board committee composed of independent, unrelated board members.
   c. Defined total compensation mix, up to and including, as warranted:
      (1) Base pay.
      (2) Incentive plans.
      (3) Benefit plans.
      (4) Perquisites.
d. **Total compensation references to:**
   1. Market comparator data.
   2. Functionally comparable positions.

e. **A documented process that outlines:**
   1. Terms of compensation arrangements.
   2. Approval date.
   3. Names of board members on the committee who approved the compensation decision.
   4. Data used in the compensation decision.
   5. Disclosures of conflict of interest, if any.
   6. Review of executive compensation records at least annually.
   7. Authority of board members to exercise executive compensation actions.

**Intent Statements**

The board’s role in determining executive compensation remains a high-profile task for the governing board whether organizations are for-profit or not-for-profit. A board-endorsed compensation philosophy is intended to provide a broad-based foundation for designing an effective compensation and performance management plan for executive leadership. It should be broad enough to provide an enduring foundation, yet be specific enough for the board to make compensation decisions at least annually on an informed and reasonable basis. A compensation plan must attract and retain leadership talent, yet respond to market trends, reflecting the value of the functional demands of executive work and rewarding performance results. Further, tests of reasonableness regarding executive pay also place board members at potential personal risk. That risk is minimized by ensuring that executive compensation decisions are independently approved by the governing board or committee acting on behalf of the board in a non-conflict-of-interest position. Further, appropriate practice would also involve using comparability data before approving a compensation arrangement, followed by documenting the process that supports that decision.

**Examples**

As a general guide, publicly traded for-profit companies have models of executive compensation programs/approaches or protocols that detail the principles and philosophies of various compensation models. These, with modification, could be used by not-for-profit organizations. Comparison to or benchmarking of total compensation plans can include many sources: salary surveys (regional/national), profit versus non-profit, functional responsibility of leadership regardless of tax status, and comparators or comparator mixes that can establish a policy line for executive leadership pay.

**Resources**

For U.S. nonprofits, Section 53.4958-6 of the Treasury Regulations also outlines a process that a board of a tax-exempt entity should follow to reduce exposure to penalties in relation to unreasonable compensation.

(canadian society of association executives)

**1.B. 7. The governing board reviews its governance policies at least annually.**

**Examples**

Examples of how to conduct this review may include a review of policies by a board committee with the review documented in meeting minutes, or a staff liaison to the board may help to facilitate this review with the board.

**Documentation Examples**

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Board organizational chart
- Ethical practices policy
- Board selection and composition policies
- Board leadership policies
Section 1.B. Governance (Optional)

- Board structure and performance policies
- Documentation of board self-assessment at least annually
- Individual board member self-assessment documentation
- Conflict-of-interest declarations signed at least annually
- Ethical code of conduct declarations signed at least annually
- Sample board meeting agendas/meeting minutes
- Sample meeting materials
- Executive leadership development and evaluation policies
- Executive compensation policies
- Executive leadership succession plan, reviewed at least annually
- Formal written review at least annually of executive leadership performance
- Evidence of review of governance policies at least annually
Set Strategy

Each organization has at its core a purpose developed through environmental assessment. Setting strategy is the activity of understanding the environment and organizational competencies, identifying opportunities and threats, and articulating a high-level map of the direction to take in order to achieve, sustain, and advance organizational purpose in a competitive environment. Strategy translates the salient environmental factors into tangible planning assumptions, sets goals and priorities, and globally aligns resources to achieve performance targets.

C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

1.C. The ongoing strategic planning of the organization considers:
   a. Expectations of persons served.
   b. Expectations of other stakeholders.
   c. The competitive environment.
   d. Financial opportunities.
   e. Financial threats.
   f. The organization’s capabilities.
   g. Service area needs.
   h. Demographics of the service area.
   i. The organization’s relationships with external stakeholders.
   j. The regulatory environment.
   k. The legislative environment.
   l. The use of technology to support:
      (1) Efficient operations.
      (2) Effective service delivery.
      (3) Performance improvement.
   m. Information from the analysis of performance.

Intent Statements

1.l.(1)–(3) Technology has an ever increasing role and presence in today’s human service environment. Although the use of technology and the sophistication of that technology will vary among organizations, each organization considers current literature and professional consensus in determining its current and future technology needs and identifies the resources needed to advance its use of technology to
support operations, effective service delivery, and performance improvement.

This standard relates to Standards 1.J.1. and 1.J.2. See the Glossary for the definition of strategic planning.

Examples

1.f. Capabilities can include succession planning for key positions in administration, finance, and service delivery.

1.g. Consideration of service area needs may include waiting list and information regarding persons served found ineligible for, or excluded from, services.

1.h. Consideration of your community demographics is important in planning as changes in demographics directly impact the population your programs serve. Consider as an example an organization that was started more than 30 years ago in a very rural area, which has become industrial or has experienced a settlement of a large immigrant population. Such a demographic change affects many areas including finances and expectations of the community members.

1.i. External stakeholders may include educational institutions.

1.k. An organization evaluates changes in public funding from legislation, such as the Patient Protection and Affordable Care Act and Medicaid waivers, and integrates the information into the planning process.

1.l.(1)–(2) Some organizations have found that providing community-based staff with laptop computers and/or tablets increases the amount of time they can spend in services as it relieves the travel-time associated with having to go to an administrative site to complete notes and reports.

Resources

1.l.(1)–(2) There are numerous web-based resources that may be used, including:

- www.techsoup.org
- www.nonprofit.about.com

1.C. The organization implements a strategic plan that:

a. Is developed with input from:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.

b. Reflects the organization’s financial position:
   (1) At the time the plan is written.
   (2) At projected point(s) in the future.
   (3) With respect to allocating resources necessary to support accomplishment of the plan in the following areas:
      (a) Financial.
      (b) Workforce.

c. Sets:
   (1) Goals.
   (2) Priorities.

d. Is reviewed at least annually for relevance.

e. Is updated as needed.

Intent Statements

The strategic plan sets forth an organizational roadmap for the future in consideration of relevant business, environmental, and other factors. Because sound business practice demands that the plan be used as a dynamic tool, it should be reviewed at least annually and modified as appropriate.

Examples

The strategic plan addresses the programs/services seeking accreditation. If the programs/services are part of a larger organization and not specifically addressed in its strategic plan, the programs/services may establish a separate plan or generate a supplement to the organization’s plan that addresses input, financial position, and goals and priorities pertinent to the programs/services.

2.a. Input used is directly related to Standard 1.D.1. in which input is gathered from all stakeholders using a variety of mechanisms. Input might include information from input forums,
surveys, and performance improvement activities.

2.b.(2) An organization is better able to define success with proactive long-term financial planning measures. As the future financial position of an organization is impacted by ever-changing marketplace factors such as billing, payment, reimbursement methodologies, and costs, the strategic plan might include information reflecting long-term financial planning to support the goals and priorities identified. Points in the future might be one year, two years or other points in time depending on regulatory and business factors impacting the organization.

2.d.–e. An organization determines the method of review and update. As environmental factors play an important role, if there are significant changes, this could prompt leadership to consider updating more often than annually to maintain the relevance of the plan to current conditions.

Examples

An annual report might include information on the strategic direction and achievement of an organization’s strategic objectives. It is not expected that an organization share information it considers confidential and critical to its positioning.

1.C. The strategic plan is shared, as relevant to the needs of the specific group, with:

a. Persons served.

b. Personnel.

c. Other stakeholders.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Strategic plan
- Strategic planning documents
- Leadership or management meeting minutes, where strategic planning was discussed
- Financial reports
- Input received from persons served, personnel, and other stakeholders
- Meeting agendas or minutes where strategic plan has been shared with personnel
Persons Served and Other Stakeholders—Obtain Input

In a service environment, organizational success cannot be achieved or sustained without success for the persons served. Actively engaging the persons served as part of the planning and service processes has been demonstrated to result in better outcomes. In fact, the more the organization obtains feedback from persons served and other stakeholders relative to all appropriate organizational functions, the better the outcomes reported. The important role of input from persons served and other stakeholders is recognized by its prominent position in the ASPIRE to Excellence framework. This input process engages all parties in a sense of shared future that promotes long-term organizational excellence and optimal outcomes.

D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization’s focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

1. The organization demonstrates that it obtains input:
   a. On an ongoing basis.
   b. From:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   c. Using a variety of mechanisms.

Intent Statements

Input is requested and collected to help determine the expectations and preferences of the organization’s stakeholders and to better understand how the organization is performing from the perspective of its stakeholders. The input obtained relates to the persons served and the organization’s service delivery and business practices. The organization identifies the relevant stakeholders, in addition to the persons served and personnel, from whom it solicits input.

Examples

There are a variety of mechanisms to solicit and collect information. They range from the informal to the formal. Some examples include written surveys, advisory groups, face-to-face
Section 1.D. Input from Persons Served and Other Stakeholders

Meetings, conferences, focus groups, telephone conversations, listservs/chat rooms, consumer boards/councils, presentations to stakeholders, suggestion boxes, complaints, and communication logs. Input can also be obtained by having board members or an advisory committee who are representative of the populations and cultures served.

It is important to not only use a variety of mechanisms, but also collect information throughout the year. Simply having an annual public forum would not meet the intent of this standard.

1.c. Mechanisms may include:
- Input forums.
- Surveys.
- Complaint, grievance, or incident summaries.
- Performance improvement activities.
- Strategic, financial, and human resource planning.
- Environmental scans.
- Program/service development.

Please see the Glossary for the definition of strategic planning.

1.D. 2. The leadership:
   a. Analyzes the input obtained.
   b. Uses the input in:
      (1) Program planning.
      (2) Performance improvement.
      (3) Strategic planning.
      (4) Organizational advocacy.
      (5) Financial planning.
      (6) Resource planning.
      (7) Workforce planning.

Intent Statements
The input is continually analyzed, and the analysis is integrated into the business practices of the organization. The input is analyzed to help determine if the organization is:
- Meeting the current needs of the persons served and other stakeholders.
- Offering services/products that are relevant to the persons served and other stakeholders.
- Identifying potential new opportunities for the growth and development of programs and services.

Examples
Input can be used in various ways: developing or revising individual service plans; changing service delivery designs; developing, improving, or eliminating services; short- and long-range planning; and prioritizing staff training needs.

The organization uses stakeholder input to direct its ongoing process for quality improvement. This process is a continuous cycle of quality improvement in which the organization seeks and uses the input it gets from its stakeholders.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Leadership and other meeting minutes, including persons served meetings.
- Written surveys and results.
- Strategic planning documents.
- Satisfaction surveys from persons served and other stakeholders, such as board members, funder and referral sources, parents and guardians, staff persons, and other community members.
- Information regarding community input and input from persons served.
Implement the Plan

The strategic plan, based on a thorough assessment of environmental factors, provides a roadmap to achieving organizational purpose. To actually achieve its purpose, the organization must translate strategic goals into tangible action. Implementation is the development and enactment of tactical steps designed to achieve strategic goals. Sound implementation requires a solid foundation of service delivery and business practices operationalized via organizational resources, including personnel, technology, and assets. Excellence is attained through the translation of strategy into practices that, when performed by a competent workforce and enhanced by the effective use of available resources, achieve the desired outcomes.

E. Legal Requirements

Description
CARF-accredited organizations comply with all legal and regulatory requirements.

1.E.1. The organization demonstrates a process to comply with the following obligations:
   a. Legal.
   b. Regulatory.
   c. Confidentiality.
   d. Reporting.
   e. Licensing.
   f. Contractual.
   g. Debt covenants.
   h. Corporate status.
   i. Rights of the persons served.
   j. Privacy of the persons served.
   k. Employment practices.
   l. Mandatory employee testing.

Intent Statements
The organization should engage in activities designed to promote awareness, understanding, and satisfaction of its various obligations at all times. Satisfaction of obligations is necessary for the organization’s success, sustained existence, and ability to positively affect the lives of persons served. Failure to satisfy obligations may result in monetary or other penalties, potentially impacting the viability of the organization, as well as harm to those the obligations are intended to protect. The organization should monitor its environments for new and revised obligations and utilize knowledgeable resources to become familiar with obligations and the requirements to meet them.

Examples
1.a.–e. With regard to fundraising practices, compliance with legal, regulatory, confidentiality,
reporting, and licensing requirements may include valuing donations according to guidelines, annual tax filings, documentation provided to donors, and obtaining the required licenses to conduct fundraising activities and events.

1.i. The organization ensures that the rights of the persons served are protected and advocates for their rights. Personnel demonstrate knowledge of and compliance with all applicable laws. Policies regarding the human rights and dignity of the persons served have been written and communicated to personnel through the organization’s code of ethics and to the persons served in a manner understandable to them. A good practice an organization may follow is to include this information in its employee handbook or present it through audio or video recordings, pictures, and other media.

1.l. Local health and licensing agencies can provide guidance in this area.

1.E. 2. The organization implements written procedures to guide personnel in responding to:
   a. Subpoenas.
   b. Search warrants.
   c. Investigations.
   d. Other legal action.

Examples
With these responsibilities, the organization is committed to protecting its personnel when actions of the organization are being put under scrutiny. Personnel will be given assistance during any investigative process.

1.E. 3. Policies and written procedures are implemented that address:
   a. Confidential administrative records.
   b. The records of the persons served.
   c. Security of all records.
   d. Confidentiality of records.
   e. Compliance with applicable laws concerning records.
   f. Timeframes for documentation in the records of the persons served.

Intent Statements
In order to protect the privacy of all stakeholders and any confidential information that its records may contain, an organization ensures that it addresses the applicable legal and regulatory requirements concerning privacy of health information and confidential records. Security includes such things as storage, protection, retention, and destruction of records. Safeguards such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

This standard applies to current and historical records and to hard copy records as well as electronic records.

Organizations are encouraged to review current provisions of legislation on freedom of information and protection of privacy (such as HIPAA and HITECH in the U.S. and PIPEDA in Canada) for potential impact on the maintenance and transmission of protected health information. Of particular note are provisions related to information security, privacy, and electronic data interchange.

Examples
Security and confidentiality can be addressed through mechanisms such as having designated personnel who are responsible for records maintenance and control; limiting access to confidential records to authorized personnel only; protecting records from permanent loss or damage; ensuring that electronic records have regular backup; and clearly defining and implementing timeframes and procedures for retention and destruction of records.

3.a. Confidential administrative records could include personnel records, contracts, budgets, billing information, legal information, records of donations and/or donors, and other protected or sensitive information and records.

3.f. An organization would establish its own timeframes for entries into records, which could include timeframes for entering critical incidents or interactions into the records of the persons served and timeframes for entering confidential data into administrative records. It would also be the responsibility of an organization to determine what the content of its records will include or exclude.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Reports from regulatory agencies
- Reports associated with legal actions
- Reports associated with contractual relationships
- Policies and written procedures regarding administrative records and records of the persons served
- Personnel policies
- Written procedures for responding to various legal actions
- For organizations in the United States, I-9 information, if applicable

F. Financial Planning and Management

Description
CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

1.F. 1. The organization's financial planning and management activities are designed to meet:
   a. Established outcomes for the persons served.
   b. Organizational performance objectives.

Examples
1.a. This may tie to Section 1.M. Performance Measurement and Management. See Standard 1.M.6. related to service performance indicators such as efficiency, effectiveness, access, and satisfaction.

1.b. The organization's performance objectives may include, but are not limited to areas of potential financial risk such as reductions in funding or new regulations that might impact services or expand the population to be served. This may tie to Standard 1.M.3. related to setting and measuring performance indicators for business function improvement.

1.F. 2. Budgets are prepared:
   a. Prior to the start of the fiscal year.
   b. That:
      (1) Include:
         (a) Reasonable projections of:
            (i) Revenues.
            (ii) Expenses.
            (iii) Capital expenditures.
2.b.(3)(b) Approval of the budget could be conducted by an owner, executive leadership, governing board, or other authority. If an organization is dependent on funding from an external entity’s budget that has not been finalized prior to the beginning of the fiscal year, an organization may adopt a provisional budget until the final budget is approved for the year.

3. Actual financial results are:
   a. Compared to budget.
   b. Reported, as appropriate, to:
      (1) Personnel.
      (2) Persons served.
      (3) Other stakeholders.
   c. Reviewed at least monthly.

Examples
3.b.(2) Persons served may be interested in the financial status, stability, or viability of an organization for a variety of reasons; e.g., they are personally responsible for the payment of fees; they anticipate being engaged with the organization for an extended period of time; they are seeking new or enhanced equipment, technology, facilities, or programs/services and want to know whether the organization’s budget will support these; they are considering donating to or investing in the organization; etc.

Nonprofit organizations are subject to reporting requirements, including financial reporting, with information publicly available. In some settings, a contract for services between an organization and a person served may include requirements for reporting specified information. An organization may publish annual reports, performance reports, newsletters, news releases, or post information on a website that reflects its overall status and plans, including the finances needed to support them.

3.c. The review of actual financial results may be conducted by program management, finance staff, or the governing board.

4. The organization identifies and reviews, at a minimum:
   a. Revenues.
   b. Expenses.
   c. Internal:
      (1) Financial trends.
      (2) Financial challenges.
      (3) Financial opportunities.
      (4) Management information.
d. External:
   (1) Financial trends.
   (2) Financial challenges.
   (3) Financial opportunities.
   (4) Industry trends.

e. Financial solvency, with the development of remediation plans if appropriate.

Examples
4.c.–d. An organization could demonstrate that consideration of these items occurred through meeting minutes or during interviews with a surveyor in which the process of how these were considered is described.

4.c.(4) Management information may include items such as:
   ■ Time spent on billable versus non-billable activities.
   ■ Occupancy rate of residential beds.
   ■ Number of available foster homes.
   ■ Caseload size.
   ■ Percentage of private pay versus Medicare/Medicaid or pay from other public funds.

4.d. External events that have a financial impact on the organization include items such as:
   ■ Changes in reimbursement rates.
   ■ Competition in the marketplace.
   ■ Changes in consumer preferences.
   ■ Interest rates and the availability of financing.
   ■ Regulatory and legislative changes.

4.d.(4) Industry trends may include items such as:
   ■ Information that may be at a national, state or provincial, regional, or local level. This could be a comparison to providers of similar services throughout the region at the time or it could also mean comparison to similar business activities that are operated.
   ■ Practices in service delivery or business management that are becoming more widespread and could impact the program.

An organization can demonstrate that consideration of these items occurs through meeting minutes or during interviews with a surveyor in which the process of how these were considered are described.

4.e. Financial solvency could be described as the ability of an organization to meet its financial obligations, to meet long-term expenses, and to accomplish long-term expansion and growth.

1.F. 5. If the organization has related entities, it identifies:
   a. The types of relationships.
   b. Financial reliance on related entities.
   c. Responsibilities between related entities and the organization, including:
      (1) Legal.
      (2) Contractual.
      (3) Other.
   d. Any material transactions.

Intent Statements
Full disclosure of relationships demonstrates an organization’s commitment to excellence and transparency. The organization discloses information to persons served and other stakeholders that explains its assets and liabilities, reflects the position and responsibilities of any parent or sponsoring organizations, and discloses any material and legal relationships with other entities.

Examples
Organizations often form strategic relationships with other entities to share financial and nonfinancial resources or to guarantee debt. At times, organizations benefit from a third-party revenue source. The relationship of this revenue source and the risks or value of this relationship should be disclosed.

Examples of relationships include:
   ■ Parent-subsidiary structures.
   ■ Affiliations.
   ■ Alliances.
   ■ Guarantees.
   ■ Limited partnerships.
   ■ Other third-party operating support.
   ■ Material contracts such as food services, pharmacy, and therapy.
   ■ Financial support from related foundations.
Disclosure of these relationships can be accomplished through:

- Audited financial statements.
- Annual reports distributed to residents and persons served.
- Marketing materials.
- Tax report filings.

5.d. Material, when used in accounting, is defined as the magnitude of an omission or misstatement of accounting information that makes it probable that the judgment of a reasonable person relying on that information would have been changed or influenced by the omission or misstatement. When used in finance, it refers to the magnitude of the financial impact on an organization. If the magnitude of the items relative to the whole organization is significant, then it is material. For example, a company with $2,000 of total assets has $1,000 worth of investments, the investment is material. A $1,000 impact on a $500 million total asset corporation is immaterial.

1.F. 6. The organization:

a. Implements fiscal policies and written procedures, including internal control practices.

b. Provides training related to fiscal policies and written procedures to appropriate personnel including:
   (1) Initial training.
   (2) Ongoing training.

Intent Statements
To reduce risk, it is important that the organization, regardless of size, establish who has responsibility and authority in all financial activities, such as in purchasing materials and capital equipment, writing checks, making investments, fundraising, and billing.

Examples
6.a. Policies and written procedures may address methods for receiving cash, checks, donations, or other financial instruments; disbursing funds, including petty cash, other cash, checks, or other financial instruments; managing the use, receipt, or disbursement of funds through purchase orders, invoices, organizational credit cards and debit cards, and/or lines of credit with outside vendors; managing donations; and investing funds.

The organization may want to seek guidance from a source with the expertise to confirm that it is in accord with legal requirements and following generally accepted accounting principles.

1.F. 7. If the organization bills for services provided, it conducts a documented review of a representative sample of bills of the persons served:

a. At least quarterly.

b. That addresses:
   (1) Whether bills are accurate.
   (2) Trends.
   (3) Areas needing improvement.
   (4) Actions to be taken.

Intent Statements
A review of bills of the persons served to determine that they are accurate is a proactive method for an organization to help reduce or eliminate costly audit exceptions. This review and corresponding action will assist in that process. Refer to the Glossary for the definition of representative sample.

Examples
This review focuses specifically on the appropriateness of billing and coding practices and can be conducted as part of the quality review that is required at least quarterly for programs or as a separate process. In a program where individual records of the persons served are not maintained, this standard is not applicable.

The review is conducted by persons trained to compare the dates and service codes on the organization’s billing system to the dates, units, and types of services provided to the persons served. This type of review is often conducted by trained support staff.

This type of review may be required by some funding or regulatory sources, but it is also a good practice to incorporate into a fiscal management program to ensure that services are being billed appropriately.
Although only a quarterly review is required, as part of risk management an organization may choose to conduct this review more frequently, such as when billing or coding procedures are revised, new personnel are hired or new information systems are implemented, or to determine accuracy of billing following corrective training.

7.b.(3)–(4) Actions to be taken address the areas identified as needing improvement. For example, errors in billing may be addressed with education for billing personnel on why bills were rejected or declined, training on proper coding, issuing corrected bills, or return of overpayments to persons served or payers. Service delivery personnel may be trained on requirements for documentation in the records of persons served that justifies the billing.

8. The organization, if responsible for fee structures:
   a. Identifies the basis of the fee structures.
   b. Demonstrates:
      (1) Review of fee schedules.
      (2) Comparison of fee schedules.
      (3) Modifications when necessary.
   c. Discloses to the persons served all fees for which they will be responsible.

Intent Statements
An accountable organization assists the persons served in understanding the fee structure and whether there might be any additional charges to the individual.

Examples
On a regular basis, the organization can evaluate its current fee structure to ensure that the fees are adjusted as necessary to reflect changes in services, the cost of delivering services, third-party/funder rate adjustments, and the local market.

8.b. The organization may demonstrate this in different ways. It might include dates on documents, mention this activity in meeting minutes, various staff could discuss how this process occurred, etc.

8.b.(2) Comparison of fee schedules could be with what it has charged before and what new analysis might show is needed; it could be comparing to fee schedules from the funding source. It does not require that it be external to the organization.

9. If the organization takes responsibility for the funds of persons served, it implements written procedures that address:
   a. Identification of the role of the organization.
   b. How the persons served will give informed consent for the expenditure of funds.
   c. How the persons served will access the records of their funds.
   d. How funds will be segregated for accounting purposes.
   e. Safeguards in place to ensure that funds are used for the designated and appropriate purposes.
   f. When interest-bearing accounts are used, how interest will be credited to the accounts of the persons served.
   g. How account reconciliation is provided to the persons served at least monthly.
   h. How funds will be returned to the persons served upon transition/exit from the program.

Intent Statements
If the organization serves as a representative payee for the persons served, is involved in managing the funds of the persons served, receives benefits on behalf of the persons served, or temporarily safeguards funds for the persons served, it demonstrates that it has a system in place to protect the fiscal interests of the persons served.

Examples
The organization may function in an official capacity such as a representative payee or other formally appointed representative with financial responsibility for the person served, or it may safeguard funds as a courtesy to the persons served; e.g., holding money in a bank account.
or keeping money or credit cards in a secure place for use by or on behalf of the persons served.

1.F. 10. The organization provides documented evidence of:
   a. An annual review or audit of the financial statements of the organization conducted by an independent accountant authorized by the appropriate authority.
   b. Any recommendations that resulted from the review or audit of its financial statements, if applicable.
   c. Management’s response to the recommendations, including corrective actions taken or reasons why corrective actions will not be taken, if applicable.

Intent Statements
An accountant authorized by the appropriate authority means a CPA in the United States; in countries outside the United States, the terminology for a similar accountant qualified to conduct a review or audit would be used. The CPA, chartered accountant, or similar accountant retained must be independent of the organization; i.e., may not be contracted with the organization for its regular accounting needs, represent the organization’s funding sources, or be a member of the governance authority.

It is important for the organization to determine that its financial position is accurately represented in its financial statements. Accountants may typically undertake three types of engagements: audit, review, and compilation. Each is described in more detail below, but in summary, the audit is the most extensive effort and accordingly the highest cost to the organization.

An audit requires an examination of the financial statements in accordance with generally accepted auditing standards, including tests of the accounting records and other auditing procedures as necessary. An audit will result in a report expressing an opinion as to conformance of the financial statements to generally accepted accounting principles.

A review consists principally of inquiries of company personnel and analytical procedures applied to financial data. It is substantially less in scope than an examination using generally accepted auditing standards. Typically, a review will result in a report expressing limited assurance that there are not material modifications that should be made to the statements.

As part of a compilation engagement, an accountant will compile the financial statements based on management representations without expressing any assurance on the statements. A compilation will not meet this standard.

Examples
The scope of this independent examination may vary based on the accounting requirements to which the organization is subject. It may be a full audit or a review. For a governmental entity, this standard may be met by review within its own system of oversight.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Annual approved budgets
- Reviews of financial plans
- Financial audits or reviews
- Written procedures for handling the funds of the persons served, if applicable
- Documented reviews of records of persons served
- Fiscal policies
- Financial remediation plans, if appropriate
- Fee schedules, if applicable
- A management letter, if applicable
- Cost analysis of services provided
- Financial reports
- Cash management policies
- Documented review of accuracy of billing and coding of services with the services provided, if applicable
G. Risk Management

Description
CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

1.G. The organization implements a risk management plan that:
   a. Includes:
      (1) Identification of loss exposures.
      (2) Analysis of loss exposures.
      (3) Identification of how to rectify identified exposures.
      (4) Implementation of actions to reduce risk.
      (5) Monitoring of actions to reduce risk.
      (6) Reporting results of actions taken to reduce risks.
      (7) Inclusion of risk reduction in performance improvement activities.
   b. Is:
      (1) Reviewed at least annually for relevance.
      (2) Updated as needed.

Intent Statements
The risk management plan is designed to manage risk and reduce the severity of a loss if one were to occur.

Examples
There will be a range of risks in all organizations, regardless of whether they are a for-profit or a nonprofit organization. Risk management focuses on an in-depth assessment of these risks and what must or can be done as preventive measures, coping measures should the risk occur, measures to protect the organization and prevent loss, and corrective measures to prevent the risk of further occurrence.

1.a.(1) Identifying exposure highlights risks that may cause a loss and resources of value that may be affected. Some may result in minor annoyances or a waste of resources, while others could expose the organization to litigation, government sanction, property loss, or business interruption. Potential risks may include changes in funding, new or growing populations, problems with the organization’s facilities or grounds, newly identified security issues, or internal procedures.

1.a.(2) Analyzing exposure (risk analysis) determines the potential frequency and severity of any identified risk, as well as the overall financial burden of aggregate losses.

1.a.(3) Once an exposure is analyzed, there are several methods available to deal with the potential loss:
- Risk control through avoiding the exposure altogether (if possible), reducing the probability of loss, reducing the severity of the consequences if a loss were to occur, and/or transferring the loss to another organization through a contractual transfer.
- Risk financing is done by either assuming the financial responsibility for the loss (through self-insurance) or by transferring it to an outside organization (through insurance).

1.a.(5) Monitoring measures and comparing actual versus planned performance of the selected techniques enables the organization to evaluate the plan and determine whether different options may be necessary.

1.G. As part of risk management, the insurance package of the organization:
   a. Is reviewed:
      (1) For adequacy.
      (2) At least annually.
   b. Protects assets.
   c. Includes:
      (1) Property coverage.
      (2) Liability coverage.
      (3) Other coverage, as appropriate.

Intent Statements
When effectively managed, insurance, whether third-party or self-insurance, can cover many tangible risks an organization faces. The organization’s insurance package includes appropriate
coverage for any services it may provide in more than one state/province or other jurisdiction.

Examples
Insurance is an important component of an organization's risk management strategy. Insurance policies provide adequate amounts and types of coverage for all aspects of the organization's operations and protect and defend persons, such as personnel and board members, volunteers, and persons served, against reasonable claims due to adverse events for which the organization is liable. Types of coverage could include vehicles, workers' compensation, directors' and officers' liability, errors and omissions, cybersecurity, property, and casualty.

The organization conducts a regular review of its insurance coverage with the assistance of someone who is knowledgeable about insurance needs and types of coverage. This person may be an experienced insurance broker who is aware of the needs, risks, and assets of the organization.

1.G. 3. The organization implements written procedures regarding communications that address:
   a. Media relations.
   b. Social media.

Examples
Media relations procedures might include who may or may not talk to the media, whom to notify of requests for interviews, whom to contact after hours, use of press releases, or media relations philosophy.

Social media procedures might address the organization's definition of social media; e.g., Facebook, Twitter, blogs, message boards; acceptable uses of social media; who has access and authority to post or modify information; privacy settings; parameters for communicating with persons served and prospective persons served; protection of health information; and how violations of the procedures will be managed.

1.G. 4. If any of the services delivered by the program seeking accreditation are provided under contract with another organization or individual, reviews of the contract services:
   a. Assess performance in relation to the scope and requirements of their contracts.
   b. Ensure that they follow all applicable policies and procedures of the organization.
   c. Ensure that they conform to CARF standards applicable to the services they provide.
   d. Are performed at least annually.

Intent Statements
This standard relates to Standard 2.A.1. in Section 2 on scope of services and applies to contracted personnel, the contracting of any part of an accredited program, and all other contracted services related to service delivery to the persons served by the program(s) seeking accreditation. Refer to the Glossary for the definition of contract.

Examples
Reviews of contract services may be conducted by leadership, a contract manager/management office, risk management, human resources, etc.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Risk management plan
- Reports from regulatory agencies
- Reports associated with legal actions
- Performance improvement plans
- Personnel policies manual
- Insurance policies
- Financial reports
H. Health and Safety

Description
CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Applicable Standards
When determining applicability, please refer to the Glossary for the definitions and clarification of all italicized terms.

Standards in this subsection apply to all locations of an organization that meet the following descriptions, unless an identified exception applies:

- Locations owned/leased by the organization that are:
  - Used for delivery of the programs or services seeking accreditation.
  - Administrative locations where personnel related to the programs or services seeking accreditation are located.

- Donated locations/space that are controlled/operated by the organization and are:
  - Used for the delivery of the programs or services seeking accreditation.
  - Administrative locations where personnel related to the programs or services seeking accreditation are located.

Identified exceptions:
Standards 1.H.7., 1.H.13., and 1.H.14. are NOT applied to locations that meet any of the following criteria:

- Private homes of persons served.
- Community settings that are not owned/leased or controlled/operated by the organization.
- Used solely by an employee-owner for administration and no other persons or personnel are located, meet, or are served at the location.
Section 1.H. Health and Safety

- Used by the organization for service delivery one hour or less in any week.
- Used by the organization for administration by less than the equivalent of one full-time employee in any week.

Please contact your CARF resource specialist if you have questions or need further clarification.

1.H. 1. The organization maintains a healthy and safe environment.

Examples
The physical environment of the organization shows evidence of ongoing attention to safe practices, reduction of health and safety risks, and an overall concern for the health and safety of the persons served and personnel. Health and safety requirements are sometimes determined by local or other governmental authorities. Documentation of daily maintenance tasks is not required.

1.H. 2. The organization implements written procedures to promote the safety of:
   a. Persons served.
   b. Personnel.

Intent Statements
Regardless of setting, the organization must demonstrate satisfactory efforts to provide services as safely as possible and promote a safe work environment.

Examples
Written procedures could include the identification of personnel responsible for implementation of health and safety procedures.

1.H. 3. Persons served receive education designed to reduce identified physical risks.

Examples
When safety concerns are identified for persons served, information and training relative to that risk is offered as a means to reduce risk and promote safety.

1.H. 4. Personnel receive documented competency-based training:
   a. At orientation in the following areas:
      (1) Health and safety practices.
      (2) Identification of unsafe environmental factors.
      (3) Emergency procedures.
      (4) Evacuation procedures, if appropriate.
      (5) Identification of critical incidents.
      (6) Reporting of critical incidents.
      (7) Medication management, if appropriate.
      (8) Reducing physical risks.
      (9) Workplace violence.
   b. At least annually the following areas:
      (1) Health and safety practices.
      (2) Identification of unsafe environmental factors.
      (3) Emergency procedures.
      (4) Evacuation procedures, if appropriate.
      (5) Identification of critical incidents.
      (6) Reporting of critical incidents.
      (7) Medication management, if appropriate.
      (8) Reducing physical risks.
      (9) Workplace violence.

Intent Statements
See the Glossary for the definition of competency-based training.

Examples
4.b. In addition to training on health and safety in an office setting, training is provided on an ongoing basis regarding the potential risks involved in working in community settings or a person’s home. Training includes, but is not limited to, identification of potential risks, ways to prevent risks, and emergency procedures. Comprehensive procedures help to ensure that personnel can demonstrate their competency in the health and safety arena. Consideration for planning and training activities is a primary objective.
Some organizations have found it helpful to begin by assigning responsibility for developing a training plan. The plan could include the training and information needs of personnel, contractors, visitors, managers, and those with an emergency response role identified in the plan. The plan may include identification of:

- Who will be trained.
- Who will do the training.
- What training activities will be used.
- When and where each session will take place.
- What the objectives of each session will be.
- How the session will be evaluated and documented.

Reviews conducted after each training activity would benefit from involving the training participants in the evaluation process.

Some activities organizations may consider using are:

- Orientation and Education Sessions—These are regularly scheduled to allow discussion, provide information, answer questions, and identify needs and concerns.
- Tabletop Exercise—Members of the emergency management group meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios. This is a cost-effective and efficient way to identify areas of overlap and confusion before conducting more demanding training activities.
- Walk-Through Drill—The emergency management group and response teams actually perform their emergency response functions. This activity generally involves more people and is more thorough than a tabletop exercise.
- Functional Drills—These drills test specific functions such as medical response, emergency notifications, and warning and communication procedures and equipment, though not necessarily at the same time. Personnel are asked to evaluate the systems and identify problem areas.
- Evacuation Drills—Personnel walk the evacuation route to a designated area where the procedures for accounting for all personnel are tested. As they evacuate, participants are asked to make notes of things they notice that might become possible hazards during a real emergency evacuation, such as stairways cluttered with debris or inadequate lighting the hallways.
- Full-Scale Exercise—A real-life emergency situation is simulated as closely as possible. This exercise involves the organization's emergency response personnel, employees, the management, and community response organizations.

Employee Training—General training for all employees addresses:

- Individual roles and responsibilities.
- Information about threats, hazards, and protective actions.
- Notification, warning, and communication procedures.
- Means for locating family members in an emergency.
- Emergency response procedures.
- Evacuation, shelter, and accountability procedures.
- Emergency shutdown procedures.

The scenarios developed during the vulnerability analysis can serve as the basis for training events.

4.a.(9) and 4.b.(9) Training might include what types of behaviors, actions, or communication constitute workplace violence; e.g., bullying; intimidation; sexual harassment; disruptive behavior; assaultive behavior; or unauthorized possession and/or use of a weapon such as a gun, knife, Taser, or bomb. Training may also include actions to take under such circumstances; e.g., communication with the offending party, the mechanism to seek assistance within the organization, and reporting requirements.

1.H. There are written emergency procedures:

   a. For:
      (1) Fires.
      (2) Bomb threats.
      (3) Natural disasters.
(4) Utility failures.
(5) Medical emergencies.
(6) Violent or other threatening situations.

b. That satisfy:
   (1) The requirements of applicable authorities.
   (2) Practices appropriate for the locale.

c. That address, as follows:
   (1) When evacuation is appropriate.
   (2) Complete evacuation from the physical facility.
   (3) When sheltering in place is appropriate.
   (4) The safety of all persons involved.
   (5) Accounting for all persons involved.
   (6) Temporary shelter, when applicable.
   (7) Identification of essential services.
   (8) Continuation of essential services.
   (9) Emergency phone numbers.
   (10) Notification of the appropriate emergency authorities.

Intent Statements

Established emergency procedures that detail appropriate actions to be taken promote safety in all types of emergencies.

Being prepared and knowing what to do help the persons served and personnel to respond in all emergency situations, especially those requiring evacuation. The evacuation procedure guides personnel to assess the situation, to take appropriate planned actions, and to lay the foundation for continuation of essential services.

Examples

The procedures should include actions to be taken by personnel in the event of an emergency, consider any unique needs of the persons served, and be appropriate and specific to the service delivery site or location.

Depending on the type of emergency, the procedure could include immediate response, evacuation, use of appropriate suppression techniques, notification of the proper authorities, sheltering in place, and reporting requirements.

In developing emergency procedures the organization identifies critical products, services, and operations that may be impacted in an emergency and backup systems, internal capabilities, and external resources that may be needed or accessed.

5.a.(1) Procedures for fire safety can include how staff will be trained on the use of fire suppression equipment, etc.

5.a.(3) The organization evaluates safety concerns related to possible natural disasters and their potential effects on the organization's staff members, the persons served, and property and develops procedures detailing action to be taken in the event of occurrence of a natural disaster. Possible natural disasters are those typical of a particular geographic location. They may include tornadoes, severe rainstorms, hurricanes, floods, earthquakes, blizzards, ice storms, and snowstorms.

5.a.(4) Procedures for utility failures may include use of an emergency generator system; emergency lighting systems; battery-operated flashlights, lanterns, or lamps; cell phones; and a contract with a vendor to supply bottled water.

5.a.(5) Medical emergencies might include someone unable to get up from a fall; a severe cut or allergic reaction; loss of consciousness due to a change in blood pressure, stroke, cardiac event, or medication misuse; or suicidal ideation.

5.a.(6) Violent or other threatening situations may include explosions, gas leaks, biochemical threats, acts of terrorism, use of weapons, and aggressive or assaultive behaviors of persons served, personnel, or visitors.

5.c. Evacuation may be addressed in a separate procedure or incorporated into relevant emergency procedures such as those for fire and bomb threats. The procedures address the entire spectrum of an evacuation, including an evacuation when evacuees cannot return to the facility. The procedures for evacuation identify the
responsibilities of personnel who may assist in the process of evacuation.

Procedures include a predetermined site for the gathering of all individuals upon evacuation. The evacuation plan considers not only the possible physical barriers of the facility, but also the individualized needs of those to be evacuated, such as persons with mobility impairments who will need assistance, or persons with cognitive, hearing or visual impairments. The temporary shelter considers the unique health, safety, and accessibility needs of persons served, to the extent possible. Procedures identify protocol to follow in the event that an incident may require movement to a temporary shelter.

Procedures include the process for notifying personnel if individuals are not present. Procedures may include protocols that provide direction to personnel if services will be curtailed.

5.c.(6) Temporary shelter is typically needed if the organization provides a residential/housing, inpatient, day treatment, or crisis stabilization program in which the persons served remain at the site for extended hours; overnight; or for several days, weeks, or months.

5.c.(7)–(8) Essential services may include the provision of medications, residential or other housing support services, or assistance with daily living requirements.

Resources

Local Red Cross associations, state/provincial or other jurisdictional regulations, regional disaster preparedness groups, and many websites offer current and useful information in the development of emergency plans.

The Federal Emergency Management Agency (FEMA) is a national resource for education, training, and emergency information in the United States. FEMA has established an emergency planning guide for business and industry that provides advice for creating and maintaining an overall emergency management plan specific to each organization’s corporate culture.

Other free emergency procedures that may be incorporated into your plans are also available online. Resources include:

- [www.ada.gov/emergencyprepguide.htm](http://www.ada.gov/emergencyprepguide.htm)

Other websites that offer resources for developing emergency procedures include:

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers:
  - [https://asprtracie.hhs.gov/cmsrule](https://asprtracie.hhs.gov/cmsrule)

- [Homeland Security Active Shooter Preparedness:](https://search.dhs.gov/search?query=active+shooter&affiliate=dhs)
- [www.ready.gov](http://www.ready.gov)
- [Emergency Preparedness for People with Disabilities and Other Vulnerable Populations:](http://inclusionresearch.org/inclusivepreparedness)
Occupational Safety and Health Administration at the United States Department of Labor: www.osha.gov/SLTC/emergency-preparedness/index.html


Harris Family Center for Disability and Health Policy Emergency Preparedness: www.cdihp.org/products.html

Disaster Resources for People with Disabilities and Emergency Managers: www.jik.com/disaster.html

Disaster Preparedness for People with Disabilities: www.disability911.com


Tips for Retaining and Caring for Staff after a Disaster: https://asprtracie.hhs.gov/documents/tips-for-retaining-and-caring-for-staff-after-disaster.pdf


Public Safety Canada: www.public-safety.gc.ca. Provincial or territorial emergency measures organizations can also be used as resources.

Canadian Centre for Occupational Health and Safety: https://ccohs.ca/oshanswers/hspgrams/planning.html

1.H. 6. The organization has evacuation routes that are:
   a. Accessible.
   b. Understandable to:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders, including visitors.

Examples

6.a. Evacuation routes refer to the clearly visible and known routes of egress. Signage such as a posted map or diagram is not required. If an organization chooses to use signage, this may be simple Exit signs over doors, Braille representation, diagrams, or directional signs showing corridors and line of travel to exit doors, and accessibility of the signage would consider location, height, and other needs relative to the persons served and other stakeholders. Additionally, the exit ways should be clear of obstructions such as equipment, furniture or locked doors. Evacuation routes should not result in individuals getting to an unsafe location such as ungraded land, a rooftop with no opportunity for egress, or where emergency personnel cannot reach the individuals.

1.H. 7. An unannounced test of each emergency procedure:
   a. Is conducted at least annually:
      (1) On each shift.
      (2) At each location.
   b. Includes, as relevant to the emergency procedure, a complete actual or simulated physical evacuation drill.
   c. Is analyzed for performance that addresses:
      (1) Areas needing improvement.
      (2) Actions to be taken.
      (3) Results of performance improvement plans.
      (4) Necessary education and training of personnel.
   d. Is evidenced in writing, including the analysis.
NOTE: This standard does not apply to services in this standards manual that are provided in private homes or apartments.

Intent Statements

It is expected that each emergency procedure addressed in Standard 1.H.5. (fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations) is tested, analyzed for performance, and documented, including the analysis. Practicing emergency procedures helps the persons served and personnel to better respond in actual emergency situations. Simulated evacuations should be limited to situations where actual evacuations are not possible. Emergency procedure testing is part of an organization’s performance improvement activities. Analysis of results of the tests may indicate ways to improve performance.

Examples

Each emergency procedure (e.g., the procedure for fires, bomb threats, natural disasters, utility failures, medical emergencies, and other threatening situations) is tested annually at all locations that pertain to the service seeking accreditation whether they are service sites or administration only. A test or drill does not necessarily require actual evacuation, although evacuation is preferred, when possible. The test or drill should be realistic and occur at random on different shifts, if applicable to the organization.

All persons served within the agency or organization require some form of training. Procedures for training could include:

- Assessments that determine the individual needs in the event of an emergency situation of persons served.
- Needed training activities for persons served.
- Assistance from local resources emergency planning resources.
- Random and shift drills, as determined by the needs of persons served.
- Simulation of a full-scale emergency evacuation at least annually or as determined by the needs of persons served.
- Documentation and reporting regarding exercises and analysis of training drills for modification, if needed.

Evaluation of emergency procedures could include:

- Involving a health and safety committee or planning team to evaluate and update the organization’s emergency management procedure.
- Identifying need areas and vulnerability and addressing these issues.
- Emergency procedure lessons learned from drills and actual events.
- Ensuring that responsibilities and roles are understood by all persons on the emergency management team.
- Emergency procedures reflecting physical plant or practice changes.
- Up-to-date records.
- Ensuring that outcomes of training objectives are met.
- Ensuring that community resources are consulted and provided with updates at least annually.
- Updating letters of agreement at least annually.

Evaluation and modification of procedures could occur during the following times:

- Training.
- After training drills.
- As risks increase.
- After actual emergencies.
- When responsibility is reassigned.
- When changes are made to the physical plant.
- When changes occur in the physical plant proximity.
- When a policy or procedure is revised.
- When briefing personnel on emergency plan changes.

Persons served, as appropriate, are educated and trained about emergency and evacuation procedures.

1.H. 8. There is ready access to:
   a. First aid expertise.
   b. First aid equipment.
   c. First aid supplies.
d. Relevant emergency information on the:
   (1) Persons served.
   (2) Personnel.

Intent Statements

It is important to provide a safe setting for the persons served and personnel. The adequacy of first aid expertise reflects the needs of the population served as well as the service setting. Necessary emergency resources, including people trained to respond and the location of first aid equipment and supplies, are known and quickly available during program hours. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

8.d. The organization has a mechanism in place to ensure that emergency information is kept current on persons served and personnel.

Examples

The organization defines how it will have ready access to first aid. This may be accomplished by training key personnel in first aid. If in a school or medical or correctional setting, personnel within the program/service site could be used.

8.d. This standard gives the organization flexibility in determining the most accessible location for emergency information. The location could depend on the size of the program or the organization, staffing patterns, and the type of program or setting. The organization may collect such information in the personnel or administrative files, records of persons served, a notebook, or a special file. In an inpatient or residential setting, it would be appropriate for the information to be in a format that could be removed from the site when an evacuation is necessary.

This is information that might be needed if personnel or a person served has an emergency and may include information on medical conditions, emergency contact persons, a primary care doctor, allergies, or the use of medications or assistive devices. If the persons served are transported for group activities or services, a summary of this information is available to the personnel overseeing the outing.

1.H. 9. The organization implements written procedures regarding critical incidents that include:
   a. Prevention.
   b. Reporting.
   c. Documentation.
   d. Remedial action.
   e. Timely debriefings conducted following critical incidents.
   f. The following critical incidents:
      (1) Medication errors.
      (2) Use of seclusion.
      (3) Use of restraint.
      (4) Incidents involving injury.
      (5) Communicable disease.
      (6) Infection control.
      (7) Aggression or violence.
      (8) Use and unauthorized possession of weapons.
      (9) Wandering.
      (10) Elopement.
      (11) Vehicular accidents.
      (12) Biohazardous accidents.
      (13) Unauthorized use and possession of legal or illegal substances.
      (14) Abuse.
      (15) Neglect.
      (16) Suicide and attempted suicide.
      (17) Sexual assault.
      (18) Other sentinel events.

Intent Statements

An organization should consider the persons served, personnel, and other stakeholders, such as visitors to its program, in developing its procedures for critical incidents. Although an organization is expected to have procedures that include all of the types of critical incidents listed in this standard that are applicable to its operations, it would be possible for a procedure to adequately address more than one type of critical incident. An organization is not required to have a separate procedure for each type of incident as long as all critical incidents are appropriately considered.
Examples

The organization follows legal requirements regarding investigation and the reporting of incidents to the proper authorities. Reporting requirements can be obtained from licensing agencies, protection and advocacy services, and funding sources.

Policy is developed that includes the procedures in place for determining what constitutes a critical incident, how investigations are to be conducted, how documentation is to be completed, who is responsible for completing documentation, who is to be notified, and where written documentation of incidents is to be kept.

Regulations and/or policy may require documentation of what is considered a “near miss,” in which serious consequences were avoided, but which would require review in order to promote a safer environment. This is a concept being effectively used by some organizations.

A training system is put in place to ensure that all personnel are trained in, and aware of, the reporting requirements. Due to the importance of this information, an organization may choose to make this training part of all employees’ initial orientation and at least annual training. It may be helpful to document the completion of the training in an employee’s personnel file and review the information at the time of the employee’s performance review.

The reporting of critical incidents is essential. Reporting ensures that information is communicated and that significant events that could jeopardize the health and safety of participants and personnel are documented. Personnel should be familiar with all circumstances that are considered critical incidents. Although Standards 1.H.9.f.(1)–(18) identify incidents that must be considered critical, it is not an exhaustive list.

Additionally, even if an organization’s policy on nonviolent practices (as required by Standard 2.F.1. in Section 2.F. Promoting Nonviolent Practices) identifies that it does not engage in seclusion or restraint activities, it must still include seclusion and restraint in its procedures for critical incidents.

A critical incident form can be developed so that all necessary information about the incident is included. Information to include on the incident form includes the date, time, and location of the incident; who was involved; what led to the incident; a description of what happened; the consequences of the incident; witnesses; who was notified; and follow-up recommendations.

Personnel completing the form are to provide descriptive and factual information.

The organization determines and develops a policy determining what format and where the documentation of incidents is to be maintained. Licensing agencies view critical incident reports as confidential legal documents and require them to be stored in a secure area. Timelines regarding how long documentation of critical incidents must be kept are also typically set by licensing agencies.

An organization may be required to store incident reports in the records of the persons served, an incident file, etc. An incident log may also be kept to summarize causes and trends of incidents at a glance.

Software programs are being used by some organizations to ensure more consistency in documentation and to facilitate analysis.

As applicable, organizations should note requirements of:

- Child abuse and neglect laws.
- Vulnerable adult regulations.
- In a correctional facility in the United States, the federal "Prison Rape Elimination Act of 2003."

9.f.(13) This includes use or possession of any licit substance that is in violation of the organization’s policies and procedures.

In its written procedures the organization addresses the possession and use of medical marijuana, including topics such as whether it is legal or illegal, how it is managed, the impact of its use on other persons served, and sharing with or selling to other persons served.
1.H. 10. A written analysis of all critical incidents is provided to or conducted by the leadership:
   a. At least annually.
   b. That addresses:
      (1) Causes.
      (2) Trends.
      (3) Actions for improvement.
      (4) Results of performance improvement plans.
      (5) Necessary education and training of personnel.
      (6) Prevention of recurrence.
      (7) Internal reporting requirements.
      (8) External reporting requirements.

Intent Statements
An integrated approach to the management of critical incidents is essential to effective risk management.

Examples
If critical incidents are analyzed at the level of the larger entity or organization, there is still a process to review, analyze, and address the data associated with critical incidents specific to the programs/services seeking accreditation. Analyzing critical incidents at the level of the program/service could identify program/service specific causes, trends, actions, prevention of recurrence, and education needs that may differ from the rest of the organization. The written analysis might be a separate report or contained within the organizationwide report.

This report is a critical component to the concept of prevention in both risk management and performance improvement activities. In order to determine the causes and trends of critical incidents, an organization first develops a procedure that indicates how frequently reviews are to be conducted and the persons or positions responsible for the reviews.

Critical incidents may be reviewed by one or more committees to ensure that a thorough analysis is completed. An organization may develop a safety committee responsible for reviewing all incidents involving accidents, injuries, illnesses, and “near miss” events.

A well-rounded committee would include members from the medical, administration, transportation, social services, human resources, and training and development departments.

An organization may also develop a human rights committee to review critical incidents. Members of this committee would benefit from a background in behavior analysis and client rights. This committee would review all critical incidents to determine antecedents, changes in client behavior, the influence of personnel interactions and interventions, the need for environmental modifications, that client rights are upheld, and that individuals are treated with dignity and respect.

Regardless of who reviews critical incidents, a thorough analysis includes the following:

- A determination of the cause of each incident. Did the incident occur as the result of an environmental flaw, a lack of personnel training factors, or a failure to follow the organization’s policies and procedures?

- Identification of trends in critical incidents. Are common themes emerging in the incident reports? An examination of trends evaluates the location of critical incidents, the time of incidents, the personnel involved in incidents, the involvement of persons served in incidents, the types of incidents, methods of intervention, etc.

- The purpose of the above analysis is to enable the development of actions for improvement to prevent similar events from occurring in the future. Once an analysis of the incidents has been completed, the committee members are responsible for making recommendations and determining actions that the organization needs to take to improve the areas identified.

Recommendations may include environmental modifications, additional personnel training, changes in policies and procedures, and other actions. The designated committee revisits recommendations at its next meeting to evaluate the results of the actions taken for improvement, ensuring that the recommended changes that have been made were effective.

Meeting minutes are completed for each committee meeting. Minutes are shared with those in all
areas affected by the committee’s recommendations to ensure communication of need areas, as well as provide documentation of need.

10.b.(7)–(8) Regulations with regard to the reporting of an incident to the appropriate personnel may vary. Some incidents may involve issues that are internal to the operation of the organization and that are reported only to the appropriate supervisors. However, incidents of neglect, abuse, or death must be reported to the appropriate external authorities, as required by law.

11. The organization implements procedures:
   a. For:
      (1) Infection prevention.
      (2) Infection control.
   b. That include:
      (1) Training regarding:
          (a) Infections.
          (b) Communicable diseases.
      (2) Appropriate use of standard or universal precautions.
      (3) Guidelines for addressing these procedures with:
          (a) Persons served.
          (b) Personnel.
          (c) Other stakeholders.

Intent Statements
The persons served, personnel, and other stakeholders should be provided with training based on individual needs. Each organization is encouraged to check legal and regulatory requirements regarding the use of standard or universal precautions in the programs provided and with the populations served.

11.b.(2) In Canada this may be referred to as routine practices.

Examples
The organization could provide staff education on universal precautions, handwashing technique, the use of alternative cleansing solutions, or the use of aseptic techniques. Posted signs, items in the newsletter, or other means could be used to educate family members, volunteers, and other visitors about preventing the spread of infection. The organization could have surveillance activities for monitoring and trending acquired infections. A written infection control plan and other policies could be developed to include surveillance, isolation and precautions, health of persons served, employee health, education, antibiotic usage and resistance, and HIV-related issues.

11.b.(2) Each organization is encouraged to check legal and regulatory requirements regarding the use of standard or universal precautions in the programs provided and with the populations served. Laws and regulations vary by state and by program type.

11.b.(3)(a) The persons served will be provided with training based on individual needs, such as risk-taking behavior, drug use, long-term involvement in services, or greater potential risk of exposure.

Education for the persons served regarding the prevention and control of infection or communicable diseases can occur during orientation, in individual and group sessions, and through provision of written materials.

Resources
Resources used in the development of infection control procedures could include the Centers for Disease Control [www.cdc.gov/infectioncontrol/index.html](http://www.cdc.gov/infectioncontrol/index.html), the Association for Professionals in Infection Control and Epidemiology [www.apic.org](http://www.apic.org), the Public Health Agency of Canada [www.phac-aspc.gc.ca](http://www.phac-aspc.gc.ca), Infection Prevention and Control Canada [www.ipac-canada.org](http://www.ipac-canada.org), or state/provincial or other jurisdictional departments of health outbreak manuals.

Resources specific to hand hygiene include:
- Infection Prevention and You: [http://professionals.site.apic.org](http://professionals.site.apic.org)
- Centers for Disease Control and Prevention Hand Hygiene in Healthcare Settings: [www.cdc.gov/handhygiene/index.html](http://www.cdc.gov/handhygiene/index.html)
### Applicable Standards

Standard 1.H.12. applies only to programs that provide transportation for the persons served.  
**NOTE:** This standard does not apply to vehicles used only for transporting materials.

1.H. 12. When transportation is provided for persons served there is evidence of:
- a. Appropriate licensing of all drivers.
- b. Regular review of driving records of all drivers.
- c. Insurance covering:
  - (1) Vehicles.
  - (2) Passengers.
- d. Safety features in vehicles.
- e. Safety equipment.
- f. Accessibility.
- g. Training of drivers regarding:
  - (1) The organization’s transportation procedures.
  - (2) The unique needs of the persons served.
- h. Written emergency procedures available in the vehicle(s).
- i. Communication devices available in the vehicle(s).
- j. First aid supplies available in the vehicle(s).
- k. Maintenance of vehicles owned or operated by the organization according to manufacturers’ recommendations.
- l. If services are contracted, a review of the contract at least annually against elements a. through k. of this standard.

### Intent Statements

Transportation for the persons served is provided in a safe manner consistent with the regulations of the local authorities. This standard will apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

12.j. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

12.l. See the Glossary for the definition of contract.

### Examples

12.a. Verification of driver’s licenses occurs on all personnel, including volunteers, who provide transportation for persons served.

12.b. The review of driving records includes identified criminal record checks on persons providing transportation for children, adolescents, or vulnerable adults in addition to the review of driving records. The organization sets its own parameters regarding acceptability of driving records and determines the most opportune time to secure this information. It should, however, adhere to a timeframe that ensures that a review is ongoing.

12.e. If an organization transports infants and children, the intent of this standard includes the use of age-appropriate restraining devices secured in the vehicles.

Other safety equipment could include cell phones, flares and cones, flashlights, disposable cameras, fire extinguishers, tire gauges, jack and lug wrench, spare fuses, and jumper cables.

12.h. The written procedures for handling emergencies include roadside emergencies and individual emergencies that may occur during operation of the vehicle.

12.j. If personal vehicles are used to transport persons served, the organization might consider stocking a safety bag or kit with supplies that could be picked up whenever a personal vehicle is used.

1.H. 13. Comprehensive health and safety inspections:
- a. Are conducted:
  - (1) At least annually.
  - (2) By a qualified external authority.
b. Result in a written report that identifies:
   (1) The areas inspected.
   (2) Recommendations for areas needing improvement.
   (3) Actions taken to respond to the recommendations.

Intent Statements
External inspections are completed at least annually to enhance and maintain the organization’s health and safety practices. External inspections must include all facilities regularly utilized by the organization.

13.a.(1) This inspection may be conducted in a single, uninterrupted process that moves methodically and comprehensively through an entire program area or physical location, or the organization may have several external inspections conducted that together constitute a comprehensive inspection of all areas relevant to the operation of its programs or services.

Examples
External inspection by a compliance/safety officer may include:
- A representative of the fire department.
- A representative of a local health department.
- A licensed or registered safety engineer.
- A representative of an agency that provides OSHA, health, or physical plant inspections on a consultative or licensing basis. In Canada, this could include a representative from a provincial or territorial body designated under legislation related to workplace safety.
- An engineer involved in industrial operations. This person is knowledgeable regarding the health and safety requirements applicable to the services provided.
- A plant engineer or safety specialist.
- A safety consultant who represents the organization’s fire or workers’ compensation carrier or who is in private practice.
- An industrial health specialist.
- A representative of the organization’s insurance carrier or a private insurance carrier.

When the program is provided by a unit of a larger entity, such as a hospital, the larger entity’s safety engineers or other personnel are not considered external authorities. External means external to the entire system, not just to a unit of the organization. Exceptions include settings such as Veterans Health Administration or Veterans Affairs Canada sites, other federal or tribal programs, and government-owned organizations where certain functions may be conducted by departments within the larger organization. In these instances, the organization should contact the CARF office for assistance identifying who may conduct the inspection.

Any external authority used by the organization (e.g., a representative of a licensure body) should be recognized and credentialed as such (e.g., a licensed or registered safety engine or risk management authority).

The externally conducted inspections may include inspections of:
- Emergency warning devices, means of egress, and emergency plans.
- Operations involving hazardous materials and processes, including the safe and effective management of biohazardous materials.
- Heating and cooling systems.
- Walking and working surfaces.
- Electrical systems.
- Health and sanitation provisions with regard to food preparation, eating areas, and air contaminants.
- The working environment, including ventilation, illumination, noise, and air contaminants.
- Structural integrity of facility.
- The provisions for fire protection to ensure that they are in accordance with applicable fire safety requirements.
- Operation of machinery.
1.H. 14. Comprehensive health and safety self-inspections:

a. Are conducted at least semiannually on each shift.

b. Result in a written report that identifies:
   (1) The areas inspected.
   (2) Recommendations for areas needing improvement.
   (3) Actions taken to respond to the recommendations.

Intent Statements

Regular self-inspections help personnel to internalize current health and safety requirements into everyday practices. Self-inspections must include all facilities regularly utilized by the organization.

Examples

A self-inspection is defined as one that is conducted by individuals or groups within the organizational structure. This includes professional personnel or internal groups who have received training in conducting inspections. Internal groups include safety committees, safety circles, or operation teams. Anyone within the organizational structure, such as managers, supervisors, direct service employees, and maintenance personnel, may participate in a self-inspection.

The purpose of self-inspections is to identify and correct existing workplace hazards and to determine whether regulatory standards are being met. A good practice for self-inspection is to use the same format and criteria as the external authority. A self-inspection can also be used to keep the organization ready for compliance inspections by external regulatory agencies. Ongoing evaluations are the key to continuous improvement. Because personnel are more readily available than outside parties to participate in ongoing evaluation, self-inspections figure prominently in the overall organizational health and safety audit plan and schedule.

The self-inspections should cover all applicable areas, including as appropriate:
- Heating and cooling systems.
- Electrical systems.
- Emergency warning devices.
- Walking and working surfaces.
- Ingress and egress.
- Health and sanitation related to:
  - Food preparation.
  - Eating areas.
  - Restrooms.
- Structural integrity of facility.
- Storage of hazardous materials.
- Fire protection systems and equipment.
- Air contaminants and ventilation.
- Recreation/visitation areas.
- Other areas appropriate to the services provided.

A small site may be fully evaluated in a single inspection, while inspection of a larger facility might need to be conducted in phases. Health and safety inspection plans are scheduled for the entire workplace twice a year.

Knowing when, where, and how specific safety policies and programs are succeeding or failing is crucial to continuous improvement. Thorough and objective evaluation of the overall health and safety program requires that an inspection be completed on each shift with a sample of staff members. Management should identify if employees and persons served are adhering to established health and safety policies and procedures. Regular inspections help determine if safety practices are being followed at each site and on each shift.

Any inspection process is incomplete until its findings have been reported to and acted on by management in a timely and meaningful manner. Management establishes standards for inspection reports and procedures for follow-up that facilitate improvement. Each inspection process concludes with a report that identifies areas covered in the inspection. Reported areas of noncompliance cite regulatory standards and describe the physical hazard, unsafe work...
practice, or other area for improvement, in specific terms.

The report goes beyond the description of inspection details. The report includes the factors causing each deficiency, an evaluation of when and where similar hazards or deficiencies may exist, and guidelines for responding to them, which could include interim corrective measures.

Management or the designated personnel then develop an action plan for improvement. The action plan assigns a person or group as responsible and accountable for execution of the written plan of corrective action. The action plan identifies the specific hazards or deficiencies discovered in the inspection and conditions that could cause problems throughout the facility.

Management requires complete reports from the personnel accountable for follow-up to ensure that the action plan is being implemented. Evaluation and assessment of the outcomes of corrective actions are monitored so that the desired goals are being attained.

1.H.15. If applicable, there are written procedures concerning hazardous materials that provide for safe:
   a. Handling.
   b. Storage.
   c. Disposal.

Examples
Hazardous materials could include biohazardous substances, industrial strength cleaning supplies, oil-based paints, fluorescent light bulbs, copier toner, and computer monitors.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
   ■ Health and safety policies and procedures
   ■ Health and safety training information
   ■ Inspection report from an external authority and corrective actions, if any recommendations were noted
   ■ Self-inspection reports and follow-up, including response to recommendations
   ■ Written emergency procedures
   ■ Written evidence of unannounced tests of emergency procedures and corrective actions, if any recommendations were noted
   ■ Written incident procedures and copies of incident reports
   ■ Documentation showing all incidents are reviewed and analyzed to identify trends and an action plan established to reduce risks
   ■ Records of training for staff on incident reporting
   ■ Infection prevention and control procedures
   ■ Medication management procedures, if applicable
   ■ Procedures for the use of standard or universal precautions
   ■ Documentation of provision of competency-based safety training for personnel
   ■ Minutes of safety committee meetings
   ■ A list of personnel trained in safety techniques
   ■ A list of personnel and others on the safety committee
   ■ Information on vehicles and drivers, if applicable
   ■ Copies of licenses and certificates when applicable
   ■ Accident reporting requirements
   ■ Written emergency procedures available in vehicles that are used to transport persons served, if applicable
   ■ Transportation procedures, if applicable
   ■ Documentation of safety training for persons served
   ■ Written procedures concerning safe handling, storage, and disposal of hazardous materials
I. Workforce Development and Management

Description
CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

1. The organization documents the composition of its workforce, including all human resources involved in the delivery, oversight, and support of the programs/services seeking accreditation.

Examples
Discussions of the organization's mission, culture, philosophy, and plans are embedded throughout its workforce development and management practices. As important cornerstones of the organization, these topics are reinforced throughout:
- Recruitment, selection, orientation, and ongoing training and development activities.
- Written and verbal communications.
- Efforts to seek input and feedback from persons served, the workforce, and other stakeholders for planning and improvement purposes.
- Each individual's knowledge of how he or she contributes to decreasing risks, increasing the value of the services delivered, and advancing the organization's strategic direction.

Intent Statements
A strategic approach to workforce development and management contributes to organizational effectiveness. For an organization to implement its mission, strategy, and philosophies, as well as practice within its culture, it requires a workforce that is committed to these concepts. Selection and orientation of the workforce and its development and management are all critical to the overall success of the organization.

This standard relates to a number of others in Section 1 including, but not limited to, Standard 1.A.3.a. on establishment of the organization's mission and direction; 1.A.5. on cultural competency and diversity; 1.A.2. on person-centered philosophy; 1.M.1.–7. and 1.N.1.–3. on performance measurement, management, and improvement; 1.G.1.–4. on risk management; and 1.C.1.–3. on strategic planning.

2. Workforce development and management practices reflect the organization's:
   b. Culture.
Section 1.1. Workforce Development and Management

3. Ongoing workforce planning includes:
   a. Workforce analysis.
   b. Written job descriptions.
   c. Review and update of written job descriptions in accordance with organizational needs and/or the requirements of external entities.
   d. Recruitment.
   e. Selection.
   f. Retention.
   g. Succession planning.

Intent Statements

Workforce planning is the strategic alignment of an organization's workforce with its goals and operational plans. Regardless of the size of the organization, the purpose of workforce planning is to ensure that the organization has the right people with the right skills at the right time.

3.a. Workforce analysis is the process of analyzing the current workforce, determining future workforce needs, identifying the gaps between the present and the future, and implementing solutions that will allow the organization to accomplish its mission, goals, and objectives.

3.b. Job descriptions outline duties, responsibilities, competencies, and requirements of a particular job. They are essential in the development of programs to recruit, select, compensate, train, and assess the performance of current and future members of the workforce.

3.c. The organization determines the frequency at which job descriptions are reviewed and updated based on the needs of the organization or other external requirements. Members of the workforce are aware of their job descriptions and may provide input into changes.

3.d. Recruitment is the activity of identifying and soliciting individuals, either from within or outside of the organization, to fill current vacancies or areas of anticipated growth. Individuals with knowledge of the position(s) being recruited for have input into recruitment plans and activities. Often considered part of recruitment, sourcing is proactive searching for qualified job candidates for current or planned open positions at an organization. Sourcing may identify and collect relevant information on candidates who are actively searching for jobs (active job seekers) as well as candidates who are not actively looking for job opportunities (passive job seekers).

3.e. Selection involves activities related to choosing people who have the right qualifications to fill a current or future job opening.

3.f. Retaining a qualified and engaged workforce has a direct impact on the organization's ability to achieve its mission. Retention programs play an important role in both attracting and retaining key members of the workforce, as well as in reducing turnover and its related costs.

3.g. Succession planning identifies actions to be taken by the organization should key members of the workforce be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization.

Examples

3.d. Job seekers might be located by sourcing job boards, social media sites, alumni associations, and through all types of networking; e.g., relationships with high schools, colleges, and professional associations.

3.f. Retention strategies may include a culture that values the workforce; competitive wages; career ladders; opportunities to participate in special projects; offering activities and resources that are meaningful to the workforce such as wellness programs, child care, elder care, and continuing education/tuition support; flexible scheduling; and telecommuting.

4. The organization implements written procedures that address:
   a. Verification of:
      (1) Backgrounds of the workforce in the following areas, if required:
         (a) Criminal checks.
         (b) Immunizations.
         (c) Fingerprinting.
         (d) Drug testing.
         (e) Vulnerable population checks.
         (f) Driving records.
Section 1.1. Workforce Development and Management

(2) The credentials of all applicable workforce (including licensure, certification, registration, and education):
   (a) With primary sources.
   (b) When applicable, in all states/provinces or other jurisdictions where the workforce will deliver services.

(3) Fitness for duty, if required.

b. Actions to be taken in response to the information received concerning:
   (1) Background checks.
   (2) Credentials verification.
   (3) Fitness for duty.

c. Timeframes for verification of backgrounds, credentials, and fitness for duty, including:
   (1) Prior to the delivery of services to the persons served or to the organization.
   (2) Throughout employment.

Intent Statements

The organization is prepared to demonstrate how each of the areas listed is verified. CARF expects that the organization will follow all of the procedures and timeframes that the organization has established and that it complies with all applicable legal requirements in determining its procedures.

4.a.(1) The organization is aware of and adheres to any external requirements (e.g., of funders, regulatory entities, contractual agreements, etc.) for background checks of its workforce as well as any requirements it may have established internally. The organization determines whether it will conduct background checks in more than one state/province or jurisdiction for all or select members of the workforce.

Related to background checks for organizations in the United States that receive federal funding, Standard 1.A.7.b. addresses implementation of a procedure to identify exclusion of individuals and entities from federally funded healthcare programs.

4.a.(2)(a) Primary source verification can occur when credentials are initially earned, at the time of hire, or, for existing members of the workforce, prior to an accreditation survey. Verbal, written, or electronic confirmation of credentials (including degrees) from state/provincial or other jurisdictional boards, schools or institutions, and/or trade associations, or verification through a credentials verification organization, is required. Copies of credentials provided directly by personnel do not meet the primary source verification requirement.

High school diplomas do not need primary source verification, but college degrees, when required for the position, would need to be verified with primary sources. When a licensing authority requires and verifies the education required for the license, evidence of licensing from the licensing authority as the primary source will also serve as evidence that the education has been verified.

4.a.(2)(b) If services are delivered in more than one state/province or jurisdiction, the organization is knowledgeable about reciprocity of credentials such as licensure, certification, or registration and how this would impact in-person service delivery or service delivery via information and communication technologies.

4.a.(3) A fitness-for-duty exam is a medical examination used to determine whether a worker is physically or psychologically able to perform the essential functions of the job.

4.b. The organization has procedures in place in the event that backgrounds, credentials, or fitness for duty cannot be verified.

4.c. Timeframes are established by external authorities or, in their absence, by the organization.

Examples

4.a.(1)(a) CARF standards require criminal background checks for members of the workforce providing direct services to children or adolescents.

4.a.(1)(e) Vulnerable population checks might include verifications through an elder abuse database, adult protective services, child protective services, or a sex offender registry.

4.a.(1)(f) Verification might address:
   ■ Whether a driver’s license is current.
   ■ Whether a driver’s license is the right classification for the vehicle and type of driving the
person will be doing for the organization; e.g., transporting persons served; driving to deliver services in the homes of persons served or in the community or to meet stakeholders; driving the organization’s van or his or her own vehicle.

- Whether there are violations on the driving record.
- Proof of insurance.

4.a.(2) Procedures may include use of a standard form or checklist to document verification of credentials and other relevant information about an individual. Documentation obtained by the organization may include:

- An original letter or copy of a letter from the appropriate credentialing, licensing, or certification board.
- A copy of the license or certification provided by the credentialing organization.
- A phone log or other notation made by an individual responsible for conducting primary source verification.
- A copy of a web page listing (for those situations where verification is completed online or through the internet by checking a listing of licensed/certified personnel).

4.c.(2) The organization may conduct verifications throughout employment at times such as transfer to a new position, the addition of new job responsibilities, pending expiration of a current license or certification, newly acquired credentials, or return to work after an injury or illness.

Resources

A resource for information on medical license portability in the United States is https://imlcc.org.

1.5. Onboarding and engagement activities include:

a. Orientation that addresses the organization’s:
   (1) Mission.
   (2) Culture.
   (3) Person-centered philosophy.

(4) Performance measurement and management system.
(5) Risk management plan.
(6) Strategic plan.
(7) Workforce policies and procedures.

b. On-the-job training.
c. Position roles and responsibilities.
d. Position performance expectations.
e. Communication systems and expectations.

Intent Statements

5.a. This standard addresses organization-level orientation topics, which are typically supplemented by program/service and/or position-specific topics addressed in other sections of the standards manual.

Examples

5.a.(4) Orientation to performance measurement and management might address:

- The terminology of performance measurement and management.
- Roles and responsibilities in implementing the performance measurement and management system, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.
- How performance information is used by the organization, including to review implementation of its mission and core values, improve the quality of its programs and services, facilitate organizational decision making, review and update its strategic plan, and communicate business and service results to stakeholders.

5.b. On-the-job training may include mentoring for individuals who have limited or no experience in a program area by more experienced individuals. Such collaboration focuses on activities designed to facilitate learning of the required competencies. Consideration is given to the intensity of the collaboration (e.g., side-by-side
collaboration, on-site collaboration, collaboration via telephone), the length of the collaboration (e.g., one week, one month, several months), and whether it is necessary to have the collaboration conducted by an individual of a specific discipline.

5.d. Position performance expectations could relate to the competencies required of the position; scheduling expectations such as working weekends or shifts, rotations; supervision of others such as new team members, students, or volunteers; business travel; or use of technology.

5.e. Communication systems and expectations might address:

- Mechanisms used throughout an organization, such as an intranet system used to communicate policies, procedures, and job aids; personal use of organizational email; appropriate use of the organization’s social media channels; and use of personal devices to access organizational information and resources.
- Mechanisms used to communicate about the persons served. Refer to Standard 2.A.6.
- Expectations for maintaining confidentiality and privacy.
- Expectations for maintaining current personal and emergency contact information.

5.f. Position performance expectations could relate to the competencies required of the position; scheduling expectations such as working weekends or shifts, rotations; supervision of others such as new team members, students, or volunteers; business travel; or use of technology.

5.e. Communication systems and expectations might address:

- Mechanisms used throughout an organization, such as an intranet system used to communicate policies, procedures, and job aids; personal use of organizational email; appropriate use of the organization’s social media channels; and use of personal devices to access organizational information and resources.
- Mechanisms used to communicate about the persons served. Refer to Standard 2.A.6.
- Expectations for maintaining confidentiality and privacy.
- Expectations for maintaining current personal and emergency contact information.

1.6. The organization promotes engagement through respect for all individuals in the workforce, including:

a. Open communication.

b. A value-driven focus.

c. Initiatives that address:

(1) Recognition.

(2) Compensation.

(3) Benefits.

d. Policies and written procedures that:

(1) Address, at a minimum:

(a) Mechanism(s) to provide favorable and constructive feedback.

(b) Mechanism(s) to address concerns.

(c) Job postings.

(d) Promotion.

(e) Disciplinary action.

(f) Separation.

(g) Labor relations, if applicable.

(h) Prevention of harassment.

(2) Are accessible to the workforce.

Intent Statements

Workforce engagement refers to the level of an individual’s commitment and connection to an organization. High levels of engagement promote workforce retention, foster loyalty, and improve organizational performance and value.

6.a. Open communication is characterized by a mutual exchange of information and ideas, transparency, and access to people and information.

6.b. Refer to the Glossary for a definition of value.

6.d. This standard does not require that each individual be given a copy of the policies and written procedures, but it does require that each individual has access to the policies and written procedures and that there is notification of when there are changes to policies and procedures that the workforce should be aware of. Evidence that the policies and written procedures are provided or available does not have to be in writing.

Review of the workforce policies is part of the annual review of the organization’s policies addressed in Standard 1.A.3.k.

6.d.(1)(b) The intent of this standard is that all individuals in the workforce have access to an identified mechanism through which they may express concerns.

6.d.(1)(c)–(d) When a job is available, individuals in the workforce know where it will be posted and are clear on whether there is a possibility of promotion from within the organization.

Examples

6.a. Open communication in an organization may be demonstrated through regular meetings at which important topics and updates are shared, newsletters, suggestion boxes, management rounds, open-door policies, and opportunities to provide input into the plans and activities of the organization.

6.c.(1) Examples of recognition initiatives include employee of the month or year awards, opportunities to earn additional time off or
entry into a gift drawing as incentives to complete certain activities, participation in special projects, career ladders, goal-sharing programs, and personal recognitions on anniversaries or for a job well done.

6.d.(1) Policies and written procedures might address:

- Mechanisms to provide feedback, such as a suggestion box, forums with leadership, open-door policy of leadership, or annual workforce satisfaction survey.
- Workforce grievance procedures; how to deal with allegations of violations of ethical codes (related to standard 1.A.6.b.); how to deal with allegations of waste, fraud, abuse and other wrongdoing (related to standard 1.A.7.d.).
- Conflict resolution, mediation, and collective bargaining agreements.

6.d.(1)(h) Harassment in the workplace might include unwelcome physical or verbal behavior such as offensive jokes, belittling comments, slurs, epithets, name calling, physical threats or assaults, ridicule or mockery, insults, offensive objects or pictures, or other interference with work performance that creates an intimidating or hostile work environment. Harassment can also include sexual harassment such as unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature.

6.d.(2) When there are new policies and written procedures, or changes to existing policies and procedures, the workforce might be notified via departmental, team, or one-on-one meetings; posting notices in a common area of the building; email; the organization’s intranet system; or dissemination of a form requesting verification by individuals that they have completed a regular review of specified documents.

---

1.I. Workforce development activities include:

a. Identification of competencies:
   (1) To support the organization in the accomplishment of its mission and goals.
   (2) To meet the needs of the persons served.

b. Assessment of competencies.

c. Identification of timeframes/frequencies related to the competency assessment process.

d. Competency development, including the provision of resources.

e. Performance appraisal.

f. Education and training.

Intent Statements

Refer to the Glossary for a definition of competency.

Examples

7.a. This may include competencies specific to a position, such as service delivery or clinical competencies, as well as competencies related to customer service, person-centered approaches to service delivery, communication with stakeholders, etc.

7.d. Competency development may occur through opportunities on the job as well as externally. Resources to develop competencies might include journal subscriptions, online access to learning opportunities and reference materials or journals, access to evidence-based practice databases and reviews, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resource or education efforts with other area providers of services, and financial support and/or time off to participate in special interest groups or to attend courses or conferences.
8. The organization implements written procedures for performance appraisal that address:
   a. The identified workforce.
   b. The criteria against which people are being appraised.
   c. Involvement of the person being appraised.
   d. Documentation requirements.
   e. Timeframes/frequencies related to the performance appraisal process.
   f. Measurable goals.
   g. Sources of input.
   h. Opportunities for development.

Intent Statements
Organizations vary in their preferences and approaches to performance appraisal. For some, a traditional approach suits their needs, while others are evolving to a more fluid process that may look different for different members of the same workforce. To meet this standard the organization demonstrates implementation of a performance appraisal process that includes all of the elements of the standard as they apply to the groups that comprise its workforce (as documented in Standard 1. in this section). This allows the organization flexibility to determine what meets its needs relative to appraisal of employees, contractors, students, volunteers, etc.

Examples
8.b. Criteria might be included in a performance appraisal tool, job description, behavior attributes, expectations established through goal setting, employee handbook, etc.
8.d. This refers to documentation requirements of the performance appraisal process, such as whether a certain form is to be used, what elements are to be addressed, where documentation of performance appraisals is maintained, and at what intervals documentation is required.
8.f. A measurable goal describes an expected outcome, result, or output, which could be qualitative or quantitative, and has a timeline associated with reaching it. In addition, effective goals may be characterized as participative; reasonable; specific; challenging but attainable; flexible; easily monitored for progress; in alignment with an organization’s mission, strategy, and goals; and they may be individual, team-based, or project-based.

One approach to establishing goals is SMART goals—goals that are specific (simple, sensible, significant), measurable (meaningful, motivating), achievable (agreed, attainable), relevant (reasonable, realistic, and resourced, results-based), and time-bound (time-based, time-limited, time/cost limited, timely, time sensitive). For more information, visit www.mindtools.com/pages/article/smart-goals.htm.
8.g. Sources of input to the performance appraisal might include the person being appraised, supervisors, peers, persons served, families/support systems, external stakeholders, etc.
8.h. Opportunities for development may include supervisory/management training; clinical training to develop expertise in a particular practice, technique, or piece of equipment; training to move into another area of a continuum of services; precepting students or responsibility for a student internship program.

9. There is an adequate workforce to:
   a. Implement the plans of the persons served.
   b. Ensure the safety of persons served.
   c. Manage unplanned absences.
   d. Meet the performance expectations of the organization.

Intent Statements
This standard relates to the organization’s performance measurement and management, i.e., the collection, analysis, and use of data in areas such as finance, risk management, human resources, health and safety, service delivery, etc. Whether or not performance targets are met in these areas may reflect the adequacy of the workforce to meet the needs of the organization and the persons served.

No ratios are established by CARF for the number of persons served to the number of personnel. During a survey, the organization is able to articulate its strategy to determine what workforce is necessary to meet ongoing needs and to
minimize the impact of absences and vacancies in its workforce.

Examples

9.a. Indications that the workforce is not adequate to implement the plans of the persons served may include wait lists or delays for specific services the program indicates in its scope that it can provide, turning potential persons served away; lacking specific types of providers to fulfill individual plans, inconsistent assignment of individuals in the workforce, and persons served not accomplishing their goals or the expected outcomes established by the team.

Maintaining a staffing pattern that is too low for the numbers or needs of persons served, or personnel who lack the training, education, and experience to intervene safely without using seclusion or restraint may also reflect a workforce that is not adequate to implement the plans of the persons served.

1.I. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant:

a. Regulatory requirements.
b. Licensure requirements.
c. Registration requirements.
d. Certification requirements.
e. Professional degrees.
f. Training to maintain established competency levels.
g. On-the-job training requirements.

Intent Statements

The organization is knowledgeable about and ensures that services are provided in accordance with external and internal requirements and education relevant to its workforce.

Examples

10.a. Regulatory requirements may specify a certain credential for a position, a number of hours of service delivery, a number of hours of inservice training, etc.

11. The organization’s succession planning addresses, at a minimum:

a. Its future workforce needs.
b. Identification of key positions.
c. Identification of the competencies required by key positions.
d. Review of talent in the current workforce.
e. Identification of workforce readiness.
f. Gap analysis.
g. Strategic development.

Intent Statements

This standard relates to Standards 1.A.3.m. and 1.B.5. on succession planning.

An organization relies on its workforce to carry out its mission, provide programs and services, and meet organizational goals. Important to any size organization, succession planning helps an organization prepare to support program and service continuity when key individuals leave, either planned or unexpectedly.

11.b. Key positions include those requiring specialized skills or levels of experience and those that may be difficult to replace.

11.d. A review of talent involves assessment of the current workforce with the goal of identifying those who have the skills and knowledge or the potential along with the desire to be promoted to existing and new positions.

11.e. Identification of workforce readiness considers the skills and knowledge already present in members of the workforce who have been identified for promotion to existing or new positions and the skills and knowledge that may need development.

11.f. Once an organization has identified positions that may be vacated due to retirements, difficult for which to recruit, require extended training, etc., it assesses the current workforce to determine whether there are candidates with the skills, knowledge, and potential to fill those positions or whether it needs to recruit and/or train candidates for those positions. Gap analysis identifies disparities between what is needed in the workforce and what is available.
### J. Technology

**Description**

Guided by leadership and a shared vision, CARF-accredited organizations are committed to exploring, and, within their resources, acquiring and implementing technology systems and solutions that will support and enhance:

- Business processes and practices.
- Privacy and security of protected information.
- Service delivery.
- Performance management and improvement.
- Satisfaction of persons served, personnel, and other stakeholders.

#### 1.J. To identify gaps and opportunities in the use of technology, leadership supports ongoing assessment of:

- **a. The organization’s current use of technology and data, including:**
  1. Hardware.
  2. Software.
  3. Communication technologies.
  4. Sensitive data.
  5. Services purchased or contracted.

- **b. Input on the organization’s use of technology from:**
  1. Persons served.
  2. Personnel.
  3. Other stakeholders.

**Intent Statements**

The leadership is knowledgeable about the organization’s technology systems and is actively involved in its technology planning rather than it being considered the sole responsibility or purview of information and technology personnel.

**Examples**

Ongoing assessment of gaps and opportunities relies, in part, on consistent management of the organization’s existing technology and data assets. This includes tracking of the lifecycle of assets and, in advance of those timeframes,
assessing the best of course of action. For example:

- Cell phones used by personnel have an upgrade option at an appropriate interval. Ahead of that time, the organization considers any input it has received from personnel on the utility and performance of the phones, assesses whether it will upgrade the phones, whether it will change cell phone plans, whether it will continue with the same cell phone carrier, etc.

- Laptop computers used by personnel average a five-year life expectancy before needing replacement. The organization periodically assesses new models, accessories, software upgrades, and alternatives such as tablets and establishes a plan for laptop replacement.

- The organization has software maintenance contracts and cloud subscriptions that require regular renewal. Throughout the periods of those contracts, the organization is assessing whether the services are meeting its needs, whether resolution of issues has been adequate, costs of renewal, duration of the contracts, and whether it will renew or seek new options.

Other components of ongoing assessment might include:

- Patching and malware prevention, including regular assessment of the organization’s operating systems and application updates. Often updates are released to patch security vulnerabilities in the operating system or software. Anti-malware/anti-virus software should be updating regularly; typically updates are automatic and multiple times a day. It’s also good practice to keep the firmware of network switches and routers up to date.

- Perimeter security, which includes firewall/intrusion prevention; documentation of rules regarding what resources are open externally and why; keeping firmware/operating systems up to date; making sure that updates for malicious prevention are occurring and working; and checking log files for indications of problems, errors, failures, and traffic that has been prevented. The organization might use free online security testers to evaluate the security settings of its web servers.

- Data security, which includes patching and software updates and controlling input to prevent database server exploitation.

- Network diagrams, which include keeping up-to-date diagrams of local and wide area network infrastructure, including equipment information such as make/model and routing and network addressing. This may also include mapping of application interactions, data repository, and flow.

- Asset list, which includes tracking what assets (hardware/software/systems) are in use and retired. This helps an organization know what it has, what it needs to keep patched, what has been stolen or destroyed, what has warranties and when they expire, what needs to be insured, what needs to be replaced and when, etc.

- Risk assessment, which helps the organization think about what risks exist, what can be fixed easily or not, what is high risk and worth fixing, etc. Frequently revisiting risks and remediation helps ensure that risk assessment and remediation planning stay relevant.

Through close tracking the organization minimizes its risks related to technology and data assets, assets continue to effectively and efficiently serve the intended purpose, and it has ample opportunity to consider and plan for updates and upgrades.

1.a.(3) Communication technologies might include telecommunications systems, websites, and social media.

1.a.(4) Sensitive data might include confidential corporate information and personal data about persons served or personnel that are protected by data privacy laws.

1.a.(5) This might include services provided by vendors such as technology consulting; software development and support; desktop, network, or other hardware support; website maintenance; and cloud services.

1.b.(1) The organization may seek input from persons served on the ease with which they can use the technology available or the technology choice.
they would like to see implemented in the future. For example:

- Searching the organization’s website for locations, contact information, services available, hours of operation, or performance and outcomes information.
- A portal through which they could schedule, submit insurance information, pay bills, email a provider, or download records.
- Information and communication technologies that would allow persons served to consult specialists, receive services remotely, or submit data collected by the persons served to their providers; e.g., weight, blood pressure, or glucose levels.
- A voice response system that they can easily navigate to reach someone at the organization or to bypass information they are already familiar with.

1.b.(2) Personnel may provide input on technology they use to perform their job duties, such as:

- Electronic medical record systems.
- Mobile technology that can be used for communication, documentation, etc.
- Billing software and systems.
- Remote access to the organization’s systems and resources.
- Intranet that provides access to policies and procedures, databases, reporting, etc.

1.b.(3) The organization may have requirements from external stakeholders such as funders who require electronic exchange of information about persons served or electronic claims submission.

1.b.(4) Technology maintenance.
1.b.(5) Technology replacement.
1.b.(6) Resources needed to accomplish the goals.
1.b.(7) Timeframes.

c. Supports:
1.c.(1) The business processes of the organization.
1.c.(2) Protection of sensitive data.
1.c.(3) Efficient operations.
1.c.(4) Effective service delivery.
1.c.(5) Access to services.
1.c.(6) Performance improvement.

d. Aligns with the organization’s strategic plan.
e. Is reviewed and updated as needed.

Intent Statements

The technology and system plan addresses the programs/services seeking accreditation. If the programs/services are part of a larger organization and not specifically addressed in its technology and system plan, the programs/services may establish a separate plan or generate a supplement to the organization’s plan that addresses the elements in this standard.

1.J. 3. The organization implements policies and procedures in the following areas:

a. Acceptable use.
b. Backup/recovery.
c. Business continuity/disaster recovery.
d. Security, including:
   1) Access management.
   2) Audit capabilities.
   3) Data export and transfer capabilities.
   4) Decommissioning of physical hardware and data destruction.
   5) Protection from malicious activity.
   6) Remote access and support.
   7) Updates, configuration management, and change control.

1.J. 2. The organization implements a technology and system plan that:

a. Is based on:
1) Its current use of technology and data.
2) Identification of gaps and opportunities in the use of technology.

b. Includes:
1) Goals.
2) Priorities.
3) Technology acquisition.
Examples

3.a. Acceptable use policies and procedures might address authorized use of organization-issued technology such as computers, tablets, cell phones, and USB drives; use of email, the internet, information systems, networks, etc., including what a user is and is not allowed to do with those resources, such as whether an organization-issued laptop may be taken off the premises, whether personnel can use the internet for personal purposes during breaks, and whether printing of personal documents is allowed. Policies and procedures may also address the use of personal devices and technology for business operations.

3.b. Backup/recovery refers to the process of backing up data and setting up systems that allow data recovery in case of data loss or corruption. Policies and procedures might address the type of backup used; e.g., on site (backing up data onto a local storage device such as a tape drive or another server’s hard drive) or off site (backing up data to a remote location, a co-location facility, or using an online cloud backup service); regular monitoring and testing of backup and restore processes to verify they function as expected; data retention timeframes; the need for multiple copies of data; and distribution of data in backup and recovery planning. An organization will want to broadly consider its use of technology for both business processes and service delivery in establishing adequate procedures and what could be at risk should data be lost from systems such as payroll; billing; scheduling; medical records; or portable devices used for communication, documentation, or other transfer of data about persons served.

3.c. Business continuity/disaster recovery is a set of processes used to help an organization recover from a disaster and continue or resume routine business operations. Business continuity addresses the availability of essential business functions and processes during and after a disaster and may include the replacement of personnel, service availability issues, business impact analysis, and change management. Disaster recovery processes may include server and network restoration, copying backup data, and provisioning backup systems.

3.d.(1) Access management refers to identification and management of access to and use of technology and information resources, including authorization and de-authorization or deactivation, physical access, and electronic access. User authorization and de-authorization may address password settings; e.g., complexity, expiration, use of temporary passwords; what happens when someone begins or leaves employment; supervisor access to confidential records of their employees; etc.

3.d.(2) Audit capabilities refers to a record or audit log showing who has accessed a computer system and what operations he or she has performed during a given period of time.

3.d.(3) Data export and transfer capabilities may include defining what data are proprietary and secure, how data may be exported or transferred; e.g., email, on a flash drive, etc.; and whether data can be transferred to personal devices and back to organization-owned equipment. For example, an organization may have a policy that electronic medical records are not to be transferred via email or accessed from/stored on personal devices.

3.d.(4) Decommissioning of physical hardware and data destruction refers to the removal of hardware from active status and how that hardware will be disposed of without risking access to data; e.g., what an organization does with hard drives and backup tapes that are no longer used.

3.d.(5) Protection from malicious activity addresses protection from malicious software such as worms, viruses, trojans, spyware, adware, rootkits, etc., that accesses protected data, deletes data, or adds software not approved by the organization or user. Protection may be accomplished by firewalls, spam filtering, and other systems designed to prevent abuse or unauthorized use of systems.

3.d.(6) Remote access is the ability to access a computer or network from a separate location; e.g., someone at a branch office, a telecommuter, and/or someone traveling who may need access to the organization’s network or resources. Procedures may address who can remotely access organization information and technology and for what purpose, what equipment can be used to
Section 1.J. Technology

perform the remote access (organization-owned devices vs. personal devices), whether access is temporary or ongoing or limited to specific days or hours, and how access is accomplished. Remote access can be set up using a local area network (LAN), wide area network (WAN) or a virtual private network (VPN) so that resources and systems can be accessed remotely.

3.d.(7) Configuration management tracks an organization's hardware, software, and related information; e.g., software versions and updates installed on the organization's computer systems, network addresses belonging to the hardware devices used, etc. Change control is a systematic approach to modifying software applications or systems, patch installation, or network upgrades. Change control reduces the risk when introducing new technology (hardware or software) or changes to existing technology (e.g., software changes, operating system updates, firmware updates) by ensuring that testing and analysis are performed to understand the impacts of the change and by having procedures defined for the deployment of changes to ensure an orderly transition.

1.J. 4. A test of the organization's procedures for business continuity/disaster recovery:
   a. Is conducted at least annually.
   b. Is analyzed for:
      (1) Effectiveness.
      (2) Areas needing improvement.
      (3) Actions to be taken.
      (4) Results of performance improvement plans.
      (5) Necessary education and training of personnel.
   c. Is evidenced in writing, including the analysis.

Intent Statements
These tests are similar in nature to the tests of emergency procedures required in Standard 1.H.7. and are intended to assist in determining if the procedures function as expected to protect the organization's technology and data assets and identifying any areas where performance improvement is needed.

1.J. 5. The organization provides documented training to personnel:
   a. On cybersecurity.
   b. On the technology used in performance of their job duties.
   c. Including:
      (1) Initial training.
      (2) Ongoing training.

Examples
5.a. This training will help ensure that personnel are familiar with the organization's information security procedures, understand what information is sensitive and vulnerable, and are trained on steps to take to protect data assets.
5.c.(2) Ongoing training may be provided when there is an installation of new technology or software updates that impact how technology is used by personnel or that provide new features or functionality.

Additional Resources
- SysAdmin, Audit, Network, Security (SANS) Institute Information Security Policy Templates: www.sans.org/security-resources/policies
Standards for Service Delivery Using Information and Communication Technologies

Applicable Standards
If the organization uses information and communication technologies (ICT) to deliver services, Standards 1.J.6.–12. apply.

Description
Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, telemental health, telehabilitation, telespeech, etc. Based on the individualized plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served, family/support system members, and other providers in remote settings. The use of technology for strictly informational purposes, such as having a website that provides information about the programs and services available, is not considered providing services via the use of information and communication technologies.

The provision of services via information and communication technologies may:

- Include services such as assessment, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.
- Involve a variety of professionals such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.
- Encompass settings such as:
  - Hospitals, clinics, professional offices, and other organization-based settings.
  - Schools, work sites, libraries, community centers, and other community settings.
  - Congregate living, individual homes, and other residential settings.

1.J. 6. The organization implements written procedures:

a. That address:
   (1) Consent of the person served.
   (2) Audio recording, video recording, and photographing the person served.
   (3) Decision making about when to use information and communication technologies versus face-to-face services.

b. To confirm that all necessary technology and/or equipment is available and functions:
   (1) Prior to the start of service delivery.
   (2) As needed throughout services.
   (3) At the:
      (a) Originating site.
      (b) Remote site.

Intent Statements
6.a.(1) The organization’s procedures include obtaining written consent to participate in service delivery via information and communication technologies when applicable.

Examples
6.b.(2) There may be a need to confirm availability and/or function during the course of services if new technology or equipment is being implemented, there have been problems with the technology or equipment in prior sessions, or someone new will be responsible for operating the equipment or technology.
Resources

- 6.a.(1) Telemedicine & Informed Consent: How Informed Are You?
  http://southwesttrc.org/blog/2017/telemedicine-informed-consent-how-informed-are-you
- Ontario Telemedicine Network (OTN):
  https://support.otn.ca/sites/default/files/consent_guideline.pdf

1.) 7. As appropriate, personnel who deliver services via information and communication technologies receive competency-based training on equipment:
   a. Features.
   b. Set up.
   c. Use.
   d. Maintenance.
   e. Safety considerations.
   f. Infection control.
   g. Troubleshooting.

Intent Statements

For service delivery to be effective, personnel are trained to use equipment and technology to deliver services as well as to guide persons served, members of the family/support system, and others in the remote setting on its use.

Examples

7.f. Infection control addresses equipment used at the originating site and the remote site. For example:

- Equipment that touches any part of the body or is used to look into someone’s eyes, ears, or mouth is properly sanitized between each use.
- The person served and family members in the home are instructed in proper handwashing technique, shielding coughs and sneezes, and the use, if necessary, of gloves or masks to minimize risks associated with sharing equipment.
- When the person served is using a computer at a school or library, the keyboard, mouse, and headset are cleaned appropriately before they are used.

1.) 8. As appropriate, instruction and training are provided:
   a. To:
      (1) Persons served.
      (2) Members of the family/support system.
      (3) Others.
   b. On equipment:
      (1) Features.
      (2) Set up.
      (3) Use.
      (4) Troubleshooting.

1.) 9. Service delivery includes:
   a. Personnel to provide assistance with accessing services provided by the organization.
   b. Based on identified need:
      (1) An appropriate facilitator at the site where the person served is located.
      (2) Modification to:
          (a) Treatment techniques/interventions.
          (b) Equipment.
          (c) Materials.
          (d) Environment of the remote site, including:
              (i) Accessibility.
              (ii) Privacy.
              (iii) Usability of equipment.

Examples

9.b.(1) Depending on the purpose of the session and the needs of the person served, professional personnel, support personnel, family members, or caregivers might function in the role of facilitator.
10. Prior to the start of each session:
   a. All participants in the session are identified, including those at:
      (1) Originating site.
      (2) Remote site.
   b. The organization provides information that is relevant to the session.

Examples
10.b. Information may be shared on the credentials of the provider, structure and timing of services, record keeping, scheduling, contact between sessions, privacy and security, potential risks, confidentiality, billing, rights and responsibilities, etc.

11. The organization maintains equipment in accordance with manufacturers' recommendations.

12. Emergency procedures address the unique aspects of service delivery via information and communication technologies, including:
   a. The provider becoming familiar with the emergency procedures of the remote site, if the procedures exist.
   b. Identification of local emergency resources, including phone numbers.

Examples
When the person served is located at an organization or a community setting the provider becomes familiar with the procedures of that setting in the event there is an emergency involving the person served. In the absence of emergency procedures for the setting where the person served is located, or when the person served is in his or her own home, the provider has immediate access to emergency contact information for the person served and information on local emergency resources, including their phone numbers.

Additional Resources
- American Telemedicine Association: www.americantelemed.org
- VA Telehealth Services: www.telehealth.va.gov/real-time
- International Journal of Telerehabilitation: telerehab.pitt.edu/ojs/index.php/Telerehab
- Center for Connected Health Policy National Telehealth Policy Resource Center: http://cchpca.org

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Technology and system plan
- Policies and procedures on technology use, backup/recovery, business continuity/disaster recovery, and security
- Documentation of business continuity/disaster recovery tests and analyses
- Documentation of training provided to personnel
- Evidence of ongoing assessments of the organization’s use of technology and data
K. Rights of Persons Served

Description
CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

1.K. The organization implements policies promoting the following rights of the persons served:
   a. Confidentiality of information.
   b. Privacy.
   c. Freedom from:
      (1) Abuse.
      (2) Financial or other exploitation.
      (3) Retaliation.
      (4) Humiliation.
      (5) Neglect.
   d. Access to:
      (1) Information pertinent to the person served in sufficient time to facilitate his or her decision making.
      (2) Their own records.
   e. Informed consent or refusal or expression of choice regarding:
      (1) Service delivery.
      (2) Release of information.
      (3) Concurrent services.
      (4) Composition of the service delivery team.
      (5) Involvement in research projects, if applicable.
   f. Access or referral to:
      (1) Legal entities for appropriate representation.
      (2) Self-help support services.
      (3) Advocacy support services.
   g. Adherence to research guidelines and ethics when persons served are involved, if applicable.
h. Investigation and resolution of alleged infringement of rights.
   i. Other legal rights.

Intent Statements

To demonstrate relevant service delivery and appropriate ongoing communication with the persons served, the organization implements a system of rights that nurtures and protects the dignity and respect of the persons served. All information is transmitted in a manner that is clear and understandable.

Examples

1.a. In a behavioral health setting, the policies address the sharing of confidential billing, utilization, clinical, and other administrative and service-related information and the operation of any internet-based services that may exist. Information that is used for reporting or billing is shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the federal rules for addiction treatment programs (42 CFR) and HIPAA in the United States. Organizations need to pay particular attention to handling of PHI.

In Canada, the regulatory requirements may be found in:

- The federal Personal Information Protection and Electronic Documents Act (PIPEDA).
  In some provinces and territories, for example British Columbia, Alberta, and Quebec, the federal government has exempted organizations from PIPEDA because substantially equivalent provincial legislation is in place.

- Provincial legislation dealing with freedom of information and protection of personal information in the public sector.

- Legislation that deals specifically with health information in those provinces and territories that have such legislation.

The parameters of confidentiality may identify items that may or may not be disclosed without authorization for the release of information as well as those areas identified in mandatory disclosure laws and regulations. Confidentiality may be limited in such settings as criminal justice or when providing services to someone who demonstrates a risk to self or others.

When developing its confidentiality policy, the organization takes into consideration staff use of email, texting, blogging, and common forums such as Facebook and Twitter for work or work-related communication.

1.c. The organization ensures that the person served is protected from physical, sexual, psychological, and fiduciary abuse; harassment and physical punishment; and humiliating, threatening, or exploiting actions. Sexual abuse or harassment may include any gestures, verbal or physical, that reference sexual acts or sexuality or objectify the individual sexually. Fiduciary abuse refers to any exploitation of the persons served for financial gain. This abuse could include misuse of the funds of the persons served or taking advantage of the provider relationship with the person served.

1.d. The persons served are provided with information pertaining to immediate, pending, and potential future treatment needs. Information is offered in a manner that is clear and understandable, with risks identified when applicable. In short-term care settings, the information may be provided verbally, with some written literature available. In longer-term programs, the information may be provided verbally, through educational or wellness workshops/sessions, through the distribution of literature, and through active participation in team meetings and treatment planning.

1.d.(2) The policy identifies how persons served can access their own record either visually or by obtaining a hard copy. It is expected that requests would be addressed in a timely manner. In lieu of laws or regulations that are more specific, a reasonable timeframe would generally be 30 days.

1.e. Commitment to treatment or other legally imposed treatment or intervention may sometimes create situations where consent for treatment is not totally voluntary.

1.e.(2) In a behavioral health program, the policy regarding authorization for the release of information conforms to Standard 2.G.1.

1.f. Information may be provided through service directories or a handbook for persons served as part of the orientation of the person served,
Section 1.K. Rights of Persons Served

The rights of the persons served are:

a. Communicated to the persons served:
   (1) In a way that is understandable.
   (2) Prior to the beginning of service delivery or at initiation of service delivery.
   (3) At least annually for persons served in a program longer than one year.

b. Available at all times for:
   (1) Review.
   (2) Clarification.

Intent Statements
To ensure that the persons served have a clear understanding of their rights, the organization communicates and shares these rights in a manner that is understandable to the persons served.

Examples
The amount of information provided may vary depending upon the type of service (e.g., crisis intervention or stabilization) or the condition of the person served (e.g., someone admitted for detoxification). The method used for communication should reflect the needs of the person served and may include verbal presentation, large print, translation into a different language, a consumer handbook, or use of a representative for the person served.

The organization:

a. Implements a policy and written procedure by which persons served may formally complain to the organization that specifies:
   (1) Its definition of a formal complaint.
   (2) That the action will not result in retaliation or barriers to services.
   (3) How efforts will be made to resolve the complaint.
   (4) Levels of review, which include availability of external review.
   (5) Timeframes that:
      (a) Are adequate for prompt consideration.
      (b) Result in timely decisions for the person served.

b. Makes complaint procedures and, if applicable, forms:
   (1) Readily available to the persons served.
   (2) Understandable to the persons served.

c. Documents formal complaints received.

An analysis of all formal complaints:

a. Is conducted at least annually.

b. Is documented, including:
   (1) Whether formal complaints were received.
   (2) Trends.
   (3) Areas needing performance improvement.
   (4) Actions to be taken to address the improvements needed.
   (5) Actions taken or changes made to improve performance.

Intent Statements
An analysis of formal complaints can give the organization valuable information to facilitate change that results in better customer service and results for the persons served.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies promoting the rights of the persons served
- Policy and procedures for formal complaints
- Definition of formal complaint
- Information regarding staff training on rights of persons served, informed consent, complaint/grievance procedures, etc.
- Handbook for persons served, orientation materials, updated information regarding rights
- Records of the persons served showing informed consent
- Conflict resolution information
- Grievance and appeal process
- Documentation of formal complaints received
- Documentation showing review of complaints at least annually
- Action plan or changes made to improve performance and to reduce complaints
- External and internal investigation reports and related corrective action plans
- Documentation that rights of persons served are reviewed at least annually with the persons served, if applicable.

L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

1.L. The organization’s leadership:

a. Assesses the accessibility needs of the:
   (1) Persons served.
   (2) Personnel.
   (3) Other stakeholders.

b. Implements an ongoing process for identification of barriers in the following areas:
   (1) Architecture.
   (2) Environment.
   (3) Attitudes.
   (4) Finances.
   (5) Employment.
   (6) Communication.
   (7) Technology.
   (8) Transportation.
   (9) Community integration, when appropriate.
   (10) Any other barrier identified by the:
        (a) Persons served.
        (b) Personnel.
        (c) Other stakeholders.

Intent Statements

The leadership has a working knowledge of what should be done to promote accessibility and remove barriers. Organizations address accessibility issues in order to:

- Enhance the quality of life for those served in their programs and services.
- Implement nondiscriminatory employment practices.
- Meet legal and regulatory requirements.
- Meet the expectations of stakeholders in the area of accessibility.
The leadership should address how input was solicited from the persons served, personnel, and other stakeholders to assist in the identification of barriers, and take into consideration any accessibility needs—physical, cognitive, sensory, emotional, or developmental—that may hinder full and effective participation on an equal basis with others.

Examples

Examples of accessibility planning may be found in minutes of meetings where analysis, action planning, and goals are established; in conversations with stakeholders; in focus groups and council meetings; in community events; in surveys, etc.

1.b.(1) Architectural or “physical” barriers are generally easy to identify and may include steps that prevent access to a building for an individual who uses a wheelchair, narrow doorways that need to be widened, bathrooms that need to be made accessible, the absence of light alarms for individuals who have a hearing impairment, and the absence of signs in Braille for individuals who have visual impairments.

1.b.(2) Environmental barriers can be interpreted as any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained. Some clinics may be located in areas where the persons served and/or personnel do not feel safe or feel that confidentiality may be risked.

In addition to such external environmental barriers, internal barriers may include noise level, lack of soundproof counseling rooms, highly trafficked areas used for service delivery, or type or lack of furnishing and décor that impact the comfort level of the persons served and personnel.

1.b.(3) Attitudinal barriers may include, but are not limited to:

- The terminology and language that the organization uses in its literature or when it communicates with persons with disabilities, other stakeholders, and the public (e.g., does the organization use “person first” language?).

- How persons with disabilities are viewed and treated by the organization, their families, and the community (e.g., dependent versus independent or interdependent and not valuable versus valuable.).

- Whether or not consumer input is solicited and used.

- Whether or not the eligibility criteria of the organization screen out individuals with specific types of disabilities.

1.b.(6) Communication barriers may include the absence of a telecommunication device for the deaf (TDD) and the absence of material in a language or format that is understood by the persons served.

1.b.(8) Transportation barriers may include persons being unable to reach service locations at all or to participate in the full range of services and other activities.

1.b.(9) Barriers to community integration include any barrier that would keep the persons served from returning to full participation in their community of choice. For example, participation in sports may be limited by the lack of a lift at the public swimming pool for access by persons served with limited mobility or the lack of scheduling availability of the local gym for an adaptive sports program; accommodations may be needed for the persons served to return to previous volunteer activities with the community food bank.

1.b.(10) Customer satisfaction surveys may help identify other barriers. Other barriers may include those raised by evolving technology, upkeep of previous repairs or changes, or issues more specific to the populations to whom the organization provides services.

Any other barriers to services that are identified should be addressed.

Resources

Information on the ADA is provided by the U.S. Department of Justice. The ADA website is located at [www ada gov](http://www.ada.gov).

Information on the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) is available at [www ontario ca/page/accessibility-laws](http://www.ontario.ca/page/accessibility-laws).
1.b.(6) Resources on accessibility and health literacy include:

- Shirley Ryan AbilityLab Health Literacy: www.sralab.org/lifecenter/resources/health-literacy-using-plain-language-health-communications
- United States Department of Health and Human Services Agency for Healthcare Research and Quality: www.ahrq.gov/topics/health-literacy.html
- Center for Plain Language: www.centerforplainlanguage.org
- World Wide Web Consortium Web Accessibility Initiative: www.w3.org/WAI
- Canadian Literacy and Learning Network: www.literacy.ca/?q=literacy/clearwriting
- LiteracyBC: www.literacybc.ca/PLRC/ResourceCentre.html
- Language Portal of Canada: www.noslangues-ourlanguages.gc.ca
- Canadian Public Health Association Plain Language Service: www.cpha.ca/plain-language-service

1.L. The organization implements an accessibility plan that:

a. Includes, for all identified barriers:
   (1) Actions to be taken.
   (2) Timelines.

b. Is reviewed at least annually for relevance, including:
   (1) Progress made in the removal of identified barriers.
   (2) Areas needing improvement.

c. Is updated as needed.

Intent Statements

There may be barriers identified that the organization does not have the authority or resources to remove; effective accommodations may be the appropriate action to be taken in those circumstances.

Examples

Written documentation of potential barriers to services exists. When identifying potential barriers to services, the organization looks at barriers within the organization itself and in the community, including the attitudes that its staff members and other stakeholders have of persons with disabilities, which may greatly impact initial and ongoing access to services.

1.L. 3. Requests for reasonable accommodations are:

a. Identified.

b. Reviewed.

c. Decided upon.

d. Documented.

Intent Statements

The organization evaluates and carefully considers the merits of all requests for accommodation to determine whether any remedial actions are appropriate.

Please see the Glossary for a definition of reasonable accommodations.

Examples

A request for a reasonable accommodation does not automatically require that the organization meet the request. There should be a review of the request. How is the organization alerted to the need for the reasonable accommodation? What is the review process? Who is identified as responsible for approving or denying the accommodation request? What are the decision-making criteria?

When an accommodation cannot be made, the organization demonstrates a referral system that assists the persons served in the use of other resources that are accessible.

In Canadian Secure Services programs, the organization has a process in place to consider requests for leaves of absence.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written accessibility plan
- Identification of accessibility barriers
- Review of accessibility plan at least annually
- Requests for reasonable accommodations
- Documentation regarding reasonable accommodations that have been provided
- Meeting minutes
- Information regarding leadership advocacy activities
- If virtual access to services is provided, policies/procedures to ensure accessibility and accommodations
Review Results

To stay on target at both strategic and tactical levels, the organization must constantly monitor and assess its performance against a series of performance indicators and targets. Only by setting specific, measurable goals and tracking performance can the organization determine the degree to which it is achieving the desired service and business outcomes. Appropriate organizational and stakeholder representatives must review and analyze results to determine areas for improvement. This review and analysis positions the organization to develop and initiate performance improvement changes.

M. Performance Measurement and Management

Description

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and analyzed, and information is used to manage and improve service delivery.

1.M. The organization has a written description of its performance measurement and management system that includes, at a minimum:
   b. Programs/services seeking accreditation.
   c. Objectives of the programs/services seeking accreditation.
   d. Personnel responsibilities related to performance measurement and management.

Intent Statements

A critical component of quality, the implementation of performance measurement and management systems for both business and service delivery allows an organization to look objectively at how well it is accomplishing its mission. There is a direct connection between a number of day-to-day processes addressed throughout the CARF standards, e.g., those related to financial management, complaint management, professional development for personnel, individualized service delivery, etc., and performance management in that those processes become sources of information used to analyze performance. This written description provides the context for the organization’s efforts.
and could be used to educate personnel and other relevant stakeholders about its approach to performance measurement and management, included in marketing or performance information that is shared with stakeholders, and/or incorporated into ongoing strategic planning activities.

**Examples**

1.c. The objectives of the programs/services offered include both business and service delivery objectives, e.g., the program will have less than a certain percentage of turnover in personnel who have been employed for more than a year, safety drills will be completed by a certain date, a certain percentage of persons served will return to work, or a certain percentage of persons served will return home without the need for assistance.

1.d. Personnel may have a variety of roles and responsibilities in implementing performance measurement and management systems, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.

**1.M. 2. The organization demonstrates how its data collection system addresses the following:**

- **a. Reliability.**
- **b. Validity.**
- **c. Completeness.**
- **d. Accuracy.**

**Intent Statements**

Accurate and consistent data will be the deciding factor in the success of an organization moving to or maintaining a fact-based, decision-making model.

**Examples**

There are a variety of ways an organization can demonstrate that it addresses the integrity of the data it uses for outcomes assessment, performance improvement, and management decision making. These approaches can range from the simple to sophisticated. It is not required that the organization subscribe to a proprietary data vendor in order to achieve data integrity.

**2.a. Reliability.** The organization takes steps to ensure that data are collected consistently in a way that could be reproduced at another time or by other data gatherers. For example:

- New and existing personnel are trained on recording each data element they are responsible for collecting; measures or codes are explained and periodically reviewed.
- Inter-rater reliability assessments can be conducted in which different staff members record measures for the same persons served, and data are compared statistically to assess whether different staff members arrive at the same ratings for a given individual.
- The organization wants to measure severity at intake to the program. It searches the literature and selects a measure that has been widely tested and demonstrated to be reliable with this population.
- The organization serves a large number of people each year. Rather than send satisfaction questionnaires to all of them, the organization selects a random sample of 50 percent from each of its program areas’ clientele. Before the questionnaires are sent, the data manager reviews the characteristics of the sample to ensure that the sample is representative of the total group served in terms of diagnosis/reason for seeking services, age, gender, and ethnicity.

**2.b. Validity.** The organization chooses indicators, measures, and data elements that measure what it intends to measure. For example:

- Stakeholders express interest in return-to-work and in minimizing days lost due to incapacity for persons referred to the program. The organization chooses to collect employment status at follow-up and asks about the number of days of work lost due to activity limitations instead of just the diagnostic data it has always summarized.
- A program’s stakeholders are interested in reducing the level of impairment in persons served. The program does a literature review
and selects a standardized tool or measure known to be valid and reliable.

2.c. Completeness. The organization takes steps to ensure that the data used for decision making are as complete as possible, no accredited programs are omitted from the information and performance improvement effort, no groups of persons served are omitted from the data gathering or analysis, no data elements or indicators are systematically missing, and any database is checked for completeness of records before final analyses are run and decisions made. For example:

- The quality council and data manager collaborate on designing an information system regarding the persons served that includes necessary data elements for all programs of the organization. They decide to design an organizationwide system, but identify each record with the particular program in which the person participates so analysis can be done separately for all the programs to be surveyed.

- Staff training for the data-recording activities includes attention to the importance of recording each data field for every person served.

- The data manager routinely cross checks the number of client records in the database with the operations officer’s report of the number of persons served during a reporting period to ensure that data are available on all persons served before analysis is conducted and reports are generated. Missing records are located and entered into the database before analysis is conducted.

2.d. Accuracy. The organization takes steps to ensure that data are recorded properly and that errors are caught and corrected. For example:

- Spot checks of the records of the persons served are made to ensure that data abstracted from the record are correctly placed into the database.

- The data manager routinely reviews the distribution of values in test data runs and asks the direct care staff members to double check the accuracy of cases that seem to be outside of expectations in terms of maximum or minimum values. (For example, did someone really stay in the program 205 days or was it 20 days?)

1.M. 3. The data collected by the organization:

a. Include:
   - (1) Financial information.
   - (2) Accessibility information.
   - (3) Resource allocation.
   - (4) Surveys, if applicable.
   - (5) Risk management.
   - (6) Governance reports, if applicable.
   - (7) Human resource activities.
   - (8) Technology.
   - (9) Health and safety reports.
   - (10) Strategic planning information.
   - (11) Field trends, including research findings, if applicable.
   - (12) Service delivery.

b. Address:
   - (1) The needs of persons served.
   - (2) The needs of other stakeholders.
   - (3) The business needs of the organization.

c. Allow for comparative analysis.

d. Are used to set:
   - (1) Written business function:
     - (a) Objectives.
     - (b) Performance indicators.
     - (c) Performance targets.
   - (2) For each program seeking accreditation, written service delivery:
     - (a) Objectives.
     - (b) Performance indicators.
     - (c) Performance targets.

Intent Statements

Organizations continually collect data from a variety of internal and external sources. These data are analyzed and the results are used to make informed decisions about the needs of the persons served and other stakeholders as well as the business needs of the organization. Business function and service delivery objectives, performance indicators, and performance targets
are set as appropriate to the specific needs of the organization. There does not necessarily need to be a performance indicator and target for each area of data collected.

3.d.(2)(b) At a minimum, service delivery performance indicators for each program seeking accreditation include indicators for effectiveness of services, efficiency of services, service access, and satisfaction and other feedback from a variety of perspectives including the persons who received the services and other stakeholders. These indicators are the basis for the measurement of service delivery indicators addressed in Standard 1.M.6.b.

See the Glossary for definitions of performance indicator and performance target.

Examples
The organization uses information and establishes performance indicators as appropriate to its specific needs. There does not necessarily need to be an indicator for each of these items.

3.a.(4) Surveys may refer to satisfaction questionnaires, state/provincial or other jurisdictional surveys, national surveys, CARF surveys, other accreditation surveys, needs assessments, etc.

The organization takes a proactive role by ensuring that specific activities, such as strategic planning and risk analysis, are conducted to protect the organization’s assets, maintain its viability, and position itself as the quality expectations of stakeholders change.

In strategic planning, the organization may begin by doing an environmental scan and asking all of its stakeholders for input.

In its review of the implementation of the written accessibility plan, the organization ensures that the planned actions are actually taken to reduce barriers to services. This certainly has implications for budget planning.

Addressing business improvement strategies based on the information gathered can be done in a variety of ways:

- Periodically, a report could be completed that encompasses the critical issues surrounding business performance. With advance planning and a consistent outline to follow in order to comment on relevant data, the report could be pulled together at the end of the fiscal or calendar year, whichever timeframe is more meaningful to the organization.

- In large organizations that have several administrative personnel, the report could be gathered by different personnel or board members and summarized by one individual. The board could address governance reports, the lead financial person could summarize financial data, the safety lead could comment on relevant health/safety reports, and the technology lead personnel could summarize information that impacts technology needs.

- In smaller organizations that have few administrative personnel, one person might summarize the report. However, there should be less to comment on in each area, considering the different scopes of large and small organizations. As a result of the different complexities of varied organizations, the report should reflect the specific issues facing the organization.

- A large organization may produce a report that contains many pages, attachments, charts, and other relevant information. A small organization may produce a much shorter report, but it will still cover the topics relevant to its challenges.

4. The organization collects data about the characteristics of the persons served.

Intent Statements
Characteristics include a wide variety of data that reflect relevant information about the persons served. As data are collected and aggregated at the level of each program/service seeking accreditation, the identification and analysis of any significant performance differences of the program/service in serving relevant groups ties into later being able to target specific program improvements.

Examples
Smaller organizations may need to include all persons served in their performance improvement systems to ensure that the characteristics of persons served are included. However, when an organization serves a large number of individuals, the performance improvement system may include a representative sample of all individuals.
it served or intended to serve. A representative sample of the persons the program served, or intended to serve, could include categories of characteristics such as age, gender, ethnicity, linguistic needs, locations, and severity of disability/disorder. It is important to include the persons the organization served or intended to serve to ensure that those individuals who drop out prematurely or who do not return are included in the performance improvement system. Valuable information for program improvement can be gathered from persons who leave the program prior to successful completion. An organization that follows up only on successful discharges would not be in conformance to this standard.

1.M. 5. The organization collects data about the persons served at:
   a. The beginning of services.
   b. Appropriate intervals during services.
   c. The end of services.
   d. Point(s) in time following services.

Examples
Data are collected and aggregated at the level of each individual program/service seeking accreditation. This is important for analysis that can therefore identify performance differences between programs and target specific improvements.
5.d. For follow-up, organizations may attempt to contact each person or a representative sample of persons who have left services/supports. Refer to the Glossary for the definition of representative sample.

1.M. 6. The organization measures:
   b. Service delivery performance indicators for each program/service seeking accreditation in each of the following areas:
      (1) The effectiveness of services.
      (2) The efficiency of services.
      (3) Service access.

(4) Satisfaction and other feedback from:
   (a) The persons served.
   (b) Other stakeholders.

Intent Statements
Refer to the Glossary for definitions of effectiveness, efficiency, and service access.

Examples
6.b.(1) Effectiveness measures address the quality of care through measuring change over time. Specific effectiveness measures for behavioral health programs can include:
   ■ Maintenance of abstinence.
   ■ Community integration.
   ■ Reduction or elimination of incidence of relapse.
   ■ Reduction or elimination of negative involvement with the criminal justice system.
   ■ Improvement of physical health.
   ■ Improvement in school functioning.
   ■ Reduction of hospitalization.
   ■ Reduction of symptoms.
   ■ Increase in the level of psychological functioning.
   ■ Increase in self-esteem.
   ■ Acceptance rate of participants into a program.
   ■ Home visitation completion rates.
   ■ Reduction of reported interventions by the program.
   ■ Decreased episodes of anger.
   ■ Reduction or elimination of the prevalence of a prevention target.
   ■ Number, duration, and frequency of symptomatic and/or asymptomatic behaviors.
   ■ Involvement in activities of daily living.
   ■ Employment status.
   ■ Community tenure.
   ■ Housing situation.
   ■ Receipt of entitlement benefits.
   ■ Quality of relationships.
Health status.
Subjective psychological well-being.

6.b.(2) Efficiency measures are usually administratively oriented and may include, but are not limited to:

- Service delivery cost per service unit.
- Occupancy rates.
- Retention rates.
- Direct service hours of clinical staff.
- Personnel turnover.
- Length of stay.
- Service utilization.

6.b.(3) Access to service can be measured by:

- Waiting time for routine or emergency care.
- Convenience of service hours and locations.
- Telephone response time or abandonment rates.
- Time taken to set a first or subsequent appointment.
- The success of formal referral mechanisms.
- Waiting list information on persons found ineligible for services.

6.b.(4) Satisfaction measures are usually oriented toward consumers, family members, personnel, the community, and funding sources and may include, but are not limited to:

- Was the person served given hope?
- Was the person served treated with dignity and respect?
- Did the organization focus on the recovery for the person served?
- Were grievances or concerns addressed?
- Overall feelings of satisfaction.
- Use of informed choices about modes of treatment, medications, etc.
- Satisfaction with physical facilities, fees, access, service effectiveness, and service efficacy.

Data regarding the satisfaction of the persons served with services are collected from persons active in long-term services and from those who leave services in a relatively short time. Such data may be collected in a variety of ways, including interviews following discharge, telephone surveys, mail surveys, proxy measures used with persons unable to communicate directly, and formalized published satisfaction scales. The results of consumer satisfaction surveys can be collected either continuously throughout the year or at regularly scheduled points in time, such as quarterly.

1.M. 7. For each service delivery performance indicator, the organization determines:

a. To whom the indicator will be applied.

b. The person(s) responsible for collecting the data.

c. The source from which data will be collected.

d. A performance target based on an industry benchmark, the organization’s performance history, or established by the organization or other stakeholder.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Description of performance measurement and management system
- Management reports
- Strategic plan
- Budgets and financial reports
- Accessibility plans
- Technology plan
- Risk management plan
- Environmental health and safety reports
- Satisfaction information of persons served and other stakeholders
- Demographics information of persons served
- Documentation of data collection process
- Data collected
- Quality assurance reports
- Written business function objectives, performance indicators, and performance targets
- For each program seeking accreditation, written service delivery objectives, performance indicators, and performance targets
Effect Change

Following the review and analysis of results, the organization must carefully evaluate the information learned so that it may be translated into focused actions to improve performance against targets. The evaluation drives the organization to engage in a dynamic, proactive process to review, renew, or revise its strategy and tactics, while ensuring alignment of organizational purpose, service and business practices, and organizational resources. Achieving excellence requires a disciplined continuous improvement process.

N. Performance Improvement

Description

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

1.N. A written analysis is completed:
   a. At least annually.
   b. That analyzes performance indicators in relation to performance targets, including:
      (1) Business functions.
      (2) Service delivery of each program seeking accreditation, including:
         (a) The effectiveness of services.
         (b) The efficiency of services.
         (c) Service access.
         (d) Satisfaction and other feedback from:
            (i) The persons served.
            (ii) Other stakeholders.
      (3) Extenuating or influencing factors.
   c. That:
      (1) Identifies areas needing performance improvement.
Section 1.N. Performance Improvement

(2) Results in an action plan to address the improvements needed to reach established or revised performance targets.

(3) Outlines actions taken or changes made to improve performance.

Intent Statements

Through implementation of the standards in Section 1.M., the organization establishes its framework for performance measurement and management, including the identification of objectives, performance indicators, and performance targets related to business functions and service delivery. Analyzing each performance indicator in relation to its target, including consideration of extenuating or influencing factors that may impact performance, provides the organization with information on areas meeting or exceeding targets and areas in need of improvement. An action plan for improvement can then be developed in accordance with the organization’s priorities, resources, and other considerations.

Examples

The performance analysis reviews data aggregated at a program/service level for each program/service seeking accreditation in order that the action plan can target improvements at the individual program/service level.

1.a. An analysis of performance information at least annually provides information to aid in the strategic positioning of the organization. An organization may choose to measure progress and conduct reviews more frequently because of the value the information provides in managing programs and services.

1.b. The performance analysis is designed to support the actions and activities for improving the business functions and service delivery of the organization through reviews by the governance authority, communicating information with stakeholders, and supporting the plans for improving individual service delivery. The summary analysis gives needed information for making decisions and improvements in services. Data and information in the report may be presented in written form, in charts, or in graphs.

1.b.(3) Examples of extenuating or influencing factors that could impact performance include a change in leadership, relocation, reductions in budget, personnel shortages, and new regulations.

1.c. Although CARF does not prescribe the style or structure of the action plan, best practices suggest plans contain at least the following:

- An update on action items from the previous report (e.g., what has been accomplished or has resulted from changes suggested by analysis of the previous year’s outcomes)
- Demographic data
- Follow-up data collected from those who have exited services
- A report on the data collected (effectiveness, efficiency, service access, and satisfaction measurements) for each program/service aggregated individually and discussion of analysis of the data
- A conclusion, including recommendations and a to-do list with action items

The intent is that the organization compare the results achieved for each of the targets to those identified for effectiveness, efficiency, service access, satisfaction of persons served, and satisfaction of other stakeholders.

An organization demonstrates commitment to the continuous improvement of organizational quality and service excellence. Information from the analysis is used for improving the delivery of and planning for services. Some examples of its use could include identifying efficient and effective methods of providing services/supports; recognizing personnel accomplishments; reassessing the mission; recruiting personnel based on outcomes targets; and identifying issues, concerns, or trends that should be considered in changing services and updating the strategic plan.

An action plan provides information to aid in the strategic positioning of the organization. The plan gives pertinent information for making decisions and improvements in services and actively supporting the actions and activities of organizational improvements through reviews by the governance authority, communication of
1.N. 2. The analysis of performance indicators is used to:
   a. Review the implementation of:
      (1) The mission of the organization.
      (2) The core values of the organization.
   b. Improve the quality of programs and services.
   c. Facilitate organizational decision making.
   d. Review or update the organization's strategic plan.

Intent Statements
Mission-driven measurement underpins the performance improvement framework that is created through the standards. Analyzing performance indicators provides a basis for decision making that aligns with and validates that the organization's mission and core values are in place and practiced. Although not every performance indicator that is measured and analyzed may be acted on, the information gleaned from the analysis allows for a fact-based approach to decision making, planning, and performance improvement.

Examples
The organization demonstrates:
- Knowledge of the needs and goals of its customers (persons served and other stakeholders).
- Knowledge of the operational status of the organization, the business strategies it employs to be successful, and how performance improvement is utilized at all levels of the organization.
- How it measures the activities and goals of persons served.
- How it makes decisions to expand, open new sites, develop new services, modify a treatment approach, or change personnel patterns.
- Methods for reaching these decisions, which may include reviews of information, outcomes management reports, budgets, strategic plans, and satisfaction surveys. A CARF-accredited organization uses a fact-based decision-making process to identify and respond to organizational needs.

1.N. 3. The organization communicates performance information:
   a. To:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders.
   b. According to the needs of the specific group, including:
      (1) The format of the information communicated.
      (2) The content of the information communicated.
      (3) The timeliness of the information communicated.
   c. That is accurate.

Intent Statements
In a consumer-driven market, CARF-accredited organizations realize the importance of sharing their performance information with the persons served and other stakeholders. The information is tailored to meet the needs of a variety of stakeholders both internal and external to the organization.

Examples
Sharing performance information with internal and external stakeholders is a vital aspect of continuously improving the services of the organization.

There are various ways to communicate outcomes information, including press releases, annual reports, posting summaries or graphics on the organization's website, and newsletters. The report is tailored to the audience in an understandable language or medium, including the use of charts, graphs, and audio or video recordings. Typical practice in continuous quality improvement is to share the information with all stakeholders who have given input.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A written performance analysis (outcomes performance report) at least annually
- Management reports or meeting minutes
- Strategic plans
- Budgets
- Accessibility plans
- Technology plan
- Risk management plans
- Environmental health and safety reports
- Satisfaction information of persons served and other stakeholders
- Demographics information of persons served
- Follow-up information
- Dashboards, score cards, or written outcomes information provided to stakeholders, if applicable
- Quality assurance reports
- Action plan to address improvements needed
- Mission and core values of the organization
SECTION 2

General Program Standards

Description
For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. A commitment to quality and the involvement of the persons served span the entire time that the persons served are involved with the organization. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. The persons served have the opportunity to transition easily through a system of care.

Applicable Standards
The standards in Section 2 typically apply to all of the programs in Sections 3 and 4; however, some exceptions apply. Please refer to the following grid to determine the standards in Section 2 that are applicable to the programs in Sections 3 and 4 for which your organization is seeking accreditation.
### Section 2. General Program Standards

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 3. Core Treatment Program Standards

#### Crisis Intervention, Crisis Stabilization, and Detoxification/Withdrawal Management

<table>
<thead>
<tr>
<th></th>
<th>apply all</th>
<th>apply*</th>
<th>apply*</th>
<th>apply*</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>apply*</th>
<th>apply all</th>
</tr>
</thead>
</table>

**Student Counseling**

<table>
<thead>
<tr>
<th></th>
<th>apply all</th>
<th>apply 2.B.1.–8.d.(1)e., 9., and 14.</th>
<th>not applicable</th>
<th>not applicable</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>apply 2.G.1.</th>
<th>apply all</th>
</tr>
</thead>
</table>

**All other Behavioral Health Core Treatment Programs**

<table>
<thead>
<tr>
<th></th>
<th>apply all</th>
<th>apply all</th>
<th>apply all</th>
<th>apply all</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>apply all</th>
<th>apply all</th>
</tr>
</thead>
</table>

### Section 4. Core Support Program Standards

#### Assessment and Referral and Call Centers

<table>
<thead>
<tr>
<th></th>
<th>apply 2.A.1.–10., 15., 16., 18.–20., 23., and 24.</th>
<th>apply 2.B.1.–12.*</th>
<th>not applicable</th>
<th>not applicable</th>
<th>not applicable</th>
<th>not applicable</th>
<th>apply*</th>
<th>apply*</th>
</tr>
</thead>
</table>

#### Community Housing, Employee Assistance, and Supported Living

<table>
<thead>
<tr>
<th></th>
<th>apply 2.A.1.–20.</th>
<th>apply</th>
<th>apply</th>
<th>apply</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>apply</th>
<th>apply all</th>
</tr>
</thead>
</table>

#### Diversion/Intervention

<table>
<thead>
<tr>
<th></th>
<th>apply 2.A.1.–20.</th>
<th>not applicable</th>
<th>not applicable</th>
<th>not applicable</th>
<th>not applicable</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>not applicable</th>
<th>not applicable</th>
</tr>
</thead>
</table>

#### Prevention and Comprehensive Suicide Prevention

<table>
<thead>
<tr>
<th></th>
<th>apply 2.A.1.–10., 15., 16., 18., and 19.</th>
<th>not applicable</th>
<th>not applicable</th>
<th>not applicable</th>
<th>apply 2.E.1.; all others, as applicable</th>
<th>apply 2.F.1. and 2.F.2.; all others, as applicable</th>
<th>not applicable</th>
<th>not applicable</th>
</tr>
</thead>
</table>

* Note of exception:
In these clinically driven programs of brief duration, documentation may not be as extensive as in programs of longer duration. Consumer-run programs may not necessarily reflect in-depth clinical documentation.
A. Program/Service Structure

Description
A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

**NOTE: Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.**

2.A. 1. Each program/service:
   a. Documents the following parameters regarding its scope of services:
      (1) Population(s) served.
      (2) Settings.
      (3) Hours of services.
      (4) Days of services.
      (5) Frequency of services.
      (6) Payers and funding sources.
      (7) Fees.
      (8) Referral sources.
      (9) The specific services offered, including whether the services are provided directly, by contract, or by referral.
   b. Shares information about the scope of services with:
      (1) The persons served.
      (2) Families/support systems, in accordance with the choices of the persons served.
      (3) Referral sources.
      (4) Payers and funding sources.
      (5) Other relevant stakeholders.
      (6) The general public.
   c. Reviews the scope of services at least annually and updates it as necessary.

Intent Statements
The scope is defined at the level of the program/service and provides the persons served, families/support systems, referral sources, payers and funding sources, and other relevant stakeholders with information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.

Examples
Many organizations may incorporate this information in the program description required in Standard 2.A.9.

1.b. Training programs often use websites to post information regarding fees as well as hours and days of classes.

2.A. 2. The organization provides the resources needed to support the overall scope of each program/service.

Intent Statements
The ability to provide the program/services defined in the scope statement is evidenced by adequate materials, equipment, supplies, space, finances, training, and human resources.

Examples
The program has the facilities, space, materials, and staffing to provide the proper amount of care for the proper length of time based on the needs of the persons served.

Resources may include confidential interview rooms if face-to-face counseling is provided or large space if the program includes the use of group activities. Training programs often provide or give access to study space, texts, and web-based resources to support the curriculum.

2.A. 3. Based on the scope of each program/service provided, the organization documents its:
   a. Entry criteria.
   b. Transition criteria, if applicable.
   c. Exit criteria.
Intent Statements

The organization determines which persons it is qualified and able to serve and identifies conditions/time/events for transition and/or exit. This includes transitions to other levels of care/services as well as transitions within a program/service. Transition criteria may also address continuing stay criteria. Transition may not always occur based on the nature of the program/service.

Examples

While a program/service may use terms that are different than those above, the concepts are the same. The program may develop their own criteria or base their criteria on best practices within the field including: diagnoses, ASAM Level of Care Criteria, medical necessity, or Children's Global Assessment of Functioning.

3.a. Entry criteria may also be called admission criteria, enrollment criteria, or move-in criteria. Entry criteria regarding admission and readmission should be clearly written, should be adhered to, and should consist of how to prioritize admissions, decision making responsibilities, and what would cause a person seeking services to be excluded or found ineligible.

When this determination is formalized and in writing, it significantly minimizes subjectivity during the screening or admission process. Clearly written and defined admission criteria reduce the need to exercise subjective judgment in making a decision regarding whether a particular program is applicable to a person’s needs.

Training programs often outline the specific admission criteria such as: prerequisite coursework, minimum grades, and preferred background.

The criteria address both the initial admission of a person served and subsequent readmissions.

3.b.–c. Transition criteria may also be called referral, aftercare, or continuing care criteria or guidelines. Exit criteria may also be called agreement, contract termination, criteria graduation, or discharge criteria.

Written transition and discharge criteria are established and are used in such documents as program descriptions, admission/readmission criteria, or other documents.

2.A. 4. When a person is found ineligible for services:
   a. The person is informed as to the reasons.
   b. In accordance with the choice of the person:
      (1) The family/support system is informed as to the reasons.
      (2) The referral source is informed as to the reasons.
   c. Recommendations are made for alternative services.

Examples

Persons who are found to be ineligible for services are given the reasons and directed to alternative or more appropriate services.

4.a. Informing persons as to why they are ineligible gives them the opportunity to more effectively target a service delivery system.

4.b. In some situations, the referral source is providing the information for the screening and will be informed as to reasons for ineligibility without specific consent.

4.c. When an individual is not accepted into a training program, suggestions are made to improve his or her future successful admission.

2.A. 5. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Intent Statements

The service delivery model and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes. For example, alcohol and other drug programs will not prevent access to...
medication-assisted therapies (MAT) to persons served based solely on its treatment philosophy. If persons served would benefit from MAT and a program does not offer such, then a referral will be made.

Examples

The organization uses field-recognized practices and, ideally, adopts evidence-based or research-supported practices where the evidence and research are sound.

Some interventions may be more commonly accepted by a particular culture or supported by evidence as more effective when used within specific populations or to treat certain disabilities or disorders.

Evidence of conformance to this standard may be demonstrated through minutes of meetings in which these topics were discussed, literature available to the personnel in a program library, development of treatment guidelines, etc.

Resources used in this process might include journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resources, or education efforts with other area providers of services.

2.A. 6. To facilitate integrated service delivery, each program/service implements communication mechanisms regarding the person served that:

a. Address:
   (1) Emergent issues.
   (2) Ongoing issues.
   (3) Continuity of services, including:
      (a) Contingency planning.
      (b) Future planning.
   (4) Decisions concerning the person served.

b. Ensure the exchange of information regarding the person-centered plan.

Intent Statements

This standard addresses the need for timely communication to ensure that services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples

Communication mechanisms may include written communication; face-to-face meetings; electronic medical records, or other electronic means.

2.A. 7. The program/service demonstrates:

a. Knowledge of the legal decision-making authority of the persons served.

b. When applicable, the provision of information to the persons served regarding resources related to legal decision-making authority.

Intent Statements

The person served may not have the capacity or be of the age to make decisions in his or her own best interests. An individual may need to be assigned to make decisions regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from jurisdiction to jurisdiction; e.g., healthcare power of attorney, power of attorney, and guardianship. The program/service should be able to discuss how it addresses the issue of the legal decision-making authority of the persons served.

7.b. Any limitation on a person’s legal decision-making authority should be continued only as long as is appropriate and necessary. The program/service assists the person served and his or her family members/support system to access resources, such as attorneys with expertise in this area, who can assist with facilitating changes, if appropriate, in legal autonomy status.

2.A. 8. When services are provided from or within a mobile unit, written procedures are implemented that address, at a minimum, the unique aspects of the following areas related to mobile settings:

a. Responsibilities of:
   (1) Drivers.
   (2) Service providers.
b. Confidentiality of:
   (1) Records of persons served.
   (2) Communication.
c. Privacy related to service delivery.
d. Accessibility.
e. Availability of information on resources to address needs unable to be met at the mobile setting.
f. Security of:
   (1) Medications provided from or within the mobile unit, when applicable.
   (2) Equipment and supplies used in service provision.
   (3) The mobile unit when not in use.
g. Safety of:
   (1) Records of persons served.
   (2) Personnel.
h. Maintenance of:
   (1) Equipment.
   (2) Vehicles.

Intent Statements

Mobile unit services are services provided from a vehicle such as a motor home or van that functions as a site for the program/service seeking accreditation.

Examples

8.b. Written procedures address confidentiality related to the use of mobile technology for documentation and telephonic communication about the persons served.

8.d. The mobile unit:

- Provides adequate space for persons served to approach and move around inside of it.
- Is equipped with a ramp, handrails, and adaptive equipment for use by personnel and/or persons served.
- Operates from a location where there is ample parking.
- Operates from a location that limits exposure to the sun and noise in the environment such as traffic noise.

8.f.(3) Security of the mobile unit when it is not in use might address the location where the unit is parked overnight and/or between stops, locking the unit, protection of records, and the use of security personnel or surveillance systems to monitor the unit.

8.g. Safety considerations might include communication systems available, availability of emergency procedures in the mobile unit, what to do in the event of an emergency situation, determination of the location where the mobile unit provides services, and minimum personnel that must be present during hours of operation.

8.h. Maintenance of mobile units might include keeping logs of mileage, gasoline use, oil changes, and tire wear.

2.A. 9. Each core program for which the organization is seeking accreditation has a written program description that guides the delivery of services and includes:

a. A description of the program.
b. The philosophy of the program.
c. Program goals.
d. Service/treatment modalities to be provided to achieve the program objectives, including:
   (1) Description of the service/treatment modalities.
   (2) The credentials of staff qualified to provide the service/treatment modalities.
e. Identification or a description of special populations and mechanisms to address their needs.

Intent Statements

The intent of this standard is to clearly define, in writing, how service delivery is accomplished. Description would include broad strategies to be used to achieve objectives and the rationale for the choice of service modality(ies). Many organizations may incorporate the information required in a program description to meet Standard 2.A.1.a.

Examples

The written program description can be described in policy and procedure manuals, the performance improvement plan, program handbooks, brochures, or other documentation. It may vary in length, depending on the size of
the organization and the services that are provided.

9.a. The program description includes information such as the populations and age groups served, relevant characteristics of the populations, hours and days of operation, after-hours contact, and admission criteria.

9.b.–c. The philosophy and goals of a program may be the same as the philosophy and goals of the organization; however, they are restated in the program descriptions for clarity.

9.d. The program description includes modalities used for prevention, intervention, and treatment as appropriate. The description can identify the type(s) of therapy(ies) used for specific needs of persons served and include when medications are routinely prescribed.

9.e. Special populations may include children and adolescents, aging and older adults, pregnant women, persons with intellectual or other developmental disabilities, persons with HIV/AIDS, IV drug users, DUI offenders, sexual offenders, or substance abuse offenders.

10. Services are designed and implemented to:
   a. Support the recovery, health, or well-being of the persons or families served.
   b. Enhance the quality of life of the persons served.
   c. Reduce symptoms or needs and build resilience.
   d. Restore and/or improve functioning.
   e. Support the integration of the persons served into the community.

Intent Statements

Services provided by the organization are designed and implemented to increase independence and maximize integration into the community.

10.a. Recovery focuses on the development of new meaning and purpose as individuals or families grow beyond the problems associated with the concerns that led them to seek services; i.e. mental illness, addiction, or family violence.

11. When applicable, there are policies and written procedures that address positive approaches to the program’s use of behavioral interventions, including:
   a. An emphasis on building positive relationships with persons served.
   b. Evaluation of the environment.
   c. Appropriate interaction with staff to:
      (1) Promote de-escalation.
      (2) Manage behavior.
   d. Empowering persons served to manage their own behavior.

Intent Statements

The intent of the standard is that organizations implement policies and procedures that support the use of positive alternatives to behavioral interventions such as redirecting and de-escalation in its effort to avoid negative behaviors by the persons served. The policies and procedures should reflect the use of positive approaches prior to the implementation of behavioral interventions.

The organization demonstrates commitment to a system that nurtures personal growth and dignity, and it supports the use of positive approaches and supports. This standard would apply to any program that deals with persons with a history of behavioral problems (e.g., anger, PTSD) or where the goal is to help the persons served change their behavior. Thus, you could see these policies and procedures in almost any behavioral health program except perhaps prevention/intervention, diversion, or call centers.

12. When applicable, the program implements:
   a. Written procedures governing the use of:
      (1) Special treatment interventions.
      (2) Restrictions of rights.
   b. Methods to ensure that intrusive procedures are administered in a safe manner, with consideration given to the:
      (1) Physical history of the persons served.
2.A. Program/Service Structure

(2) Developmental history of the persons served.

(3) Abuse history of the persons served.

c. A process of regularly evaluating:

(1) Any restrictions placed on the:
   (a) Rights of the persons served.
   (b) Privileges of the persons served.

(2) Methods to reinstate restricted or lost:
   (a) Rights of the persons served.
   (b) Privileges of the persons served.

(3) The purpose or benefit of any type of restriction on rights or privileges.

Intent Statements

12.a.(1) When used, special treatment interventions are individually applied based on the specific needs of the persons served and as determined safe and effective.

12.c. Some organizations, aside from using seclusion/restraint, restrict privileges when a person enters treatment. As a general rule, the rights of persons served are described in writing in the organization’s client rights statement or document and are “non-negotiable”; i.e., they cannot be lost by the person served or taken away by the organization. In contrast, privileges are often extended to persons served as a result of exceptional conformance to program rules or due to extraordinary progress. Privileges, unlike client rights, can be lost through violations of program rules or a failure to demonstrate progress in treatment.

Examples

12.a. Special treatment interventions may span the range from additional sessions or milieu chores to loss of phone and visitation privileges. This standard includes all interventions used, as appropriate to the person served, including involuntary emergency medication.

12.b. Examples of intrusive procedures may include strip searches or pat downs.

12.c. For example, an alcohol and drug residential treatment program may not allow visitors the first week a person is in treatment, or a weekend pass may be revoked if a person served has violated the conditions of treatment for that particular organization.

2.A. 13. The program receives medical consultation regarding medically related policies or procedures, when appropriate.

Intent Statements

Medical consultation is typically provided by a medical director who is a physician. However, there may be circumstances in which the consultation is provided by a licensed physician’s assistant, a nurse practitioner, or a registered nurse. The person does not have to be a staff member but can be connected through a contract or a consulting or voluntary agreement.

Examples

Medical consultation may be indicated for policies and procedures involving medication use, seclusion or restraint, human resources, health and safety, admission eligibility, infection control, medical emergencies, or other medically related issues.

2.A. 14. In a medically supervised program, there is a medical director who is a physician.

Intent Statements

To ensure that proper care is provided in a medically supervised program, there should be a medical director who is a physician.

Examples

This includes medically supervised assertive community treatment, detoxification/withdrawal management, inpatient treatment, partial hospitalization, or residential treatment programs serving persons with medical needs.

In an addiction treatment program, the program is encouraged to use a physician certified in addiction treatment by the American Society of Addiction Medicine (ASAM), American Board of Addiction Medicine (ABAM), the Canadian Society of Addiction Medicine (CSAM), or other similar organization.
2.A. 15. The program offers one or more of the following:
   a. Peer support.
   b. Local advocacy groups.
   c. Consumer/survivor/ex-patient groups.
   d. Self-help groups.
   e. Other avenues of support.

Intent Statements
The program will provide, arrange, or refer when needed to applicable support services.

Examples
15.a. Peer support services may be provided by peer staff or through the use of on-site support groups. Peer support may be provided by individuals with direct consumer experience or family members of persons served.
15.b. Such local groups could include:
   ■ Alcoholics Anonymous or other 12-step groups, such as Alanon/Alateen.
   ■ The local chapter of the National Alliance for the Mentally Ill.
   ■ The local chapter of the Association of Psychosocial Rehabilitation Services.
   ■ Medical condition support groups.
   ■ Parents Anonymous.
   ■ Veterans service organizations.
   ■ The local chapter of People First.
   ■ The local area Center for Independent Living.

Efforts should also be made to recognize culturally specific support groups.

2.A. 16. The program ensures that information and education that is relevant to the needs of the persons served is provided.

Examples
Information may be provided that focuses on medical, housing, mental health, alcohol, and other drug issues; relationships; life skills, etc. Education may be provided through:
   ■ Individual and group sessions.
   ■ Group education.
   ■ Audio/video or written materials.

   ■ The internet.
   ■ Resource listings.

Education may also be provided through other resources, including community colleges and area special education providers, and community providers and may include assisting the persons served to access information on their own.

2.A. 17. Families are:
   a. Encouraged to participate in educational programs offered by the organization.
   b. Invited to participate in clinical programs or services with the persons served, with consent or legal right.

Intent Statements
The program seeks to engage the family of the person served into care. The family can include traditional family members such as the person’s spouse, parents, siblings, or other involved relatives. When related persons are not involved or their involvement is impractical or inappropriate, the program seeks to involve other individuals in the person’s life to provide support. Support systems are vital to successful recovery, and the program encourages strengthening or developing community supports to improve and maintain outcomes upon completion of care.

2.A. 18. Written procedures specify that the program provides or arranges for crisis intervention services.

Intent Statements
The organization must have procedures for crisis intervention.

Examples
The organization may have its own on-call or direct crisis response service or may contract or collaborate with area providers that offer crisis intervention services.
2.A. 19. To meet the needs of the persons served, the program demonstrates how it uses technology to:
   a. Increase access to services.
   b. Increase supports.
   c. Enhance services.

Intent Statements
Program management and leadership seek to find and implement technologies that assist the persons served in meeting their goals. The program can describe what technologies it has implemented and what it is considering for the future.

Examples
19.a. The program may improve access to services through the use of websites, patient portals, telehealth services, social media, text messaging, and other methods to remind the persons served of appointments.

19.b. Increased supports could include use of technological supports between services, such as recovery-based applications or encouraging persons served to use online support communities and electronic communications with personnel, as appropriate.

19.c. The program may enhance services through technology such as patient portals for making appointments, requesting refills of medications and accessing medical records; and/or through the use of online tools such as outcomes measures, cognitive behavioral therapy (CBT) tools, online assessments, and other services.

2.A. 20. For personnel providing direct services, the organization includes the following in its assessment of competency and competency-based training:
   a. Areas that reflect the specific needs of the persons served.
   b. Clinical skills that are appropriate to the position.
   c. Person-centered plan development.
   d. Interviewing skills.
   e. Program-related research-based treatment approaches.

   f. Identification of clinical risk factors, including:
      (1) Suicide.
      (2) Violence.
      (3) Other risky behaviors.

Intent Statements
The intent of this standard is to ensure that the necessary competencies are established and demonstrated.

Examples
In most organizations, the evaluation of staff competencies begins with ensuring that all clinical staff members are licensed/certified by a credentialing body that uses a competency-based process for issuing licenses and certification. Beyond that, evaluation of professional competencies is part of an ongoing process of supervision that provides direct and periodic observation and documentation of screenings, intakes, group and individual counseling/therapy sessions, and other events involving service delivery.

Competency-based training may include training that is provided or recognized by a professional association, part of a formal training curriculum, or approved for continuing education units (CEUs) by a credentialing or licensing body. Competency in the areas in which training has occurred can be assessed by observing work and documenting that the skills or knowledge presented are being used on the job, through supervision and clinical review when assessments can be made regarding the retention and use of the training information, or through post-tests that are administered.

When needed, competency-based training is provided through inservice or access to external resources.

Resources
20.f.(1) CARF's 2016 Quality Practice Notice (QPN) on Suicide Prevention provides additional information and resources. The QPN is available on the CARF website at www.carf.org/QPN_SuicidePrevention_Sept2016.
2.A. 21. Team members, in response to the needs of the persons served:
   a. Help empower each person served to actively participate with the team to promote recovery, progress, or well-being.
   b. Provide services that are consistent with the needs of each person served through direct interaction with that person and/or with individuals identified by that person.
   c. Are culturally and linguistically competent.
   d. Meet as often as necessary to carry out decision-making responsibilities.
   e. Document:
      (1) The attendance of participants at team meetings.
      (2) The results of team meetings.

Intent Statements
The size and composition of the team will vary according to the services provided to each person served. Certain programs, services, or needs of the persons served may require that the team include personnel from a variety of disciplines.

Examples
21.a. This may be demonstrated through the active involvement of the person served in the development of the person-centered plan, participation in team meetings, or periodic review of identified goals.

2.A. 22. A designated individual(s) assists in coordinating services for each person served by:
   a. Assuming responsibility for ensuring the implementation of the person-centered plan, if applicable.
   b. Ensuring that the person served is oriented to his or her services.
   c. Promoting the participation of the person served on an ongoing basis in discussions of his or her plans, goals, and status.
   d. Identifying and addressing gaps in service provision.
   e. Sharing information on how to access community resources relevant to his or her needs.
   f. Advocating for the person served, when applicable.
   g. Communicating information regarding progress of the person served to the appropriate persons.
   h. Facilitating the transition process, including arrangements for follow-up services.
   i. Involving the family or legal guardian, when permitted.
   j. Coordinating services provided outside of the organization.

Intent Statements
Having a person designated to coordinate services ensures a more seamless process, thereby increasing the likelihood that all pertinent areas are effectively addressed.

Examples
The individual(s) who coordinates services may be an employee of the organization, a peer advocate, on the organization's payroll, under a contractual arrangement, on an internship, or a volunteer placement. Various designations may be used, such as peer advocate, case manager, case coordinator, program coordinator, primary clinician/contact, or team leader.

22.e.–f. For persons with intellectual or other developmental disabilities who are in long-term residential services, this means offering community-based options such as independent living programs.

22.h. Includes the transition of the person served from one program to another within the same organization.

2.A. 23. The organization implements a policy and written procedures for the supervision of all individuals providing direct services.

Intent Statements
The intent of this standard is to ensure that all individuals providing direct services (including staff members, volunteers, trainees, interns,
and contracted personnel) are provided with appropriate supervision or direction. Because of labor relations concerns, procedures may differ when the organization uses contracted personnel.

**Examples**

Supervision may occur through the supervisor’s participation in treatment/service planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and individuals providing direct services.

### 2.A. 24. Documented ongoing supervision of clinical or direct service personnel addresses:

- **a. Accuracy of assessment and referral skills.**
- **b. The appropriateness of the treatment or service intervention selected relative to the specific needs of each person served.**
- **c. Treatment/service effectiveness as reflected by the person served meeting his or her individual goals.**
- **d. Risk factors for suicide and other dangerous behaviors.**
- **e. The provision of feedback that enhances the skills of direct service personnel.**
- **f. Issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries.**
- **g. Clinical documentation issues identified through ongoing compliance review.**
- **h. Cultural competency issues.**
- **i. Model fidelity, when implementing evidence-based practices.**

### Intent Statements

This standard addresses clinical supervision and the provision of clinical consultation as opposed to what may be considered daily supervision. Clinical supervision is provided by persons qualified to provide this service as determined by state/provincial licensure or certification, the experience level of the supervisor, or the organization’s rules governing the qualifications of clinical supervisors.

### Examples

Supervision may occur through the supervisor’s participation in treatment/service planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and personnel.

Clinical supervision documentation specifically includes assessment of professional competencies and clinical skills and recommendations for improvement, as opposed to daily supervision. When direct service staff are consultants or independent contractors, expectations regarding 24.a.–i. may be identified in written agreement.

**24.e.** May include information on best practices or identify areas for needed professional growth.

### Resources

24.d. CARF’s 2016 Quality Practice Notice (QPN) on Suicide Prevention provides additional information and resources. The QPN is available on the CARF website at [www.carf.org/QPN_SuicidePrevention_Sept2016](http://www.carf.org/QPN_SuicidePrevention_Sept2016).

### 2.A. 25. The program implements policies and procedures that address:

- **a. The handling of items brought into the program:**
  - (1) By:
    - (a) Persons served.
    - (b) Personnel.
    - (c) Visitors.
  - (2) Including:
    - (a) Illegal drugs.
    - (b) Legal drugs.
    - (c) Prescription medication.
    - (d) Weapons.

- **b. The use of tobacco products in all:**
  - (1) Locations.
  - (2) Vehicles owned or operated by the organization.

### Intent Statements

Based on the type of program(s) the organization provides, the policies and procedures identify for
each stakeholder relevant detail for each item identified in the standard.

Examples

25.a.(1)(c) Visitors may be given a list of items that are not allowed to be brought into the program area when visiting persons served, or a list of items considered to be contraband could be posted in visible location for visitors to see upon entry. Safe storage is provided for items on the exclusion list.

25.a.(2)(a) Illegal drugs include street drugs and alcohol (if under the legal drinking age). When applicable, this includes drug paraphernalia.

25.a.(2)(b) Legal drugs may include over-the-counter drugs, vitamins, herbs, and alcohol.

25.a.(2)(d) Weapons includes ammunition and explosives.

25.b. Tobacco products include chewing tobacco, shisha, nicotine gum, and electronic and green cigarettes.

2.A. 26. Programs that treat persons with substance use disorders implement written procedures that address the use of drug screening, including:

   a. An individualized approach with frequency based on the needs of the person served.

   b. Specific treatment conditions that would warrant drug screening.

   c. Collection of specimens in a respectful manner.

   d. Ensuring that drug screening results are not used as the sole basis for:
      (1) Treatment decisions.
      (2) Termination from treatment.

Intent Statements

Programs utilize drug testing as a part of the therapeutic process. After admission, the frequency of drug testing is based on the needs of the persons served and takes into consideration how it is perceived by the persons served. Some individuals may find frequent testing motivating, while others may perceive it as indicating a lack of progress and trust. Because testing is less effective when it is predictable, programs could consider ways to make testing as random as possible.

The results of the drug testing are utilized to formulate clinical interventions and not used punitively.

Programs that do not use broad drug screening practices are not required to implement such practices to meet this standard.

Peer Support Services

Peer support services (inclusive of youth or family supports) can include a wide range of planned activities to assist persons served in exercising control over their own lives and their recovery or resilience-building process. Peer support may include peer mentoring or coaching, resource connecting, facilitating and leading recovery, educational and support groups, advocating for the person/family served, and/or building community supports.

Because peer supports are guided by a foundation of lived experience, peer support specialists are persons who share with others based on that experience to encourage, motivate and support persons served and/or their families. They may be referred to as youth or family support specialists or mentors, recovery coaches, guides, peer resource specialists, peer service interventionists, or similar titles.

Peer and youth support services are designed to have persons with lived experience work directly with persons served. Family support services are designed to have persons who have lived experience through their family member’s participation in services directly work with the family of persons served.

Applicable Standards

When an organization employs peer support specialists in any of the core programs seeking accreditation, the following standards must be applied in addition to other applicable standards in Section 1, Sections 2.A.–H., and the specific program standards and a specific population designation (if applicable).
2.A. 27. The organization implements policies and procedures that are inclusive of a peer workforce.

Intent Statements
The organization’s policies and procedures are written with consideration of the various personnel it utilizes, such as professional staff, peer support staff, direct care staff, nondirect care staff, volunteer staff, contract staff, and interns.

2.A. 28. Peer support specialists assist in peer support services:
   a. Design.
   b. Development.
   c. Implementation.

Intent Statements
The organization involves members of the peer support workforce in the process of designing and implementing these services to ensure that the peer support expertise is included. The organization should be able to demonstrate how it collected the input of the peer support workforce in design, development, and implementation.

2.A. 29. The organization demonstrates a climate of recovery and/or resilience building by:
   a. Respecting the unique role of peer support specialists.
   b. Training personnel on the role of peer support specialists.

Intent Statements
29.b. All personnel will have a clear understanding of the unique role of peer support specialists and how their role differs from the roles of other clinical and direct service team members.

2.A. 30. Peer support specialists receive documented competency-based training that:
   a. Is based on a recognized peer support curriculum or a curriculum designed and developed with the input of peer support specialists.
   b. Is provided with the involvement of peer support specialists, as applicable.
   c. Includes:
      (1) Initial training on the following topics:
         (a) Personal advocacy.
         (b) Engagement.
         (c) Recovery and resiliency principles.
         (d) Community supports/connections.
         (e) The effective use of sharing life experiences.
         (f) Parenting skills, as applicable.
      (2) Ongoing training on current practices in peer support services.
   d. Is provided in a manner that is:
      (1) Understandable.
      (2) Appropriate to the developmental age of the peer support specialist being trained.

Intent Statements
The organization ensures that the peer support workforce is adequately trained to perform the work assigned. When the organization provides its own training, it should seek curriculum from nationally recognized sources such as SAMSHA, the Psychosocial Rehabilitation Association, the Certification Commission for Family Support, or other competent source. When the organization hires Certified Peer Specialists (or other peer support specialists with an equivalent credential), it is accepted that the peer support specialist has received appropriate initial training.
Section 2.A. Program/Service Structure

2.A. 31. The organization’s written ethical codes of conduct specifically address boundaries related to peer support services.

Examples
This may include how peer support specialists’ boundaries with persons served differ from those of personnel in areas such as sharing meals, attending social events, sharing lived experience, social media connections, and communication (electronic and other).

2.A. 32. Based on the needs and preferences of the persons served, peer support:

a. Is provided consistent with or complementary to the person’s identified plan, when applicable.

b. Includes the following direct service activities performed by peer support specialists, as applicable:
   (1) Engaging the person served.
   (2) Supporting personal recovery goals or building on resiliency.
   (3) Community networking.
   (4) Advocating with and for the person served.
   (5) Parenting skills.
   (6) Mentoring.
   (7) Bridging or navigating.

c. Includes the following educational activities for the persons served, as applicable:
   (1) Self advocacy.
   (2) Wellness.
   (3) Life skills.
   (4) Goal setting.
   (5) Decision-making skills.

Intent Statements
Direct service activities may be provided individually or in a group setting and may be provided face to face, telephonically, or electronically.

Examples
32.b.(2) Peer support specialists can share their personal success stories, serve as role models, or help the persons served to articulate their personal goals and identify means to reach those goals. Peer support specialists can help the person served make new friends and begin to build alternative social networks.

32.b.(3) Community networking may include social, recreational, spiritual, educational, or vocational linkages. Peer support specialists encourage and support participation in self-help groups and provide specific information about various groups that may be helpful to the person served.

32.b.(6) Mentoring involves supporting an individual’s efforts to achieve his/her goals through coaching, encouraging, providing positive guidance, sharing life experiences, and offering feedback to assist with personal development.

32.b.(7) Navigating includes assisting the person served to find and access services/benefits and to make appeals and respond to denials if needed. Bridging refers to efforts made to make cooperative connections between the person served and others and create ties to those who may be helpful to them in a variety of ways. It can also involve helping to resolve differences and reduce barriers.

32.c.(3) Life skills are basic skills used to handle problems and questions commonly encountered in daily life. This could include problem solving, accepting responsibility, money management, and honoring commitments. Self-care skills such as cooking, cleaning, laundry, and shopping are also essential life skills.

2.A. 33. Peer support services are provided in locations that meet the needs of persons served.

Examples
Peer support services may be provided in the community, outpatient or inpatient settings, recovery community organizations or centers, the home of the person or family served, churches, child welfare organizations, recovery homes, drug courts, pre-release jail and prison programs, parole and probation programs, behavioral health agencies, HIV/AIDS support centers, medical centers, and/or other social service centers.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A written plan for each core program surveyed
- Documentation of the attendance of participants at team meetings
- Written procedures for crisis intervention services
- Documentation of team meetings
- Record of competency-based training
- Policies inclusive of a peer workforce, if applicable
- Documentation of competency-based training for peer support specialists, if applicable
- Written ethical codes of conduct that specifically address boundaries related to peer support services, if applicable
- Written procedures that address drug screening

B. Screening and Access to Services

Description

The process of screening and assessment is designed to determine a person’s eligibility for services and the organization’s ability to provide those services. A person-centered assessment process helps to maximize opportunities for the persons served to gain access to the organization’s programs and services. Each person served is actively involved in, and has a significant role in, the assessment process. Assessments are conducted in a manner that identifies the historical and current information of the person served as well as his or her strengths, needs, abilities, and preferences. Assessment data may be gathered through various means including face-to-face contact, telehealth, or written material; and from various sources including the person served, his or her family or significant others, or from external resources.

**NOTE:** Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.

2.B. 1. Person-centered care is demonstrated throughout the screening and/or assessment process.

2.B. 2. The program demonstrates efforts to minimize the times between first contact, screening, and admission or referral.

Examples

The program is able to describe the activities it has implemented to decrease wait times for services from initial contact to engagement in care. If an organization has implemented an open access system for admissions, it can still demonstrate how it reduces wait times for referral into care.
Screening/Eligibility

2.B. 3. The organization implements policies and written procedures that define:
  a. If/how screening is conducted.
  b. Eligibility for services.
  c. How admissions are:
     (1) Conducted.
     (2) Prioritized, if necessary.
  d. Who is responsible for making admission decisions.
  e. Exclusionary or ineligibility criteria.

e. Ensures that:
   (1) Screening tools used are uniformly administered.
   (2) Personnel are trained on use of tools prior to administration.

Intent Statements
The admission process includes the screening of potential persons to be served.

Examples
Screening may include a review of all information available, discussions with referral sources, and, if necessary, face-to-face contacts. Information may be found in admission reports or screening logs.

4.b.(3) May include residency, geographic area, status of person served, or other criteria.

4.b.(4) May include public sources, grant eligibility, private pay resources, or third-party funding.

4.d.(1) An interview can be done face-to-face, via telephone interview, or by other technological means; and may include parents, guardians, or others.

4.d.(2) May be more applicable prior to admission to a residential program.

4.e. This standard is applicable only when screening tools are used.

2.B. 4. When screening is conducted by the organization, it:
  a. Is documented.
  b. Includes a review of each person’s eligibility for admission based on:
     (1) Presenting problem(s).
     (2) Identification and documentation of any urgent or critical needs of the person to be served.
     (3) Legal eligibility criteria, when applicable.
     (4) Availability of funding sources.
  c. Identifies:
     (1) Whether the organization can provide the appropriate services needed.
     (2) Alternate resources when services cannot be provided.
  d. Includes:
     (1) An interview with the person to be served or referral source.
     (2) When appropriate, a pre-admission on-site visit to the organization and its programs by the person to be served/legal guardian.

2.B. 5. If the screening identifies an urgent and critical need, appropriate action is taken immediately.

Intent Statements
The organization safely responds to the person’s needs whether directly or through referral.

2.B. 6. If the screening identifies unsafe substance use:
  a. A brief intervention is conducted either directly, through referral, or as part of the treatment program.
  b. The individual is referred for a full assessment, if needed.

Intent Statements
This standard is directed toward programs that are not primarily addiction treatment programs.
If a waiting list is maintained, the organization:

a. Documents the person’s:
   (1) Date of placement on the list.
   (2) Identified needs.

b. Maintains current waiting list information through:
   (1) Ongoing review and updating of the list.
   (2) Implementation of procedures for referral of persons in crisis to necessary care.

c. Documents all contacts with the persons on the waiting list.

d. Responds to long-term waiting lists through:
   (1) Strategic or community-based planning.
   (2) Involvement of support services.
   (3) Referral to available services/community supports.

Intent Statements

The use of a waiting list involves an active review process that leads to a determination of eligibility based on the organization’s entrance/admission criteria. It also helps to ensure that needed services are being provided in a timely manner.

Examples

Referral lists are not the same as waiting lists. They are different in that referral lists include all persons referred for services. Such lists are not necessarily used to determine the sequence of admission. In certain situations, such as under Centers for Medicare and Medicaid Services (CMS) waivers, there may be requirements that there be no waiting list.

7.b.(1) Review of a waiting list may be documented in meeting minutes or by signing and dating the list itself to indicate review.

Monitoring a waiting list could include tracking the length of time on the waiting list before admission and the percentage of persons admitted. This information may assist in an organization’s planning process.

Orientation

Each person served receives an orientation that:

a. Is provided in a timely manner based on:
   (1) The person’s presenting condition.
   (2) The type of services provided.

b. Is understandable to the person served.

c. Is documented.

d. Includes, as applicable:
   (1) An explanation of:
      (a) The rights and responsibilities of the persons served.
      (b) Complaint and appeal procedures.
      (c) Ways in which input can be given.
      (d) The organization’s:
         (i) Confidentiality policies.
         (ii) Intent/consent to treat.
         (iii) Behavioral expectations of the person served.
         (iv) Transition criteria and procedures.
         (v) Discharge criteria.
         (vi) Response to identification of potential risk to the person served.
         (vii) Access to after-hour services.
         (viii) Standards of professional conduct related to services.
         (ix) Requirements for reporting and/or follow-up for the mandated person served, regardless of his or her discharge outcome.

7.d.(3) Evidence of referrals or other actions taken may be included on the waiting list itself or documented in a referral log.
Section 2.B. Screening and Access to Services

(e) Any and all financial obligations, fees, and financial arrangements for services provided by the organization.

(f) The program’s health and safety policies regarding:
   (i) The use of seclusion or restraint.
   (ii) Use of tobacco products.
   (iii) Illegal or legal substances brought into the program.
   (iv) Prescription medication brought into the program.
   (v) Weapons brought into the program.

(g) The program rules and expectations of the person served, which identifies the following:
   (i) Any restrictions the program may place on the person served.
   (ii) Events, behaviors, or attitudes and their likely consequences.
   (iii) Means by which the person served may regain rights or privileges that have been restricted.

(2) Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.

(3) Education regarding advance directives, when indicated.

(4) Identification of the purpose and process of the assessment.

(5) A description of:
   (a) How the person-centered plan will be developed.
   (b) The person’s participation in goal development and achievement.

(c) The potential course of treatment/services.

(d) How motivational incentives may be used.

(e) Expectations for legally required appointments, sanctions, or court notifications.

(f) Expectations for family involvement.

(6) Identification of the person(s) responsible for service coordination.

Intent Statements
This standard relates to the involvement of the persons served and their understanding of exactly what will happen as services are delivered. While the orientation can be provided in a written or verbal manner, documentation supports that it has been conducted. Orientation can be provided by more than one person and over time. The extensiveness of the orientation may be impacted by the type of service provided or the condition of the person served at the time of admission.

Examples
8.b. When written material is given to the persons served regarding their rights, orientation, and other topics, it should be provided at a reading level understandable to the persons served.

8.d.(1)(c) This would include an explanation of the organization’s practices for obtaining input from the persons served as well as opportunities offered through the organization’s outcomes management process, specifically regarding assessment of service and satisfaction by the person served. Input may be given through groups or individual sessions, suggestion boxes; surveys, grievance forms, etc.

8.d.(1)(e) Information includes length of time benefits will be paid by payer source if this information is available at time of orientation and how updates of benefits will be provided.

8.d.(1)(f)(iii) Includes alcohol and over-the-counter medications.

8.d.(3) Includes psychiatric advance directives, when legally available. The following factors will
impact the applicability of this standard: laws or regulations, the type of service provided, or the specific population served.

8.d.(5)(f) The program provides information to the person served about the services offered that family members or other members of the person’s support system can and should participate in.

See the Glossary for the definition of advance directives.

Assessment

2.B. 9. Assessments are conducted by qualified personnel:
   a. Knowledgeable to assess the specific needs of the persons served.
   b. Trained in the use of applicable tools, tests, or instruments prior to administration.
   c. Able to communicate with the persons served.

Examples

Qualified personnel are determined by the organization’s leadership. The organization may base its determination on the skills, experience, and/or education of personnel and by state, federal, provincial, or other regulating guidelines.

2.B. 10. When assessment results in diagnosis(es), the diagnosis is determined by a practitioner legally qualified to do so in accordance with all applicable laws and regulations.

2.B. 11. The assessment process includes information obtained from:
   a. The person served.
   b. Family members/legal guardian, when applicable and permitted.
   c. Other collateral sources, when applicable and permitted.
   d. External sources, when the need for specified assessments not able to be provided by the organization is identified.

Intent Statements

The program seeks information from a variety of sources that can ensure the assessment accurately reflects the history and the impacts on the functioning of the person served. Speaking with sources other than the person served should be done in accordance with applicable privacy laws and regulations.

Examples

11.c. Collateral sources may include:
   ▪ Parents/guardians.
   ▪ Teachers.
   ▪ Social workers.
   ▪ Probation officers.
   ▪ Physicians.
   ▪ Friends.
   ▪ Peers.

2.B. 12. The assessment process:
   a. Focuses on the person’s specific needs.
   b. Identifies the goals and expectations of the person served.
   c. Is responsive to the changing needs of the person served.
   d. Includes screening for suicide risk for all persons served age 12 and older using a standardized tool normed for the population served.
   e. Includes provisions for communicating the results of the assessments to:
      (1) The person served/legal guardian.
      (2) Applicable personnel.
      (3) Others as appropriate.
   f. Provides the basis for legally required notification when applicable.
   g. Occurs within timeframes established by the organization or external regulatory requirements.
   h. Reflects significant life or status changes of the person served.

Intent Statements

Assessment information may be ongoing and collected over time or by various programs within
an organization. The expectation is that the program has collected information adequate to result in individualized and goal-oriented, person-centered planning.

12.b. This part of the assessment identifies what the person wants or why the person is coming for services.

12.d. The intent of this standard is to ensure universal screening for all persons served age 12 and older. Programs may choose to screen persons younger than 12 at their discretion when clinically indicated.

Examples

12.a. Specific needs may be related to:

- Age or developmental level.
- Gender.
- Sexual orientation.
- Social preferences.
- Cultural background.
- Psychological characteristics.
- Physical condition.
- Spiritual beliefs.

12.d. The most common tool for assessing suicide risk is the Columbia Suicide Severity Rating Scale (CSSRS), and there are several versions of this tool for use with different populations and at different times. There is a significant amount of resource information available at the Columbia Lighthouse Project website at http://cssrs.columbia.edu/.

Another tool to consider is the SAFE-T screener and information can be found here: www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card.

A screener that has been normed for children and adolescents age 12 and older is the ASQ, and information about this tool can be found at www.sprc.org/sites/default/files/resource-program/asQToolkit_0.pdf and at www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml.

12.f. Notification may include child and adult protective services, committing or referring courts, a local provider identified under the Indian Child Welfare Act, or probation or parole officers. Reports may also be required when there are threats of violence toward others in what is commonly known in the U.S. as Tarasoff warnings, also known as “duty to warn.”

2.B. The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person’s:

a. Presenting issues from the perspective of the person served.

b. Personal strengths.

c. Individual needs.

d. Abilities and/or interests.

e. Preferences.

f. Previous behavioral health services, including:

   (1) Diagnostic history.

   (2) Treatment history.

g. Mental status.

h. Medication, including:

   (1) Medication history and current use profile.

   (2) Efficacy of current or previously used medication.

   (3) Medication allergies or adverse reactions to medications.

i. Physical health issues, including:

   (1) Health history.

   (2) Current health needs.

   (3) Current pregnancy and prenatal care.

   (4) Medical conditions.

j. Use of complementary health approaches.

k. Co-occurring disabilities and disorders.

l. Current level of functioning.

m. Pertinent current and historical life information, including his or her:

   (1) Age.

   (2) Gender.

   (3) Sexual orientation.

   (4) Gender identity.
Section 2.B. Screening and Access to Services

(5) Culture.
(6) Spiritual beliefs.
(7) Education history.
(8) Employment history.
(9) Military history.
(10) Living situation.
(11) Legal involvement.
(12) Family history.
(13) Relationships, including families, friends, community members, and other interested parties.

n. History of trauma:
   (1) That is:
      (a) Experienced.
      (b) Witnessed.
   (2) Including:
      (a) Abuse.
      (b) Neglect.
      (c) Violence.
      (d) Sexual assault.

o. Use of alcohol, tobacco, and/or other drugs, including:
   (1) Current use.
   (2) Historical use.

p. Risk factors for:
   (1) Suicide.
   (2) Other self-harm or risk-taking behaviors.
   (3) Violence toward others.

q. Literacy level.

r. Need for assistive technology in the provision of services.

s. Need for, and availability of, social supports.

t. Advance directives, when applicable.

u. Psychological and social adjustment to disabilities and/or disorders.

v. Resultant diagnosis(es), if identified.

**NOTE:** In Canadian programs (such as Outpatient Treatment) where laws or regulations prohibit the collection of specifically identified information, an abbreviated assessment is allowed.

Examples

In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, Detoxification, or Employee Assistance Programs), peer-run/driven programs (such as Community Integration), or targeted case management such as Healthy Families America (HFA), the amount of information collected may be limited by time or the condition of the person served or the nature of service being provided.

13.b. Personal strengths may include assets, resources, and natural positives.

13.c. Individual needs may include liabilities, weaknesses, and what the person needs to recover.

13.d. Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

13.e. Preferences are those things the person served feel will enhance his or her treatment experience.

13.f. Previous behavioral health data may include:
   - Psychiatric assessments.
   - Psychological assessments.
   - Medication use.
   - Hospitalizations.
   - Alcohol and other drug services.
   - Pertinent medical care.
   - Community programs.

13.i.(2) Includes dental health, as well as visual or hearing concerns, when they appear to be a contributing factor to the presenting condition of the person served.

13.i.(3) Health issues related to pregnancy could include use of legal and or illegal drugs, whether prenatal care is being provided, or whether the pregnancy affects the woman’s participation in the program.

Intent Statements

The intent of the standard is to collect an adequate amount of information to develop an appropriate plan of care and to subsequently provide appropriate and safe services. The information may be obtained from external sources.
13.j. According to the National Institutes of Health National Center for Complementary and Integrative Health (nccih.nih.gov/health/integrative-health), the terms complementary and alternative refer to healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

13.k. It is particularly important to identify any co-occurring disabilities and/or disorders, including primary care issues that may impact the therapeutic relationship with the person served.

13.l. Current levels of functioning may include cognitive, emotional, and behavioral functioning.

13.m.(2)–(6) Gender, sexual orientation, gender identity, cultural background, and spiritual beliefs may be essential components to recovery or treatment and therefore are not excluded as a factor when gathering information.

13.n.(2)(a) Abuse may include previous trauma survivor concerns; spousal/partner abuse; abuse suffered as a child; physical, sexual, emotional, or psychological abuse; PTSD, including from military service; and information, when applicable, as to whether the person served was a victim, perpetrator, or witness.

13.p. Programs should look holistically at the risk factors of the person served for suicide, violence, or other risky behaviors. Personnel are encouraged to look across life domains in a thorough clinical assessment to evaluate current intent and plans as well as risk factors that indicate the need for development of a safety plan with the person served.

13.p.(1) Organizations can consider wide implementation of a standardized screening tool to assess suicide risk. An example is the Columbia Suicide Severity Risk Scale (SSRS). There are several versions with utility to programs, including the Lifetime/Recent version, the Since Last Visit version, and the Screener version. Typically, suicide assessments evaluate:

- Risk factors:
  - Current psychiatric illness/symptoms.
  - Alcohol and/or other drug use.
  - Serious physical or emotional pain.
  - Previous self-harm or suicide attempts.
  - Suicide attempts or completion in close family/support network.
  - Age, gender, and social situation.
  - Relationships that may be supportive/protective or that may pose a threat (abuse or neglect).
  - Lack of adequate coping skills/mechanisms.
  - Financial difficulties.
  - Access to lethal methods.

- Current intent and plans:
  - Wish to be dead.
  - Feelings of hopelessness.
  - Regret/remorse over current/previous attempt.
  - Expectation about outcome of self-harming behavior or suicide attempt/threat.
  - Specific plans.
  - Lethality and frequency of plans or attempts.
  - Other self-harming behavior.
  - Current suicide intent/wishes.
  - Length of time suicidal feelings have been present.
Section 2.B. Screening and Access to Services

- Mental state at time of self-harm or suicide attempt or threat (alcohol or drug intake, social situation, relationship changes, bereavements).
- Plans for others after death, including suicide notes, changes to will, and consequences.

13.p.(2) This could include, but is not limited to, such things as cutting, needle sharing, unprotected sex, driving at excessive speeds, driving under the influence, and extreme sports.

13.p.(3) Programs assess the possibility that the person served may harm others in their living environment or other environments. To assist this assessment, programs might consider the use of the Historical, Clinical, Risk-Management-20 Version 3 (HCR-20) for assistance in evaluating risks.

13.t. The intent of the standard is to provide the person served with the specific opportunity to communicate whether or not he or she has an advance directive that may impact the course of the particular services provided. See the Glossary for the definition of advance directives. Applicability will generally occur in those states that allow psychiatric advance directives.

Resources

13.p.(1) CARF’s 2016 Quality Practice Notice (QPN) on Suicide Prevention provides additional information and resources. The QPN is available on the CARF website at www.carf.org/QPN_SuicidePrevention_Sept2016.

2.B. 14. The assessment process includes the preparation of a written interpretive summary that:
   a. Is based on the assessment data.
   b. Identifies any co-occurring disabilities, comorbidities, and/or disorders.
   c. Is used in the development of the person-centered plan.

Intent Statements

The interpretive summary is a written clinical formulation designed to integrate and interpret from a broader perspective all history and assessment information collected. It identifies needs and addresses how they are considered when developing the person-centered plan.

Examples

The interpretive summary could address:
- The central theme(s) apparent in the presentation of the person served.
- Histories and assessments (medical, psychosocial, spiritual, or vocational), with special emphasis on potential interrelationships between sets of findings.
- The perception of the person served of his or her needs, strengths, limitations, and problems.
- Clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes after discharge (i.e., recovery).
- Recommended treatments, including any special assessments or tests, as well as routine procedures (e.g., laboratory tests).
- A general discussion of the anticipated level of care, length, and intensity of treatment and expected focus (goals) with recommendations.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies and procedures defining access to services
- Policies and procedures for the screening process
- Documentation of initial screening
- Criteria for admission to and exclusion from services
- Waiting lists and relevant written procedures, if applicable
- Documentation of contact made with persons on the waiting list
C. Person-Centered Plan

Description

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of his or her plan. The person-centered plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and potential solutions. The planning process is person-directed and person-centered. The person-centered plan may also be referred to as an individual service plan, treatment plan, or plan of care. In a family-centered program, the plan may be for the family and identified as a family-centered plan.

NOTE: Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.

2.C. 1. A written person-centered plan is:

a. Developed with:
   (1) The active participation of the person served.
   (2) The involvement of family/legal guardian of the person served, when applicable and permitted.

b. Prepared using the information from the assessment process.
c. Based upon the person’s:
   (1) Strengths.
   (2) Needs.
   (3) Abilities.
   (4) Preferences.

d. Focused on the integration and inclusion of the person served into:
   (1) His or her community.
   (2) The family, when appropriate.
   (3) Natural support systems.
   (4) Other needed services.
e. Communicated to the person served in a manner that is understandable.
f. Provided to the person served, when applicable.

Intent Statements
Although CARF does not prescribe any particular form or format to be used for the person-centered plan, this standard has specific requirements with regard to the components of the plan and how to develop and review it.

1.d. This standard requires both integration and inclusion, which is interpreted to mean that the person is present at and participates in integrated settings and situations.

Examples
1.c.(1) Personal strengths may include assets, resources, and natural positives.

1.c.(2) Individualized needs may include liabilities, weaknesses, and what the person needs to recover.

1.c.(3) Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

1.c.(4) Preferences are those things the person served feel will enhance his or her treatment experience.

1.d.(3) Natural supports may include extended family, friends, volunteer organizations, self-help or support groups, churches or other religious/spiritual supports.

2.C. 2. The person-centered plan includes the following components:

a. The identification of the needs/desires of the person served through:
(1) Goals that are expressed in the words of the person served.
(2) When necessary, clinical goals that are understandable to the person served.
(3) Goals that are reflective of the informed choice of the person served or parent/guardian.

b. Specific service or treatment objectives that are:
(1) Reflective of the expectations of:
   (a) The person served.
   (b) The service/treatment team.
(2) Reflective of the person's:
   (a) Age.
   (b) Development.
   (c) Culture and ethnicity.
(3) Responsive to the person's disabilities/disorders or concerns.
(4) Understandable to the person served.
(5) Measurable.
(6) Achievable.
(7) Time specific.
(8) Appropriate to the service/treatment setting.

c. Identification of specific interventions, modalities, and/or services to be used.

d. Frequency of specific interventions, modalities, or services.

e. When applicable, information on, or conditions for:
(1) Any needs beyond the scope of the program.
(2) Referrals for additional services.
(3) Transition to other community services.
(4) Community-based service options available to persons in long-term residential support programs.
(5) Available aftercare options, when needed.

f. When applicable, identification of:
(1) Legal requirements.
(2) Legally imposed fees.

Intent Statements
The person-centered plan includes two main components, the first of which addresses the global needs of the person served. The organization demonstrates, through the identification of goals, its knowledge and awareness of the critical global needs of the person served. This component includes goals expressed in the words of the person served and is based on his or her needs and preferences. While goals written in clinical terms may also be required, it is expected that
these goals will be understandable to the person served.

The second component of the plan provides the blueprint for individual service development and is consistent with the outcomes expected by the person served and the organization. This includes the development of clinical service or treatment objectives that are measurable and time specific.

2.f.(2) This standard refers to any court-ordered restitution or fines.

Examples

The person-centered plan may vary in size and complexity based on the type of service provided. In a short-term crisis program, such as crisis intervention, crisis stabilization, or detoxification, the plan may address only the immediate stabilization of the person served and the transition to other services.

2.a.(1) The words of the person served may be quoted, paraphrased, written by him or her, or described. Direct quotes are not required.

2.C. 3. The program implements written procedures identifying timeframes for reviewing and modifying person-centered plans to ensure that the plan for each person served:
   a. Reflects current issues.
   b. Maintains relevance.

Intent Statements

Person-centered plans meet the needs of the person served through regular review and updating based on ongoing assessments. Programs consider the minimum frequency for review of plans based on the intensity of services and external requirements. Goals, objectives, and interventions are updated to remain current and relevant.

2.C. 4. When assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan:
   a. Is completed:
      (1) With the person served.
      (2) As soon as possible.
   b. Includes:
      (1) Triggers.
      (2) Current coping skills.
      (3) Warning signs.
      (4) Actions to be taken to:
         (a) Respond to periods of increased emotional pain.
         (b) Restrict access to lethal means.
      (5) Preferred interventions necessary for:
         (a) Personal safety.
         (b) Public safety.
      (6) Advance directives, when available.

Intent Statements

The assessment should gather sufficient information to determine when the person served has risk factors consistent with risky activities or potential for self-harm or harm to others, as noted in Standard 2.B.13.p. The program should consistently identify when personal safety and overdose plans are clinically indicated and should assist the provider and supports to provide methods for responding to dangerous behaviors exhibited by the person served in a safe and effective manner.

Examples

A personal safety plan may be referred to as a crisis intervention or behavioral management treatment plan, a crisis plan, or may be referred to in a psychiatric advance directive.

4.b.(4)(b) Acute episodes of strong suicidal ideation are generally brief, and often people choose a suicide method that is readily available. Reducing access to the most lethal means can increase survival even when people make attempts.
2.C. 5. When the person served has concurrent disorders or disabilities and/or comorbidities:
   a. The person-centered plan specifically addresses these conditions in an integrated manner.
   b. Services are provided by personnel, either within the organization or by referral, who are qualified to provide services for persons with concurrent disabilities and/or disorders.

Intent Statements
Given the incidence of concurrent disabilities and/or disorders, effectively addressing these is critical to successful recovery. The intent of this standard is that when the assessment identifies concurrent needs, they are addressed either through provision of service by the organization or referral to other providers.

Examples
5.a. In addition to behavioral health issues, such as addictions or mental illness, and intellectual or other developmental disabilities, concurrent disabilities and disorders include all chronic medical conditions for which the organization will provide or ensure monitoring/treatment.

2.C. 6. Progress notes:
   a. Document:
      (1) Progress toward achievement of identified:
         (a) Objectives.
         (b) Goals.
      (2) Significant events or changes in the life of the person served.
      (3) The delivery and outcomes of specific interventions, modalities, and/or services that support the person-centered plan.
      (4) Changes in:
         (a) Frequency of services.
         (b) Levels of care.
   b. Are:
      (1) Signed.
      (2) Dated.

Intent Statements
The progress notes are signed and dated by each individual making an entry into the record. A reviewer of the progress notes is able to readily identify the goals and objectives that were achieved or revised during the reporting period, occurrences in the life of the person served that may impact the course of treatment or service, and the specific services and interventions that the organization has provided.

Examples
6.b. The use of initials would not meet the intent of the standard unless a signature sheet is used to verify the person signing. Electronic systems that restrict or automatically identify the person entering the data and the date the information is entered will conform to the intent of this standard.
6.b.(2) Dated refers to the month, day, and year, but does not require the specific time of day.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Person-centered plans
- Primary assessment and interpretive summary
- Progress notes
- Safety plans, as needed
D. Transition/Discharge

Description

Transition, continuing care, or discharge planning assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization. The transition process is planned with the active participation of each person served. Transition may include planned discharge, placement on inactive status, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.

The transition plan is a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation. It is prepared with the active participation of the person served when he or she moves to another level of care, after-care program, or community-based services. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served receives a copy of the transition plan.

A discharge summary is a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the organization (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the organization provided and the response by the person served.

Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual’s ongoing recovery or well-being. The organization proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary may be a combined document or part of the plan for the person served as long as it is clear whether the information relates to transition or pre-discharge planning or identifies the person’s discharge or departure from the program.

NOTE: Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.

2.D. 1. The program implements written procedures for:
   a. Referrals.
   b. Transfer to another level of care, when applicable.
   c. Transfer to other services.
   d. Inactive status, if appropriate.
   e. Discharge.
   f. Follow-up.
   g. Identifying:
      (1) When transition planning will occur.
      (2) Where the following are documented:
         (a) Transitional planning.
         (b) Discharge summary.

Examples

Identified needs may be specific to the individual’s age, gender, disability/disorder, or other special circumstances.

Referrals may be made for:
- Alcohol and other drug services.
- Case management.
- Community housing programs.
- Supported living programs.
- Day habilitation programs.
- Community employment services.
- Domestic violence services.
- Crisis intervention services.
Section 2.D. Transition/Discharge

- Electronic or virtual services.
- Inpatient services.
- Medical services.
- Medication management.
- Meeting legal requirements of the person served.
- Outpatient therapy services.
- Partial hospitalization.
- Psychological services.
- Psychiatric services.
- Recreation/community living services.
- Relapse prevention groups.
- Residential treatment.
- Self-help groups.
- Social/protective services.
- Therapeutic foster care.
- Vocational rehabilitation.
- Employment services.
- Psychosocial rehabilitation.
- Psychosocial education, including training in money management and personal living skills.
- Income maintenance.
- Dietary services.
- Physical/occupational therapy.
- Speech-language pathology.
- Developmental training.
- Educational services.
- Person-centered plan coordination.
- Continuing care.

Preparation for transition requires giving more than routine notice to the person served that he or she is nearing completion of the program. It is necessary that there be early and active involvement by the person served, the family, referral sources, and other community agencies that will be serving the person. Transition services are particularly critical when adolescents are reaching the age of majority and will require ongoing services in adulthood.

In programs such as health homes, integrated behavioral health/primary care, or programs managing behavioral health conditions in which there is not an expectation of discharge, there might be only minimal transition plans for assisting the person served should he or she drop out of care.

Examples

Transition planning for persons with intellectual disabilities should be a part of planning from the beginning. Persons are given supports to explore other options that are available and connected with resources for growth, such as self-advocacy groups.

Clinical indication recognizes that in certain programs, transition planning may be delayed. In longer-term programs, such as assertive community treatment, initial planning may focus on engagement as opposed to transition. In a membership-based program, transitioning may be a choice of the person served. In an opioid treatment program, the preferred goal may be continued engagement as opposed to transition.

2.D. The written transition plan:

a. Is prepared or updated to ensure a seamless transition when a person served:
   (1) Is transferred to another level of care or an aftercare program.
   (2) Prepares for a planned discharge.

b. Identifies the person’s current:
   (1) Progress in his or her own recovery or move toward well-being.
   (2) Gains achieved during program participation.
c. Identifies the person’s need for support systems or other types of services that will assist in continuing his or her recovery, well-being, or community integration.

d. Includes information on the continuity of the person’s medication(s), when applicable.

e. Includes referral information, such as contact name, telephone number, locations, hours, and days of services, when applicable.

f. Includes communication of information on options and resources available if symptoms recur or additional services are needed, when applicable.

g. Includes:
   (1) Strengths.
   (2) Needs.
   (3) Abilities.
   (4) Preferences.

Intent Statements
An essential concept of this standard is to ensure a smooth or seamless transition when a person served is transferred to another level of care, another component of care, or is discharged from the program.

Examples
A transition plan may be identified by another title such as continuing care plan, referral plan, discharge plan, or aftercare plan (see the Glossary for definition). Transition planning may be documented in progress notes, through a revision of the person’s plan, or in a separate document.

In some programs, a similar plan may be prepared when the person served is placed on inactive status. There may be times when the transition plan is incorporated into the person-centered service/treatment plan of the person served.

It is recognized that there may be times when the person served chooses to abruptly leave a program and transition planning is not possible. In those cases, documentation would include a discharge summary.

3.g.(1) Personal strengths may include assets, resources, and natural positives.
3.g.(2) Individualized needs may include liabilities, weaknesses, and what the person needs to recover.
3.g.(3) Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.
3.g.(4) Preferences are those things the person served feel will enhance his or her treatment experience.

4. The written transition plan is:
   a. Developed with the input and participation of:
      (1) The person served.
      (2) The family/legal guardian, when applicable and permitted.
      (3) A legally authorized representative, when appropriate.
      (4) Team members.
      (5) The referral source, when appropriate and permitted.
      (6) Other community services, when appropriate and permitted.
   b. Given to individuals who participate in the development of the transition plan, when permitted.

Intent Statements
4.b. A copy of the plan is provided to the person served and other transition planning participants as permitted when beneficial to the person served and as an assist to the referral source or the receiving program(s).

5. The program implements procedures for referrals and transfers to ensure that the process is effectively completed.

Intent Statements
When persons served are referred or transferred to another program upon completion, they frequently are unsuccessful in becoming fully engaged in the new program. This can have significant negative impacts on gains made to reduce symptoms and increase functioning.
Examples

The program could follow up with persons served to ensure that they were able to successfully access the next program, and if not, help them to effectively navigate any barriers. The program might communicate with the next program to verify that persons served have entered the program and provide any assistance needed to help with the transition. When there are gaps in time between programs, providing personal contact for the persons served to support them during this period can be encouraging and lead to success in accessing ongoing care.

Discharge

2.D. 6. For all persons leaving services, a written discharge summary is prepared to ensure that the person served has documented treatment episodes and results of treatment. The discharge summary:
   a. Includes the date of admission.
   b. Describes the services provided.
   c. Identifies the presenting condition.
   d. Describes the extent to which established goals and objectives were achieved.
   e. Describes the reasons for discharge.
   f. Identifies the status of the person served at last contact.
   g. Lists recommendations for services or supports.
   h. Includes the date of discharge from the program.
   i. Includes information on medication(s) prescribed or administered, when applicable.

Intent Statements

A discharge summary is a tool that facilitates continuity of care and serves to document a baseline which may be helpful for future service provision.

Examples

6.d. This could include gains achieved by the persons served during program participation, strides made by the person served in the recovery process, or any positive move toward well-being.

6.g. This should include referral resource information, contact name, telephone number, and hours and days of operation.

2.D. 7. When an unplanned discharge occurs, follow-up is conducted as soon as possible to:
   a. Provide necessary notifications.
   b. Clarify the reasons for the unplanned discharge.
   c. Determine with the person served whether further services are needed.
   d. Offer or refer to needed services.

Intent Statements

The program makes an effort to contact persons who drop out of care to determine whether further services are needed and if the person served needs referral to other services.

Examples

7.a. Notifications may be required when the person served is referred under legal process such as a commitment or court-ordered services, when the person served is under legal custody or guardianship, or under certain contracts for services.

2.D. 8. When a person is transferred or discharged, the program identifies:
   a. A process to ensure coordination.
   b. The person responsible for coordinating the transfer or discharge.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written procedures for referrals, transfers, discharges, and follow-up
- Written transition plans
- Written discharge summaries
E. Medication Use

Description

Medication use is the practice of controlling, administering, and/or prescribing medications to persons served in response to specific symptoms, behaviors, or conditions for which the use of medications is indicated and deemed efficacious. The use of medication is one component of treatment directed toward maximizing the functioning of the persons served while reducing their specific symptoms. Prior to the use of medications other therapeutic interventions should be considered, except in circumstances that call for a more urgent intervention.

Medication use includes all prescribed medications, whether or not the program is involved in prescribing, and may include over-the-counter or alternative medications. Alternative medications can include herbal or mineral supplements, vitamins, homeopathic remedies, hormone therapy, or culturally specific treatments.

Medication control is identified as the process of physically controlling, storing, transporting, and disposing of medications, including those self-administered by the person served.

Medication administration is the preparing and giving of prescription and nonprescription medications by authorized and trained personnel to the person served. Self-administration is the application of a medication (whether by oral ingestion, injection, inhalation, or other means) by the person served to his/her own body. This may include the program storing the medication for the person served, personnel handing the bottle or prepackaged medication dose to the person served, instructing or verbally prompting the person served to take the medication, coaching the person served through the steps to ensure proper adherence, and/or closely observing the person served self-administering the medication.

Prescribing is the result of an evaluation that determines if there is a need for medication and what medication is to be used in the treatment of the person served. Prior to providing a prescription for medication, the prescriber obtains the informed consent of the individual authorized to consent to treatment and, if applicable, the assent of the person served. Prescription orders may be verbal or written and detail what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Note: CARF has determined that the use of Narcan/Naloxone should be handled as a first-aid supply and not a medication. Therefore, the Medication Use standards are not applicable when these medications are used as a life-saving measure. CARF expects that the medications are secured, but readily accessible when needed, and at least some program personnel are trained on their use and administration.

Applicable Standards

All policies, procedures, and practices related to medication use are implemented consistent with federal, state/provincial, and other jurisdictional laws, regulations, and licensure requirements. The standards in this section apply as follows:

- All programs seeking accreditation (with the exception of Assessment and Referral and Call Center programs) must apply Standard 1. in this section, regardless of their involvement in medication use.

- Programs that provide medication control, administration, or prescribing must apply Standards 2.–9. as follows:
  - Programs that provide medication control: Standards 2.–5.
  - Programs that provide medication administering: Standards 2. and 4.–6.
  - Programs that provide medication prescribing: Standards 2., 4., and 6.–9.

2.E. The organization implements a policy that identifies for each program the scope of medication services, including whether or not it directly provides medication:
  a. Control.
  b. Administering.
  c. Prescribing.
Intent Statements

There may be separate policies for each program if the scope of medication services varies, or there may be one policy for the organization that reflects variances that may exist between programs.

Policies specify whether personnel must administer all medications or self-administration is permitted and whether nonprescription medications may be used in the program.

2.E. 2. When the program provides medication control, administering, and/or prescribing, documented training and education regarding medications:

a. Is provided to direct service personnel:
   (1) At orientation.
   (2) At least annually.

b. Is provided in accordance with identified needs to:
   (1) The persons served.
   (2) When applicable, family members or others identified by the persons served.

c. Includes:
   (1) The purpose of the medication.
   (2) The benefits and risks associated with medication use.
   (3) Contraindications.
   (4) Side effects.
   (5) Missed doses.
   (6) Potential implications of diet and exercise when using medications.
   (7) Risks associated with medication use during pregnancy.
   (8) The importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence.
   (9) The need for laboratory studies, tests, or other monitoring procedures.
   (10) Early signs that medication efficacy is diminishing.

(11) Signs of nonadherence to medication prescriptions.

(12) Potential drug reactions when combining prescription and nonprescription medications.

(13) Instructions on self-administration, when applicable.

(14) The expected course of use of medication, including discontinuation.

(15) The availability of financial supports and resources to assist the persons served to obtain needed medications.

(16) What to do in the event there is a question or concern about a medication the person served is taking or has been prescribed.

Intent Statements

Although this standard outlines the same topic areas for training and education provided to personnel, persons served, and family members or others, the content and training methods will vary according to their needs and levels of understanding. When providing training to persons served and family members or others, the training is specific to the medications the person served is taking or planning to take. The training provided to personnel is more generalized, often focusing on the medications most frequently used by persons served in the program.

2.c.(10) Refer to the Glossary for the definition of efficacy.

Examples

2.b.(2) Based on the age or competency of the person served, training and education may need to be provided to others involved in the administration or monitoring of medications used by the person served.

2.c.(2) Risks include medications that may be habit forming and adverse reactions to medications such as allergic reactions, bleeding, loss of consciousness, etc.

2.c.(4) Side effects might include drowsiness, skin irritation, headache, nausea, dry mouth, etc.
2.c.(8) Potential obstacles might include the cost of obtaining a medication if an individual’s insurance doesn’t cover it, partially covers it, or a generic is not available.

2.c.(12) Examples of nonprescription medications that may potentially cause a drug reaction include over-the-counter medications such as cold or flu remedies, as well as alternative medications such as herbal supplements and culturally specific treatments prescribed by traditional healers (medicine men or women, curanderas, and shamans). Alcohol, tobacco, caffeine, and illegal drugs may also cause reactions.

Resources

There are many training and education resources that a program can access to provide to persons served and direct service personnel. Both print and video resources may easily be found through a web search, with many free of cost. Additionally, many jurisdictions have specific requirements for personnel who administer medications, including detailed training curricula and guidelines with resources. Some resources that may be helpful include:

- National Council on Patient Information and Education: www.bemedwise.org
- National Alliance on Mental Illness: Mental Health Medications: www.nami.org/Learn-More/Treatment/Mental-Health-Medications
- National Resource Center for Permanency and Family Connections: www.nrcpcf.org/fostering_connections/psychotropic_medications.html
- Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges: www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf
- American Academy of Pediatrics Healthy Child Care: www.healthychildcare.org/HealthyFutures.html
- As They Grow: Teaching Your Children How To Use Medicines Safely: www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-Counter-Medicines/ucm094876.htm
- Early Childhood Education Linkage System: www.ecels-healthychildcarepa.org/resources
- Parents360 Rx Action Toolkit: pact360.org/programs/parents360rx

2.E. 3. When the program physically controls medications, written procedures are implemented that address:

a. Inventory.
b. Safe storage.
c. Safe handling.
d. Safe disposal.
e. The following, as applicable:
   (1) Obtaining medications.
   (2) Transportation and delivery.
   (3) Packaging and labeling.
   (4) Self-administration.
   (5) Off-site use.
   (6) A verification process for medications brought to the program for a person served that includes for each medication:
      (a) Accurate identification.
      (b) The amount/quantity of the medication brought to the program.
      (c) Proper dosing instructions.
      (d) Instructions for use, including the method/route of administration.
Section 2.E. Medication Use

(7) How nonprescription medications for persons served will be approved for use within the program.

(8) Return of surplus medications to the persons served upon transition/discharge.

Intent Statements

Medication control is the process of physically controlling, storing, transporting, and disposing of medications, including those self-administered by the persons served.

3.e.(4) The procedures address whether self-administration includes only prescribed medications or also over-the-counter and alternative medications; how medications that may be needed in an emergency, such as insulin or an EpiPen®, will be immediately accessible; and expectations regarding supervision and monitoring by personnel to ensure that medication is properly taken and that the person served is observed for any adverse reactions to the medication.

3.e.(5) Off-site use requires alternative procedures for various elements of this standard.

Examples

3.a. Inventory might also be referred to as medication reconciliation.

3.e.(5) Off-site use may occur when a person served requires medication during a time when he or she is visiting with family away from the program’s premises or when program personnel take the persons served on an outing into the community.

3.e.(7) Some programs require that nonprescription medications may be used by persons served only if they are supplied by the individual (or family/caregiver) in their original packaging. Some programs limit the use of nonprescription medications even further to only bottles or packages that have never been opened, while other programs may not allow any use of nonprescription medications unless they are supplied by the program.

Resources

3.d. Resources related to safe disposal of medications include:

- Dispose My Meds: www.disposeymeds.org

2.E. 4. When the program provides medication control, administering, or prescribing, documentation of all medications for each person served, including prescriptive and nonprescription medications, includes:

a. The name of the medication.

b. The dosage.

c. The frequency.

d. Instructions for use, including the method/route of administration.

e. Contact information for the prescribing professional, including:

   (1) Name.

   (2) Telephone number.

f. When applicable, information on medications administered, including:

   (1) The time the medication was administered.

   (2) Identification of the person administering.

   (3) Confirmation of dose accepted or refused.

   g. Observed and reported medication reactions.

   h. PRN medication given to the person served, including the reason.

   i. Medication errors.

Examples

A program may document the above information in the record of the person served, in a medication administration record, or in a combination of the two.

4.g. Medication reactions may be observed by program personnel or reported by the persons served or family members, caregivers, etc.
2.E. 5. When the program provides medication control or administering, it provides ready access to the telephone number of a poison control center to:
   a. The persons served.
   b. Program personnel.

Intent Statements
This includes control or administering of prescription and nonprescription medications.

2.E. 6. A program that provides administering or prescribing of medications implements written procedures that address:
   a. How medications are integrated into the individualized plan of the person served.
   b. Active involvement of the persons served, when able, or members of the family when appropriate, in making decisions related to the use of medications.
   c. Availability of consultation 24 hours a day, 7 days a week from a physician, pharmacist, or qualified professional licensed to prescribe.
   d. Review of past medication use, including:
      (1) Efficacy.
      (2) Side effects.
      (3) Adverse reactions.
   e. Identification of alcohol, tobacco, and other drug use.
   f. Use of over-the-counter medications.
   g. Use of medications by children/youth in out-of-home placements, if applicable.
   h. Use of medications by women of childbearing age, if applicable.
   i. Use of medications during pregnancy, if applicable.
   j. Special dietary needs and restrictions associated with medication use.
   k. Necessary laboratory studies, tests, or other monitoring procedures.
   l. Documented assessment of abnormal involuntary movements in persons served receiving antipsychotic medications, if applicable:
      (1) At the initiation of treatment.
      (2) At a frequency that meets the needs of the persons served.
   m. Coordination with the physician(s) providing primary care.
   n. Review of medication use activities as part of the performance measurement and management system.
   o. An evaluation of the risk of diversion.
   p. Behaviors related to stockpiling of medicine.
   q. Actions to be taken in case of emergencies related to the use of medications.
   r. How the persons served obtain the medications needed to promote desired treatment/service outcomes while in the program.
   s. Management of biohazards associated with the administration of medications.

Intent Statements
6.c. Consultation can be obtained through direct employment, contract, consultant agreements, or medical facility agreements. Programs may use telepsychiatry or telemedicine as a method of obtaining consultation.
6.g. Out-of-home placements refers to children and youth in the foster care system who have been removed from their homes and put into a placement. When a program serves this population, its written procedures take into consideration the disproportionate data on medications prescribed for children and youth in the foster care system compared to those who are not.
6.k. Procedures for laboratory studies, tests, or other monitoring procedures are implemented in accordance with established practices in medicine.
6.l. Documentation may include formal assessment or observation by appropriate medical personnel. Based on the setting and population served, the program determines the appropriate
Section 2.E. Medication Use

frequency for ongoing assessment of abnormal involuntary movements in persons served.

6.o. A medication is considered diverted when a person who legally obtains a prescription subsequently transfers the medication to another person for use or distribution. When prescribing a medication that has a strong potential for abuse, the prescriber should consider the risk of diversion of the medication based on the history, support network, and financial circumstances of the person served.

6.p. Stockpiling of medication refers to inappropriate and sometimes excessive accumulation of prescribed medication for later use. There are a number of risks associated with this practice. Persons served may continue to take a medication after a change in dose or medication has been ordered, creating uncertainty about the effectiveness of the changed order. Persons served who stockpile medications may not adequately attend to expiration dates on medications and take them after their effectiveness has diminished. Additionally, stockpiling medications may be a precursor to suicide or self-injury. Programs can consider methods to address these concerns either systemically or on a case-by-case basis.

6.q. Emergencies related to the use of medications can present in several forms; e.g., allergic reactions, medication errors, and overdoses, and having procedures to address them is vital to maintaining a healthy and safe environment.

Examples

6.b. Decisions related to the use of medications may include initial consent or assent to begin a medication, decisions related to dosage changes, withdrawal of consent or assent due to adverse reactions, etc.

6.e. Other drug use includes legal and illegal drugs.

6.m. Depending upon the primary care an individual receives, the program may be coordinating with an identified physician, a physician practice or clinic, a nurse practitioner, etc. The procedure might require that unsuccessful attempts for the coordination of care with the primary care physician be documented.

6.n. Examples of indicators a program that does not prescribe (and is therefore not subject to peer review of its prescribing practices) might track in its performance measurement and management system include the percentage of persons served on prescription medications, the average number of medications persons served are taking, and the number of medication and/or dosage changes during time in the program. If a program contracts with several prescribers, knowing which one(s) tend to add or remove medications may be valuable. If a program serves children and youth in the foster care system as well as children and youth who are not, it may look at whether children/youth in foster care are medicated at a higher rate.

6.p. Behaviors may include requesting early refills of a medication, alleging that a prescription was lost and therefore could not be filled, alleging that medication fell down the sink or into the toilet, etc. Programs may require that at each visit all medications are brought in for reconciliation with the amount prescribed, may conduct random drug screens, or may conduct random mouth checks post administration. Some prescribers will only prescribe medications that can be administered through long-acting IM or IV injection or through oral ingestion to be given at a clinic.

6.r. Programs may assist the persons served to obtain medications by applying for free or discounted medication programs and patient assistance programs available through pharmaceutical companies or linking the persons served to physicians or other qualified professionals licensed to prescribe.

6.s. Biohazards associated with the administration of medications include items that have been contaminated with blood or other bodily fluids, such as needles, gloves, bandages, bedding, diapers, etc.

Resources

2019 Behavioral Health Standards Manual

Section 2.E. Medication Use

2.E. 7. A program that provides prescribing of medications demonstrates the use of treatment guidelines and protocols that promote prescribing consistent with standards of care.

Intent Statements
There is emerging consensus in psychiatry and other medical disciplines on best practices in medication prescribing, including the use of guidelines, algorithms, and protocols, as well as the evaluation of the efficacy and safety of new medications. Each program regularly monitors and evaluates these practice trends in the field, including consideration of the use of formularies to measure cost effectiveness to the person served.

Examples
Standards of care might consider the diagnostic conditions, age, or gender of the persons served as well as the level or setting of care.

Resources

2.E. 8. A program that provides prescribing of medications implements written procedures that address:

a. Screening for common medical comorbidities.
b. Evaluation of coexisting medical conditions for potential medication impact.
c. Identification of potential medication interactions.
d. Documentation of:
   (1) Informed consent for each medication prescribed.
   (2) Assent for each medication prescribed, when possible.

e. The expected course of use for each medication, including discontinuation.
f. Ongoing reassessment of the current medication profile.
g. Use of a Prescription Drug Monitoring Program (PDMP), when available.

Intent Statements
8.c. Medication interactions may occur between any types of medications, including prescribed medications, over-the-counter medications, and alternative medications. Prescribers must have a current, accurate account of all medications a person served is taking prior to them being able to safely prescribe.

8.d. To facilitate the decision-making roles of the persons served, and, as applicable, family members and others, they are given information in language that is understandable.

8.d.(2) The concept of assent is agreement and is applicable when a person served does not have legal authority to give informed consent. This relates to Standard 8. in Section 2.A regarding legal decision-making authority.

8.g. Consulting a PDMP, when available, is particularly important when prescribing medications at risk of misuse, abuse, or diversion.

Examples
8.a. The American Psychiatric Association (www.psych.org) and the American Diabetes Association (www.diabetes.org) have published consensus guidelines identifying the frequency and types of laboratory tests and metabolic screenings appropriate for persons prescribed antipsychotic medications.

8.d. Evidence of informed consent for prescribed medications may include signed consent forms, a notation by the prescriber in the record of the person served that the medication has been discussed and agreed upon, or medication(s) to be prescribed listed on an individualized plan that is actively developed with the person served.
8.f. Balancing the benefits and risks of the medications a person served might be taking, ongoing reassessment considers whether:

- The person served obtained and is taking the medication as prescribed.
- The medication is having the intended effect.
- There are side effects or adverse reactions that need to be addressed.
- The dosage is appropriate or requires adjustment.
- To continue/discontinue a medication.

Resources

Prescription Drug Monitoring Program Training and Technical Assistance Center:
www.pdmpassist.org

2.E. 9. In a program that provides prescribing of medications:

a. A documented peer review is conducted:
   (1) At least annually.
   (2) By a qualified professional licensed to prescribe or a pharmacist.
   (3) On the records of a representative sample of persons for whom prescriptions were provided.
   (4) To assess the appropriateness of each medication, as determined by:
      (a) The needs and preferences of the person served.
      (b) The condition for which the medication is prescribed.
      (c) Dosage.
      (d) Periodic reevaluation of continued use related to the primary condition being treated.
      (e) The efficacy of the medication.
   (5) To determine whether:
      (a) The following were identified and, if needed, addressed:
         (i) Contraindications.
         (ii) Side effects.
         (iii) Adverse reactions.
   (b) Necessary monitoring protocols were implemented.
   (c) There was simultaneous use of multiple medications, including:
      (i) Polypharmacy.
      (ii) Co-pharmacy.

b. Information collected from the peer review process is:
   (1) Reported to appropriate personnel.
   (2) Used to improve the quality of services provided.
   (3) Incorporated into the performance measurement and management system.

Intent Statements

The peer review is applicable whether the program employs or contracts with prescribers and whether they are full- or part-time. The review is conducted by a qualified professional with legal prescribing authority or a pharmacist who is not immediately responsible for the prescribing process but is able to provide feedback to the prescribing practitioners. The persons conducting the peer review possess content expertise in working with the medication protocols used within the program for the population(s) served.

9.a.(1) The minimum frequency for peer review is annually, although the program may determine that a more frequent review is appropriate based on the risks associated with the population served, the addition of new prescribers, introduction of new protocols, etc. The resources required to conduct more frequent peer reviews may be offset, in part, by the reviews including fewer records and therefore taking less time.

9.a.(3) Refer to the Glossary for the definition of representative sample.

9.a.(5)(c) Refer to the Glossary for the definitions of polypharmacy and co-pharmacy.

Examples

Programs that have only one prescriber may choose to partner with another program, prescriber, organization, or pharmacy to accomplish
the peer review process. Programs that contract with prescribers may rotate their reviews among the prescribers, ensuring that a prescriber is not reviewing his or her own records. Some programs have engaged local medical and pharmacy students/interns under the appropriate supervision for assistance with the peer review process. This provides the medical and pharmacy students/interns with practical experience and provides the program a link to medical professionals with current knowledge on new medications and the latest research on existing medications.

9.a.(5)(b) Monitoring may refer to laboratory studies, tests, or other monitoring procedures or to protocols such as frequency of visits.

Additional Resources

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation of education and training provided to direct service personnel at orientation and at least annually
- Documentation of education and training provided to persons served, family members, or others identified by the persons served, in accordance with identified needs
- Written procedures related to medication control, administering, and/or prescribing, as applicable
- Documentation of all medications for each person served
- Documentation of peer review of medication prescribing practices at least annually, if applicable

F. Promoting Nonviolent Practices

Description
CARF-accredited programs strive to create learning environments for the persons served and to support the development of skills that build and strengthen resiliency and well-being. The establishment of quality relationships between personnel and the persons served provides the foundation for a safe and nurturing environment. Providers are mindful of creating an environment that cultivates:

- Engagement.
- Partnership.
- Holistic approaches.
- Nurturance.
- Respect.
- Hope.
- Self-direction.

It is recognized that persons served may require support to fully benefit from their services. This may include, but is not limited to, praise and encouragement, verbal prompts, written expectations, clarity of rules and expectations, or environmental supports.

Even with support there are times when persons served may demonstrate signs of fear, anger, or pain that could lead to unsafe behaviors. Personnel are trained to recognize and respond to these behaviors through various interventions, such as changes to the physical environment, sensory-based calming strategies, engagement in meaningful activities, redirection, active listening, approaches that have been effective for the individual in the past, etc. When these interventions are not effective in de-escalating a situation and there is imminent risk to the person served or others, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort.

As the use of seclusion or restraint creates potential physical and psychological risks to the persons subject to the interventions, to the personnel who administer them, and to those
who witness the practice, an organization that utilizes seclusion or restraint should have the elimination thereof as its goal.

Seclusion refers to restriction of the person served to a segregated room or space with the person's freedom to leave physically restricted. Voluntary time out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the person served is considered in seclusion only if freedom to leave the segregated room or space is denied.

Restraint is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication as an immediate response to a dangerous behavior. The following are not considered restraints for the purposes of this section of standards:

■ Assistive devices used for persons with physical or medical needs.

■ Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to others.

■ Holding a person's hand or arm to safely guide him or her from one area to another or away from another person.

■ Security doors designed to prevent elopement or wandering.

■ Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel. When permissible, consideration is given to removal of physical restraints while the person is receiving services in the behavioral healthcare setting.

■ In a correctional setting, the use of seclusion or restraint for purposes of security.

Seclusion or restraint by trained and competent personnel is used only when other, less restrictive measures have been ineffective to protect the person served or others from unsafe behavior. Peer restraint is not an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation or in lieu of adequate programming or staffing.

Applicable Standards

All policies, procedures, and practices related to seclusion and restraint are implemented consistent with federal, state/provincial, and other jurisdictional laws, regulations, and licensure requirements. The standards in this section apply as follows:

■ All programs seeking accreditation (with the exception of Assessment and Referral and Call Center programs) must apply Standards 1. and 2., regardless of whether they use seclusion or restraint.

■ Programs that use seclusion or restraint must also apply Standards 3.–13.

2.F. 1. The organization implements a policy for each program that identifies:

a. How it will respond to unsafe behaviors of the persons served.

b. Whether, and under what circumstances:
   (1) Seclusion is used.
   (2) Restraints are used.

Intent Statements

Each program seeking accreditation must have a policy that outlines its position on the use of seclusion and/or restraint. Personnel and the persons served (refer to Standard 8. in Section 2.B.) understand the program's policy and position on the use of seclusion and restraint, and it is clearly understood under what circumstances, if any, seclusion or restraint would be used. There may be separate policies for each program seeking accreditation within an organization if variances exist between how programs respond to unsafe behaviors of the persons served and/or whether and under what circumstances seclusion or restraint is used.

Examples

Unsafe behaviors are typically those characterized as dangerous and causing potential harm to self or others. Unsafe behaviors may include impulsive and chronic physical aggression toward others including threats of violence and possessing and utilizing weapons, cutting
Section 2.F. Promoting Nonviolent Practices

2.F.2. As applicable to the population served, all direct service personnel receive documented competency-based training:
   a. At orientation.
   b. At least annually.
   c. That addresses prevention of unsafe behaviors, including:
      (1) Contributing factors or causes that may lead to unsafe behaviors.
      (2) Health conditions that may contribute to unsafe behaviors.
      (3) How interpersonal interactions may impact the behaviors of the persons served, including:
         (a) How persons served interact with each other.
         (b) How personnel interact with persons served.
         (c) How personnel interact with each other.
      (4) Use of alternative interventions in an effort to avoid the use of seclusion or restraint.

Intent Statements

2.c.(2) The training addresses health conditions, both physical and behavioral, that may underlie or influence unsafe behaviors on the part of the persons served.

2.c.(4) Done in a supportive and respectful manner, alternative interventions are implemented to prevent or de-escalate a potential crisis.

Examples

2.c.(1) Although contributing factors or causes leading to unsafe behavior vary considerably between individuals and programs, consideration should be given to the physical environment as well as conditions in the milieu or the social environment. An individual's history of unsafe behaviors and how he or she has responded to various interventions may be the best predictor of future behaviors and responses.

2.c.(3) Programs may consider training in eCPR, a holistic empowering approach to assisting persons served to cope with emotional crises. Information on this approach can be found at www.emotional-cpr.org.

2.c.(4) Examples may include engagement, one-to-one attention, meditation, de-escalation, self-protection, time out, re-direction, sensory or comfort rooms, mediation, conflict resolution, prompting, and active listening.

2.F.3. Policies are implemented that specify:
   a. Seclusion or restraint is used only as a safety intervention of last resort to prevent harm to the person served or others.
   b. Seclusion or restraint is not used as coercion, discipline, convenience, or retaliation by personnel.
   c. Seclusion or restraint is not used in lieu of adequate programming or staffing.
   d. Orders for all seclusion or restraint are administered by personnel who are competent in the proper techniques.
   e. Standing orders authorizing the use of seclusion or restraint are not issued.

2.F.4. All personnel involved in the direct administration of seclusion or restraint receive documented, competency-based training that is provided by persons or entities qualified to conduct such training:
   a. At orientation.
   b. At least annually.
   c. That addresses:
      (1) The circumstances under which seclusion or restraint is indicated.
(2) Interventions to be used for seclusion or restraint that minimize harm, including:
   (a) Interventions done by an individual.
   (b) Interventions done by a team.

(3) Signs of physical distress in a person who is being secluded or restrained.

(4) Risks of seclusion or restraint:
   (a) To the persons served.
   (b) To personnel.
   (c) Including:
      (i) Physical risks.
      (ii) Psychological risks.

(5) First aid.

(6) Cardiopulmonary resuscitation (CPR).

(7) How to continually assess for the earliest release of the seclusion or restraint.

Examples

Programs may choose to use a formalized training program developed for the purpose of behavior management and crisis intervention. Many programs offer a variety of training options, including those that can be customized and provided on-site as well as multi-day certification courses at various locations. Most training programs also offer a “train the trainer” option to allow an individual to receive specialized, advanced training so he or she is then qualified to train other personnel within the program. Formalized training programs typically offer a certification indicating that the individual has successfully passed a competency evaluation of the skills and coursework included in the training.

Many programs have found it beneficial to incorporate the viewpoint of persons served in the development and/or delivery of training, allowing their voices of experience to add a dimension to the training that is often overlooked.

4.b.–c. Ongoing training is intended to refresh and enhance the competency of personnel. While the program may review important material that has been previously covered, it may also focus on specific items in response to data collected throughout the year. Data from critical incident reports and debriefings are often good sources to identify areas for performance improvement. Ongoing training is also beneficial to address any changing characteristics or needs of the population served, as well as introduce new techniques that have been developed and changes in regulatory requirements.

Resources

- Physical and Psychological Management Techniques (PMT): [www.pmtassociates.net](http://www.pmtassociates.net)
- Professional Assault Crisis Training (ProACT): [www.proacttraining.com](http://www.proacttraining.com)
- Non-Abusive Psychological and Physical Intervention (NAPPI) Training: [http://nappi-training.com](http://nappi-training.com)
- Safe Crisis Management (SCM): [www.safe crisismanagement.com](http://www.safe crisismanagement.com)
- Handle With Care Behavior Management System (HCW): [http://handlewithcare.com](http://handlewithcare.com)
- Therapeutic Crisis Intervention (TCI): [http://rcpp.cornell.edu/tci/tci-1_system.html](http://rcpp.cornell.edu/tci/tci-1_system.html)
- Crisis Prevention Institute (CPI): [www.crisisprevention.com](http://www.crisisprevention.com)
- The Mandt System: [www.mandtsystem.com](http://www.mandtsystem.com)

2.F. 5. The program implements a plan to eliminate the use of seclusion and/or restraint that:
   a. Includes:
      (1) The role of leadership.
      (2) Use of data to inform practice.
      (3) Development of a workforce culture that supports resiliency and well-being.
Section 2.F. Promoting Nonviolent Practices

(4) Input regarding the use of seclusion and/or restraint from:
   (a) Persons served.
   (b) Families.
   (c) Advocates.
(5) Consideration of the results of the debriefing process.
(6) Identification of environmental factors that may contribute to unsafe behaviors.
(7) Actions to be taken to minimize environmental factors that may contribute to unsafe behaviors.
(8) Identification of specific strategies to prevent crises.
(9) Timelines to reduce the use of seclusion and/or restraint.

b. Is shared with:
   (1) Personnel.
   (2) Persons served.
   (3) Other stakeholders.

c. Is reviewed at least annually, including:
   (1) Progress made in reduction of use.
   (2) Areas needing improvement.

d. Is updated as needed.

Intent Statements
Refer to the Glossary for the definition of plan.

The program strives to eliminate the use of seclusion and restraint. Depending on the needs of the persons served and the type of program provided, elimination may not occur, but the program is always looking at what could be done differently to progress in that direction. If a program uses both seclusion and restraint, it is expected that the plan addresses elimination of both.

5.a.(3) Workforce culture includes attitudes, skills, and practices.
5.a.(5) Details of the debriefing process are addressed in Standard 11.

Examples
5.a.(2) Examples may include data from critical incident reports and information from debriefings as well as input received from the leadership reviews of each event.

2.F. 6. Written procedures for seclusion and restraint are implemented that include protocols for:
   a. Children and youth.
   b. Adults.
   c. Special populations.
   d. Individual interventions.
   e. Team interventions, including:
      (1) Defining team leadership.
      (2) Assigning team duties.

Intent Statements
6.a.–b. The program is expected to have protocols for each of these populations unless it excludes through its written scope, program description, admission criteria, or other mechanism children, youth, or adults.

Examples
6.c. Special populations might include persons who have medically complex needs, older adolescents transitioning to adulthood, LGBTQ, foster children and youth, older adults, or programs that specialize in working with persons who have autism, sexual offenders, and victims of trafficking or domestic abuse.

2.F. 7. Written procedures are implemented that address:
   a. Risk assessment of each person served:
      (1) Including:
         (a) Medical history.
         (b) Trauma history.
         (c) History of unsafe behaviors resulting in seclusion or restraint.
         (d) Identification of interventions that have been successful in interrupting unsafe behaviors, when applicable.
(2) That results in identification of:
   (a) Risks associated with the potential use of seclusion or restraint.
   (b) Precautions to be taken.

b. When applicable, identification of actions to be taken by personnel to de-escalate unsafe behaviors, including:
   (1) Documentation in the record of the person served.
   (2) Communication with program personnel.

Intent Statements

When a program uses seclusion or restraint, the assessment process addresses the risks associated with potentially utilizing these interventions with the persons served. While some or all of this information may have been gathered as part of the assessment process addressed in Section 2.B Screening and Access to Services, the focus of this standard is on identification of the specific risks to each person served and the precautions to be taken should seclusion or restraint become necessary.

The information gathered on the person’s history of unsafe behaviors and interventions that have been effective in de-escalating those behaviors, including the person’s input on preferred interventions, guides identification of what interventions can be used in future situations to avoid the use of seclusion or restraint and/or minimize risk to the person served. It is important that personnel are aware of this information in advance of circumstances that may require intervention. The risk assessment may be done by the program or obtained from an external resource, or the required information may be gathered through a combination thereof.

Examples

7.a.(1)(a) This aspect of the risk assessment identifies whether the person served has any medical conditions that could interfere with the program’s use of seclusion or restraint; e.g., a person who has recently broken a limb may be at higher risk of additional injury if a traditional four point restraint is used, or a child who has asthma that is triggered by anxiety may be at higher risk of an adverse reaction if seclusion is used.

7.a.(1)(b) This aspect of the risk assessment addresses whether the person served has a history of trauma and how that may impact the program’s use of seclusion or restraint. For example, if a person served has been the victim of an assault by a group of males, consideration is given to whether intervention by female personnel or not replicating the same number of persons involved in the assault could make a difference if restraint becomes necessary for the safety of the person served or others.

2.F. 8. When seclusion or restraint is used, documentation in the record of the person served demonstrates:
   
   a. Less-restrictive interventions were attempted prior to the use of seclusion or restraint.
   
   b. Administration in a safe manner, with consideration given to the history of the person served.
   
   c. Personnel communication to the person served that the purpose of the seclusion or restraint is to keep him/her and others safe.
   
   d. Monitoring by trained personnel in accordance with established protocols, including continual face-to-face monitoring when there is simultaneous use of seclusion and restraint.
   
   e. Ongoing reevaluation of the person served to determine whether seclusion or restraint is still needed.
   
   f. Removal of the person served from the seclusion or restraint as soon as the threat of harm is no longer present.
   
   g. Immediate medical attention for any injury resulting from seclusion or restraint.
   
   h. Notification as soon as possible of the initial use of seclusion or restraint to:
      (1) The family.
      (2) The treating practitioner.
Examples
8.d. Monitoring protocols often vary between persons in seclusion or in restraint. Some programs use a 15-minute monitoring schedule for persons in restraint and check vital signs, circulation, hydration, and elimination needs; the level of distress and agitation of the person served; mental status, cognitive functioning, skin integrity, nutritional needs, range of motion, and other care needs particular to the individual.

9. Written procedures regarding orders are implemented that specify:
   a. Seclusion or restraint is ordered by a physician or designated qualified practitioner who has training and competence in the prevention and management of unsafe behaviors.
   b. A physician or designated qualified practitioner provides face-to-face evaluation of the person served within one hour of the order for seclusion or restraint being given.
   c. An order for seclusion or restraint does not exceed one hour for a child or youth or four hours for an adult.
   d. Orders for renewal may only occur following a face-to-face evaluation by a physician or designated qualified practitioner.
   e. Orders for seclusion or restraint may be renewed for a total of up to 24 hours.
   f. After 24 hours, a new order is required following a face-to-face evaluation by a physician or designated qualified practitioner.
   g. All orders are entered into the record of the person served as soon as possible but not more than two hours after implementation.
   h. The physician or designated qualified practitioner signs all orders within the time period mandated by law.

Intent Statements
Face-to-face evaluations assess the physical, emotional, and psychological well-being of the person served.

10. If there is a room designated for the use of seclusion or restraint:
   a. It provides for:
      (1) The safety of the person served.
      (2) Continuous, face-to-face observation.
      (3) Access to bathroom facilities, directly or through escort.
   b. It promotes the privacy and dignity of the person served.
   c. There is an identified procedure for exit in case of emergency.

Intent Statements
The physical environment safely and humanely accommodates the intervention of seclusion and/or restraint.
10.a(2) Personnel are available to immediately respond to signs of distress.

11. Following the use of seclusion or restraint, a debriefing process:
   a. Is initiated as soon as possible and no more than 24 hours after the incident.
   b. Includes, unless contraindicated:
      (1) The person served.
      (2) All involved personnel.
      (3) Family members.
      (4) Others observing the incident, when permitted.
   c. Is documented, including:
      (1) A description of the incident.
      (2) From the perspective of the person served, what he/she experienced.
      (3) The antecedents of the incident.
      (4) An assessment of contributing factors.
Section 2.F. Promoting Nonviolent Practices

(5) Actions taken by personnel in an attempt to avoid the use of seclusion or restraint.
(6) The reasons for the use of seclusion or restraint.
(7) The specific intervention used.
(8) The person’s reaction to the intervention.
(9) Actions that could make future use of seclusion or restraint unnecessary.
(10) Modifications made to the individualized plan to address issues or behaviors that impact the need to use seclusion or restraint, as applicable.

Intent Statements
The debriefing process is conducted in a way that is least traumatizing to the person served, family members, personnel, and others who were involved in or witnessed the use of seclusion or restraint. While the intent is to learn from the debriefing process, it may be determined that participation of a particular individual in the process is contraindicated. During a survey, the program is prepared to explain its rationale if this has occurred.

The format of the debriefing process may vary as long as all of the elements of the standard are addressed. For example, rather than having everyone meet together at the same time, information for the debriefing may be gathered from the person served through a one-on-one conversation separate from the other parties involved or via phone call with family members or personnel who are not on site at the time the debriefing occurs.

Examples
A person served may be excused from the debriefing process if there is concern that it may be too traumatizing to relive the details of the intervention or the person needs more time to deal with his or her feelings toward personnel who administered the seclusion or restraint.
Specific personnel may be excluded from the debriefing process if there is concern about their own trauma response to the incident or they request to not participate.

2.F. 12. A written procedure is implemented that addresses leadership review of all uses of seclusion or restraint:
   a. After every occurrence.
   b. Within a designated timeframe.
   c. To determine:
      (1) Compliance with applicable policies and procedures.
      (2) The need for performance improvement.

Intent Statements
Reviews are conducted in accordance with the timeframe specified in the written procedure.

Examples
The organization identifies who will conduct the review. Some organizations may have the executive director or CEO conduct the reviews, while others may delegate the responsibility to program leadership, a risk manager, or other personnel with appropriate knowledge of seclusion and restraint.

2.F. 13. A documented analysis of the program’s use of seclusion and/or restraint:
   a. Is conducted at least annually.
   b. Addresses:
      (1) Trends, including:
         (a) Patterns of use.
         (b) History of use by personnel.
         (c) Environmental contributing factors.
         (d) Program design contributing factors.
      (2) Areas in need of performance improvement.

Intent Statements
Seclusion and restraint are subject to extensive review. As noted in Standards 11. and 12., each use of seclusion or restraint is reviewed through a debriefing process within 24 hours of occurrence as well as by leadership. In addition, aggregate information is analyzed at least annually for trends. Information from these reviews is considered in identifying opportunities for performance improvement, including formulation of the plan.
Section 2.F. Promoting Nonviolent Practices

to eliminate the use of seclusion and/or restraint addressed in Standard 5.

The minimum frequency for review of aggregate information is annually, although the leadership or program may determine that a more frequent review is indicated.

Additional Resources

- Evidenced Based Program and Practice on Seclusion and Restraint Reduction: http://legacy.nreppadmin.net/ViewIntervention.aspx?id=278

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Plan to eliminate use of seclusion and restraint, if applicable
- Written procedures that include protocols for use of seclusion and restraint, if applicable
- Written procedures that address risk assessment of the persons served and identification of actions to de-escalate unsafe behaviors, if applicable
- Documentation in the records of persons served of all use of seclusion or restraint, if applicable
- Written procedures regarding orders for seclusion and restraint, if applicable
- Documentation of timely debriefings following any use of seclusion or restraint, if applicable
- Written procedure for leadership review of all use of seclusion and restraint, if applicable
- Documented analysis of trends in the use of seclusion or restraint and areas in need of improvement
G. Records of the Persons Served

Description
A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

NOTE: Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.

2.G. 1. The organization implements policies and procedures regarding information to be transmitted to other individuals or agencies that include:
   a. The identification of information that can legally be shared without an authorization for release of information.
   b. Forms to authorize release of information that:
      (1) Comply with applicable laws.
      (2) Identify, at a minimum:
         (a) The name of the person about whom information is to be released.
         (b) The content to be released.
         (c) To whom the information is to be released.
         (d) The purpose for which the information is to be released.
         (e) The date on which the release is signed.
         (f) The date, event, or condition upon which the authorization expires.
         (g) Information as to how and when the authorization can be revoked.
         (h) The signature of the person who is legally authorized to sign the release.
    c. A description of how it tracks information released.

Intent Statements
Organizations in the United States submitting or maintaining information in electronic formats regarding the persons served need to pay particular attention to requirements of the HIPAA and 42 CRF, Part 2 (PIPEDA/FOIPA in Canada). Authorization to share information is documented and specifically refers to the information being transmitted. Signed authorization forms that are not specific or that are “boilerplates” will not meet this standard. The standards do not address the specific instances in which it is necessary to have a signed release-of-information form. The intent of this standard is that, if the organization is providing any information that identifies a person served, it has an authorized release-of-information form completed, unless exempted by law. However, this does not mean that there should be a separate release form for every instance (every phone call or conversation with the same agency) in which information is released; one release per agency or person, with a time limitation, is sufficient. There are occasions when signed release-of-information forms are required by law.

Examples
1.b.(2)(f) Release forms stipulate the expiration date by either providing an actual date or by indicating that the release is valid for only a specific amount of time from the date it was signed. Typically, the authorization will not exceed one year. However, some laws may require that the authorization for release of information be for the tenure of a specific relationship; i.e., during the length of a person’s time on probation or parole.

2.G. 2. The individual record communicates information in a manner that is:
   a. Organized.
   b. Clear.
   c. Complete.
   d. Current.
   e. Legible.
Intent Statements

The intent of this standard is that the records be organized in a systematic way to ensure that information is readily accessible. CARF does not prescribe any particular type of organizing or filing system.

Examples

2.c. Complete refers to a central record containing information regarding all the services the person receives. This is considered the main record.

2.G. 3. All documents generated by the organization that require signatures include original or electronic signatures.

Intent Statements

Written signatures are defined as full signatures, not initials. Electronic systems that restrict or automatically identify the person entering the data and the date the information is entered will conform to the intent of this standard.

2.G. 4. The individual record includes:
   a. The date of admission.
   b. Information about the individual’s personal representative, conservator, guardian, or representative payee, if any of these have been appointed, including the name, address, and telephone number.
   c. Information about the person to contact in the event of an emergency, including the name, address, and telephone number.
   d. The name of the person currently coordinating the services of the person served.
   e. The location of any other records.
   f. Information about the individual’s primary care physician, including the name, address, and telephone number, when available.
   g. Financial agreement with the person served.
   h. Healthcare reimbursement information, if applicable.
   i. The person’s:
      (1) Health history.
      (2) Current medications.
      (3) Preadmission screening, when conducted.
      (4) Documentation of orientation.
      (5) Assessments.
      (6) Person-centered plan, including reviews.
      (7) Transition plan.
   j. Progress notes.
   k. A discharge summary.
   l. Correspondence pertinent to the person served.
   m. Authorization for release of information.
   n. Documentation of internal or external referrals.

Intent Statements

In order to be comprehensive, the records of the persons served should contain the information above.

Examples

4.g. This could include situations where the person’s fee is paid by Medicaid, Medicare, etc.
4.i.(7) A transition plan would not be relevant if the person served left services without notice.
4.k. There should be a discharge summary for all persons who have left an organization’s services.

2.G. 5. Entries to the records of the persons served follow the organization’s policy that specifies timeframes for entries.

Intent Statements

Clearly defined timelines for admission notes, assessments, treatment plans, and progress notes are important for comprehensive and efficient service provision.

Examples

Timeframes are needed for treatment planning and can be based on federal, state, provincial, or funding source requirements.
Section 2.H. Quality Records Management

2.G. 6. If duplicate information or reports from the main record of a person served exist, or if working files are maintained, such materials:
   a. Are not substituted for the main record.
   b. Are considered secondary documents, with the main record of the person served receiving first priority.

Intent Statements
Although duplicate records may be maintained at multiple sites, a central record is kept current and complete.

Examples
In some settings, separate treatment and medical records are required to be maintained. Together, these constitute a single, main record.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
   ■ Individual records
   ■ A policy for making entries to records
   ■ Release forms
   ■ Duplicate reports or files

H. Quality Records Management

Description
The organization implements systems and procedures that provide for the ongoing monitoring of the quality, appropriateness, and utilization of the services provided. This is largely accomplished through a systematic review of the records of the persons served. The review assists the organization in improving the quality of services provided to each person served.

NOTE: Please refer to the grid of Applicable Standards on page 116 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.

2.H. 1. The program conducts a documented review of the services provided:
   a. At least quarterly.
   b. That addresses, as evidenced by the record of the person served:
      (1) The quality of service delivery.
      (2) Appropriateness of services.
      (3) Patterns of service utilization.
      (4) Model fidelity, when an evidence-based practice is identified.

Intent Statements
The procedures for review of services include:
   ■ Oversight of the review process by the management of the program.
   ■ Use of individual reviewers who carry out professional functions and who may be either internal or external to the program. A committee is not required to carry out the professional reviews.
   ■ In small programs and small remote sites, the accomplishment of reviews through ongoing supervision and case review, a system of quarterly peer review, or the use of an outside reviewer on a quarterly basis.

Examples
1.b.(4) In programs that use evidenced-based practices, the quarterly review includes key...
components of the model. This might include frequency of services, delivery of specific curriculum, or implementation of specific protocols for handling particular behaviors. For example, if a program uses cognitive behavioral therapy (CBT), there would be evidence of the irrational self-talk that is being countered with new statements. If motivational interviewing is used, there would be evidence of the stage of change and progress made. The documentation would show that the clinician is implementing the model.

2.H. 2. The quarterly review is performed:
   a. By personnel who are trained and qualified.
   b. On a representative sample of persons served.
   c. That includes:
      (1) Current records.
      (2) Closed records.
   d. In accordance with an established review process.

Intent Statements

Records should be reviewed by personnel who are trained to perform the reviews.

Examples

The procedures for review of services may include:

- Oversight of the review process by the management of the organization.
- Use of individual reviewers who carry out professional functions and who may be either internal or external to the organization. A committee is not required to carry out the professional reviews.
- In small organizations and small remote sites, the accomplishment of reviews through ongoing supervision and case review, a system of quarterly peer review, or the use of an outside reviewer on a quarterly basis.

In a program with short lengths of stay, or in situations where the records will not be available following discharge, a review of the records of the persons served may include a review of the records of those persons discharged during the current quarter as well as persons currently being served.

In programs serving few people or having long terms of treatment, it may only be possible to review closed records annually.

2.b. See the Glossary for the definition of representative sample.

There are tools available through software such as Excel to help determine a representative sample to enhance validity in records review.

2.H. 3. When records are selected for review, the person responsible for providing the service/treatment is not:
   a. Solely responsible for the selection of his/her records to be reviewed.
   b. A reviewer of his/her records.

Examples

Creative means may be used if there is a limited number of qualified personnel available to perform a review. For example, if there is only one therapist on staff, an organization may invite another similarly qualified individual who works in the geographic area to review the quality of the person-centered plans. The organization should consult state/provincial/territorial/tribal and federal confidentiality regulations with regard to who can assist in the review of services and the confidentiality assurances necessary for the review to be completed.

2.H. 4. The records review addresses whether:
   a. The persons served were:
      (1) Provided with an appropriate orientation.
      (2) Actively involved in making informed choices regarding the services they received.
   b. Confidential information was released according to applicable laws/regulations.
   c. The assessments of the persons served were thorough, complete, and timely.
Section 2.H. Quality Records Management

2.H. The organization demonstrates that the information collected from its established review process is:
   a. Used to improve the quality of its services through performance improvement activities.
   b. Used to identify personnel training needs.
   c. Reported to personnel.

Intent Statements

This type of review is often referred to as a quality assurance or peer review, and it focuses on the care of the persons served on a case-by-case basis.

It provides an opportunity for professional staff members (and qualified others) to objectively review and suggest alternative program or service strategies to the team responsible for establishing and carrying out the person’s individual program.

Examples

For short-term services: When assessment and referral or brief services, such as crisis intervention, detoxification, or employee assistance, are provided, the review will address only those portions of this standard that are applicable.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation of a professional review of current and closed records at least quarterly
- Evidence that the review addresses the areas listed can be demonstrated on a checklist, table, or other type of form that summarizes the review
- Evidence that the review is done by trained and qualified personnel; a policy can state who the organization determines to be qualified and trained, and signed reviews can support that the policy is being met
SECTION 3

Core Treatment Program Standards

Description
The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

Applicable Standards
All organizations applying for accreditation for a behavioral health core program are responsible for applying the standards in Sections 1–2, unless otherwise indicated under the applicable standards section and in the table on page 116 in Section 2, General Program Standards. Note the requirements for programs serving children and adolescents under the Guidelines for Organizations Seeking a Specific Population Designation on page 283.

Behavioral Health Field Categories

For each behavioral health core program selected for accreditation, an organization must identify under which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program and to distinguish the specific fields in behavioral health that the core program reflects and serves.

The behavioral health field categories are Addictions Pharmacotherapy, Alcohol and Other Drugs/Addictions, Mental Health, Psychosocial Rehabilitation, Family Services, Integrated AOD/Mental Health, Integrated IDD/Mental Health, and Comprehensive Care. The following are descriptions of each field category:

- **Addictions Pharmacotherapy**: Core programs in this field category are designed to provide services to persons who have harmful involvement with alcohol or other drugs/addictions. These are medically managed programs that provide medications in addition to psychosocial interventions designed to assist persons served to achieve their highest possible recovery. Programs in the United States that administer methadone must use the Opioid Treatment Program standards manual and would not be appropriate for this field category. This field category applies only to Office-Based Opioid Treatment programs.

- **Alcohol and Other Drugs/Addictions**: Core programs in this field category are designed to provide services for persons who have or are at risk of having harmful involvement with alcohol or other drugs/addictions, including process addictions, such as addiction to gambling, pornography, video gaming, etc. These programs use a team approach to minimize
the effects and risks associated with alcohol, other drugs, or other addictions.

- **Mental Health:** Core programs in this field category are designed to provide services for people with or who are at risk for psychiatric disabilities/disorders or have other mental health needs. These programs encompass a wide variety of therapeutic settings and intervention modalities and may provide services to those with behavioral health disabilities or co-occurring disabilities; intellectual or developmental disabilities; victims or perpetrators of domestic violence or abuse; persons needing treatment because of eating or sexual disorders; and/or drug, gambling, or internet addictions.

- **Psychosocial Rehabilitation:** Core programs in this field category demonstrate a strong collaborative partnership with the persons served, the development of opportunities for personal growth, a commitment to community integration, goal-oriented and individualized supports, and the promotion of satisfaction and success in community living. Programs in this category may serve persons with a variety of concerns, including persons with developmental or physical disabilities.

- **Family Services:** Core programs in this field category are designed to maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals. Core programs in this field category are directed at the reduction of symptoms and/or the improvement of functioning for the person served or family unit.

- **Integrated AOD/Mental Health:** Core programs in this field category are designed to provide a combination of alcohol and other drugs/addictions and mental health services. This may include services provided in a psychosocial format. Services may be provided through a seamless system of care for individuals with needs in one or both areas or for persons with identified co-occurring disorders, including any of the concerns listed under the Mental Health field category.

- **Integrated IDD/Mental Health:** Core programs in this field category are designed to provide services to persons whose primary diagnoses are intellectual or other developmental disabilities and who are at risk for or exhibiting behavioral disorders or have identified mental health needs. These programs encompass many therapeutic settings and intervention modalities and a commitment to community integration.

- **Comprehensive Care:** Core programs in this field category are designed to provide any combination of behavioral health services related to mental illness, addictions or intellectual/developmental disabilities, and management of or coordination with the healthcare needs of the person served. This field category applies only to Health Home or Integrated Behavioral Health/Primary Care programs. If you choose this category for any programs other than Health Home or Integrated Behavioral Health/Primary Care, please call the CARF office to discuss this option.
Guidelines for Organizations Seeking a Specific Population Designation

If an organization is required or chooses to add a Specific Population Designations to a core program(s) being surveyed, the standards for these designations will be applied at the time of the survey in addition to the core program standards. See Section 5 for details and applicable standards. The Specific Population Designations available are:

- 5.A. Adults with Autism Spectrum Disorder (ASD:A)
- 5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)
- 5.C. Children and Adolescents (CA) (may be required—see Section 5, page 283)
- 5.D. Consumer-Run (CR)
- 5.E. Criminal Justice (CJ) (may be required—see Section 5, page 283)
- 5.F. Eating Disorders (ED) (includes Eating Disorders for Children/Adolescents (EDCA—see Section 5, page 283)
- 5.G. Juvenile Justice (JJ) (May be required—see Section 5, page 283)
- 5.H. Medically Complex (MC) (may be required; includes Medically Complex for Children/Adolescents (MCCA)—see Section 5, page 283)
- 5.I. Older Adults (OA)

A. Assertive Community Treatment (ACT)

Description

Assertive Community Treatment (ACT) is a multidisciplinary team approach that assumes responsibility for directly providing acute, active, and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The program team provides assistance to individuals to maximize their recovery, ensure consumer-directed goal setting, assist the persons served to gain hope and a sense of empowerment, and provide assistance in helping the persons served become respected and valued members of their community. The program provides psychosocial services directed primarily to adults with severe and persistent mental illness who often have co-occurring problems, such as substance abuse, or are homeless or involved with the judicial system.

The team is the single point of clinical responsibility and is accountable for assisting the person served to meet his or her needs and to achieve his or her goals for recovery. Multiple members of the team are familiar with each person served to ensure the timely and continuous provision of services. Services are provided on a long-term care basis with continuity of caregivers over time. The majority of services are provided directly by ACT team members, with minimal referral to outside providers, in the natural environment of the person served and are available 24 hours a day, 7 days per week. Services are comprehensive and highly individualized and are modified as needed through an ongoing assessment and treatment planning process. Services vary in intensity based on the needs of the persons served.

Assertive Community Treatment has been identified as an effective model for providing community-based services for persons whose needs and goals have not been met through traditional office-based treatment and rehabilitation services. Desired outcomes specific to ACT services may include positive change in the following areas: community tenure, independent living, quality of life, consumer satisfaction of...
the person served, functioning in work and social domains, community integration, psychological condition, subjective well-being, and the ability to manage his or her own healthcare.

In certain geographic areas, Assertive Community Treatment programs may be called Community Support programs, Intensive Community Treatment programs, Mobile Community Treatment Teams, or Assertive Outreach Teams.

**Applicable Standards**

An organization seeking accreditation for an assertive community treatment program must apply the standards in Sections 1 and 2, in addition to the standards in this subsection.

3.A. 1. Assertive community treatment (ACT) services are provided by one or more multidisciplinary treatment teams.

3.A. 2. The ACT team:
   a. Has sufficient staff to provide identified hours of coverage.
   b. Includes the variety of disciplines necessary to meet the needs of the persons served.
   c. At least annually reviews its capacity to provide comprehensive integrated treatment services.
   d. Makes recommendations to the organization’s administration to ensure the team’s ability to meet the needs of the persons it serves.

**Intent Statements**

2.a. Staff sufficiency includes plans for backup in case of emergency and planned absences.

3.A. 3. Based on the needs of the persons served, the composition of the ACT team provides for a staff-to-client ratio of at least one full-time equivalent direct care staff member for each eight to fifteen persons served.

3.A. 4. The ACT team is coordinated by a team leader who:
   a. Is a qualified behavioral health practitioner.
   b. Has specialized knowledge and competencies that meet the needs of the persons served.
   c. Provides clinical supervision to ACT team staff.
   d. Provides direct services to persons served by the ACT team.

**Intent Statements**

4.a. See the Glossary for the definition of a qualified behavioral health practitioner.

3.A. 5. The majority of the ACT team members are qualified behavioral health practitioners.

**Intent Statements**

The program can demonstrate that on a consistent basis the ACT team is composed primarily of qualified behavioral health practitioners.

3.A. 6. Each ACT team has one or more nursing staff members who:
   a. Participate(s) in treatment planning meetings based on the needs of the persons served.
   b. Provides sufficient nursing coverage to meet the needs of the persons served.
   c. Directly provide(s) services.
3.A. Assertive Community Treatment (ACT)

Intent Statements

The number of nursing staff members may vary depending on the responsibilities of the nursing staff and the needs of the persons served. Nurses provide nursing consultation to the team. It is expected that registered nursing coverage would relate to the amount of medical or medication use responsibilities required. Systems should be in place to provide for backup in case of emergency or planned absences.

3.A.  7. Each ACT team has a psychiatrist or a physician specialist in addiction medicine who:
   a. Is a member of the team.
   b. Directly provides services.
   c. Is available to participate in treatment planning meetings based on the needs of the persons served.
   d. Provides clinical consultation and supervision to the team.

Intent Statements

On a team providing services to persons with psychiatric needs, a psychiatrist is a member. A team primarily serving persons with addictions may have a physician specialist. Other prescribers such as advanced practice nurses or physician assistants who have training in serving the targeted population are acceptable alternatives to a physician as allowed by applicable regulations and practice acts.

3.A.  8. The organization demonstrates its efforts to recruit staff or volunteers, who are peers, to become team members and to provide peer support or consultation to persons served by the ACT team.

Intent Statements

Peer support staff members or volunteers can provide a unique perspective to the rest of the team and work to foster positive, effective relationships with the persons served. This position may be shared between two or more individuals.

3.A.  9. The treatment plan is reviewed at least quarterly and modified as necessary based on the needs of the person served.

Intent Statements

State, federal, or provincial regulations may require the program to review treatment plans on a more frequent basis.

3.A.  10. The ACT team:
   a. Is the central point for delivering services, as based on the needs of the persons served.
   b. Is available to the persons served.
   c. Directly conducts initial and ongoing assessments of the person served.
   d. Directly provides treatment planning.
   e. Delivers the majority of the treatment, rehabilitation, and recovery support services needed by the persons served, including:
      (1) Symptom assessment and management.
      (2) Individual supportive therapy.

3.A.  11. The ACT team directly provides the following crisis intervention services:
   a. Developing an initial crisis intervention plan upon contact for each person served.
   b. Providing telephone intervention services.
   c. Providing face-to-face assessment services.
   d. Providing mobile services.
   e. Implementation of written emergency procedures that address:
      (1) Screening for medical or emergency psychiatric services when indicated.
      (2) Making referrals to emergency medical or psychiatric services when indicated.
      (3) Identifying personnel trained in emergency procedures.
      (4) Handling standing orders, when appropriate.
Section 3.A. Assertive Community Treatment (ACT)

f. Implementation of procedures for:
   (1) Involving significant others with the consent of the persons served.
   (2) Obtaining information on advance directives of the persons served, when available.

g. On-call availability 24 hours a day, 7 days a week.

h. Collaboration with other community organizations that provide emergency services to ensure continuity of care of the persons served.

Intent Statements

In a rural setting, the ACT team provides or assists in the delivery of the crisis intervention services. During normal hours of operation the rural ACT team provides crisis intervention services directly. During other hours, it may arrange coverage through a reliable and trained crisis intervention service.

11.g. May be provided by telephone coverage.

3.A. 12. The ACT team directly provides the following case management services:
   a. Assisting the persons served to:
      (1) Achieve their objectives.
      (2) Optimize their independence.
      (3) Optimize their productivity through community supports or linkages.
      (4) Develop additional competencies needed in order to increase social support networks.
   b. Assisting the persons served to access transportation when needed.
   c. Assisting the persons served to understand the impact of employment on accessing and securing future benefits.

3.A. 13. The ACT team directly provides the following community integration services:
   a. Enhancing the understanding of the persons served regarding their psychiatric disorders or behavioral health needs.
   b. Improving the ability of the persons served to cope with their current conditions.
   c. Assisting the persons served to achieve their goals of choice in the following areas:
      (1) Community living.
      (2) Vocational/educational development.
      (3) Use of leisure-time opportunities.

Examples

A variety of means, including teaching, planning of social and leisure-time activities, side-by-side support and coaching, and organizing individual and group social and recreational activities can be used to assist the persons served in community integration. These supports are directed toward assisting the persons served in improving communication skills; developing assertiveness and increased self-esteem; developing social skills and meaningful personal relationships; effectively relating to landlords, neighbors, and others; and familiarizing themselves with and increasing their use of available social and recreational opportunities.

13.c.(2) May include volunteer activities.

3.A. 14. The ACT team assists the persons served in securing arrangements to meet their basic needs, including:
   a. Financial benefits.
   b. Food, clothing, and household goods.
   c. Short-term shelter.
   d. Long-term housing.
   e. Housing subsidies.
   f. Medical benefits/care.
   g. Dental benefits/care.
   h. Vision benefits/care.
Examples

14.a. Financial benefits can include social security income, social security disability income, food stamps, and other financial resources available to the persons served.

3.A. 15. The ACT team assists the persons served in securing and maintaining housing that is:
   a. Safe.
   b. Affordable.
   c. Accessible.
   d. Consistent with the goals and choices of the person served.

3.A. 16. The ACT team directly provides services to support activities of daily living in community-based settings through:
   a. Individualized assessment.
   b. Problem solving.
   c. Side-by-side assistance and support.
   d. Skill training.
   e. Ongoing supervision.
   f. Securing of environmental adaptations, if needed.

3.A. 17. Daily living support activities include assisting the persons served to gain or use the skills required to:
   a. Maintain personal hygiene and grooming.
   b. Perform household activities.
   c. Develop or improve money-management skills.
   d. Access means of transportation.
   e. Maintain good physical health and nutrition.

3.A. 18. The ACT team is directly responsible for providing medication management in accordance with the standards in Section 2.E. Medication Use.

3.A. 19. The ACT team psychiatrist routinely, with the consent of the persons served, and as appropriate:
   a. Assesses the symptoms and behaviors of the persons served and prescribes appropriate medication.
   b. Regularly reviews and documents the symptoms as well as the response of the persons served to the prescribed medication treatment.
   c. Educates the persons served, and their family and significant others when appropriate, regarding their disabilities and abilities.

Intent Statements

19.a. Although the ACT team psychiatrist is usually the psychiatrist responsible for prescribing medications to persons served by the team, in unique situations, a person served may continue to receive services from a psychiatrist with whom a therapeutic relationship has been previously established.

3.A. 20. The ACT team directly provides substance abuse services that include interventions that assist persons served to:
   a. Identify substance use and its effects.
   b. Recognize the relationships between substance use, mental illness, and psychotropic medications.
   c. Develop motivation for decreasing substance use.
   d. Develop coping skills and alternatives to substance use.
   e. Achieve periods of abstinence and stability.
   f. Access/utilize self-help or support groups.
Section 3.A. Assertive Community Treatment (ACT)

3.A. 21. The ACT team directly provides vocational services by actively assisting the person served to find, obtain, and maintain employment or volunteer opportunities in community-based sites that are consistent with their goals and choices.

Intent Statements
If the ACT team collaborates with other providers of vocational services, the expectation is that they are actively involved in ensuring that the services are provided and available to the persons served. Simply having the services available or referring the persons served to other providers would not meet the intent of this standard.

3.A. 22. With consent of the persons served, the ACT team provides services to the families and other major supports of the persons served, including:
   a. Education about the illness/disorder of the persons served.
   b. Education about the strengths and abilities of the persons served.
   c. When applicable, education about the role of the family in the therapeutic process.
   d. Intervention to prevent or resolve conflict.
   e. Ongoing communication and collaboration between the team and the family.

3.A. 23. The ACT team provides:
   a. Assertive outreach and engagement to assist the persons served in their own environment.
   b. At least 75 percent of its service contacts in the community, outside of the clinical office setting.

Intent Statements
An essential principle of ACT programs is that the team members provide support and services to the persons served in the community and their natural environment.

3.A. 24. The ACT team:
   a. Provides multiple contacts per week based on the clinical needs of the persons served.
   b. Increases service intensity to the persons served when their needs require additional contacts.

3.A. 25. The ACT team provides ongoing support and liaison services for persons who are hospitalized or in criminal justice or other restrictive settings.

Intent Statements
The length of time during which these supportive services occur may be limited by state or other regulations.

3.A. 26. The ACT team provides outreach and follow-up to persons who have been admitted to its program, are in active status, and:
   a. Become isolated in the community.
   b. Are admitted to more intensive levels of treatment but are likely to return to the program.

3.A. 27. ACT programs operate in response to the needs of the persons served, with flexible hours of operation that include evenings, weekends, nights, and holidays.

3.A. 28. Team members on duty have daily staff meetings to:
   a. Review the clinical status of the persons served.
   b. Review the current needs of the persons served.
   c. Update staff members on treatment contacts that occurred during the previous day(s).
Section 3.A. Assertive Community Treatment (ACT)

3.A. d. Identify contacts with the persons served that need to occur.
3.A. e. Develop the daily work schedule for the team.
3.A. f. Review treatment plans, when appropriate.
3.A. g. Adjust service intensity for persons served as needed.

Intent Statements
Team members in a rural area may periodically use telephonic, electronic, or other means to conduct staff meetings.

3.A. 29. Information shared at organizational staff meetings is documented.

Examples
Documentation may occur in a daily log, weekly contact schedule for each person served, progress note in the record of the person served, or daily staff assignment sheet.

3.A. 30. Designated space is available for team meetings.

3.A. 31. Clinical supervision of all team members is ongoing and sufficient to ensure quality services.

Examples
Clinical supervision may occur through the supervisor’s participation in treatment planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and staff members.

3.A. 32. Clinical supervision is provided by the team leader, psychiatrist, or other designated and qualified person on the team.

3.A. 33. The team has access to the records of the persons served at all times.

3.A. 34. The team interacts with community organizations, agencies, and groups to facilitate community adjustment and access to resources for the persons served.

3.A. 35. Discharge from the program occurs:
3.A. a. When the persons served and program staff members mutually agree to the termination of services.
3.A. b. When the person served moves outside the geographic area of the team’s responsibility. In such cases, the ACT team:
   (1) Arranges for transfer of mental health service responsibility to a provider in the location to which the person served is moving.
   (2) When feasible, maintains contact with the person served until service transfer is arranged.
3.A. c. When the person served demonstrates an ability to function in all major role areas (i.e., work, social, self-care), with only minimal assistance from the program for a period of one year or more as agreed to by the person served and his or her ACT team.
3.A. d. When the person served is not court ordered and requests termination of services.
3.A. e. When the team, despite repeated efforts, cannot locate the person served.

3.A. 36. Documentation of discharge is completed by identified member(s) of the treatment team.
Intent Statements
Documentation of discharge is done in accordance with Section 2.D. Transition/Discharge and Standard 4.k. in Section 2.G. Records of the Persons Served.

3.A. Discharge documentation includes the signature of:
   a. The primary case manager for the person served.
   b. The team leader.
   c. The psychiatrist, when possible.
   d. The person served, when possible.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Initial and ongoing assessments
- Treatment plan
- Crisis intervention plan developed per intervention
- Written emergency procedures
- Individualized assessment of activities of daily living skills
- Documentation of medication treatment and symptomatology and side effects
- Review of clinical records, daily work schedule, treatment plans, and progress notes
- Discharge plan

B. Case Management/Services Coordination (CM)

Description
Case management/services coordination programs provide goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Successful service coordination results in community opportunities and increased independence for the persons served. Programs may provide occasional supportive counseling and crisis intervention services, when allowed by regulatory or funding authorities.

Case management/services coordination may be provided by an organization as part of its person-centered planning and delivery, by a department or division within the organization that works with individuals who are internal and/or external to the organization, or by an organization with the sole purpose of providing case management/services coordination. Such programs are typically provided by qualified case managers/coordinators or by case management teams.

Organizations performing case management/services coordination as a routine function of other services or programs are not required to apply these standards unless they are specifically seeking accreditation for this program.

Applicable Standards
An organization seeking accreditation for a case management/services coordination program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.B. The persons served are linked to services and resources to achieve objectives as identified in their person-centered plan.
3.B. 2. Personnel providing services have a working knowledge of the:
   a. Services that are appropriate for the needs of the persons served.
   b. Support systems that are relevant to the lives of the persons served.

Intent Statements
In order to provide the linkages, coordination, and support needed by the persons served, the case managers are able to demonstrate knowledge of healthcare, social services, employment, housing, recreational opportunities, and other services and systems available in the community.

3.B. 3. Based on the needs of the persons served, case management/services coordination includes:
   a. Activities carried out in collaboration with the persons served.
   b. Outreach to encourage the participation of the persons served.
   c. Coordination of, or assistance with, crisis intervention and stabilization services, as appropriate.
   d. Assistance with achieving goals as defined by the persons served.
   e. Optimizing resources and opportunities through:
      (1) Community linkages.
      (2) Enhanced social support networks.
   f. Assistance with:
      (1) Accessing transportation.
      (2) Securing safe housing that is reflective of the:
         (a) Needs of the persons served.
         (b) Abilities of the persons served.
         (c) Preferences of the persons served.
      (3) Exploring employment or other meaningful activities.
   g. Provision of, or linkage to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:
      (1) Budgeting.
      (2) Meal planning.
      (3) Personal care.
      (4) Housekeeping and home maintenance.
      (5) Other identified needs.
   h. Evidence of linkage with necessary and appropriate:
      (1) Financial services.
      (2) Medical or other healthcare.
      (3) Other community services.

Intent Statements
These case management activities are carried out in partnership and collaboration with the persons served. Elements provided are dependent on the needs of persons served and/or funder/regulatory requirements.

3.c. In some programs, such as Healthy Families America, guidelines specify a variety of positive outreach methods and are used to build trust, engage the person served in services, and maintain ongoing involvement.

3.h.(2) Medical or other healthcare includes the coordination of the healthcare of the persons served. Often individuals are seeing a variety of healthcare professionals and using a variety of medications that need to be monitored and coordinated. When working with infants or children, healthcare includes immunizations.

3.B. 4. The organization provides case management activities in locations that meet the needs of the persons served.

Intent Statements
Services, such as assessment, planning, coordination, and monitoring, can be provided in any setting that provides the best access to the persons served and is preferred by the persons served.

Examples
Such locations may include residences, correctional settings, shelters, community resource sites, hospitals, schools, medical, or other service sites.
Section 3.B. Case Management/Services Coordination (CM)

3.B. 5. The intensity of case management is based on the needs of the person as identified in his or her person-centered plan.

Intent Statements

The intensity of case management and the frequency of contact are individualized and clearly defined.

Examples

There is wide variability among types of case management. Many programs provide intensive case management to a small, select group of individuals, and other programs provide services only periodically. However, there is a clear relationship between how often individuals are served and their specific needs.

Some programs, such as Healthy Families America, have clearly defined criteria for increasing/decreasing the intensity of services.

3.B. 6. When multiple case management providers exist:

a. A primary case manager is identified.

b. There is coordination to:
   (1) Facilitate continuity of care.
   (2) Reduce duplication of services.

3.B. 7. With the permission of the persons served, personnel provide advocacy by sharing feedback regarding the services received with the agencies and organizations providing the services.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Person-centered plans for the persons served
- Assessment and documentation of progress toward individual goals
C. Community Integration (COI)

Description
Community integration is designed to help persons to optimize their personal, social, and vocational competency in order to live successfully in the community. Activities are determined by the needs of the persons served. The persons served are active partners in all aspects of these programs. Therefore, the settings can be informal in order to reduce barriers between staff members and program participants. In addition to services provided in the home or community, this program may include a psychosocial clubhouse, a drop-in center, an activity center, or a day program.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services based on the identified needs and desires of the persons served. A person may participate in a variety of community life experiences that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

**Note:** The use of the term persons served in Community Integration may include members, attendees, or participants.

Applicable Standards
An organization seeking accreditation for a community integration program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

If it is a consumer-run program, the organization would apply Section 1; Section 2.E. and 2.F., as applicable; and Section 5.D.

3.C. 1. The persons participating in services/activities move toward:
   a. Optimal use of:
      (1) Natural supports.
      (2) Self-help.
   c. Greater choice.
   d. Greater control of their lives.
   e. Increased participation in the community.

3.C. 2. Services/activities are organized around:
   a. The stated goals of the persons served.
   b. The identified preferences of the persons served.
   c. The identified needs of the persons served.
   d. Improving the ability of the persons served to understand their needs.
   e. Assisting the persons served to achieve their goals of choice in the following areas:
      (1) Community living skill development.
      (2) Interpersonal relations.
      (3) Recreation or use of leisure time opportunities.
      (4) Vocational development or employment.
      (5) Educational development.
      (6) Self-advocacy.
      (7) Access to nondisability related social resources.
Intent Statements

The organization demonstrates that a range of basic services is provided. These services could be arranged within a psychosocial clubhouse, an activity center, or a day program, but the common services consist of providing assistance with independent living skills and the other activities described in this standard.

2.e.(1) The program assists the person served to develop the skills needed to live as independently as possible in the community.

Examples

2.e.(1) Assistance may be provided to develop or enhance skills related to performing household activities, cooking, grocery shopping, laundry, or money management.

2.e.(3) This may include volunteer activities.

3. If work is performed by program participants, legal wage guidelines are observed.

4. Services are provided at times and locations that meet the needs of the persons served.

Intent Statements

The program's services and hours of operation, including evenings, weekends, and holidays, are evaluated periodically to ensure that the services are available and accessible to meet the needs and interests of the persons served.

5. Personnel are available to meet with persons served to discuss matters of mutual interest or concern.

Examples

These meetings could be community meetings or house meetings for the purpose of collaboratively discussing issues such as:

- Program operations and activities.
- Hours of operation.
- Problems.
- Plans.
- The use of program resources.

6. The organization provides information or referral to assist the persons served in securing assistance to meet their basic needs.

Examples

This may include any of the following based on the needs of the person served:

- Income maintenance.
- Benefits.
- Food, clothing, and household goods.
- Short-term or emergency shelter.
- Housing subsidies, including long-term housing.
- Medical and healthcare.
- Information on the impact of employment on securing and accessing future benefits.
- Transportation.
- Other community supports.

Other relevant behavioral health services may include therapy, testing, medication management, crisis intervention, and psychiatric assessment.

7. The program's outreach to and follow-up procedures for the persons served are directed to:

a. Those who drop out of services.

b. Those who have been admitted to a treatment, institutional, or other setting.

Intent Statements

Each program is encouraged to work cooperatively with other agencies in the community to develop a seamless continuum of services and to reduce all barriers to access. The intent of this standard is to ensure that the program implements procedures that describe how the program will coordinate services and referrals to reduce disruption of the persons served.
D. Court Treatment (CT)

Description

Court Treatment programs provide comprehensive, integrated behavioral health services that work in conjunction with the judicial system. The purpose of court treatment programs is to appropriately respond to the abuse of alcohol and/or other drugs, mental illness, post traumatic stress disorder, family problems, or other concerns and their related criminal and/or civil judicial actions, in order to reduce recidivism and further involvement in the criminal justice system. Court treatment includes services provided to persons referred through various types of problem-solving courts including drug, mental health, veterans, family dependency, tribal, re-entry, and others.

The treatment team works in collaboration with judges, prosecutors, defense counsel, probation authorities, law enforcement, pretrial services, treatment programs, evaluators, and an array of local service providers. Treatment is usually multi-phased and is typically divided into a stabilization phase, an intensive phase, and a transition phase. During each phase, the treatment team is responsible for assessing the behavioral health needs of the person served within the parameters of the legal sanctions imposed by the court. The treatment team either directly provides or arranges for the provision of screening and assessment, case management, detoxification/withdrawal support, intensive outpatient treatment, outpatient, residential treatment, medication use, self-help and advocacy, recovery, health and wellness, relapse prevention, and education regarding factors contributing to the person’s court involvement.

A court treatment program may be a judicial or law enforcement organization that provides or contracts for the identified services or may be a direct treatment provider working as part of the court treatment team.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Records of the persons served
- Meeting schedules and notes
Applicable Standards
An organization seeking accreditation for a court treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

**NOTE:** Court Treatment programs serving juveniles must also apply the standards in Section 5.C. Children and Adolescents (CA) or Section 5.G. Juvenile Justice (JJ).

3.D. 1. The court treatment program works:
   a. With the following, as appropriate:
      (1) Prosecutors.
      (2) Defense counsel.
      (3) Court personnel.
      (4) Other criminal justice representatives.
   b. To design policies and procedures for:
      (1) Screening.
      (2) Eligibility.
      (3) Case processing.

3.D. 2. Participation in a court treatment program is not denied solely on the basis of inability to pay fees, fines, or restitution.

3.D. 3. The program communicates the need for ongoing judicial interaction to each court treatment participant.

**Intent Statements**
The assigned clinician or case manager communicates with the participant on a regularly scheduled basis to determine progress and compliance. Status hearings are used to monitor program compliance, participation, and progress for each court participant. The court applies appropriate incentives or sanctions to match treatment progress.

3.D. 4. A written assessment is conducted for each person served that includes:
   a. A detailed history of the person’s criminal behavior, including:
      (1) Arrests.
      (2) Convictions.
      (3) Violations of parole and/or probation.
      (4) Prior incarcerations.
      (5) Pending cases.
   b. Information on the person’s participation in organizations or groups that encourage criminal behavior.
   c. The relationship between the person’s behavioral health and his or her criminal activity, including, as applicable:
      (1) Alcohol and other drug use.
      (2) Mental illness.
      (3) Post traumatic stress disorder.
      (4) Family concerns.
      (5) Violence.
   d. Risk to self, other persons served, personnel and/or the community.

**Intent Statements**
In conducting an assessment in a court program, the collection of information related to criminal behavior is emphasized.

3.D. 5. A court treatment program provides, or ensures the provision of, the following case management services based on the needs of the persons served:
   a. Optimizing of resources and opportunities through community linkages.
   b. Assistance with developing or enhancing social support networks.
   c. Assistance with accessing:
      (1) Transportation services, as needed.
      (2) Safe housing that is reflective of the:
          (a) Abilities of the person served.
(b) Preferences of the person served.

d. Provision of, or linkage to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:
   (1) Budgeting.
   (2) Meal planning.
   (3) Personal hygiene.
   (4) Housekeeping.

e. An ongoing assessment of the needs of the persons served to determine appropriateness of services directly provided or accessed.

f. Evidence of linkage with necessary and appropriate services, including, when applicable:
   (1) Financial.
   (2) Medical or other healthcare.
   (3) Medication use.
   (4) Educational.
   (5) Employment.
   (6) Other community supports.

3.D. 6. The intensity of case management is based on the needs of the person served.

3.D. 7. When multiple case management providers exist, linkage is made to:
   a. Ensure continuity of care.
   b. Reduce duplication of services.

3.D. 8. The court treatment program provides, or ensures the provision of, the following outpatient services:
   a. Individual counseling/therapy.
   b. Family counseling/therapy.
   c. Group counseling/therapy.
   d. Psycho-education.

3.D. 9. Written procedures specify that the court treatment program provides or arranges for the provision of the following services when needed by the person served:
   a. Detoxification/withdrawal support.

3.D. 10. When applicable, frequent alcohol and other drug testing is used to monitor abstinence.

Intent Statements
The participant is involved in randomly or regularly scheduled alcohol or other drug testing during participation in the program. Abstinence is monitored by drug testing that occurs no less than twice per week. Test results are communicated to the participant and the court.

3.D. 11. Records of the persons served document, on an ongoing basis, the specific treatment interventions that are provided.

3.D. 12. Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, criminal justice behavioral health services.

3.D. 13. All members of the team:
   a. Have access to the confidential information that is required for the team members to perform their functions.
   b. Are bound by applicable state, federal, or provincial confidentiality laws.
Examples
13.a. Access to clinical records can include access to information such as:
- Person-centered plans.
- Custody records.

3.D. 14. Training:
   a. Is provided to personnel prior to the delivery of services.
   b. Includes regular interdisciplinary joint cross-training related to clinical and criminal justice issues.
   c. Includes such topics as:
      (1) The requirements imposed on personnel from the criminal justice system who participate on the treatment team.
      (2) Safeguards that are available to personnel.

Intent Statements
14.a. Behavioral health professionals who work in criminal justice settings encounter a unique service delivery system with both opportunities and challenges. The intent of this standard is to ensure that individuals new to this type of setting receive full and complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work.

14.b. Interdisciplinary cross-training refers to criminal justice staff members providing criminal justice training to clinical staff members and also to clinical staff members providing clinical training to criminal justice staff members. It also requires that training be conducted jointly with members from both the criminal justice and clinical services participating.

Examples
14.c.(1) May include requirements such as mandatory reporting.

3.D. 15. The treatment team works in a partnership with the judge to:
   a. Review treatment progress on an ongoing basis.
   b. Respond to the progress and/or non-compliance of each person served.

3.D. 16. The person served is provided with a description of the relationship between the criminal justice entity and the program, including:
   a. The extent and limitations of confidentiality and sanctions.
   b. The possible implications of having a criminal justice member on the team.

Intent Statements
Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team.

The person served has the option of refusing to have the criminal justice system actively involved in the treatment process and be told of the consequences.

Examples
The team involves a blend of behavioral health providers and criminal justice personnel, such as correctional officers, control agents, guards, and probation and parole officers.

16.b. The staff members of the program might discuss the possible advantages and disadvantages of having a criminal justice member on the team, including such issues as:
- Access to confidential records.
- Action the criminal justice member may be forced to take based on information provided by the team.
- The impact on the therapeutic relationship.

3.D. 17. A review of the person-centered plan for persons served in a court treatment program occurs at least once per month.
3.D. 18. If the person served is sanctioned to an external setting for 30 days or more:
   a. An updated transition plan is completed.
   b. His or her status is tracked/monitored.

3.D. 19. When the person served is referred to a different level of care in the community, the court treatment program establishes a process to consistently receive information regarding his or her status.

Intent Statements
Case management activities support regular communication and coordination of services with the provider of treatment services delivered outside the court treatment program. Case management services provide ongoing assessment of the participant’s progress and needs, provide structure and support for participants who experience difficulties with using services, and ensure communication with the court.

3.D. 20. When appropriate, and with the consent of the person served, the program coordinates treatment with other services.

3.D. 21. The person-centered plan for a person receiving education and training services in a court treatment program:
   a. Addresses issues specific to his or her individual needs.
   b. Is consistent with his or her cognitive and learning abilities.
   c. Is consistent with the program’s philosophy of treatment.
   d. Addresses:
      (1) Relapse prevention.
      (2) Potential contingency plans.

Intent Statements
21.b. The intent of this standard is to ensure that the assessment has included cognitive and learning abilities and that reading materials, assignments, and the requirements for participa-

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Person-centered plans for the persons served
- Assessment and documentation of progress toward individual goals
E. Crisis Intervention (CI)

Description
Crisis intervention programs offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress or in response to acts of domestic violence or abuse/neglect. Crisis intervention services consist of mobile response, walk-in centers, or other means of face-to-face assessments and telephone interventions.

Applicable Standards
An organization seeking accreditation for a crisis intervention program must apply the standards in Section 1. In addition, standards in Section 2 (please consult grid on page 116 for applicability) must be applied in addition to the standards in this subsection.

3.E. 1. The organization implements an identified written procedure for timely engagement of the person served.

3.E. 2. The written crisis assessment includes at a minimum:
   a. Presenting concerns.
   b. Suicide risk.
   c. Issues since last stabilization, when applicable.
   d. Current living situation.
   e. Availability of supports.
   f. Risk of harm:
      (1) To self or others.
      (2) From others.
   g. Current medications and compliance.
   h. Use of alcohol or drugs.
   i. Medical conditions.
   j. When applicable, history of previous crises, including response and results.

3.E. 3. The crisis assessment leads to an initial crisis intervention plan, developed upon contact with each person served, that includes:
   a. Identified immediate response needs.
   b. Identified follow-up when referral is made.
   c. A statement of crisis resolution.

Intent Statements
Since crisis intervention programs consist of immediate and short-term response to the crises, the plan for care may be shorter than the person-centered plan described in Section 2.C. The plan may only address the immediate services needed to respond to the current crisis of the person served and the transition to other services.

3.E. 4. The program provides:
   a. Telephone intervention services.
   b. Face-to-face assessment services.

Intent Statements
At a minimum, a crisis intervention program provides services over the telephone (including TDD when needed) and face-to-face at a treatment location, home, shelter, hospital, or other community site.

4.a. Telephone intervention services are generally shorter in duration, and the information gathered will be minimized because there is less time to access and intervene in the crisis. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

4.b. Although the use of electronic means may be included, it would not suffice in meeting this standard.

3.E. 5. There are procedures for the provision of mobile services.

Intent Statements
Mobile services include the capacity to respond to the site where the individual in crisis is located.

Examples
Mobile services may be provided by the organization, or linkages for the provision of emergency
or crisis intervention services may be established through such community organizations as visiting nurse groups, community mental health centers, and case management programs.

3.E. 6. Personnel providing mobile services are trained or certified in first aid and CPR.

3.E. 7. There are written emergency procedures that address:
   a. Screening for medical conditions.
   b. Making referrals to emergency medical services when indicated.
   c. Identifying personnel trained in emergency procedures.
   d. When appropriate, identifying personnel other than physicians who can perform special procedures, including the circumstances under which they can perform these procedures and the degree of supervision required to perform these procedures.
   e. Handling standing orders.
   f. Involuntary hospitalization.

Intent Statements

Often crisis intervention services involve the provision of emergency care. The intent of this standard is to ensure that staff members, resources, and procedures are available to respond to these circumstances. Special procedures may include the provision of medications or other medical services.

3.E. 8. Crisis intervention services are available 24 hours a day, 7 days a week.

Intent Statements

The intent of this standard is to ensure that comprehensive crisis intervention services are directly available at all hours to the population served.

3.E. 9. Qualified behavioral health practitioners are available 24 hours a day, 7 days a week.

3.E. 10. The program has the capability to make appropriate clinical decisions to:
   a. Determine an appropriate course of action.
   b. Stabilize the situation as quickly as possible.

Intent Statements

The program has staff with appropriate clinical training, education, or experience to make clinical decisions, and records reflect that clinical decisions are made. Basic components of any crisis intervention service are the ability to quickly assess the problem, decide on the appropriate course of action, and bring together the necessary services and providers to stabilize the situation as soon as possible.

3.E. 11. The program implements written procedures to guide access to inpatient services or less restrictive alternatives.

3.E. 12. There are procedures for the involvement of family members, identified legal representatives, or others, with legal right or the consent of the persons served.

Intent Statements

These procedures should follow the legal requirements regarding the confidentiality rights of the persons served.

3.E. 13. Personnel demonstrate knowledge of:
   a. The appropriate use of community resources.
   b. Crisis intervention techniques.
   c. Procedures for involuntary hospitalization.
Intent Statements
Evidence of orientation and training may be documented in personnel records and inservice training logs.

13.a. Information about community resources, such as transportation services, hospital emergency services, ambulance services, and information and referral services, is made available to the persons served through program personnel.

13.c. Every state and province has established laws and regulations for the involuntary hospitalization of individuals who are typically determined to be a threat to themselves or others. The crisis intervention personnel demonstrate knowledge of the laws and procedures for involuntary hospitalization.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written procedure for timely engagement of the person served
- Written crisis assessment
- Initial crisis intervention plans
- Written emergency procedures
- Written procedures to guide access to inpatient services or less restrictive alternative
- Records of the persons served

F. Crisis Stabilization (CS)

Description
Crisis stabilization programs are organized and staffed to provide the availability of overnight residential services 24 hours a day, 7 days a week for a limited duration to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the needs of the persons served. Often crisis stabilization programs are used as a preemptive measure to deter unnecessary inpatient hospitalization.

Applicable Standards
An organization seeking accreditation for a crisis stabilization program must apply the standards in Section 1. In addition, standards in Section 2 (please consult grid on page 116 for applicability) must be applied in addition to the standards in this subsection.

3.F. 1. The program has the capacity to admit persons served 24 hours a day, 7 days a week.

3.F. 2. An initial crisis stabilization plan:
   a. Is developed upon admission for each person served.
   b. Addresses the person-centered plan if one is available.
   c. Identifies any directives from the person served and/or legal guardian.

Intent Statements
Because crisis stabilization programs consist of short lengths of stay in response to crises, the plan for care may be shorter than the person-centered plan described in Section 2.C.

3.F. 3. The program has on-site personnel 24 hours a day, 7 days a week.

3.F. 4. Licensed medical personnel are available 24 hours a day, 7 days a week.
Intent Statements

Personnel may include physicians, licensed registered nurses, licensed practical nurses, and licensed physicians’ assistants who can be available on site or on call.

3.F. 5. Documented daily therapeutic interventions occur between the persons served and a qualified behavioral health practitioner.

Intent Statements

Although a particular treatment service is not required, there is daily contact with program staff members, case managers, or other appropriate professionals.

See the Glossary for the definition of a qualified behavioral health practitioner.

3.F. 6. The needs of the persons served are continuously evaluated to ensure that appropriate services are provided prior to discharge from crisis stabilization.

3.F. 7. Appropriate referral and linkage to needed services is conducted at the earliest possible interval in the service provision.

3.F. 8. The program ensures that transportation arrangements are made for persons served to immediately needed care/service.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Crisis stabilization plans for the persons served
- Staffing pattern chart or schedule
G. Day Treatment (DT)

Description
Day treatment programs offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the persons served in achieving the goals identified in their person-centered plans. Day treatment programs are offered four or more days per week, typically with support available in the evenings and on weekends. A day treatment program may prevent or minimize the need for a more intensive level of treatment. It may also function as a step-down from inpatient care or partial hospitalization or as transitional care following an inpatient or partial hospitalization stay to facilitate return to the community.

Applicable Standards
An organization seeking accreditation for a day treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.G. The program is available for each person served:
   a. At least four days per week.
   b. At least three hours per day.

Intent Statements
While the program is available to the persons served three hours per day, four days per week, individualized plans and variable lengths of stay will determine the degree to which each person actually participates in a day treatment program.

3.G. The majority of program hours consist of scheduled treatment services that include at least three of the following:
   a. Individual counseling/therapy.
   b. Family counseling/therapy.
   c. Group counseling/therapy.
   d. Education, including at least one of the following topic areas:
      (1) Alcohol, tobacco, or other drugs.
      (2) Medication.
      (3) Psychoeducation.
   e. Occupational therapy.
   f. Other therapy services as appropriate.

Intent Statements
The program ensures that the majority of services delivered are therapeutic activities designed to assist the persons served to achieve the goals outlined in their person-centered plans and may include services provided through technology. There may be some activities that are social or otherwise supportive in nature, but those services are secondary to the intention of providing therapeutic activities.

Examples
2.f. Could include activities such as art therapy, dance therapy, and animal-assisted therapy.

3.G. Based on the needs of the persons served, the program offers additional activities that include, but are not limited to, the following areas:
   a. Emotional.
   b. Environmental.
   c. Financial.
   d. Intellectual.
   e. Occupational.
   f. Physical.
   g. Social.
   h. Spiritual.

Intent Statements
These other activities provided by the program are designed to increase functioning of the persons served and serve as examples of additional nontherapeutic activities performed by the program. Additionally, these activities are focused on improving dimensions of wellness of persons served.
Resources
Additional information on dimensions of wellness can be found at promoteacceptance.samhsa.gov/10by10/dimensions.aspx.

3.G. The program has consistently:
   a. Assigned personnel.
   b. Scheduled activities.

Intent Statements
4.a. The program establishes a stable staffing pattern by assigning the same personnel to the program. Should the need arise, the organization may add personnel from a consistent pool to provide the needed intensity of interventions.

3.G. The program’s services are provided by an interdisciplinary team.

Intent Statements
Please see the Glossary for the definition of interdisciplinary.

3.G. The program provides or arranges for psychiatric services to meet the needs of the persons served.

Intent Statements
Psychiatric services are provided to persons served who need them by the program through its own psychiatrist, a contract psychiatrist, or other appropriate arrangement. Other appropriately trained and supervised psychiatric providers such as Advanced Practice Registered Nurses, Physician Assistants, or Prescribing Psychologists may be used.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A program schedule
- Individual program plans for the persons served
- Records of the persons served
H. Detoxification/Withdrawal Management (DTX)

Description
A detoxification/withdrawal management program is a time-limited program designed to assist the persons served with the physiological and psychological effects of acute withdrawal from alcohol and other drugs. Based on current best practices in the field, the program's purpose is to provide a medically safe, professional and supportive withdrawal experience for the persons served while preparing and motivating them to continue treatment after discharge from the program and progress toward a full and complete recovery. The program is staffed to ensure adequate biomedical and psychosocial assessment, observation and care, and referrals to meet the individual needs of the persons served. Additionally, the program develops and maintains a rich network of treatment providers for referrals after completion of the program to ensure the best possible match for the persons served to ongoing treatment services. A detoxification/withdrawal management program may be provided in the following settings:

- **Inpatient:** This setting is distinguished by services provided in a safe, secure facility-based setting with 24-hour nursing coverage and ready access to medical care. This is for persons served who need round-the-clock supervision in order to successfully manage withdrawal symptoms or when there are additional complications or risk factors that warrant medical supervision, such as co-occurring psychiatric or other medical conditions.

- **Residential:** This setting is distinguished by services provided in a safe facility with 24-hour coverage by qualified personnel. Persons served need the supervision and structure provided by a 24-hour program but do not have risk factors present that warrant an inpatient setting. It may also be appropriate for persons who lack motivation or whose living situation is not conducive to remaining sober.

- **Ambulatory:** This setting is distinguished by services provided in an outpatient environment with the persons served residing in their own homes, a sober living environment or other supportive community settings. Persons served in ambulatory settings typically have adequate social supports to remain sober, family involvement in care planning, the ability to maintain regular appointments for ongoing assessment and observation, and the ability to successfully self-manage prescription medications. Persons served in ambulatory settings are concurrently enrolled in or actively linked to a treatment program.

Applicable Standards
An organization seeking accreditation for a detoxification/withdrawal management program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection, as follows:

- **Inpatient** detoxification/withdrawal management programs must meet Standards 1.–24.

- **Residential** detoxification/withdrawal management programs must meet Standards 1.–22. and Standard 25.

- **Ambulatory** detoxification/withdrawal management programs must meet Standards 1.–19. and Standards 26.–28.

An organization seeking accreditation for a detoxification/withdrawal management program must include all levels of detoxification/withdrawal management that it provides in the accreditation survey.

---

3.H. 1. The program’s documented admission criteria address, at a minimum:
   a. Identified risks.
   b. Mental health needs.
   c. Physical needs.
   d. Support environment.
   e. Relapse risk.
   f. Withdrawal risk.
Intent Statements

The program describes in its admission criteria its capacity to serve and manage behaviors and risks associated with each of the dimensions identified.

1.a. The program identifies the risks that persons served may present and describes the limitations of the program and how it will handle persons whose risks fall outside of the program’s expertise.

1.b. The program describes types of co-occurring psychiatric illnesses and/or symptoms it can manage based on the competencies of personnel.

1.c. The program describes its abilities and limitations related to the physical health needs and medical stability of persons served.

1.d. Based on the detoxification/withdrawal management setting, the program describes the requirements for the support environment of the persons served.

1.e. Based on the detoxification/withdrawal management setting, the program’s admission criteria ensure that the setting matches the needs of the persons served based on their risk of relapse.

1.f. Based on the detoxification/withdrawal management setting, the program establishes criteria that ensure that the level of supervision available in the program is appropriate to the withdrawal risk of the persons served.

Examples

1.a. Examples of risks include suicide, violence, date/time of last use, prior withdrawal management concerns, etc.

1.d. When the setting is ambulatory, the admission criteria may address what types of supports must be present to manage medications that are prescribed (if applicable), the availability of transportation to appointments, and the use of drugs/alcohol by others where the persons served reside.

1.e. Ongoing reassessment.

1.f. The person’s potential to benefit.

1.g. The person’s preferences.

Intent Statements

The program accepts into its care persons who, based on an assessment of their needs and preferences, are most likely to benefit from the program and setting offered.

3.H. 3. For each person served, a medical evaluation:

a. Is obtained within 24 hours of admission to the program.

b. Is documented.

c. Includes:

(1) A physical examination.

(2) Orders for appropriate services.

(3) Face-to-face consultation.

Intent Statements

3.H. 3.c.(1) Readmission within 30 days would not require a new physical examination unless specified otherwise by regulation. When allowed by medical practice boards or other regulation, a physician’s assistant or nurse practitioner may conduct the physical examination.

3.H. 3.c.(3) When admission occurs on a weekend or holiday, face-to-face consultation may be delayed until the first working day following admission, unless earlier consultation is medically necessary. Face-to-face consultation could be done through telehealth services that allow the physician to see the person served from a separate location.

Examples

3.H. 3.c.(2) Orders may include medications, laboratory tests, physical activity or restrictions, notification requirements, or others.

3.H. 4. A risk assessment for each person served:

a. Is conducted at the time of admission.

b. Identifies:

(1) Suicide risk.

(2) Risk of self-harm.

(3) Risk of harm to others.

(4) Trauma.
c. Results in a personal safety plan when risks are identified.

Intent Statements
This standard relates to Standard 2.B.13.; however, the expectation for a detoxification/withdrawal management program is that the risk assessment is conducted at the time of admission and not delayed until a later time when a full assessment may be conducted.

4.a. At the time of admission is considered to be when the admission order is written.

Examples
4.b.(4) Trauma may be experienced or witnessed and may include domestic/intimate partner violence.

4.c. Refer to Standard 2.C.4. for additional information and requirements related to development of personal safety plans for the persons served.

3.H. 5. Initial and ongoing assessments of each person served include:
   a. An assessment of the person's readiness to change.
   b. The use of appropriate symptom scales and/or standardized tools to support admission and continued stay decisions.

Intent Statements
These assessments are in addition to assessments performed in accordance with Standard 2.B.13.

5.b. Based on the needs of the persons served, the program uses the appropriate symptom scales and/or standardized tools to assess needs at admission, to monitor ongoing risks and needs, and to plan for transition/discharge.

Examples
5.b. Examples of appropriate scales include, but are not limited to:


3.H. 6. The program has a qualified program director who:
   a. Has appropriate training and experience in detoxification and withdrawal management.
   b. Has responsibility and authority to direct:
      (1) Establishing the program's policies and procedures.
      (2) Educational activities with the program personnel.
      (3) Program development and modification.
      (4) Review of all critical incident reports.
      (5) Performance improvement activities.

Intent Statements
The person fulfilling these responsibilities does not have to come from any particular discipline. The organization determines who has responsibility for the areas listed and the job title.

Examples
The medical director or another qualified person may fill this role.

3.H. 7. The program has a qualified medical director who:
   a. Has appropriate training and experience in detoxification and withdrawal management.
   b. Has a written agreement with the organization that outlines his or her responsibilities.
   c. Leads the medical staff of the program.
d. Actively participates in:
(1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.
(2) Development of ongoing relationships with the medical community.
(3) Development and implementation of a medical quality review process.
(4) Establishing written treatment protocols that:
   (a) Address detoxification/withdrawal management for:
      (i) Alcohol and other drugs.
      (ii) Special populations.
      (iii) Co-occurring conditions.
   (b) Include:
      (i) Expectations regarding variances from the protocol.
      (ii) Under what circumstances a physician should be consulted.
      (iii) Expected timeframe for physician response.
      (iv) Monitoring of vital signs.
      (v) Face-to-face contact with the persons served.
      (vi) Documentation requirements.

Intent Statements
The medical director provides significant programmatic leadership and participates in management and quality monitoring activities. The medical director can be a physician employed directly by the organization or on a contract.

7.a. If the organization engages a medical director who lacks sufficient training and experience in detoxification/withdrawal management, the organization can develop a plan to ensure that the requisite experience is obtained with appropriate consultation and/or supervision.

Examples
7.b. The responsibilities may be defined in a written job description or contract.

3.H. 8. The program implements the appropriate detoxification protocol for each person served based on his or her assessed needs.

Intent Statements
In accordance with Standard 7. in this section, the program has written treatment protocols for detoxification/withdrawal management for alcohol and other drugs, special populations, and co-occurring conditions. The program demonstrates adherence to the protocols by personnel and that the appropriate protocol is utilized for each person served.

Examples
The organization might utilize forms for concurrent review, post-discharge audit, or peer review to monitor its implementation of detoxification/withdrawal management protocols.

3.H. 9. Services are provided by an interdisciplinary team that includes, at a minimum:
   a. The person served.
   b. Members of the family/support system, as appropriate.
   c. Qualified behavioral health practitioners.
   d. Providers of appropriate medical services.
   e. Other assigned personnel.

Intent Statements
It should be evident that various team members interact with persons served and that members of the family/support system, as appropriate, have involvement with and input to the team.

Examples
Evidence of team interactions may be demonstrated through minutes, logs, or other professional and appropriate means.
Section 3.H. Detoxification/Withdrawal Management (DTX)

3.H. 10. A physician is available to the program 24 hours a day, 7 days a week.

Intent Statements
In addition to in-person availability, a physician may be available through a variety of mechanisms, including, but not limited to, telephone, telehealth services, FaceTime, Skype, or other use of technology. The purpose of this standard is to provide real-time direction to personnel regarding care and crisis intervention for the persons served.

3.H. 11. The persons served are provided with services designed to motivate them to continue treatment following detoxification/withdrawal management.

Intent Statements
It is important to begin the treatment process as soon as possible and to begin intervening at a point when the persons served may be most open to counseling. When the persons served are being treated for physical withdrawal, they are also engaged in counseling that encourages the continuation of services.

3.H. 12. The program provides or arranges for:
   a. Medical consultative services.
   b. Ancillary medical services.
   c. Pharmacy services.
   d. Emergency medical services.
   e. Other services, as appropriate.

Examples
12.a. Medical consultative services may include medical services to address the needs of persons served that are outside the expertise of the program's medical director.
12.b. Ancillary medical services may include services such as laboratory and occupational, physical, or speech therapy.

3.H. 13. The program:
   a. Links with resources in each of the following areas:
      (1) Abstinence-based programs.
      (2) Medication assisted treatment programs.
      (3) Specialized treatment programs.
      (4) Self-help programs.
      (5) Other recovery and social support services.
   b. Identifies key communication contacts at the programs/services with which it links.
   c. Provides or refers the persons served to the programs/services that meet their needs.

Intent Statements
As detoxification/withdrawal management programs are frequently an entry point to the addictions treatment system, the program cultivates a robust network of providers for referral of the persons served based upon their specific needs.

Examples
13.a.(3) Treatment programs may be gender specific, age specific, or specialize in services for persons with co-occurring disorders, persons in the criminal justice system, and the LGBTQ community.
13.a.(5) Other recovery and social support services could include community social services, entitlement programs, housing services, employment programs, and other similar supports.

3.H. 14. All direct service personnel receive competency-based training in:
   a. First aid.
   b. Cardiopulmonary resuscitation (CPR).
   c. The use of emergency equipment, when present.

Intent Statements
Licensed nursing staff and physicians are exempt from this requirement as their professional training and licensing ensure competency.
Examples

14.c. Emergency equipment could include automatic external defibrillators, eyewashing stations, splints, tourniquets, and EpiPens®.

3.H. 15. The program implements written procedures for transfer to emergency medical services that include:

a. The process to transfer a person to a hospital or emergency services.
b. Access to documentation of services received during absence from the program, including medications prescribed.
c. Documentation of actions taken when the person served returns from the emergency service provided.

Intent Statements

These procedures address acute psychiatric and other medical illnesses/conditions that fall outside the scope of the program to manage. The procedures are designed to ensure that there is not a break in care and that the emergency treatment is coordinated by the program, including following through on orders from the treating entity.

3.H. 16. The program provides documented, competency-based training to direct service personnel:

a. At:
   (1) Orientation.
   (2) Regular intervals.
b. That includes, at a minimum, the following topics:
   (1) Risk assessment.
   (2) Detoxification/withdrawal management protocols.
   (3) Withdrawal syndromes.

c. By personnel who are trained and qualified.
d. In accordance with an established review process.
e. That addresses, at a minimum:
   (1) Consistency of detoxification/withdrawal management protocol implementation, including:
      (a) Medication errors.
      (b) Timeliness of laboratory tests, including:
         (i) Orders.
         (ii) Specimen collection.
         (iii) Review of results.
         (iv) Actions taken.
      (c) Vital signs taken at the appropriate intervals.
      (d) Timeliness of physician response.
   (2) Negative outcomes.

Intent Statements

This standard is intended to complement Standard 2.H.4. to ensure that the unique aspects of service delivery in a detoxification/withdrawal management program are reviewed at least annually.

3.H. 17. The program conducts a documented review of the medical services provided:

a. At least annually.
b. On records of a representative sample of the persons served.

c. Used to identify personnel training needs.

d. In accordance with an established review process.
e. That addresses, at a minimum:
   (1) Consistency of detoxification/withdrawal management protocol implementation, including:
      (a) Medication errors.
      (b) Timeliness of laboratory tests, including:
         (i) Orders.
         (ii) Specimen collection.
         (iii) Review of results.
         (iv) Actions taken.
      (c) Vital signs taken at the appropriate intervals.
      (d) Timeliness of physician response.
   (2) Negative outcomes.

Intent Statements

The program establishes a mechanism to share the results of the reviews of medical services (as required in Standard 17. in this section) with personnel and address areas needing improvement through training or other quality improvement activities.
Section 3.H. Detoxification/Withdrawal Management (DTX)

3.H. 19. The program:

a. Identifies an indicator to measure successful transitions of the persons served into ongoing services post discharge.

b. At least annually addresses:
   (1) Performance in relationship to an established target.
   (2) Trends.
   (3) Actions for improvement.
   (4) Results of performance improvement plans.

   (5) Necessary education and training of:
      (a) Persons served.
      (b) Families/support systems.
      (c) Personnel.
      (d) Other stakeholders, as appropriate.

Intent Statements
This standard complements Standard 1.M.6.b. and addresses measurement of the effectiveness of the detoxification/withdrawal management program. As these programs are frequently an entry point to the addictions treatment system, a significant responsibility of these programs is placement into care post discharge. Through this standard, the program measures its effectiveness at transitioning persons served into ongoing treatment services.

Inpatient and Residential Detoxification/Withdrawal Management Programs

Applicable Standards
Inpatient and residential detoxification/withdrawal management programs must also meet Standards 20.–22.

3.H. 20. The program’s physical facilities provide:

a. An environment that is conducive to a detoxification/withdrawal management program.

b. Personal privacy.

c. Security of personal belongings.

d. Space for:
   (1) Quiet activities.
   (2) Family or other guests.
   (3) Therapeutic activities.
   (4) Cultural and/or spiritual activities.
   (5) Meals.
   (6) Based on gender, age, and needs, separate areas for:
      (a) Sleeping.
      (b) Hygiene.

Intent Statements
The program operates in designated space that allows for an appropriate treatment environment and is respectful of personal privacy to the degree possible.

20.d. The program is not required to maintain exclusive spaces for each of these, but appropriate areas are available and provided as needed.

Examples
20.d.(1) Quiet activities may include de-escalation and meditation.

3.H. 21. To ensure the safety of persons served and personnel, the program implements written procedures for searches:

a. Of persons served.

b. Of belongings.

c. That:
   (1) Preserve privacy.
   (2) Preserve dignity.
   (3) Are sensitive to potential trauma of the persons served.

d. Of the physical facility.

Intent Statements
Detoxification/withdrawal management programs ensure that personnel and persons served remain safe in the program, without introduction of weapons, drugs, or alcohol into the milieu. Personnel are adequately trained in the search process in order to respect the dignity and privacy of the persons served. Programs may find it necessary to conduct searches of the persons served, their belongings, or the physical facility.
based on observed behaviors of persons served or others.

Examples

21.c.(3) The program might specify that searches are done by personnel who are the same sex as the person served. The program could solicit permission to search to provide the persons served with some feeling of control of the process.

3.H. 22. The program implements written procedures that address:
   a. Visitation.
   b. Mail.
   c. Telephone use.
   d. Use of personal electronics.

Examples

22.d. The use of personal electronic devices can have a positive influence on the person served, particularly through the use of apps targeting recovery and self-regulation. Programs could attempt to strike a balance in the use of these devices, rather than simply prohibiting their use.

Inpatient Detoxification/Withdrawal Management Programs

Applicable Standards

Inpatient detoxification/withdrawal management programs must also meet Standards 23. and 24.

3.H. 23. Each day, a physician determines the medical necessity of the person served to remain in the inpatient detoxification/withdrawal management program.

Intent Statements

The person served is transitioned from the inpatient setting to a less intensive level of care as soon as clinically appropriate. When allowed by medical practice boards or other regulation, a physician’s assistant or nurse practitioner may make this determination.

Examples

This may be accomplished through options such as telephone consultation with team members or the use of telehealth services if there is not a physician/physician extender on site on a daily basis.

3.H. 24. Licensed nursing services are provided on site 24 hours a day, 7 days a week.

Residential Detoxification/Withdrawal Management Programs

Applicable Standards

Residential detoxification/withdrawal management programs must also meet Standard 25.

3.H. 25. Detoxification/withdrawal management services are provided by qualified personnel 24 hours a day, 7 days a week.

Intent Statements

The detoxification/withdrawal management program is staffed by skilled and trained professionals who are available to persons served at all times.

Examples

Qualified detoxification/withdrawal management personnel can include medical personnel, qualified behavioral healthcare practitioners, and healthcare technicians.

Ambulatory Detoxification/Withdrawal Management Programs

Applicable Standards

Ambulatory detoxification/withdrawal management programs must also meet Standards 26.–28.

3.H. 26. Persons served who are not concurrently enrolled in a treatment program are actively linked to an appropriate program.
Intent Statements
Persons served in an ambulatory program are engaged with active treatment in addition to the detoxification/withdrawal management program.

3.H. 27. Admission to an ambulatory setting is based on assessments that address:
   a. The ability of the person’s support system to be supportive and observant.
   b. The risk of diversion of medications prescribed as part of the program.
   c. The person’s ability to self-manage medications.

Intent Statements
If the support system of the person served does not seem consistent with the level of support required by the person, another setting should be utilized.

Examples
27.a. The support system of the person served could include family members, significant others, and/or members of a social support system.

3.H. 28. The program implements written procedures that address drug-screening practices, including:
   a. The frequency of drug screening.
   b. Provisions for the individualization of drug screening.
   c. An interpretation of the results of drug screening.
   d. Actions to be taken based on the results of drug screening.
   e. Education for:
      (1) Persons served.
      (2) Families/support systems.
      (3) Personnel.

Examples
Written procedures related to drug-screening practices might address the collection and processing of urine samples, continuing education for personnel on urinalysis practices, and emergency services procedures and define who has access to and responsibility for maintaining confidentiality of all drug-screen results information. The procedures for urine sample collection might define how respect for persons served is maintained while minimizing the potential for falsification during the collection process.

28.a. The procedures may require drug screening at the time of admission, when there appears to be a change in behavior, or at the request of the team. It may also specify only a one-time screening.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
   ■ Documentation of the program’s admission criteria
   ■ Documentation of each person’s condition; treatment plans; progress notes
   ■ Medical evaluations of each person served
   ■ Risk assessments of persons served
   ■ Personal safety plans for persons served, when risks are identified
   ■ Written procedures for transfer to medical emergency services
   ■ Documentation of competency-based training for direct service personnel
   ■ Documentation of reviews of medical services provided
   ■ Performance improvement analyses
   ■ Written procedures for searches (for inpatient and residential programs)
   ■ Written procedures that address visitation, mail, telephone, and use of personal electronics (for inpatient and residential programs)
   ■ Written procedures that address drug-screening practices (for ambulatory programs)
   ■ Written agreement with medical director
   ■ Written treatment protocols
I. Health Home (HH)

Description

A health home is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, and community and social support services. A health home allows for individual choice and is capable of assessing the various physical and behavioral health needs of persons served. The program demonstrates the capacity to address, either directly or through linkage with or referral to external resources, behavioral health conditions, such as mental illness and substance use disorders, and physical health conditions. Programs may also serve persons who have intellectual or other developmental disabilities and physical health needs or those who are at risk for or exhibiting behavioral disorders. Care is coordinated over time across providers, functions, activities, and sites to maximize the value and effectiveness of services delivered to persons served.

A health home provides comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family/support services, and linkage and referral to community and social support services. Services are designed to support overall health and wellness and:

- Embody a recovery-focused model of care that respects and promotes independence and responsibility.
- Promote healthy lifestyles and provide prevention and education services that focus on wellness and self-care.
- Ensure access to and coordination of care across prevention, primary care (including ensuring that persons served have a primary care physician), and specialty healthcare services.
- Monitor critical health indicators.
- Support individuals in the self-management of chronic health conditions.
- Coordinate/monitor emergency room visits and hospitalizations, including participation in transition/discharge planning and follow up.

A health home collects, aggregates, and analyzes individual healthcare data across the population of persons served by the program and uses that data and analysis to manage and improve outcomes for the persons served. If the health home is not the actual provider of a particular healthcare service, it remains responsible for supporting and facilitating improved outcomes by providing disease management supports and care coordination with other providers.

Applicable Standards

An organization seeking accreditation as a health home must apply the standards in Sections 1 and 2 in addition to the standards in this subsection and use the Comprehensive Care field category.

1. A written program description includes:
   a. Population(s) served.
   b. Scope of care coordination.
   c. Scope of disease management services.
   d. Population health management strategies.
   e. How each of the following are provided, accessed, and/or coordinated:
      (1) Primary care.
      (2) Behavioral healthcare.
      (3) Other healthcare.
      (4) Community and social support services.

Intent Statements

This description is designed to clearly articulate the eligibility of persons served in the health home program. This description identifies the behavioral health needs and physical health needs typically found in the population, and further describes the types of services and interventions provided by the program.

Examples

1.c. Disease management services involve a complex combination of efforts. These efforts include
gathering information about the characteristics and needs of the population served, maintaining data on best practices for both behavioral and physical healthcare, and analyzing the results and outcomes of care to ensure the best possible outcomes for the population served.

The health home program will likely tie its data collection and outcomes strategies to the standards in Section 1.M. Performance Measurement and Management and Section 1.N. Performance Improvement.

Resources

A resource for more information on health home services is www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

3.I. 2. The health home enhances access to the program through:
   a. Personnel response to phone calls within 24 hours.
   b. Capacity for same day or next day services.
   c. Flexible scheduling.
   d. Provision of services:
      (1) In locations that meet the needs of the persons served.
      (2) At times that meet the needs of the persons served.
      (3) On days that meet the needs of the persons served.

Intent Statements

As the health home program is a primary resource for physical and behavioral healthcare for a complex population, it is imperative that the program be accessible to the persons served at times that most effectively meet their needs.

Examples

2.b. The availability of services is based on the needs of the person served. The same day or next day services may be office-based services, coordination of care in community services, via communications technologies, or other appropriate methods.

3.I. 3. To meet the needs of the persons served, the program provides or makes formal arrangements for the services of a:
   a. Primary care physician.
   b. Psychiatrist or addictionologist.

Intent Statements

The health home program ensures that it can provide services to meet the needs of the persons served in both the physical and behavioral health dimensions. The program can use physician extenders (i.e., Physician Assistants, Advanced Practice Registered Nurses, Prescribing Psychologists, etc.) within their scopes of practice.

Examples

These professionals can be either employed by the organization or work under contract, memorandum of understanding (MOU), or other written agreement.

3.I. 4. The program demonstrates an integrated team approach that includes:
   a. The person served.
   b. Members of the family/support system, as appropriate.
   c. Health home personnel.
   d. Healthcare providers needed by the person served.
   e. Community and/or social support services needed by the person served.

Intent Statements

The program demonstrates how it ensures communication between the person served and service providers to maximize the person’s response to care and recovery.

Examples

4.d. The healthcare providers are determined by the specific needs of the person served, but may include external medical providers, dental providers, health educators, public health personnel, nutritionists, or other similar providers.

4.e. Community and/or social support services may include social workers, child welfare workers, probation, community housing staff, or other similar providers.
3.I. 5. The program addresses the needs of the persons served in the following areas:
   a. Health promotion.
   b. Comprehensive care management, including:
      (1) Triage based on acuity.
      (2) Assessment of service needs.
      (3) Identification of gaps in treatment.
      (4) Appropriate testing to monitor health status.
   (5) Medication reconciliation:
      (a) At admission to the health home program.
      (b) At appropriate intervals.
      (c) Upon discharge from hospitalization.
      (6) Assignment of health home team roles and responsibilities.
      (7) Development of relationships with community and/or social support services.
   c. Care coordination for each person served, including, but not limited to:
      (1) Implementation of the person-centered plan.
      (2) Ongoing monitoring of the person-centered plan, including revisions as needed.
      (3) Providing or arranging for:
         (a) Primary care.
         (b) Behavioral healthcare.
         (c) Hospital care.
         (d) Medical specialty care.
         (e) Community and/or social support services.
         (f) Other services, as appropriate.
      (4) Monitoring of critical chronic disease indicators.
   (5) Comprehensive transitional care.
   (6) Sharing information about the person served:
      (a) Including:
         (i) Strengths.
         (ii) Needs.
         (iii) Abilities.
         (iv) Preferences.
         (v) Treatment history.
         (vi) Health status.
         (vii) Current medications.
         (viii) Identified goals.
         (ix) Identified gaps in treatment, when applicable.
      (b) With the following providers involved in the care of the person served, as applicable:
         (i) Primary care.
         (ii) Behavioral healthcare.
         (iii) Hospital care.
         (iv) Medical specialty care.
         (v) Community and/or social support services.
         (vi) Others, as appropriate.
      (c) During transitions between:
         (i) Inpatient and outpatient care.
         (ii) Levels of care.
         (iii) Outpatient care providers.
         (iv) Care systems.
   d. Individual and family support services, including:
      (1) Activation of family/support system members as natural supports for the person served.
      (2) Engagement of family/support system members in health promotion/disease prevention.
   e. Referral to community and/or social support services.

Intent Statements
These are the core functions of a health home program that the program personnel can either
5. b.(7) The program might offer education to community service providers to enhance their understanding of the population served by the program and the needs of this population.

5. c.(6)(c)(iv) This might include transition between child/youth and adult systems.

3.1. A health assessment is completed for each person served:
   a. Upon admission to the health home program.
   b. At least annually.
   c. That includes:
      (1) A review of psychological factors that impact physical health.
      (2) Chronic disease status, including at least the following:
          (a) Asthma.
          (b) Cardiovascular disease.
          (c) Pulmonary disease.
          (d) Diabetes.
          (e) Hypertension.
          (f) Obesity.
          (g) Other chronic health conditions prevalent among the population served.
      (3) Metabolic syndrome screen.
      (4) Chronic pain.
      (5) Perception of needs from the perspective of the person served.
   d. That is conducted or reviewed by a nurse, nurse practitioner, or other equivalent medical personnel.

Intent Statements
The purpose of the health assessment is to guide treatment goals addressing physical health conditions of the persons served in order to promote recovery and wellness.

6. c. In programs that serve children and/or adolescents, these are included in health assessments as applicable to the needs of the individual child/youth and the populations served by the program.

Examples
6. c.(2)(c) Pulmonary diseases may include COPD, emphysema, and bronchitis.
6. d. This review may be conducted by a physician or physician extender.

Questions addressed during a health assessment screening may include the following:

- Health history:
  - Does the person have a primary care doctor or other doctor they see for care? If so, have they seen their medical doctor in the past year?
  - Has the person had a physical exam in the past year?
  - Has the person been hospitalized or gone to the emergency room for psychiatric or medical problems in the past year?
  - Is the person experiencing any pain? If so, what is the pain rating scale?
  - What is the person's health history in the areas of the skin, eyes, ears and throat, respiratory system, circulatory system, endocrine system, GI, elimination, GU, neurological, musculoskeletal, adult sexual development, and surgeries?
  - Does the person have a family member with high blood pressure, hepatitis, high cholesterol, heart attack/heart disease, or diabetes?
  - Does the person have allergies to medications, foods, or the environment?
  - Has the person ever been immunized or vaccinated? What vaccinations have they had and are these current?
  - Does the person have a dentist? Do they have any teeth, gum, or mouth problems?
Risk factors:
- Does the person use tobacco? If so, have they attempted to stop using in the past?
- To what extent does the person exercise, and are they happy with the amount of exercise they are doing?
- Is the person on a special diet? Have they had unexplained weight gain or loss in the past year?

Resources
6.c.(3) A resource for information on metabolic syndrome is [www.nhlbi.nih.gov/health/topics/topics/ms](http://www.nhlbi.nih.gov/health/topics/topics/ms)

3.I. 7. The person-centered plan:
   a. Addresses, in an integrated manner:
      1. Physical health needs.
      2. Behavioral health needs.
   b. Is shared with the person served.
   c. Is shared with all providers involved in implementing the plan.

Intent Statements
The person-centered plan is developed with the active involvement of the person served as well as the various disciplines needed to successfully implement the plan. The plan addresses and integrates, in a holistic manner, the physical and behavioral health needs of the person served.

3.I. 8. Based on need, an organized education and training program:
   a. Is provided to:
      1. Persons served.
      2. Families/support systems.
   b. Addresses, as age- and developmentally appropriate:
      1. Active involvement in care planning.
      2. Impact of health conditions of the person served on the family/support system.
      3. Interaction between behavioral health and physical health.
      4. Medication management.
      5. Prevention/intervention, including, but not limited to:
         a. Chronic disease management.
         b. Mental health.
         c. Nutrition.
         d. Physical activity.
         e. Tobacco use.
         f. Substance use.
   6. Resilience and recovery.
   7. Self-management of:
      a. Physical health.
      b. Behavioral health.
      c. Other life issues identified by the person served.
   8. Wellness.

Examples
8.b.(5)(a) When the health home serves children or adolescents, the education is provided to families or caregivers in addition to the persons served.
8.b.(7)(b) When applicable, this includes education related to ongoing mental health, substance use or abuse, and/or relapse prevention for psychiatric needs and addictions.

3.I. 9. The program provides documented cross training to direct service personnel:
   a. At:
      1. Orientation.
      2. Regular intervals.
   b. That addresses the most common conditions prevalent in the population served, including:
      1. Physical health conditions.
      2. Mental health conditions.
      3. Substance use disorders.
Examples

9.b. This could include training on common psychiatric diagnoses (symptoms and potential treatments) with medical personnel and basic training on medical conditions such as heart disease and diabetes with behavioral health personnel.

9.b.(1) Topics such as wellness, nutrition, and medical conditions could be included in training on physical health conditions.

10. The program uses patient registries and/or health records:

   a. For data:
      (1) Collection.
      (2) Analysis.

   b. To proactively manage the health home population through information about the persons served, including:
      (1) Emergency room visits.
      (2) Functional outcomes.
      (3) Health indicators.
      (4) Health promotion activities.
      (5) Hospitalizations.
      (6) Individual contacts.
      (7) Risk status.

   c. To support:
      (1) Adjustments to practices based on identified needs.
      (2) Use of population health information to improve outcomes for the persons served.

Intent Statements

While health homes are strongly encouraged to develop and use electronic health records to manage their health home program, use of a patient registry would meet the intent of this standard. In its simplest form, a patient registry is a collection of data on persons served who share certain characteristics, such as disease status or medication regimen.

10.c.(2) The program demonstrates how it analyzes the various health information data for the purposes of improving the health outcomes for the persons served. These data are used in addressing the requirements of Standard 3.I.11.

Examples

10.b.(1) This would include psychiatric emergency visits and physical health visits.
10.b.(3) Health includes physical health and behavioral health.
10.b.(6) Contacts include making referrals and following through on them.
10.c. The program analyzes its effect on persons served, addresses areas where there are less than desirable outcomes, and demonstrates how it changes practices to improve outcomes.

11. The program:

   a. Identifies an indicator(s) to measure:
      (1) Medical status of the persons served.
      (2) Behavioral health status of the persons served.
      (3) Functional outcomes of the persons served.

   b. At least annually addresses:
      (1) Performance in relationship to established targets for:
          (a) Medical status of the persons served.
          (b) Behavioral health status of the persons served.
          (c) Functional outcomes of the persons served.
      (2) Trends.
      (3) Actions for improvement.
      (4) Results of performance improvement plans.

   (5) Necessary education and training of:
      (a) Persons served.
      (b) Families/support systems.
      (c) Personnel.
      (d) Other stakeholders.

Intent Statements

See related standards in Section 1.M. for details regarding performance improvement indicators. The intent of this standard is to ensure that the areas of access, effectiveness, efficiency, and
Examples

The performance measurement system can include indicators specific to the following:

- Medical care.
- Behavioral healthcare.
- Medical linkages.
- Evidence of collaborative attention.
- The rate of screening for comorbid conditions.
- Integrated/holistic practices.
- Wellness and recovery.
- Psychoeducation.
- Education regarding interrelationships between medications for physical and psychiatric conditions.
- The relationship between physical medications and addictive disorders.

11.b. Organizations may want to consider the quality measures endorsed by the National Quality Forum (www.qualityforum.org) or those recommended by the Centers for Medicare and Medicaid Services (www.cms.gov), which include:

- Adult Body Mass (BMI) assessment.
- Ambulatory care—sensitive condition admission.
- Care transition—record transmitted to healthcare professional.
- Follow-up after hospitalization for mental illness.
- Plan—all cause readmission.
- Screening for clinical depression and follow-up plan.
- Initiation and engagement of alcohol and other drug dependence treatment.
- Controlling high blood pressure.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written program description
- Documentation of formal arrangements with primary care physicians, psychiatrists, and/or addictionologists, if applicable
- Documentation of cross training provided to direct service personnel at orientation and regular intervals
- Written person-centered plans for persons served
- Patient registries and/or electronic health records, including records of the persons served
- Performance measurement indicators including outcomes measures for medical and behavioral status and functional outcomes of persons served
Section 3.J. Inpatient Treatment (IT)

J. Inpatient Treatment (IT)

Description
Inpatient treatment programs provide interdisciplinary, coordinated, integrated, medically supervised services in freestanding or hospital settings. Inpatient treatment programs include a comprehensive, biopsychosocial approach to service delivery in a managed milieu that is recovery focused and trauma informed. There are daily therapeutic and other activities in which the persons served participate. Inpatient treatment is provided 24 hours a day, 7 days a week. The goal of inpatient treatment is to provide a protective environment that includes medical stabilization, support, treatment for psychiatric and/or addictive disorders, supervision, wellness, and transition to ongoing services. Such programs operate in designated space that allows for appropriate medical treatment and engagement.

Applicable Standards
An organization seeking accreditation for an inpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.J. 1. For each person served, a medical evaluation:
   a. Is obtained within 24 hours of admission.
   b. Includes:
      (1) A physical examination.
      (2) Orders for appropriate tests.
      (3) Face-to-face consultation.

Intent Statements
When allowed by law or funding authorities, a physician’s assistant or nurse practitioner may be used.
When an admission occurs on a weekend or holiday, face-to-face consultation may not occur until the first working day after admission unless medically required.

Examples
1.a. The medical evaluation may be obtained from an appropriately credentialed source before or after admission.

3.J. 2. A risk assessment for each person served:
   a. Is conducted at the time of admission.
   b. Identifies:
      (1) Suicide risk.
      (2) Risk of self-harm.
      (3) Risk of harm to others.
      (4) Trauma.
   c. Results in a personal safety plan when risks are identified.

Intent Statements
This standard is related to Standard 2.B.13.; however, the expectation for an inpatient program is that this assessment is conducted at the time of admission and not delayed until a later time when a full assessment may be conducted.

Examples
2.a. At the time of admission is considered to be when the admission order is written.
2.b.(4) Trauma may be experienced or witnessed and may include domestic/intimate partner violence.
2.c. Refer to Standard 2.C.4. for additional information and requirements related to development of personal safety plans for the persons served.

3.J. 3. The assessment of each person served:
   a. Is completed within 24 hours of admission to the program.
   b. Results in a preliminary treatment plan.

Intent Statements
Refer to Section 2.B. standards on assessments for additional information and requirements.
4. The program has a qualified medical director who:
   a. Demonstrates appropriate training and experience in inpatient treatment.
   b. Has a written agreement with the organization that outlines his or her responsibilities.
   c. Leads the medical staff.
   d. Actively participates in:
      (1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.
      (2) The development of ongoing relationships with the medical community.
      (3) Educational activities with the program personnel.
      (4) Performance improvement activities.
      (5) Program development and modification.
      (6) Establishing the program's policies and procedures.

Intent Statements
The medical director provides significant programmatic leadership and participates in management and performance improvement activities. The medical director can be a physician employed by the organization or on a contract.

Examples
4.a. If the organization hires a medical director who lacks sufficient training and experience in inpatient treatment, the organization can develop a plan to ensure that the requisite experience is obtained with appropriate consultation and/or supervision.
4.b. The responsibilities may be defined in a written job description or contract.

5. Licensed nursing services are provided on site 24 hours a day, 7 days a week.

Intent Statements
Licensed nursing personnel can be registered nurses, licensed practical nurses, or other equivalent personnel. On site can mean in the facility or building, not necessarily directly on the unit at all times.

6. There is a written daily schedule of activities that contribute to the recovery and wellness of the persons served.

Intent Statements
A therapeutic environment promotes the ability of each person served to meet the goals and objectives jointly agreed upon in the development of his or her plan. It is free of unnecessary interruptions and distractions.

7. Services are provided by a coordinated team that includes, at a minimum:
   a. A qualified behavioral health practitioner who coordinates the plan of the person served.
   b. Providers of appropriate medical services.
   c. Assigned inpatient personnel.

Intent Statements
It should be evident that various team members interact with persons served and communicate with each other about their interactions and plans for providing individual services to persons served.
7.a. See the Glossary for the definition of qualified behavioral health practitioner.

8. The program provides or makes formal written arrangements for:
   a. Medical consultative services.
   b. Ancillary medical services.
   c. Pharmacy services.
   d. Emergency medical services.
   e. Other services, as appropriate.
Examples

Formal written arrangements may include contracts, letters of agreement, or memoranda of understanding (MOU).

8.a. Medical consultative services may include medical services needed to address needs of persons served that are outside the scope of the program's medical director.

8.b. Ancillary medical services may include services such as laboratory, occupational or physical therapy, or speech therapy.

9. To facilitate seamless service delivery, the program:
   a. Identifies resources for ongoing care of the person served.
   b. Engages and integrates referral resources into the program.

Intent Statements

To ensure that the program successfully places persons served in the next level of care after inpatient treatment, the program develops a comprehensive post-discharge network of services. The program should integrate this network of services as fully as possible into the program to strengthen the likelihood of a successful transition into the next level of care.

Examples

9.b. The program meaningfully engages the person served with the intended referral program during the inpatient treatment episode. This can be done face to face; using communications technologies such as telemedicine, Skype, Zoom, or FaceTime; or through telephone conference calling. The purpose is to begin to develop a rapport and a relationship with the next treatment program to more successfully engage the person served in ongoing care post discharge.

10. At the time of discharge from the program, the person served has:
    a. An established appointment(s) for ongoing services.
    b. Sufficient medication, if applicable.

11. The program’s physical facilities provide:
    a. Personal privacy.
    b. Security of personal belongings.
    c. Space for:
       (1) Group interactions.
       (2) Quiet activities.
       (3) Family or other guests.
       (4) Therapeutic activities.
       (5) Cultural and/or spiritual activities.
       (6) Meals.
       (7) Recreation.
       (8) Based on gender, age, and needs, separate areas for:
           (a) Sleeping.
           (b) Hygiene.
    d. Access to an outdoor setting, if possible.

Intent Statements

The program is operated in designated space that allows for an appropriate medical treatment environment that is respectful of individual privacy to the degree possible.

11.c. The program is not required to maintain exclusive spaces for each of these, but appropriate areas should be provided and available as needed.

Examples

11.c.(2) Quiet activities may include de-escalation.

12. Each day, in programs where persons served have been committed to inpatient treatment through legal processes, a physician determines the medical necessity of the person served to remain in the inpatient treatment program.

Intent Statements

Other professionals/physician extenders may make this determination within their scope of practice.

Examples

This may be accomplished through options such as telephone consultation with team members or
the use of telemedicine if there is not a physician/physician extender on site on a daily basis.

3.J. 13. To facilitate integrated service delivery, the program demonstrates timely communication with all service providers involved with the person served.

3.J. 14. To ensure the safety of persons served and personnel, the program implements written procedures for searches:
   a. Of persons served.
   b. Of belongings.
   c. That:
      (1) Preserve privacy.
      (2) Preserve dignity.
      (3) Are sensitive to potential trauma of the persons served.

Examples
14.c.(3) The program might specify that searches are done by staff members who are the same sex as the person served, and the program could solicit permission to search to provide the persons served with some feeling of control of the process.

3.J. 15. The program implements written procedures that address:
   a. Visitation.
   b. Mail.
   c. Telephone use.
   d. Use of personal electronics.

Examples
15.d. Programs are often reluctant to allow the use of personal electronic devices. However, the use of these devices can have a positive influence on the person served, particularly the use of apps targeting recovery and self-regulation. Programs could attempt to strike a balance, rather than simply prohibiting the use of electronic devices.

3.J. 16. All direct service personnel are trained in:
   a. First aid.
   b. Cardiopulmonary resuscitation (CPR).
   c. The use of emergency equipment.

Intent Statements
Licensed nursing staff and physicians are exempt from this requirement as their professional training and licensing ensure competency.

Examples
Direct service personnel are those personnel who provide services or supports that require direct interaction with the persons served; e.g., therapists, clinicians, aides, case managers, etc.

3.J. 17. The program reduces barriers to interaction between the persons served and personnel.

Intent Statements
The program should make efforts to reduce both attitudinal and physical barriers that create distance and separation between program personnel and the persons served. Personnel should be engaged with and accessible to the persons served, rather than remaining behind glass barriers or in an office or lounge where the persons served cannot interact with them.

3.J. 18. The program provides documented, competency-based training to direct service personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, at a minimum, the following topics:
      (1) De-escalation techniques.
      (2) Risk assessment.
      (3) Trauma-informed approaches.
3.J. **The program:**

a. Identifies an indicator to measure engagement of the persons served in ongoing services post discharge.

b. At least annually addresses:

   (1) Performance in relationship to an established target.
   
   (2) Trends.
   
   (3) Actions for improvement.
   
   (4) Results of performance improvement plans.
   
   (5) Necessary education and training of:

      (a) Persons served.
      
      (b) Families/support systems.
      
      (c) Personnel.
      
      (d) Other stakeholders, as appropriate.

**Intent Statements**

This standard is related to the standards in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement.

**Documentation Examples**

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Medical evaluations of persons served
- Risk assessments of persons served
- Assessments of persons served
- Person-centered plans of served
- Daily activities schedules
- Written procedures for searches
- Written procedures that address visitation, mail, telephone use, and personal electronic devices
- Documentation of personnel training at orientation and regular intervals

**K. Integrated Behavioral Health/Primary Care (IBHPC)**

Integrated Behavioral Health/Primary Care programs have an identified level of medical supervision and are supported by an “any door is a good door” philosophy. These programs allow for choice and are capable of assessing the various medical and behavioral needs of persons served in an integrated manner. Programs demonstrate competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders, and general medical or physical concerns in an integrated manner. Integration is the extent to which care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served. Programs may also serve persons who have intellectual or other developmental disabilities and medical needs, or those who are at risk for or exhibiting behavioral disorders.

Models may include, but are not limited to, the following: contractual, where two separate, legal entities enter into an agreement to staff and operate a single program either at a location specifically identified for the provision of integrated care or located within another institution (such as a school-based health center); a distinct, integrated program located within a larger entity such as a Veterans Health Administration campus; the colocating of complementary disciplines such as the placement of behavioral staff in a primary care setting (as in a federally qualified health center) or primary care staff in a community mental health center; or a single organization that incorporates both behavioral health and primary care services into an integrated model. Although most integrated models focus on primary care, the standards could also be applied to an integrated system located in specialty care settings such as Ob-Gyn and HIV.
Applicable Standards
An organization seeking accreditation for an integrated behavioral health/primary care program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section) must be applied along with standards in this subsection, and the Comprehensive Care field category must be used.

3.K. 1. The written program description clearly defines the following:
   a. Population served.
   b. Integrated services that can be provided:
      (1) Internally.
      (2) Through contracts or other agreements.
   c. Referral procedures for other services needed by persons served.

3.K. 2. Integration of identified disciplines is supported by:
   a. Colocation and physical space arrangements.
   b. Implemented written procedures for:
      (1) Colocation.
      (2) Coordination.
   c. Applicable cross training.

Examples
2.b. Procedures may identify the following:
   ■ When or under what circumstances face-to-face or other communication will occur with the person served.
   ■ How needs will be communicated and services coordinated.
   ■ How responsibility for care coordination or follow-up will be determined.

3.K. 3. When colocation is not possible, the program is organized and delivered in a manner that ensures an integrated team approach that includes all the complementary disciplines.

Intent Statements
The organization of the program ensures a behavioral health presence in the primary care facility or a primary care presence when integrated services are provided in a behavioral health facility.

3.K. 4. The program:
   a. Identifies hours when medical services are available.
   b. Ensures that one or more of the following medical staff, legally able to independently provide the services offered, is on site during hours in which medical services are offered:
      (1) Physician.
      (2) Physician’s assistant.
      (3) Nurse practitioner.

Intent Statements
The intent of this standard is to provide for the availability of identified licensed medical staff during program hours whose scope of practice as defined under state law allows for the provision of services identified as being available.

3.K. 5. A psychiatrist or psychologist is available for consultation during hours of operation.

Intent Statements
This availability could be met via telephone or electronic means of communication.

3.K. 6. Behavioral health providers are available on site during identified hours of integrated service operation.

Intent Statements
Ideally, these individuals are on site during all hours of operation. However, in rural or small sites, it is possible that immediate availability
is only by phone. When services are provided in a large, campus-type setting, behavioral health providers may not be in the specific location of the integrated services, but on call by phone or pager to come immediately to the primary care team area.

Examples
For organizations receiving federal reimbursement, particular attention should be paid to reimbursement requirements. Behavioral health providers may include individuals trained in mental health or addictions, providing services within the scope of state practice acts. Mental health practitioners often include psychiatrists, psychologists, licensed clinical social workers, or other licensed practitioners.

3.K. 7. Adequacy of staffing includes:
   a. A variety of disciplines to respond to the needs of persons served.
   b. Staff specifically trained and knowledgeable about the unique aspects of an integrated setting.
   c. On-site coverage to allow for face-to-face linkage to appropriately trained staff.
   d. Identified backup for planned absences.

Intent Statements
Face-to-face linkage is often referred to as a “warm handoff” that includes direct contact between the person served and the receiving discipline.

Examples
Professionals generally included have the skill set to deal with problems such as addictions, behavioral/cognitive interventions, stress reduction, relaxation training, and similar issues. This helps to ensure that there is not an over-reliance on psychopharmacology.

3.K. 9. The program offers education that includes:
   a. Wellness.
   b. Resilience and recovery.
   c. The interaction between mental and physical health.
   d. Self-management of identified:
      (1) Medical conditions.
      (2) Behavioral health concerns.

Intent Statements
This education includes teaching the person served coordinated information about how to manage his or her condition; how it impacts his or her mental/physical health; and how he or she might best pursue recovery and wellness, including diet, nutrition, and exercise.

Examples
9.b. As part of recovery, education on medication use could include whether the medication has addictive qualities, has mood-altering effects, or interferes with sexual function.
9.d.(2) When applicable, includes education related to ongoing mental health, substance use or abuse, and/or relapse prevention for both psychiatric needs and addictions.

3.K. 10. Policies regarding initial consent for treatment identify:
   a. How information will be internally shared.
   b. The ability of the person served to decline integrated services.
   c. The procedures to be followed if integrated services are declined.

Intent Statements
Consent for treatment allows the person served to decline any or all services offered by the program.
3.K. 11. Written screening procedures identify additional requirements based on the:
   a. Specific needs of the population served.
   b. Presenting conditions of persons served.

Intent Statements
There needs to be a very strongly written protocol on handling the medical issues of persons with mental illness to counteract the overwhelming tendency to pathologize a medical issue as a psychiatric issue. The intent of this standard is to identify the additional information or tests that may be called for when certain conditions present, when external assessments should be considered, and the program’s response to emergency or crisis needs identified during a screening process.

Examples
Primary care settings could adopt population-based screening tools (such as the PHQ 9) rather than rely on other methods to identify those needing behavioral health services.

Where screening tools are in place, a protocol for actions to take is based on scored levels of severity. Screening tools could also be used to remeasure during the course of treatment to determine if the treatment is effective or should be adjusted or augmented (“stepped care”).

3.K. 12. Written procedures provide for an intake assessment to determine:
   a. An initial level of care.
   b. The need for:
      (1) Integrated services.
      (2) Immediate referral to specific:
         a) Internal services.
         b) External providers.

3.K. 13. An individualized integrated plan regarding medical and behavioral health needs is developed with collaboration of:
   a. The person served.
   b. All staff necessary to carry out the plan.

Intent Statements
The individualized plan is developed with the active involvement of the person served as well as the various disciplines needed to successfully implement the plan. The plan addresses and integrates, in a holistic manner, the medical and behavioral health needs of the person served.

Examples
Collaboration may include face-to-face contact or communication via telephone or other electronic participation.
13.a. May include family members, with permission, or other legal representatives of the person served.

3.K. 14. Written procedures define a follow-up process in response to the initial assessment that includes:
   a. Reassessment when appropriate.
   b. Documented active linkage and/or referral in response to identified concerns.
   c. Identification of staff member(s) responsible for care coordination.
   d. Identification of care coordination responsibilities that include contacts for:
      (1) Self management planning.
      (2) Determining availability of needed supports.
      (3) Medication adherence.
      (4) Treatment adherence.

Examples
14.a. May be necessary to assess continuing appropriateness of care level or changes necessary based on changing needs of the person served.
14.d.(2) May include natural supports such as family, community supports such as cultural or
spiritual, peer support groups, or paid program supports.

3.K. 15. Written procedures guide ongoing:
   a. Communication among interdisciplinary team members.
   b. Collaboration with external service providers.
   c. Communication with the person served and family members, when identified.
   d. Need for documentation of the results of communication and collaboration.

Intent Statements
Written procedures may define the form and content of communication among interdisciplinary team members on a “need to know” basis, while complying with information and confidentiality requirements of state, federal, or provincial authorities.

Examples
Documentation of the results of communication and collaboration may occur through case conference notes, progress notes in the records of persons served, team meeting minutes, referral documents or written correspondence.

3.K. 16. Performance measurement includes indicators addressing how services delivery responds to the needs of the persons served in an integrated/holistic manner.

Intent Statements
See related standards in Section 1.M. for details of measures and areas regarding performance improvement indicators. The intent of this standard is to ensure that the areas of access, effectiveness, efficiency, and satisfaction include indicators specifically related to the provision of integrated care.

Examples
The performance measurement system can include indicators specific to the following:
- Medical care
- Behavioral healthcare
- Medical linkages
- Evidence of collaborative attention
- The rate of screening for comorbid conditions
- Integrated/holistic practices
- Wellness and recovery
- Psychoeducation
- Education regarding interrelationships between medications for physical and psychiatric conditions
- The relationship between physical medications and addictive disorders

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Records of the persons served
- Program plans for the persons served
- Policies and written procedures
L. Intensive Family-Based Services (IFB)

Description
These intensive services are provided in a supportive and interactive manner and directed toward maintaining or restoring a positive family relationship. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multisystemic approach to treatment and have a goal of keeping families together. The services may include wraparound and family preservation programs. The program may also provide services directed toward family restoration when a child has been in an out-of-home placement.

Applicable Standards
An organization seeking accreditation for an intensive family-based services program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.L. 1. A full range of services are designed to prevent out-of-home placement and maintain intact families and include:
   a. Individual psychotherapy services.
   b. Substance abuse services.
   c. Skill development services, which include the development of:
      (1) Behavior management skills.
      (2) Life skills.
      (3) Conflict resolution skills.
      (4) Problem-solving skills.
      (5) Anger management skills.
      (6) Decision-making skills.
      (7) Crisis management skills.
   d. Family therapy.
   e. School-based services.
   f. Crisis management/stabilization services.
   g. Positive youth development services.
   h. Nutritional and health services.
   i. Service coordination.
   j. Medication management/monitoring services.

Intent Statements
The program provides services designed to meet any area of a family’s functioning.

3.L. 2. The program provides a written assessment of how each family functions.

3.L. 3. Planning is child and family centered.

3.L. 4. The organization implements a process for identifying, locating, and engaging family members, as appropriate, in services.

3.L. 5. The organization works with each child/adolescent and family to:
   a. Identify the goals of the child/adolescent and family throughout the treatment process.
   b. Monitor the progress of the child/adolescent toward achievement of the goals.
   c. Monitor the progress of the family toward achievement of the goals.

3.L. 6. The organization implements a policy that demonstrates a commitment to having an identified person/team working consistently with the family.

3.L. 7. The organization provides access to professionals trained in child/adolescent and family care, including:
   a. A psychologist.
   b. A counselor.
   c. A social worker.
   d. A psychiatrist.
e. Medical personnel.
f. Other behavioral health providers as appropriate.

Examples
7.e. May include a nurse, physical therapist, physiotherapist, or speech therapist, based on the need of the child/adolescent served.
7.f. May include a substance abuse counselor, a behavior analyst, play therapist, etc.

3.L. 8. A file of current community resources is maintained to be used for appropriate referral of the persons served.

3.L. 9. The program collaborates appropriately with other programs in planning service delivery.

3.L. 10. The organization uses a contingency plan for crises that includes:
   a. Emergency contact or crisis backup.
   b. Respite or supportive parenting.
   c. Family crisis plans.

3.L. 11. The organization provides access to a system for respite care, including 24-hour emergency care services.

3.L. 12. Services are supervised by a qualified behavioral health practitioner who:
   a. Provides clinical oversight.
   b. Directs the treatment plan.

Intent Statements
See the Glossary for the definition of a qualified behavioral health practitioner.

NOTE: Programs in Canada must meet the requirements of their respective provincial government.

3.L. 13. The organization has a plan for access to qualified professionals 24 hours a day, 7 days a week.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written assessment of family functioning in the home environment
- Policy addressing the importance of maintaining the same individual/team when working with families
- A community resource file
- Contingency plans
- Plan describing clinical supervision
- Plan for access to qualified professionals
M. Intensive Outpatient Treatment (IOP)

Description

Intensive outpatient treatment programs are clearly identified as separate and distinct programs that provide culturally and linguistically appropriate services. The intensive outpatient program consists of a scheduled series of sessions appropriate to the person-centered plans of the persons served. These may include services provided during evenings and on weekends and/or interventions delivered by a variety of service providers in the community. The program may function as a step-down program from partial hospitalization, detoxification/withdrawal support, or residential services; may be used to prevent or minimize the need for a more intensive level of treatment; and is considered to be more intensive than traditional outpatient services.

Applicable Standards

An organization seeking accreditation for an intensive outpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.M. 1. An intensive outpatient treatment program offers:
   a. At least nine direct contact hours per week to adult persons served.
   b. At least six direct contact hours per week to children/adolescents served.

3.M. 2. Intensive outpatient treatment programs provide two or more of the following services:
   a. Individual counseling/therapy.
   b. Family counseling/therapy.
   c. Group counseling/therapy.

Intent Statements

Based on the needs of the person served, the intensive outpatient program offers a variety of service modalities that are designed to assist the person served to achieve his or her goals related to psychological or social functioning, self-esteem, and coping abilities or to external opportunities such as vocational, educational, or social.

3.M. 3. The program offers education on:
   a. Wellness.
   b. Recovery.
   c. Resiliency.

Intent Statements

These educational activities may be provided in individual, group, or other settings.

Examples

3.a. Wellness education is designed to assist the person served to achieve balance in physical and emotional health and wellbeing. For additional examples and ideas, see the SAMSHA website at www.promoteacceptance.samsha.gov/10by10/default.aspx.

3.b. Recovery education includes activities designed to provide information about the person's disability/disorder with a focus on achieving the highest possible personal functioning and improvements in the person's social and occupational interactions.

3.c. Resiliency education is focused on improving the person's awareness of his or her strengths and building on those strengths.

3.M. 4. To maximize the opportunity of the persons served to participate in the program, services are provided:
   a. In locations that meet the needs of the persons served.
   b. At times that meet the needs of the persons served.
   c. On days that meet the needs of the persons served.

Intent Statements

Services can be provided in traditional office settings, community settings, online or in virtual settings, or in personal homes. Programs seek to minimize interruptions of activities such as work
and school as well as other daily responsibilities of persons served.

3.M. 5. When appropriate, and with the consent of the person served, the program integrates treatment with other services.

Intent Statements

Often persons receiving outpatient treatment are also involved with healthcare and/or social services. The intent of this standard is to ensure that the program actively seeks information from and communicates with other healthcare providers, social service entities, schools, legal entities, child welfare agencies, and other services that are likely to improve the quality of its services to persons served and the outcomes achieved.

3.M. 6. The program addresses the emerging needs of the persons served through linkage to appropriate resources and supports.

Examples

When a person served has emerging needs that are outside of the person-centered plan, such as being unable to pay utility bills, having a medical emergency in the family, or being unable to get to work due to a car breaking down, the program helps find support and assistance to address these needs through linkages to other services or providers.

3.M. 7. The program:

a. In collaboration with the person served, identifies the person's natural supports.

b. Assists the person to develop and utilize his or her natural supports.

Examples

The program demonstrates its understanding of the need for persons served to develop and maintain a healthy support system. There is evidence that the program assists the person served to create long-term natural supports to reduce reliance on providers in their transition post discharge.

3.M. 8. A review of the person-centered plan for each person served in an intensive outpatient treatment program occurs at least once per month.

Examples

The review may be documented with updates or changes to the plan, with a plan update document, or through progress notes. The program demonstrates that it is adjusting to ongoing assessments and emerging issues of the person served.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Individual person-centered plans of persons served
- Documentation of monthly reviews of person-centered plans
- Records of persons served
N. Office-Based Opioid Treatment Program (OBOT)

Description
Office-based opioid treatment (OBOT) programs are medically managed programs that provide treatment services to persons with opioid use disorders. Central to treatment are medications, typically buprenorphine or naltrexone, which are provided in concert with other medical and psychosocial interventions designed to realize a person's highest achievable recovery. Based on the needs of the persons served, these programs provide or arrange for a comprehensive array of treatment services that includes counseling/therapy, medication supports, social supports, education and training, care coordination, and other recovery-enhancing services.

OBOT programs provide services under the supervision of a physician and are guided by written treatment procedures and protocols that address the routine needs of persons with opioid use disorders, including the needs of special populations. From induction to stabilization and into maintenance, OBOT programs provide ongoing care to persons served to support their recovery.

NOTE: These services may also be known as medication-assisted treatment (MAT).

Intent Statements
The program demonstrates the capability to provide all of these services through program personnel or through close coordination of referrals. When the service is provided by an outside service provider, the program demonstrates that it has regular communication with the provider, information is shared with appropriate consents, and progress is documented in the person's record. It is not expected that each person served receives all of these services, but rather that these services are available to persons based on their assessed needs.

Applicable Standards
An organization seeking accreditation for an office-based opioid treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection and use the Addictions Pharmacotherapy field category.

NOTE: Programs that serve adolescents must also meet the Specific Population Designation standards in Section 5.C. Children and Adolescents.
The medical director for the program is a physician who:

a. Is certified in his or her specialty area by a nationally recognized board.

b. Demonstrates appropriate experience in addiction treatment through one or more of the following:

(1) A fellowship in addiction medicine or addiction psychiatry for a minimum of one year.

(2) A minimum of two years' experience providing addiction treatment services.

(3) A plan to develop competency in addiction medicine or addiction psychiatry, including continuing medical education in addiction medicine or addiction psychiatry, within two years.


d. Is responsible for:

(1) Oversight and supervision of:

(a) Medical services.

(b) Nursing services.

(2) Ensuring the adequacy of medical and treatment services provided to the persons served.

(3) Development of ongoing relationships with the medical community.

(4) Educational activities with program personnel.

e. Actively participates in performance improvement activities.

f. Establishes written treatment protocols for special populations served, including:

(1) Pregnant women.

(2) Persons with acute or persistent pain.

(3) Persons with co-occurring disorders.

(4) Adolescents.

(5) Young adults.

(6) Other populations, as appropriate.

g. Establishes written protocols for laboratory studies, including interpretation of results.

h. Is available a sufficient number of hours to meet the needs of the:

(1) Persons served.

(2) Program.

Intent Statements

Although there may be other prescribers who work in the program and prescribe medications within their individual scopes of practice and supervision, accredited programs have a board certified, trained, and experienced medical director who is a physician.

2.f.(4) Programs that serve adolescents must also meet the Specific Population Designation standards in Section 5.C. Children and Adolescents.

2.h. The medical director for these programs is not an appointment in name only. The medical director demonstrates adequate availability to provide program supervision, directs care through staff meetings or other interactions, and is available to persons served and program personnel for consultation as needed.

Examples

When the medical director is not an employee, the responsibilities could be articulated in a written agreement or contract, and reviewed at least annually as described in Standard 1.G.4.

2.a. In the United States, the medical director is board certified typically by the American Board of Addiction Medicine or in another specialty recognized by the American Board of Medical Specialties.

2.f.(3) Protocols take into consideration common co-occurring conditions such as depression, anxiety, trauma, PTSD, and others.

2.f.(6) Other populations might include veterans, persons with physical health conditions, or persons with intellectual or developmental disabilities.

2.g. Protocols may address routine laboratory studies such as a complete blood count, or tests
Section 3.N. Office-Based Opioid Treatment Program (OBOT)

3.N. The assessment process includes the preparation of a written interpretive summary that addresses the six dimensions of the American Society of Addiction Medicine (ASAM) or similar criteria.

Intent Statements
This standard relates to Standard 2.B.14., with an expectation that the program provides information in its interpretive summary reflective of the six dimensions for assessment as defined by ASAM. There may be additional information in the summary; however, assessment of each dimension with results should be included.

Resources
More information about the dimensions of assessment can be found at: www.asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/

4. The program implements written procedures for:
   a. Induction that include:
      (1) Description of services.
      (2) Measurement of withdrawal using a standard scale.
      (3) Management of:
         (a) Precipitated withdrawal.
         (b) Withdrawal.
      (4) Decision making regarding the location of induction.
      (5) Frequency of contact.
      (6) Response to relapse.
      (7) Strategies for maintaining engagement in treatment.
      (8) Overdose prevention and response.
   b. Stabilization that include:
      (1) Description of services.
      (2) Dose adjustments.
      (3) Frequency of contact.
      (4) Response to relapse.
   c. Maintenance that include:
      (1) Description of services.
      (2) Dose adjustments.
      (3) Frequency of contact.
      (4) Response to relapse.
      (5) Strategies for maintaining engagement in treatment.
      (6) Overdose prevention and response.
      (7) Dose reduction/weaning when initiated by:
         (a) The person served.
         (b) The program.

Examples
4.a.(2) It is crucial that the physician supervising the induction process evaluate the appropriate time to begin a medication regimen. The Clinical Opiate Withdrawal Scale (COWS) is the typical scale used for this purpose.
4.a.(3)(a) Precipitated withdrawal can occur when an antagonist is administered to a person served dependent on full agonist opioids. The program’s procedures describe how to avoid precipitated withdrawal, how to manage a case when precipitated withdrawal occurs, and time-frames from last use of opioids to administration of buprenorphine or naltrexone.
4.a.(3)(b) The program considers withdrawal from opioids and other drugs/alcohol in planning the delivery of care.
4.a.(4) Programs often must make the determination of office-based induction or home-based induction. The effectiveness of home-based induction can be influenced by a number of factors. When determining the potential for home-based induction, the program considers the motivation of the person served, the effectiveness of the person’s support system, risks of diversion, and other relevant factors.
4.a.(6), 4.b.(4), 4.c.(4) The program recognizes that relapse is not an unusual occurrence with this population and has strategies to skillfully
manage relapses in a caring manner. There may be times when the program determines that more intensive services are required, and the program has relationships with other treatment programs to facilitate effective referrals/Transfers.

4.a.(7), 4.b.(5), 4.c.(5) The program implements strategies to maintain persons served in the program and measures performance on this element as described in Standard 9. of this section.

4.a.(8), 4.b.(6), 4.c.(6) The program trains personnel on their role in recognizing and responding to overdose. The program likely maintains naloxone on-hand to respond immediately to overdoses. Additionally, these procedures outline strategies the program employs to prevent overdoses.

4.c.(7)(a) The program’s procedures describe how a person served can request the initiation of weaning that can lead to discontinuation of treatment. The program will likely want to discuss with the person his or her motivation for discontinuation and, should this begin, offer additional supports to the person to prevent a relapse/overdose.

4.c.(7)(b) The program may discontinue treatment due to continued violation of program rules, a change in funding or other resources for the person served, or other valid reason. The procedures describe how the weaning/discontinuation process will be managed.

5. The program implements written procedures for medication monitoring that address:
   a. Drug testing, including:
      (1) Parent compound.
      (2) Metabolites.
      (3) Interpretation of results.
   b. Diversion control.
   c. Lost or stolen medication.
   d. Medication adherence.
   e. Assessment of medication efficacy.

Intent Statements
The program should take steps to reduce the risks to persons served and others by monitoring that the person served is taking the medication as prescribed and implementing procedures to reduce the chances of lost or diverted medication.

Examples
5.a. Programs may describe in procedures when to utilize simple tests like dip sticks to test for parent compounds and when to utilize confirmation tests for the presence of metabolites.

5.b. Programs can implement a variety of activities to ensure that persons served are taking medications as prescribed and that medications are not being diverted to others. These strategies may include, but are not limited to, random call backs, witnessing of urine samples, verification testing of medication metabolites, wrapper counts, verifying lot numbers, witnessing medication administration through apps like emocha, etc.

6. The program implements written procedures for pharmacy services that address:
   a. Communication that supports clinical care.
   b. After-hours dispensing.
   c. Medication delivery.

Intent Statements
The program should seek out a pharmacy(ies) that assists the program to meet the needs of the persons served with communication that supports care coordination, flexible hours for dispensing of medications, and delivery of medications to the program as allowed.

Examples
6.a. A pharmacy can be helpful in communication if the person served is not picking up medications, if there are concerns based on other medications prescribed for the person served, if there is behavior observed that is associated with diversion, etc.

6.b. The program addresses the potential needs of persons served for pharmacy services in the evenings and on weekends and holidays through its own pharmacy services and/or the availability of services in the community.
3.N. 7. Based on the needs of each person served, the program provides documented training and education on the following topics:
   a. Disease of addiction.
   b. Secure storage of medication.
   c. Overdose prevention and response.
   e. Withdrawal symptoms.
   f. Neonatal abstinence syndrome.
   g. Managing prescribed medications for opioid use disorder in the presence of pain.

Intent Statements
This supplements the training and education for persons served addressed in Standard 2.E.2.

3.N. 8. The program provides documented training and education to direct service personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, at a minimum, the following topics:
      (1) Chronic disease model of addiction.
      (2) Behaviors associated with addiction.
      (4) Overdose prevention and response.
      (5) Specimen collection for drug testing.

Intent Statements
This relates to Standard 2.E.2. on training and education for direct service personnel in programs that provide medication control, administering, and/or prescribing.

3.N. 9. The performance measurement and management system includes an indicator to measure retention of persons served in the OBOT program.

Intent Statements
This standard is related to Standard 1.M.6.b.(1) as a measure of effectiveness of treatment. Keeping the persons served engaged in an OBOT program is crucial to their recovery and not returning to opioid use and risking an overdose.

3.N. 10. The program demonstrates efforts to educate stakeholders in the community about opioid use, including:
   a. Addiction.
   b. Treatment.
   c. Stigma-reducing language.

Intent Statements
This relates to Standard 1.A.6.d. on organizational advocacy efforts for the persons served.

Examples
Education might be provided through one-on-one contacts or to groups and include written information; lectures; videos; audio recordings; or the provision of information via informational mailings, emails, or the program’s website.

Additional Resources
- TIP 63: Medications for Opioid Use Disorder: https://store.samhsa.gov/product/SMA18-5063FULLDOC
- Providers Clinical Support System: https://pcssnow.org
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Information on scope of services
- Evidence of medical director’s qualifications, experience, and involvement in the program
- Written treatment protocols for special populations served
- Written protocols for laboratory studies
- Evidence of a written interpretive summary for each person served that addresses the ASAM or similar criteria
- Written procedures for induction, stabilization, and maintenance
- Written procedures for medication monitoring
- Written procedures for pharmacy services
- Documentation of training and education provided to persons served
- Documentation of training and education provided to direct service personnel at orientation and regular intervals
- Evidence of indicator to measure retention of persons served in the program
- Evidence of education provided to community stakeholders

O. Outpatient Treatment (OT)

Description

Outpatient treatment programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and substance use disorders and other addictive behaviors.

Applicable Standards

An organization seeking accreditation for an outpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.O. 1. Outpatient treatment programs provide one or more of the following services:
   a. Individual counseling/therapy.
   b. Family counseling/therapy.
   c. Group counseling/therapy.

Intent Statements

Based on the needs of the person served, the outpatient program offers or refers to a variety of service modalities that are designed to assist the person served to achieve his or her goals related to psychological or social functioning, self-esteem, and coping abilities or to external opportunities such as vocational, educational, or social.

3.O. 2. The program offers education on:
   a. Wellness.
   b. Recovery.
   c. Resiliency.
Intent Statements

These educational activities may be provided in individual, group, or other settings.

Examples

2.a. Wellness education is designed to assist the person served to achieve balance in physical and emotional health and well-being. For additional examples and ideas, see the SAMSHA website at www.promoteacceptance.samsha.gov/10by10/default.aspx.

2.b. Recovery education includes activities designed to provide information about the person's disability/disorder with a focus on achieving the highest possible personal functioning and improvements in the person's social and occupational interactions.

2.c. Resiliency education is focused on improving the person's awareness of his or her strengths and building on those strengths.

3.O. To maximize the opportunity of the persons served to participate in the program, services are provided:
   a. In locations that meet the needs of the persons served.
   b. At times that meet the needs of the persons served.
   c. On days that meet the needs of the persons served.

Intent Statements

Services can be provided in traditional office settings, community settings, online or in virtual settings, or in personal homes. Programs seek to minimize interruptions of activities such as work and school as well as other daily responsibilities of persons served.

3.O. When appropriate, and with the consent of the person served, the program integrates treatment with other services.

Intent Statements

Often persons receiving outpatient treatment are also involved with healthcare and/or social services. The intent of this standard is to ensure that the program actively seeks information from and communicates with other healthcare providers, social service entities, schools, legal entities, child welfare agencies, and other services that are likely to improve the quality of its services to persons served and the outcomes achieved.

3.O. The program addresses the emerging needs of the persons served through linkage to appropriate resources and supports.

Examples

When a person served has emerging needs that are outside of the person-centered plan, such as being unable to pay utility bills, having a medical emergency in the family, or being unable to get to work due to a car breaking down, the program helps find support and assistance to address these needs through linkages to other services or providers.

3.O. The program:
   a. In collaboration with the person served, identifies the person's natural supports.
   b. Assists the person to develop and utilize his or her natural supports.

Examples

The program demonstrates its understanding of the need for persons served to develop and maintain a healthy support system. There is evidence that the program assists the person served to create long-term natural supports to reduce reliance on providers in their transition post-discharge.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Records of the persons served
- Program plans for the persons served
P. Partial Hospitalization (PH)

Description
Partial hospitalization programs are time limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Partial hospitalization programs are available at least five days per week but may also offer half-day, weekend, or evening hours. Partial hospitalization programs may be freestanding or part of a broader system but should be identifiable as a distinct program or service line.

A partial hospitalization program consists of a series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency. Partial hospitalization programs are typically designed for persons who are experiencing increased symptomatology, disturbances in behavior, or other conditions that negatively impact the mental or behavioral health of the person served. The program must be able to address the presenting problems in a setting that is not residential or inpatient. Given this, the persons served in partial hospitalization do not pose an immediate risk to themselves or others. Services are provided for the purpose of diagnostic evaluation; active treatment of a person's condition; or to prevent relapse, hospitalization, or incarceration. Such a program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute level of care is tenuous.

Applicable Standards
An organization seeking accreditation for a partial hospitalization program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.P. 1. The program is provided under the direction of a clinical director who is a physician.

Intent Statements
Although other prescriber clinicians may provide services to persons served in this program, the clinical director is a physician.

3.P. 2. The program:
   a. Is available to the persons served at least five days per week.
   b. Includes a minimum of three hours of therapeutic services per day.

Intent Statements
Although the program is capable of providing a multidisciplinary program of medical and therapeutic services to the persons served three hours per day, five days per week, individualized plans and variable lengths of stay will determine the degree to which each person actually participates in a given week.

3.P. 3. The therapeutic environment includes:
   a. Consistently assigned personnel.
   b. Scheduled activities.
   c. Sufficient professional staff to:
      (1) Conduct clinical assessments.
      (2) Develop appropriate person-centered plans.
      (3) Provide therapeutic interventions.
      (4) Review goals/objectives on a biweekly basis.

Intent Statements
The environment achieves a stable staffing pattern either by assigning the same personnel to the program or by rotating personnel from a consistent pool to provide the needed intensity of interventions on a consistent basis.

3.P. 4. The program's services are provided by a multidisciplinary team.

Intent Statements
This standard reinforces a team approach to services. There is a team made up of persons from a variety of disciplines who work cooperatively in delivering partial hospitalization services. The various disciplines included are based on the needs of the person served.
5. Qualified behavioral health practitioners are on site during program hours to:
   a. Supervise personnel.
   b. Direct services.
   c. Provide direct clinical treatment services, as appropriate.
   d. Provide interventions, as necessary.

Intent Statements
See the Glossary for the definition of a qualified behavioral health practitioner.

5.b. Some services, such as education and training and therapeutic activities, may be provided by personnel who are not qualified behavioral health practitioners, but are qualified to deliver the services, specifically trained to work with the population being served, and supervised by qualified behavioral health practitioners.

5.c. Clinical treatment services are provided by qualified behavioral health practitioners within the scope of their licenses and clinical privileges.

6. A registered nurse, trained and competent in the delivery of behavioral health services, is available on site during program hours to provide necessary:
   a. Nursing care.
   b. Psychiatric nursing care.

Intent Statements
Nursing care may also include supervision of ancillary staff members (such as nursing aides or technicians) who provide supportive medically related services, as allowed by law or regulation.

In a partial hospitalization program where either the specific needs of the persons served or the program’s regulatory authorities and funding sources do not require continuous on-site nursing coverage, this standard may be met through an on-call system or clearly identified process for accessing nursing care when needed.

The nursing care and supervision could also be done by a nurse practitioner.

7. As deemed clinically necessary and based on the needs of the persons served:
   a. Psychiatric services are provided to the persons served.
   b. A psychiatrist is available 24 hours a day, 7 days a week.

Intent Statements
A psychiatrist can be available either on site or on call.

8. An initial medical and/or psychological necessity determination, establishing the need for partial hospitalization, is received upon admission and certifies:
   a. Inpatient care would be necessary if partial hospitalization was not provided.
   b. Services will be provided under the care of a physician.
   c. Services are provided under a written plan of care.

Intent Statements
In some situations, it is required that a physician certify that the person served would require inpatient care if the partial hospitalization services were not provided.

8.b. Face-to-face assessment and services can be provided when necessary.

Examples
Medical and/or psychological necessity may include the following:
- Identified need for crisis stabilization or treatment of partially stabilized mental health disorders.
- Evidence of psychiatric symptoms that cause significant impairment in day-to-day social, vocational, and/or educational functioning.
- Indication of the person’s physical and intellectual capacity to actively participate in all aspects of the therapeutic program.
- Inability to achieve sufficient clinical gains within an outpatient setting. Severity of
presenting symptoms is such that success in outpatient treatment is doubtful.

- Readiness for discharge from an inpatient setting, but needing daily monitoring, support, and ongoing therapeutic interventions.

3.P. 9. An initial assessment of the person served:
   a. Includes:
      (1) A physical examination:
          (a) Completed within 24 hours of admission.
          (b) Completed by a qualified licensed healthcare practitioner.
      (2) A mental health evaluation.
      (3) A nursing assessment.
      (4) A skills assessment conducted by an activity, occupational, or rehabilitation therapist.
   b. Is conducted within 24 hours of admission.

3.P. 10. The person-centered plan is:
   a. Completed within seven days of admission.
   b. Reviewed:
      (1) When major changes occur in treatment.
      (2) At least every two weeks.
      (3) Periodically by a physician.

3.P. 11. Access to primary medical care is available as needed.

3.P. 12. The majority of scheduled program hours consist of therapeutic services.

Intent Statements
Therapeutic services may vary according to the age, needs, or individual development or comprehension level of each person served.

3.P. 13. Therapeutic services include at least three of the following:
   a. Individual psychotherapy.
   b. Family therapy or counseling.
   c. Alcohol and other drug education.
   d. Occupational therapy.
   e. Diagnostic services.
   f. Medication education.
   g. Psychoeducation.
   h. Activity therapy.
   i. Provision of community supports.

3.P. 14. Case management services are integrated in the partial hospitalization continuum of care or are provided by external case managers.

3.P. 15. If case managers are external to the partial hospitalization program, there are meetings at least weekly with the persons served, members of the partial hospitalization treatment team, and the case manager.

Intent Statements
These meetings may be in person, via conference calls, or using technologies such as Zoom, Skype, or other similar technologies.

3.P. 16. Case management services assist with arrangements for:
   a. Financial support, if needed.
   b. Housing, if needed.
   c. Transportation to services, as needed.
   d. Maintenance of activities of daily living.

3.P. 17. Crisis management services are available 24 hours a day, 7 days a week for the persons served.
3.P. 18. Therapeutic activities include:
   a. Family members, unless clinically contraindicated.
   b. The community, when appropriate.

Examples
Such therapeutic activities could include activities designed to incorporate family and community involvement and assist the person served to move to a greater level of personal independence. The provision of therapeutic activities may be limited by specific funding sources to exclude those activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms that are currently placing the person served at risk.

3.P. 19. Referral to another level of service is made when:
   a. Medically indicated.
   b. Clinically indicated.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- A program schedule
- Treatment plans
- Case records

Q. Residential Treatment (RT)

Description
Residential treatment programs are organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, 7 days a week for persons with behavioral health or co-occurring needs, including intellectual or developmental disabilities. Residential treatment programs provide environments in which the persons served reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems. These services are provided in a safe, trauma-informed, recovery-focused milieu designed to integrate the person served back into the community and living independently whenever possible. The program involves the family or other supports in services whenever possible. Residential treatment programs may include domestic violence treatment homes, nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Applicable Standards
An organization seeking accreditation for a residential treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.Q. 1. The program provides active treatment seven days a week that, based on the needs of the persons served, consists of services in each of the following areas:
   a. Treatment services, including:
      (1) Individual counseling/therapy.
      (2) Group counseling/therapy.
      (3) Family/support system counseling/therapy.
   b. Adjunct therapies.
   c. Psychoeducation.
   d. Skill-building activities.
Section 3.Q. Residential Treatment (RT)

- Community integration.
- Social activities.
- Recreational activities.
- Spiritual activities.

**Intent Statements**

Not all listed services must be provided to each person served, but the program should have the capacity to provide each of these as needed, and each day should include activities designed to meet the needs of the persons served as defined in their individual person-centered plans. Some services may be provided off-site.

**Examples**

1.b. Examples of adjunct therapies may be art therapy, occupational therapy, equine therapy, music and other expressive arts therapies, experiential therapy, animal-assisted therapy, drumming, and adventure-based therapy.
1.c. Psychoeducation may include areas such as wellness, recovery, resiliency, and employment.
1.d. Skill-building activities could be in the areas of employment, nutrition, self-advocacy, and activities of daily living.

3.Q. 2. Services are provided by a coordinated treatment team that includes, at a minimum:

   a. A qualified behavioral health practitioner who coordinates the plan of the person served.
   b. Providers of appropriate medical support services.
   c. Assigned residential personnel.

**Intent Statements**

It should be evident that various team members interact with persons served and communicate with each other about their interactions and plans for providing individual services to persons served.

2.a. See the Glossary for the definition of qualified behavioral health practitioner.

**Examples**

2.b. Medical support services may be provided by consulting or contracted professionals.

2.c. Because residential treatment programs serve persons with varying needs, the specific qualifications and credentials of personnel are determined based on the specific needs of the persons served and the structure of the residential treatment program.

3.Q. 3. The program provides on-site personnel support 24 hours a day, 7 days a week.

**Intent Statements**

Personnel should be on the same campus and have the ability to quickly respond to emergencies. Some services or support may be provided by organizations outside of the program, such as in a correctional setting. If the program serves children or adolescents, personnel are on site 24 hours a day, 7 days a week. Whether on-site personnel remain awake at all times will be dependent on the unique needs of the persons being served.

3.Q. 4. A risk assessment for each person served:

   a. Is conducted at the time of admission.
   b. Identifies:
      (1) Suicide risk.
      (2) Risk of self-harm.
      (3) Risk of harm to others.
      (4) Trauma.
   c. Results in a personal safety plan when risks are identified.

**Intent Statements**

This standard is related to Standard 2.B.13.; however, the expectation for a residential program is that this assessment is conducted at the time of admission and not delayed until a later time when a full assessment may be conducted.

**Examples**

4.c. Refer to Standard 2.C.4. for additional information and requirements related to development of personal safety plans for the persons served.
3.Q. 5. Based on the needs of the persons served, the program provides or arranges for:
   a. Healthcare services.
   b. Pharmaceutical services.
   c. Social services.
   d. Educational services.
   e. Other services, as appropriate.

Intent Statements
The frequency and intensity of these services are directly related to the length of stay in the program. In long-term residential programs, this would include regular health monitoring and response to findings. The program should also ensure access to medications needed by persons served in addition to any prescribed in the program.

Examples
5.c. Social services may be related to areas such as benefits, child welfare, and domestic violence.
5.d. School-age children must receive educational services when treatment impacts their school attendance.

3.Q. 6. The program provides the following community living components:
   a. A written daily schedule of activities that contribute to the wellness of the persons served.
   b. A homelike and comfortable setting.
   c. Access to nutritious meals and snacks.
   d. Personal privacy.
   e. Opportunities to participate in activities that would be found in a home.
   f. Individual possessions and decorations.
   g. Regular meetings between the persons served and program personnel.

Examples
6.a. The written daily schedule includes descriptions of the activities offered.
6.b. In a correctional setting, this may not be possible and this standard would not be applicable.

6.c. The persons served have access to at least three meals and one snack per day.
6.e. The program encourages all persons served to take increasing responsibility for cooperative operation of the household.
6.f. These items are consistent with the personal choices and needs of the persons served, except for items that are contraindicated by their person-centered plans.
6.g. Activities may include typical household duties such as food preparation, making the bed, and routine cleaning.

3.Q. 7. To facilitate effective community integration, the program demonstrates how, with the consent of the persons served, it engages members of the family and/or support system in program services.

Intent Statements
The program should seek to reduce barriers to participation in the program for family members and/or members of the support system of the person served.

Examples
The program might consider the use of communication technologies such as Skype or FaceTime as ways to facilitate participation. The program might also use online training resources to extend the knowledge of behavioral health conditions with family members/support systems.

3.Q. 8. The program consults with a dietitian regarding its food services to meet the nutritional and dietary needs of the persons served.

Intent Statements
This standard does not require that the program employ a dietitian; rather, at a minimum, the program should seek consultation to ensure that typical meals meet nutritional requirements for the population served and that there are meals designed for persons with special dietary needs or restrictions.
3.Q. 9. The program's physical facilities provide:
   a. Personal privacy.
   b. Security of personal belongings.
   c. Space for:
      (1) Group interactions.
      (2) Quiet activities.
      (3) Family or other guests.
      (4) Therapeutic activities.
      (5) Cultural and/or spiritual activities.
      (6) Meals.
      (7) Recreation.
      (8) Based on gender, age, and needs, separate areas for:
         (a) Sleeping.
         (b) Hygiene.
   d. Access to an outdoor setting, if possible.

Examples
9.c. The program is not required to maintain exclusive spaces for each of these, but appropriate areas should be provided and available as needed.
9.c.(2) Quiet activities may include de-escalation.
9.c.(8)(a) Separation based on gender does not need to occur when parents and children sleep in the same area. When serving children or adolescents, age also includes developmental level.

3.Q. 10. To ensure the safety of persons served and personnel, the program implements written procedures for searches:
   a. Of persons served.
   b. Of belongings.
   c. That:
      (1) Preserve privacy.
      (2) Preserve dignity.
      (3) Are sensitive to potential trauma of the persons served.

Examples
10.c.(3) The program might specify that searches are done by staff members who are the same sex as the person served, and the program could solicit permission to search to provide the persons served with some feeling of control of the process.

3.Q. 11. The program implements written procedures that address:
   a. Visitation.
   b. Mail.
   c. Telephone use.
   d. Use of personal electronics.

Examples
11.d. Programs are often reluctant to allow the use of personal electronic devices. However, the use of these devices can have a positive influence on the person served, particularly the use of apps targeting recovery and self-regulation. Programs could attempt to strike a balance, rather than simply prohibiting the use of electronic devices.

3.Q. 12. All direct service personnel receive competency-based training in:
   a. First aid.
   b. Cardiopulmonary resuscitation (CPR).
   c. The use of emergency equipment.

Intent Statements
Licensed nursing staff and physicians are exempt from this requirement as their professional training and licensing ensure competency.

Examples
12.c. Emergency equipment could include automatic external defibrillators, eyewashing stations, splints, tourniquets, and EpiPens®.

3.Q. 13. The program reduces barriers to interaction between the persons served and personnel.

Intent Statements
The program should make efforts to reduce both attitudinal and physical barriers that create distance and separation between program personnel and the persons served. Personnel should be engaged with and accessible to the persons served, rather than remaining behind glass barriers or in an office or lounge where the persons served cannot interact with them.
3. Q. 14. The program provides documented, competency-based training to direct service personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, at a minimum, the following topics:
      (1) De-escalation techniques.
      (2) Risk assessment.
      (3) Trauma-informed approaches.

Examples
Direct service personnel are those personnel who provide services or supports that require direct interaction with the persons served; e.g., therapists, clinicians, aides, case managers, etc.

3. Q. 15. To facilitate seamless service delivery, the program:
   a. Identifies resources for ongoing care of the person served.
   b. Engages and integrates referral resources into the program.

Intent Statements
To ensure that the program successfully places persons served in the next level of care after residential treatment, the program develops a comprehensive post-discharge network of services. The program should integrate this network of services as fully as possible into the program to strengthen the likelihood of a successful transition into the next level of care.

3. Q. 16. The program demonstrates efforts to integrate with the surrounding community to:
   a. Reduce stigma.
   b. Enhance safety for the persons served.
   c. Facilitate community integration for the persons served.

Intent Statements
The residential program strives to be a good neighbor and to develop and maintain positive, cooperative relationships with neighbors and the surrounding community.

Examples
16.b. The program might establish relationships or a calling tree with neighbors who can be contacted if a person served leaves the residential facility without permission.

3. Q. 17. A review of the person-centered plan for each person served in a residential treatment program:
   a. Occurs at least once a month.
   b. Is documented.

Intent Statements
The intent of this standard is to ensure that the person-centered plan is reviewed frequently enough to track progress made toward identified goals and to note any new needs or interests.

Examples
The review may be documented with updates or changes to the plan, with a plan update document, or through progress notes. The program demonstrates that it is adjusting to ongoing assessments and emerging issues of the person served.

3. Q. 18. The program establishes collaborative relationships with resources in the community to facilitate community integration for the persons served.

Examples
Relationships are established with community partners to provide opportunities for persons served to participate in such things as volunteer activities, fitness and sports activities, support groups, and recreational activities.
Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Risk assessments of persons served
- Person-centered plans of service
- Daily activities schedules
- Written procedures for searches
- Written procedures that address visitation, mail, telephone use, and personal electronic devices
- Documentation of personnel training at orientation and regular intervals

R. Specialized or Treatment Foster Care (STFC)

Description
Specialized or treatment foster care programs use a community-based treatment approach for children/youth with emotional and/or behavioral issues. This intensive, clinically based treatment is child/youth centered and family focused and offers an alternative to inpatient or residential treatment when a child/youth can no longer live in the family home. Treatment is delivered through an integrated team approach that individualizes services for each child/youth. The treatment foster parents are trained, supervised, and supported by the program staff and play a primary role in therapeutic interventions. The program’s goal is to provide clinically effective treatment to children and youth so they may return to their family or alternative community placement and avoid being removed from a community setting. Program staff monitors the child’s/youth’s progress in treatment and provide adjunctive services per the individualized plan and program design.

Children/youth who participate in the program may also have documented reports of maltreatment, involvement with juvenile justice, and/or co-occurring disorders.

The program may also be called intensive foster care, therapeutic family services, or therapeutic foster care.

Applicable Standards
An organization seeking accreditation for a specialized or treatment foster care program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.R. 1. The program implements a process for identifying, locating, and engaging family members, as appropriate, in services.
Examples
The program demonstrates its efforts to engage family, including extended family, in services. This may include the use of internet-based search services to locate family members.

2. The program provides or arranges for documented, competency-based training to meet the identified needs of the children/youth served:
   a. To:
      (1) Personnel.
      (2) Specialized or treatment foster care providers.
   b. At:
      (1) Orientation.
      (2) Regular intervals.
   c. That covers:
      (1) Attachment theory.
      (2) Trauma.
      (3) Child/youth growth and development.
      (4) Behavior management skills.
      (5) Learning theory.
      (6) Cultural competency and diversity.
      (7) The effects of placement on children/youth.
      (8) Applicable legal issues.
      (9) Communication skills.
      (10) Required medications and/or medical services.
      (11) Other specialized training as needed.

Intent Statements
The content of each subject area should consider the specific training needs of personnel and specialized/treatment foster care providers. The training provided to personnel and foster care providers may not be identical.

Examples
2. Training may include conflict resolution and management of violent, aggressive, or sexualized behaviors.
2. Cultural competency and diversity addresses areas that are relevant to the children/youth served in the program; for example, the nuances of the various ethnic cultures and religions, the holidays celebrated, the familiar socioeconomic status of the family from which they came from, and LGBTQ and transgender matters.
2. Legal issues may include court processes if the program serves a child welfare/dependency population or children involved in the juvenile justice system.
2. Specialized training needs may include health and nutrition, the need for and use of assistive technology, substance abuse or mental health issues, or delinquency.

Resources
Additional information on specialized or treatment foster care can be found at the following links:
- Family Focused Treatment Association: www.ffta.org
- National Youth Advocate Program: www.nyap.org/specialized-foster-care

3. Documentation of training provided to foster care providers includes the:
   a. Type of training or information provided.
   b. Dates of training or information provided.
   c. Length of training or information provided.

Examples
One approach to training would be to address relevant topics pre-service and in-service.
Section 3.R. Specialized or Treatment Foster Care (STFC)

3.R. 4. The program provides access to professionals trained in child/youth and family care, based on the needs of each person served, including:
   a. A psychologist.
   b. A counselor.
   c. A family therapist.
   d. A social worker.
   e. A youth worker.
   f. A psychiatrist.
   g. Medical personnel.
   h. Other specialists, as appropriate.

Examples
4.g. May include a nurse, physical therapist, or speech therapist, based on the needs of the child/youth served.

3.R. 5. A referral network is established for the following:
   a. Emergency care.
   b. Respite care.
   c. Medical care.
   d. Other services to meet the needs of the children/youth served.

Intent Statements
The program maintains up-to-date contact information for other service providers currently working with the children/youth served and for providers of services that may potentially be needed.

3.R. 6. The children/youth served have opportunities to participate, as appropriate, in:
   a. Community activities.
   b. Cultural activities.
   c. Recreational activities.
   d. Spiritual activities.

Intent Statements
Specialized or treatment foster care programs are designed to provide treatment within a community setting to foster the development and/or strengthen the child’s/youth’s skills to allow him or her to safely remain in the community and avoid a placement outside of the community.

The program supports the foster treatment family to provide opportunities for the child/youth to access various community activities and to ensure that the child’s/youth’s cultural heritage is honored and preserved.

3.R. 7. If the program selects specialized or treatment foster care providers, it implements a comprehensive plan for recruitment, selection, and maintenance that:
   a. Is reflective of the larger community that the program serves.
   b. Includes a broad selection of families to ensure that the needs of the children/youth served are met.
   c. Meets the expressed criteria set in all applicable jurisdictional guidelines.
   d. Includes procedures for the monitoring of each home.

3.R. 8. If the program is engaged in child placement activities, it has a comprehensive process for matching children/youth with available foster care providers that:
   a. Considers the child’s/youth’s:
      (1) Needs.
      (2) Strengths.
      (3) Preferences.
   b. Considers the foster care providers’ assessed:
      (1) Skills.
      (2) Competencies.
   c. Includes an assessment of the appropriateness of the match, including:
      (1) A familiar environment.
      (2) Identification of any gaps and how the gaps will be addressed.

Intent Statements
The program facilitates placements that match the child/youth served with an appropriate family to promote placement stability.

Examples
8.c.(1) A familiar environment could include the type of residence, such as a single-family
home or a multi-family dwelling; the type of neighborhood, such as rural or urban; and the size of the household, among many variables.

3.R. 9. The program utilizes written agreements that clearly define:
   a. What the foster care providers can expect from the program, including:
      (1) Rights of specialized or treatment foster care providers.
      (2) On-call support 24 hours a day, 7 days a week.
      (3) Initial and ongoing training.
      (4) Communication about appropriate and known information about the child/youth and the family.
      (5) Available support for managing issues that arise in the placement.
      (6) Supervision and monitoring.
      (7) Payments, as applicable.
   b. What is expected of the foster care providers, including:
      (1) In collaboration with the program, implementation of specific service objectives of the individualized plan.
      (2) Providing support to the child/youth in maintaining meaningful contact with family, as appropriate.
      (3) Providing a high standard of daily care to the child/youth, including:
         (a) Nutritious meals and snacks.
         (b) A safe living environment.
         (c) A comfortable living environment.
         (d) Emotional support.
         (e) Boundaries consistent with the needs of the child/youth served.
         (f) Physical needs.
      (4) Encouraging the child/youth to personalize his or her living space with individual possessions.
      (5) Recognition and attention to any special needs of the child/youth, including:
         (a) Dietary needs.
         (b) Religious needs.
         (c) Other identified needs.
      (6) Providing a home that is safe and free from hazards.
      (7) Refraining from the use of corporal punishment and other inappropriate means of discipline.
      (8) Ensuring that the child's/youth's health-related needs are met.
      (9) Providing a supportive learning environment to build the skill levels of the child/youth.
      (10) Facilitating the child's/youth's engagement in developmentally appropriate peer and leisure activities.
      (11) Clearly communicating what is expected of the child/youth in terms of household rules.
   c. The process of termination, if necessary.
   d. An appeal process, when applicable.

Intent Statements

9.b.(1) This relates to the individualized plan components addressed in Standard 2.C.2.

Examples

9.a.(1) Rights may include items such as maltreatment allegations, placement decisions, and respite.
9.a.(6) Supervision and monitoring includes supervision of the direct case worker and, on occasion, may include the treatment foster parents.
9.b.(8) Health-related needs include immunizations, routine well-care appointments, and dental care.
3.R. 10. The program advocates for the placement of children/youth with their siblings, as appropriate.

Intent Statements
The program facilitates ongoing connections with siblings. Safety is always a consideration, and visits are supervised as needed.

3.R. 11. When placement of children/youth with their siblings is not possible, the program advocates for and facilitates regular visit with their siblings, if appropriate.

Intent Statements
See the Glossary for the definition of qualified practitioner.

3.R. 12. The program assists birth/adoptive families to receive services that promote reunification, when appropriate.

3.R. 13. If the program is responsible for reunification, it provides or arranges for supervised visits based on identified permanency goals.

3.R. 14. The program has on-call availability of supervisory staff members to respond to urgent situations 24 hours a day, 7 days a week.

3.R. 15. The services for each child/youth served are supervised by a qualified practitioner who:
   a. Provides clinical oversight.
   b. Directs the treatment plan.

Intent Statements
See the Glossary for the definition of qualified practitioner.

3.R. 16. The program has a plan for access to qualified practitioners 24 hours a day, 7 days a week.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Documentation of training provided to personnel and foster care providers
- Comprehensive plan for recruitment, selection, and maintenance of specialized or treatment foster care providers, if applicable
- Written agreements that clearly define what the foster care providers can expect from the program and what is expected of the foster care providers
- Plans for monitoring each foster home placement
- Plan for access to qualified practitioners 24 hours a day, 7 days a week
- Individual program plans for the persons served
- Records of the persons served
Section 3.S. Student Counseling (SC)

Description
Student counseling programs serve as the primary behavioral health resource for higher education campus communities and their students. Services are designed to provide students with an opportunity to develop personal insight, identify and solve problems, and implement positive strategies to better manage their lives both academically and personally. Services include individual, family, and/or group counseling, prevention, education, and outreach. In addition to working directly with students, program goals are realized through outreach, partnerships, and consultation initiatives with faculty, staff, parents, students’ internships sites, or other educational entities or community partners.

Applicable Standards
An organization seeking accreditation for a student counseling program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section) must be applied along with standards from this subsection.

3.S.1. For each person served, a written person-centered plan:
   a. Is developed with the active participation of the person served.
   b. Is prepared using the following information relative to the person served:
      (1) Relevant medical history.
      (2) Relevant behavioral health information.
      (3) Relevant social information.
      (4) Information on current and previous direct services and supports.
      (5) Other applicable information.
   c. Is based on the person’s:
      (1) Strengths.
      (2) Needs.
      (3) Abilities.
      (4) Preferences.
   d. Is reflective of the person’s:
      (1) Desired outcomes.
      (2) Cultural background and diversity.
      (3) Other issues important to the person served.
   e. Identifies:
      (1) Overall goals defined in the words of the person served.
      (2) Specific objectives that are:
         (a) Measurable.
         (b) Time limited.
      (3) Methods/techniques to be used to achieve the objectives.
      (4) Those responsible for implementation.
      (5) Barriers to the individual’s goals.
      (6) Strengths, supports, or solutions to overcome barriers.
      (7) Transitional needs.
   f. Is reviewed with respect to expected outcomes:
      (1) With the person served.
      (2) On a regular basis.
   g. Is revised, as appropriate:
      (1) Based on the satisfaction of the person served.
      (2) To remain meaningful to the person served.
      (3) Based on the changing needs of the person served.

Examples
The person-centered plan may vary in size and complexity based on the type of services needed. In a short-term crisis response, the plan may address only the immediate needs of the person served.
3.5. 2. The goals and objectives in the person-centered plan are communicated in a manner that is understandable:
   a. To the person served.
   b. To the person(s) responsible for implementing the plan.

3.5. 3. The student counseling program provides one or more of the following services:
   a. Individual counseling.
   b. Family counseling.
   c. Group counseling.

3.5. 4. The program provides or refers to a variety of services, based on the needs of the person served.

3.5. 5. The program offers education on wellness and recovery.

3.5. 6. Individuals providing student counseling services demonstrate:
   a. Knowledge of:
      (1) Appropriate community resources.
      (2) Mandatory reporting requirements.
      (3) Other laws and regulations, as applicable.
   b. Competency in:
      (1) Crisis identification.
      (2) Rapport building.
      (3) Positive engagement.
      (4) Counseling skills.

3.5. 7. The program provides services:
   a. In locations that meet the needs of the persons served.
   b. At times that are responsive to the needs of the persons served.

3.5. 8. When the need is identified, and with the consent of the person served, the program coordinates services with other educational or service providers.

3.5. 9. When a person is transferred or discharged, the program identifies:
   a. A process to ensure coordination.
   b. The person responsible for coordinating the transfer or discharge.

3.5. 10. A discharge summary is prepared for each person served who leaves the program.

3.5. 11. A complete record is maintained for each person served.

3.5. 12. Written procedures guide ongoing communication and collaboration with relevant stakeholders within the educational organization.

Examples
Stakeholders may include health services, student affairs, guidance departments, student life centers, student housing, and public safety. Procedures may guide how referrals are made, communication expectations with or without permission of the person served, or identification of expected collaboration relative to cross training, etc.
Section 3.T. Therapeutic Communities (TC)

T. Therapeutic Communities (TC)

Description
Therapeutic communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of substance abuse or other behavioral health needs and the fostering of personal growth leading to personal accountability. The program addresses the broad range of needs identified by the person served. The therapeutic community employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The therapeutic community emphasizes the integration of an individual within his or her community, and progress is measured within the context of that therapeutic community's expectation.

Applicable Standards
An organization seeking accreditation for a therapeutic community program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.T. 1. The therapeutic community model views the community as the modality for individual change—i.e., the community as the healer. The program’s written plan identifies the therapeutic community model through:
   a. Use of the mutual-help principle.
   b. Program structure.
   c. Rules.
   d. Schedules.
   e. Responsibilities.
   f. Behavioral expectations.
   g. Role modeling.
h. Feedback mechanisms.

i. Therapeutic learning interventions.

j. Therapeutic work assignments.

Intent Statements
The treatment community itself is viewed as the modality for individual change. All members of the community, including staff members and peers, role model appropriate behaviors for other community members in program functions and activities.

1.a. Mutual help, also known as self-help or peer support, requires the person served to actively participate in his or her own treatment and the treatment of others using the community as the method.

3.T. 2. The program demonstrates use of the mutual-help principle through evidence of the following:

a. Adherence to program rules.

b. Adherence to existing schedules.

c. Adherence to behavioral expectations of the community.

d. Acceptance of responsibility for:
   (1) Self.
   (2) Applicable others.
   (3) The health of the community itself.

e. Positively influencing other members of the community by teaching and by role modeling appropriate behaviors in:
   (1) Program functions.
   (2) Activities.
   (3) The community itself.

f. Providing honest feedback and guidance to other members of the community that leads to interventions occurring in a community forum.

g. Demonstration of empathy and genuine concern for other members of the community.

Intent Statements
This standard relates to the active involvement of the persons served in their treatment process and in that of their peers. An individual’s growth and change are the product of his or her own motivation and commitment, with help from others engaged in the same process.

3.T. 3. The program’s hours of operation meet the needs of the persons served.

Intent Statements
In a correction setting, the hours of operation may be determined and limited by institutional rules.

3.T. 4. The treatment environment is conducive to and supportive of recovery.

3.T. 5. When a program is provided in a residential setting, there is qualified personnel available to respond 24 hours a day, 7 days a week.

Intent Statements
Personnel should be on the same campus and have the ability to respond to emergencies quickly. If the program serves children or adolescents, personnel are on site 24 hours a day, 7 days a week. In a correctional setting, services or support outside of program hours may be provided by personnel outside of the organization or program seeking accreditation or may be provided by institutional staff. Whether on-site personnel remain awake at all times will be dependent on the unique needs of the persons being served.

3.T. 6. Whenever possible, peer mentors are used as credible role models in the program.

Examples
In a correctional setting, this may include inmates who have completed the correctional therapeutic community and are used as peer mentors to teach, facilitate, and role model for newer participants in the therapeutic community.
3.T. 7. Based on the needs of the person served, the program provides, either directly or through referral, services that seek to assist the person served with:
   a. Substance abuse issues.
   b. Criminal issues, including:
      (1) Attitudes.
      (2) Beliefs.
      (3) Behaviors.
   c. Mental health issues.
   d. Medical needs.
   e. Family issues, where appropriate.
   f. Cognitive functioning.
   g. Emotional functioning.
   h. Building of self-esteem and self-concepts.
   i. Improvement of coping abilities.
   j. Development of responsible decision-making skills.
   k. Educational opportunities.
   l. Vocational development and/or employment.
   m. Social functioning.
   n. Use of leisure time.
   o. Relapse prevention or support strategies.
   p. Community living skills.
   q. Spirituality.
   r. Family reunification.
   s. Violence reduction.
   t. Permanent and stable housing.
   u. Financial skills, including applicable restitution.

Intent Statements
The therapeutic community treatment model is distinguished by a view of substance abuse as a disorder of the whole person, involving problems with behavior, attitudes, and management of emotions. This comprehensive approach utilizes a continuum of services and allows for individualized treatment planning in response to the needs of the persons served.

Examples
7.e. Family issues may include parenting classes.

3.T. 8. The organization implements a process to ensure that personnel providing direct services demonstrate skill in the application of the therapeutic community core competencies that include an understanding of:
   a. Practicing positive role modeling.
   b. Promoting mutual help.
   c. Practicing the concept of “acting as if.”
   d. Minimizing the dichotomy of “we versus they.”
   e. Promoting a system of earned privileges and graduated responsibilities.
   f. Social learning.
   g. Utilizing the relationship between belonging and individuality.
   h. Creating a belief system in the community.
   i. Facilitating group process.
   j. Positive boundaries in the following areas:
      (1) Clinical.
      (2) Ethical.
      (3) Security (in correctional settings).

Intent Statements
8.b. Mutual help emphasizes personal responsibility and de-emphasizes the concept of “patients” being serviced by “experts.”
8.c. This is a cognitive technique that emphasizes the creating of a positive atmosphere. This technique is important because of the therapeutic community belief that acting positively, despite feeling negatively, will eventually lead to feeling positively.
8.d. To the greatest extent possible, staff members should remove all barriers between the persons served and staff members so that both are viewed as facilitating the treatment process. In a correctional setting, this must be consistent with institutional rules and regulations and practices, which are designed to ensure institutional security and staff safety. This can be achieved in correctional settings via role modeling of community techniques, such as challenging and confronting behaviors and demonstrating prosocial or right-living behaviors.
8.f. Social learning includes role modeling, peer feedback, and learning by experience.

8.g. The initial priority of the therapeutic community is to promote a strong feeling of inclusion within and bonding with the community itself, which promotes feelings of belonging and commitment. Individuality and self-realization are stressed in later phases of treatment. Balancing belonging and individualism is integral to treatment success.

3.T. 9. When the therapeutic community is in a correctional facility, security personnel are trained on the therapeutic community model.

3.T. 10. The program completes a review at least quarterly of each person’s:
   a. Plan of services.
   b. Goals.
   c. Objectives.
   d. Progress toward goals.

3.T. 11. The program provides treatment throughout the day consisting of the following, based on the needs of the persons served:
   a. A written schedule that includes:
      (1) Community activities.
      (2) Cultural activities.
      (3) Recreational activities.
      (4) Spiritual activities.
   b. Assignment of therapeutic duties and work assignments.
   c. Daily access to nutritious meals and snacks.
   d. Therapeutic activities, such as individual and group counseling.
   e. Educational activities.
   f. Training activities.
   g. Crisis intervention.
   h. Development of community living skills.
   i. Family support, with the approval of the persons served.
   j. Linkages to community resources.
   k. Development of:
      (1) Social skills.
      (2) Prosocial behavior.
      (3) Responsible concern for others.
   l. Development of a social support network.
   m. Development of vocational skills.
   n. Community building activities that use therapeutic community tools and methodology.
   o. Assistance in securing housing that is safe, decent, affordable, and accessible for the persons served.

Examples
   11.c. In a correctional setting, these are provided by the institution.
   11.f. Training may include budgeting, money management, literacy skills, or GED preparation.
   11.n. In a correctional setting, this may be linkage to continuing care.

3.T. 12. In a noncorrectional residential setting, the following community living components are provided:
   a. Opportunities to participate in activities that would be found in a home.
   b. Adequate personal space for privacy.
   c. A homelike and comfortable setting.
   d. Evidence of individual possessions and decoration, when clinically appropriate.

3.T. 13. In a residential setting, there are separate sleeping areas for the persons served based on:
   a. Gender.
   b. Age.
   c. Needs.

Intent Statements
   When parent-child treatment is provided, the same sleeping areas may be appropriate.
13.a. The organization must be able to clearly delineate male and female designated areas (separate wings, buildings, etc.).

13.c. When serving children or adolescents, needs includes developmental level.

3.T. 14. The program demonstrates that therapeutic learning interventions:
   a. Are consistent with the treatment goals.
   b. Relate to the attitudes or behaviors leading to implementation.
   c. Are understood by personnel and persons served.
   d. Are used to the greatest extent possible within the treatment environment.
   e. Are consistent with the principle of using the community as the primary instrument of facilitating change.

Intent Statements
Therapeutic learning interventions are a part of the treatment process and are linked to the treatment goals of the persons served.

Examples
They may be communicated through such means as orientation manuals, seminars, peer interactions, or staff instruction and may be applied by the community as well as personnel, particularly in a correctional setting.

14.d. Within a correctional setting, therapeutic community learning interventions are used as the primary intervention in all situations where rule violations do not automatically trigger correctional sanctions.

3.T. 15. The program demonstrates that the use of therapeutic duty assignments:
   a. Is consistent with the treatment plan of the persons served.
   b. Responds to the needs and abilities of the persons served.
   c. Includes documentation of:
      (1) Progress.
      (2) Supervision.

Intent Statements
Assignments are utilized to promote community membership, social functioning, daily living skills, individual self-esteem, responsibility, vocational development, and/or employability. Under the supervision of staff, persons served perform assignments integral to the running of the community. New persons served are assigned entry-level therapeutic duty assignments as a way to signify the start of their contribution to the community. Persons served assume greater responsibility based on treatment progress, performance, behavior, and attitude. Persons served gain valuable experience through therapeutic duty assignments and may internalize a work ethic as well as a strong sense of responsibility for the community.

3.T. 16. Provisions are made to address the need for:
   a. Cultural and/or spiritual activities.
   b. Quiet areas.
   c. Areas for visits.

Intent Statements
In a correctional setting, this results from agreements between program and correctional personnel.

16.a. In a correctional setting, this is based on institutional policy.

16.c. In a correctional setting, this is designated by the institution and is based on institutional security needs and program integrity and efficacy needs.

3.T. 17. In a correctional setting, the therapeutic community is provided in a designated space that allows for an appropriate treatment environment.

Intent Statements
This would include sufficient segregation from the general population to ensure a prosocial environment for the treatment program, as well as housing and employment, to the extent possible.
Section 3.T. Therapeutic Communities (TC)

3.T. 18. In a correctional setting, efforts are made to accept persons served into the therapeutic community at a time that will allow for transition from the treatment program into applicable community-based treatment in a timely manner.

Intent Statements
In order to best support long-term treatment gains and recovery, organizations promote treatment as close as possible to the time that the individual will be released.

3.T. 19. In a correctional setting, personnel:
   a. Have training or experience in the treatment of addictions as well as expertise in working with the criminal justice population.
   b. Reflect the unique knowledge and experience of persons who are in recovery or are ex-offenders.

3.T. 20. In a correctional setting, a written procedure exists for review of rule infractions that:
   a. Includes:
      (1) Informal review.
      (2) Formal review.
   b. Clarifies roles and responsibilities of program and correctional personnel.
   c. Considers the relationship between the safety of the institution and the value of the therapeutic intervention.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A written program plan
- A quarterly review of the plan for services, goals, and progress made
- A written schedule of activities
- Documentation of therapeutic duty assignments

■ A written program plan
■ A quarterly review of the plan for services, goals, and progress made
■ A written schedule of activities
■ Documentation of therapeutic duty assignments

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A written program plan
- A quarterly review of the plan for services, goals, and progress made
- A written schedule of activities
- Documentation of therapeutic duty assignments
SECTION 4

Core Support Program Standards

Description
The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

Behavioral Health Field Categories
For each behavioral health core program selected for accreditation, an organization must identify under which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program and to distinguish the specific fields in behavioral health that the core program reflects and serves.

The behavioral health field categories applicable to programs in this section are Alcohol and Other Drugs/Addictions, Mental Health, Psychosocial Rehabilitation, Family Services, Integrated AOD/Mental Health, and Integrated IDD/Mental Health. The following are descriptions of each field category:

- Alcohol and Other Drugs/Addictions: Core programs in this field category are designed to provide services for persons who have or are at risk of having harmful involvement with alcohol or other drugs/addictions, including process addictions, such as addiction to gambling, pornography, video gaming, etc. These programs use a team approach to minimize the effects and risks associated with alcohol, other drugs, or other addictions.

- Mental Health: Core programs in this field category are designed to provide services for people with or who are at risk for psychiatric disabilities/disorders or have other mental health needs. These programs encompass a wide variety of therapeutic settings and intervention modalities and may provide services to those with behavioral health disabilities or co-occurring disabilities; intellectual or developmental disabilities; victims or perpetrators of domestic violence or abuse; persons needing treatment because of eating

Applicable Standards
All organizations applying for accreditation for a behavioral health core program are responsible for applying the standards in Sections 1–2, unless otherwise indicated under the applicable standards section and in the table on page 116 in Section 2. General Program Standards. Note the requirements for programs serving children and adolescents under the Guidelines for Organizations Seeking a Specific Population Designation on page 283.
or sexual disorders; and/or drug, gambling, or internet addictions.

- **Psychosocial Rehabilitation**: Core programs in this field category demonstrate a strong collaborative partnership with the persons served, the development of opportunities for personal growth, a commitment to community integration, goal-oriented and individualized supports, and the promotion of satisfaction and success in community living. Programs in this category may serve persons with a variety of concerns, including persons with developmental or physical disabilities.

- **Family Services**: Core programs in this field category are designed to maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals. Core programs in this field category are directed at the reduction of symptoms and/or the improvement of functioning for the person served or family unit.

- **Integrated AOD/Mental Health**: Core programs in this field category are designed to provide a combination of alcohol and other drugs/addictions and mental health services. This may include services provided in a psychosocial format. Services may be provided through a seamless system of care for individuals with needs in one or both areas or for persons with identified co-occurring disorders, including any of the concerns listed under the Mental Health field category.

- **Integrated IDD/Mental Health**: Core programs in this field category are designed to provide services to persons whose primary diagnoses are intellectual or other developmental disabilities and who are at risk for or exhibiting behavioral disorders or have identified mental health needs. These programs encompass many therapeutic settings and intervention modalities and a commitment to community integration.

### Guidelines for Organizations Seeking a Specific Population Designation

If an organization is required or chooses to add a Specific Population Designations to a core program(s) being surveyed, the standards for these designations will be applied at the time of the survey in addition to the core program standards. See Section 5 for details and applicable standards. The Specific Population Designations available are:

- **5.A. Adults with Autism Spectrum Disorder (ASD:A)**
- **5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)**
- **5.C. Children and Adolescents (CA) (May be required—see Section 5, page 283)**
- **5.D. Consumer-Run (CR)**
- **5.E. Criminal Justice (CJ) (may be required—see Section 5, page 283)**
- **5.F. Eating Disorders (ED) (includes Eating Disorders for Children/Adolescents (EDCA—see Section 5, page 283)**
- **5.G. Juvenile Justice (JJ) (may be required—see Section 5, page 283)**
- **5.H. Medically Complex (MC) (may be required; includes Medically Complex for Children/Adolescents (MCCA)—see Section 5, page 283)**
- **5.I. Older Adults (OA)**
A. Assessment and Referral (AR)

Description

Assessment and referral programs provide a variety of activities, including prescreening, screening, psychosocial assessment, determination of need, and referral to appropriate level of care. The provision of information on available resources is not considered a full assessment and referral program. An adequate assessment must be conducted to provide more informed referrals. Such programs may be separate, freestanding programs, an independent program within a larger organization, or a specifically identified activity within a system of care. Organizations performing assessment and referral as a routine function of entrance into other core programs, such as their outpatient treatment, case management, or residential programs, are not required to apply these standards unless they are specifically seeking accreditation for assessment and referral.

Applicable Standards

An organization seeking accreditation for an assessment and referral program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section) must be applied along with standards from this subsection.

If the organization serves children and adolescents in an assessment and referral program that does only telephone assessments, only Standards 5.C.1., 5.C.2., and 5.C.8. in Section 5.C. Children and Adolescents (CA) are applicable.

4.A. 1. The program implements policies and procedures for assessment and referral that include:
   a. Identification of the use of valid, reliable, or standardized assessment tools, tests, or instruments.
   b. A demonstrated method of identifying appropriate levels of care for the person served.
   c. Linkage to:
      (1) Emergency services.
      (2) Crisis intervention services, as needed.

Intent Statements

1.a. Valid and reliable assessment tools consist of public- or private-domain tests and instruments that have been validated for use as methods of screening and assessing the severity of symptoms and level of functioning.

1.b. The organization should use valid assessment tools that determine the level of care or have criteria in place for level-of-care placement.

4.A. 2. The program provides the following services in collaboration with the person served:
   a. Assessment of the needs of the person served.
   b. Identification of the choices available for community resources.
   c. Provision of informational materials pertaining to community resources, when possible.
   d. Identification of services that are:
      (1) Culturally appropriate.
      (2) Age appropriate.
   e. Implementation of methods to:
      (1) Determine if services were accessed by the persons served.
      (2) Provide follow-up, when indicated.

Examples

2.b. The program may provide information through the use of a community resource site, brochures, or service listing(s).
4.A. When requested, the program provides a written summary of the assessment and referral(s) to the person served or his or her legal representative.

**Documentation Examples**

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies for assessment and referral
- Assessment tools
- A community resources file

**B. Community Housing (CH)**

**Description**

Community housing addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the persons served, regardless of the home in which they live and/or the scope, duration, and intensity of the services they receive. The residences in which services are provided may be owned, rented, leased or operated directly by the organization, or a third party, such as a governmental entity. Providers exercise control over these sites.

Community housing is provided in partnership with individuals. These services are designed to assist the persons served to achieve success in and satisfaction with community living. They may be temporary or long term in nature. The services are focused on home and community integration and engagement in productive activities. Community housing enhances the independence, dignity, personal choice, and privacy of the persons served. For persons in alcohol and other drug programs, these services are focused on providing sober living environments to increase the likelihood of sobriety and abstinence and to decrease the potential for relapse.

Community housing programs may be referred to as recovery homes, transitional housing, sober housing, domestic violence or homeless shelters, safe houses, group homes, or supervised independent living. These programs may be located in rural or urban settings and in houses, apartments, townhouses, or other residential settings owned, rented, leased, or operated by the organization. They may include congregate living facilities and clustered homes/apartments in multiple-unit settings. These residences are often physically integrated into the community, and every effort is made to ensure that they approximate other homes in their neighborhoods in terms of size and number of residents.
Community housing may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living can be offered in apartments or homes, or in congregate settings that may be larger than residences typically found in the community.

- Long-term housing that provides stable, supported community living or assists the persons served to obtain and maintain safe, affordable, accessible, and stable housing.

The residences at which community housing services are provided must be identified in the survey application. These sites will be visited during the survey process and identified in the survey report and accreditation outcome as a site at which the organization provides a Community Housing program.

### Applicable Standards

An organization seeking accreditation for a community housing program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

**NOTE:** Standards 1.H.13. and 1.H.14. (Section 1.H. Health and Safety) are applied to the community housing residence only when the organization owns/leases the home.

If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.

### Examples

1. a. This standard does not require a separate room for each resident, but it does suggest the provision of a safe, secure, private location that can be thought of by the person served as his or her own.

1. c. Safety needs are determined on the basis of the individuals’ strengths and needs. See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

### 4.B.

2. The organization provides the following community living components:

   a. Regular meetings between the persons served and staff.

   b. Opportunities to participate in typical home activities.

   c. Appropriate linkage when health-care needs of the persons served are identified.

   d. A personalized setting.

   e. Daily access to nutritious meals and snacks.

   f. The opportunity for expression of choice by the persons served in regard to rooms and housemates.

   g. Based on the choice of the persons served, opportunities to access:

      (1) Community activities.

      (2) Cultural activities.

      (3) Social activities.

      (4) Recreational activities.

      (5) Spiritual activities.

      (6) Employment/income generation activities.

      (7) Necessary transportation.

      (8) Self-help groups.

      (9) Other activities as identified in the person’s plan.

   h. Policies related to:

      (1) Visitors or guests.

      (2) Pets.

### Intent Statements

Persons served have a right to personal, private space.
Examples

2.a. These meetings could be community meetings or meetings for the purpose of collaboratively discussing issues such as:

- Program operations.
- Problems.
- Plans.
- The use of program resources.

2.b. The program encourages all persons served to take increasing responsibility for cooperative operation of the household. Activities may include the preparation of food and the performance of daily household duties.

2.f. Depending on the program structure and the needs of the persons served, there may be procedures for maintaining separate sleeping areas in accordance with the genders, ages, and developmental level of the persons served. Whenever possible, each person served has the choice of a private room or the opportunity to participate in the selection of roommates.

2.g.(8) Activities could include meetings of 12-step and other self-help groups.

Intent Statements

Safety needs are determined on the basis of the individuals' strengths and needs.

Examples

See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

4.B. When possible, persons served have options to make changes in their living arrangements:

- At their request.
- At the request of their families, when applicable.

4. In transitional living, on a periodic basis when initiated by the organization.

4.B. Based on informed choice.

Examples

The preference for a different living situation is typically addressed at the person's planning meeting.

Knowledge of existing and planned services is important for the persons served so that they can make informed choices about alternative living arrangements. Alternative living arrangements may be provided by the organization or other providers. The term living arrangements refers to the service model and not the residence or home itself.

4.B. Based on the needs of persons transitioning to other housing, there are procedures in place to assist them in securing housing that is:

- Safe.
- Affordable.
- Accessible.
- Acceptable.

Intent Statements

The safety and security of the living arrangements of the persons served are assessed, risk factors and accessibility issues are identified, and modifications are made to make the housing choices acceptable.

Examples

Successful transition of a person served to safe and affordable housing requires the organization to establish organizational procedures based on input from a variety of customers and stakeholders. Planning considerations should include the strengths and needs of the persons served, as well as areas of organizational consideration and resources that will need to be addressed. Those areas include accessibility plans and resources budgeted to remove barriers, appropriate review
of health and safety factors as defined by local authorities, and the various aspects of risk management, and are all part of the individual services and organizational planning necessary to secure transitional housing.

4.B.

6. Each person served receives:
   a. Skill development necessary to live as independently as possible.
   b. Ongoing support/services as he or she explores changes in his or her living arrangements.

Intent Statements
The person served has continuous access to services and support. The person’s plan is continuously monitored, and modifications are made in the plan as the needs and circumstance of the person served change.

6.b. The person served may need confidence and courage to try alternative living arrangements. It is the responsibility of the provider organization to attempt to minimize risks of trying alternative living arrangements.

Examples
A number of resources can be helpful in planning delivery of services/supports. These include the CARF publication *Using Individual-Centered Planning for Self-Directed Services*, which is available on request from your resource specialist, as well as related standards regarding accessibility, health and safety, and fiscal management found in Section 1 of this manual. Often, the development of a professional team and a circle of support and friends can be helpful in encouraging persons served to try alternative living arrangements.

4.B.

7. Personnel are on site based on the needs of the persons served, as identified in their person-centered plans.

Intent Statements
Personnel have the experience/training needed to effectively deal with the needs of the persons served.

Examples
If the program serves persons with autism, personnel have experience and training in this area.

4.B.

8. There is a system for the on-call availability of designated personnel 24 hours a day, 7 days a week.

4.B.

9. In congregate housing, provisions are made to address the need for:
   a. Smoking or nonsmoking areas.
   b. Quiet areas.
   c. Areas for visits.
   d. Separate sleeping areas based on:
      (1) Age.
      (2) Gender.
      (3) Developmental need.
   e. Other issues, as identified by the residents.

Intent Statements
When housing is shared by two or more individuals, the program actively addresses the need to designate space for privacy and individual interests.

4.B.

10. The organization assists the person served to identify and utilize available modes of transportation.

Intent Statements
When transportation cannot be accessed independently by the persons served, the organization coordinates transportation to other relevant services and activities.

4.B.

11. The organization demonstrates efforts to maintain a person’s residence as long as possible during temporary medical, legal, or personal absences.
C. Comprehensive Suicide Prevention Program (CSPP)

Description

Comprehensive suicide prevention programs are designed to reduce the incidence and impact of suicide events and promote hope and healing in the population served. Suicide prevention programs work to reduce risk factors and increase protective factors through the implementation of universal, selected, and indicated strategies that address the needs and reflect the culture and environment of the population served. They take a strategic approach to the design and implementation of activities that will be accessible to and have the greatest impact on persons served and their families/support systems, personnel, and partners and other stakeholders in the community.

Personnel in a comprehensive suicide prevention program receive competency-based training on suicide prevention, intervention, and postvention. Suicide prevention activities must be integrated into numerous community and clinical environments to be successful. To that end, comprehensive suicide prevention programs engage with stakeholders, including persons with lived experience, regarding capacity building; communication and messaging; and outreach, education, and training to increase awareness and expertise related to evidence-informed suicide prevention practices.

The program collects and analyzes data to measure its performance, inform capacity building to address gaps in resources and services, and further reduce risks and build resilience in the population served.

Applicable Standards

An organization seeking accreditation for a comprehensive suicide prevention program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section)

4.B. 12. The organization provides information to residents that includes:
   a. How to access community resources if needed.
   b. Safety issues related to the service delivery site.
   c. Access to emergency care when it is needed.
   d. Specific healthcare procedures and techniques.
   e. Contingency plans in case either the support system or the service provider is unable to deliver care.
   f. A review of how to deal with emergencies and evacuation from the residence.

   **NOTE:** This standard applies only to programs provided in apartment-type situations where agency staff do not reside at the site.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Policies related to visitors, guests, and pets
- A descriptive outline or curriculum for training
must be applied along with standards from this subsection.

If an organization is seeking accreditation for a comprehensive suicide prevention program for children or adolescents, the standards in Section 5.C. do not apply.

### 4.C. The program documents an environmental scan that:

**a.** Includes the following:

1. **Description of the population served.**
2. **Risk factors present in the population served.**
3. **Protective factors present in the population served.**
4. **Incidence of suicide events in the population served.**
5. **Means of suicide events in the population served.**
6. **Culture(s) of the population served.**
7. **Resources and services available to:**
   - (a) **Reduce risk factors.**
   - (b) **Increase protective factors.**
8. **Gaps in resources and services.**
9. **Input from:**
   - (a) **Persons with lived experience.**
   - (b) **Other relevant stakeholders.**

**b.** Is reviewed at least annually.

**c.** Is updated as needed.

#### Intent Statements

The program identifies the population it serves, paying particular attention to the elements identified in the standard. Although the program will strive to gather information with rigor, it may be influenced by the availability of data regarding suicide events in the population. Where there are gaps in the data available, the program may utilize intuitive methods based on experience.

1.a.(7)–(8) Resources and services available within the organization as well as in the community are considered.

1.b.–c. The program is not required to conduct a comprehensive environmental scan each year. However, it is expected that appropriate steps be taken, up to and including conducting a complete scan, to address information that has become outdated or is determined to be incomplete.

#### Examples

1.a.(2) Examples of risk factors that might be considered include culture, economic circumstances such as poverty, access to weapons, race considerations, and prior incidence of suicide in the population served.

1.a.(3) Examples of protective factors that might be considered include the accessibility of behavioral healthcare, social connectedness, life skills, cultural norms, and religious beliefs.

1.a.(4) Information can be sought from a variety of sources, such as the local coroner’s office, law enforcement, state suicide prevention offices, and the Centers for Disease Control.

1.a.(6) Culture in this context might include age, veteran status, gender identification, socioeconomic status, and other factors that are associated with suicidal behaviors. The culture of the population served may be supportive of seeking assistance or it might pose a barrier to doing so.

1.a.(9)(b) See the Glossary for a definition of stakeholders. For a comprehensive suicide prevention program, other relevant stakeholders might include schools, behavioral health providers, hospitals, law enforcement, first responders, and military command leadership.

### 4.C. Based on the environmental scan and its resources and priorities, the comprehensive suicide prevention program implements a plan that:

**a.** Addresses the needs of:

1. **Persons served.**
2. **Families/support systems.**
3. **The community.**

**b.** Reflects input from:

1. **Persons with lived experience.**
2. **Other relevant stakeholders.**
Section 4.C. Comprehensive Suicide Prevention Program (CSPP)

c. Includes the following areas:

(1) Evidence-informed prevention activities, including:
   (a) Universal strategies for the general population.
   (b) Selected strategies for targeted groups based on identified risk factors.
   (c) Indicated strategies for:
      (i) Identifying persons at risk.
      (ii) Assisting persons at risk.

(2) Development and/or maintenance of a network of resources and services to address needs in the following areas:
   (a) Behavioral health.
   (b) Case management.
   (c) Crisis services.
   (d) Financial.
   (e) Housing.
   (f) Legal.
   (g) Medical.
   (h) Peer support.
   (i) Spiritual support.
   (j) Vocational.
   (k) Other resources and services, as appropriate.

(3) Safety and means reduction strategies for:
   (a) The general population.
   (b) Targeted groups based on identified risk factors.
   (c) Individuals identified as being at risk.

(4) Life skills training that builds protective factors including:
   (a) Help seeking.
   (b) Stress reduction.
   (c) Coping skills.
   (d) Problem solving.
   (e) Wellness.

(5) Postvention strategies for:
   (a) Targeted groups based on identified risk factors.
   (b) Individuals at risk, including:
      (i) Attempt survivors.
      (ii) Loss survivors.

d. Is reviewed at least annually.
e. Is updated as needed.

Intent Statements

This plan provides the basis for all of the activities performed by the program and should be logically reflective of the needs identified in the environmental scan. It should be complete, thorough, and include references to each of the elements of the standard. Refer to the Glossary for the definition of plan.

2.c.(2) It is not required that there be formal written agreements with each of the types of resources and services listed, but the program should have sufficient information available to provide for professional referrals and coordination.

Resources

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action
www.ncbi.nlm.nih.gov/books/NBK109917

4.C. 3. The program implements a strategy for stakeholder engagement that includes:

   a. Promoting capacity building to address gaps in resources and services.
   b. Evidence-informed communication, including safe messaging guidelines.
   c. Outreach to relevant stakeholders to promote the objectives of the program.
   d. Education and/or training for stakeholders based on their needs and interests.

Intent Statements

The program will have a variety of stakeholders based on the population served and the complexity of its network. The program should seek
stakeholder engagement through a variety of mechanisms that are most effective based on its size and scope.

4.C. 4. The program implements written procedures for referrals to appropriate resources and services to address identified needs of persons served, including:
   a. When appropriate, the exchange of relevant information regarding the persons served.
   b. Proactive outreach to support:
      (1) Persons served during care or life transitions.
      (2) Families/support systems, as needed.

Intent Statements
When the program identifies persons needing services that are outside of its scope, there are written procedures to guide the referral process and how confidential information is handled.

Examples
4.b. When persons served transition from one program to another or from care to no care, these are identified as times of higher risk. Life transitions, such as career transitions, marital or relationship transitions, or relocation may also be identified as times of higher risk.

4.C. 5. The program implements written procedures for crisis intervention.

Intent Statements
The program must have sound and realistic procedures for managing crises reflective of the needs of the population served. Although there may be a close relationship with a crisis line, that is not a substitute for program procedures.

4.C. 6. Based on their roles and responsibilities, the program provides documented, competency-based training to personnel:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, at a minimum, the following topics:
      (1) Suicide risk factors.
      (2) Suicide protective factors.
      (3) Suicide concepts and facts.
      (4) Evidence-informed communication, including safe messaging guidelines.
      (5) Grief and loss.
      (6) Issues related to imminent harm.
      (7) Legal and regulatory considerations for persons at risk for suicide.
      (8) Means safety.
      (9) Postvention.
      (10) Referral process to network resources and services to meet the needs of persons served.
      (11) Safety planning.
      (12) Trauma-informed care.

Intent Statements
The personnel assigned to the program are trained and competent in the complex nature of the work it performs.

Resources
The following resources may assist programs in developing training curriculum.

Suicide risk and protective factors:
- Preventing Suicide: A Toolkit for High Schools: store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf
Section 4.C. Comprehensive Suicide Prevention Program (CSPP)

- Defense Suicide Prevention Office: www.dspol.mil/About-Suicide/Protective-Factors/
- youth.gov/youth-topics/youth-mental-health/risk-and-protective-factors-youth

Communication and safe messaging:
- www.sprc.org/keys-success/safe-messaging-reporting
- suicidetionMessaging.actionallianceforsuicideprevention.org
- reportingonsuicide.org

Means Safety:
- www.sprc.org/comprehensive-approach/reduce-means

Postvention:
- www.sprc.org/comprehensive-approach/postvention
- actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Managers-Guidebook-To-Suicide-Postvention-Web.pdf
- www.naspa.org/focus-areas/mental-health/postvention-a-guide-for-response-to-suicide-on-college-campuses

Safety Planning:
- www.suicidesafetyplan.com/
- www.sprc.org/resources-programs/patient-safety-plan-template
- my3app.org/safety-planning/

4.C. 7. The program provides personnel with:
   a. Opportunities to discuss suicide events without blame.
   b. Opportunities to express their emotions related to suicide events.
   c. Resources for support.

Intent Statements
Programs working in this area may experience suicide events that expose personnel to vicarious trauma. Personnel should be able to access support and discuss the events without fear of reprisal from leadership or colleagues.

Additional Resources
- American Association of Suicidology: www.suicidology.org/
- American Foundation for Suicide Prevention: https://afsp.org/
- National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org
- Suicide Awareness and Voices of Education: www.save.org
- Suicide Prevention Resource Center: www.sprc.org
- Canadian Association for Suicide Prevention: http://suicideprevention.ca
- centre for suicide prevention: www.suicideinfo.ca/
- centre for suicide prevention training workshops: www.suicideinfo.ca/workshops/
- ReachOutNow: www.reachoutnow.ca/resources_e.php
- Together to Live: www.togethertolive.ca/prevention-tools-and-resources
- LivingWorks: www.livingworks.net
- Tragedy Assistance Program for Survivors: www.taps.org
- Defense Suicide Prevention Office: www.dspol.mil
- Department of Veterans Affairs: www.research.va.gov/topics/suicide.cfm
D. Call Centers (CC)

Description

Crisis and information call centers respond to a variety of immediate requests identified by the persons served and may include crisis response, information and referral, or response to other identified human service needs.

Applicable Standards

An organization seeking accreditation for a crisis and/or information call center program must apply the standards in Section 1. In addition, the standards in Section 2 (please consult grid on page 116 for applicability) must be applied along with the standards in this subsection as follows:

- Crisis Call Centers must meet Standards 4.D.1.–13.
- Information Call Centers must meet Standards 4.D.1.–8. and 14.–16.

If an organization is seeking accreditation for a crisis and/or information call center program that serves children or adolescents, the standards in Section 5.C. do not apply. Organizations that provide both types of call center programs must seek accreditation for both.

4.D. 1. The program implements written procedures for:
   a. Determination of eligibility.
   b. Handling of calls from persons ineligible for services.
   c. Caller identification.
   d. Active rescue.
   e. Follow-up.
   f. Third-party outreach.
   g. Monitoring of calls.
   h. Recording of calls.
   i. Call refusal or termination.
   j. Safety of staff specific to a 24/7 setting.
Examples

1.a. Eligibility may be limited by scope of contract or geographic limitation.
1.h. Calls do not have to be recorded.
1.i. May address prank, abusive, or sexually inappropriate phone calls.

4.D. 2. The program provides initial and ongoing training to persons providing services that is guided by:
   a. A written training plan.
   b. A detailed curriculum.
   d. Mechanisms for:
      (1) Modeling.
      (2) Evaluation.
   e. Updating of training to reflect:
      (1) Current community issues or trends.
      (2) Field trends or research.

4.D. 3. The program provides telephone intervention services.

4.D. 4. To ensure access during identified hours of operation, the program implements written procedures that:
   a. Identify thresholds for timeliness of response.
   b. Provide for monitoring of attainment of thresholds.
   c. Identify a process for implementing changes in response to:
      (1) Results achieved.
      (2) Changes in demand or capacity.

Intent Statements
The program has procedures in place to match resources (i.e., staffing, call transferring, timeliness, etc.) to anticipated need levels to achieve desired services.

4.D. 5. The program provides or implements procedures for identifying and accessing face-to-face response when indicated.

Intent Statements
Face-to-face response may be provided by the program, or linkages for the provision of face-to-face services are identified in writing.

4.D. 6. Written procedures identify:
   a. The nature of the call.
   b. A screening process that is appropriate to the presenting concern.
   c. Suggested responses based on needs identified by the person calling.
   d. The need to document results of screening.

Intent Statements
6.b. The intent of the standard is to document the collection of an adequate amount of information to provide appropriate and safe services.

4.D. 7. Written procedures guide the potential involvement of:
   a. Social support systems, including family members.
   b. Identified legal representatives.

4.D. 8. Individuals providing services demonstrate knowledge and skill of:
   a. Appropriate community resources.
   b. Crisis identification.
   c. Rapport building and positive engagement.
   d. Mandatory reporting requirements.
   e. Other laws and regulations, as applicable.

Intent Statements
Evidence of orientation and training may be documented in personnel records and inservice training logs.
8.a. Information about community resources, such as transportation services, support groups, emergency services, ambulance services, and other information and referral services, is made
available to the persons served through program personnel.

8.d. Every state and province has established laws and regulations for individuals who are typically determined to be a threat to themselves or others or who have been involved with a reportable act of abuse.

Crisis Call Center

4.D. 9. If the assessment identifies a need for an initial crisis intervention response, it includes:
   a. When applicable, identified immediate need for response to:
      (1) Suicide risk.
      (2) Threatened or actual abuse or violence.
   b. A written statement describing the crisis resolution.

Examples
9.a.(2) May include homicide or physical or sexual abuse.

4.D. 10. A crisis call center provides or implements procedures for the provision of services 24 hours a day, 7 days a week.

4.D. 11. When a crisis call center program uses a secondary provider for roll-over call answering or 24/7 coverage, there is evidence of:
   a. Interagency coordination.
   b. Written agreements.
   c. Identified training requirements.
   d. Service evaluation.

Examples
11.b. May identify requirements for timelines of response.

4.D. 12. In a crisis call center program, the individuals providing services have the capability to make appropriate decisions to:
   a. Determine an appropriate course of action.
   b. Facilitate the stabilization of the situation as quickly as possible.

Intent Statements
The program has personnel, students, or volunteers with adequate training, education, or experience to make appropriate decisions, and records reflect that appropriate decisions are made. Basic components of any crisis response service are the abilities to quickly assess the problem, decide on the appropriate course of action, and bring together the necessary services and providers to stabilize the situation as soon as possible.

4.D. 13. In a crisis call center program, the individuals providing services demonstrate competency in:
   a. Crisis intervention techniques.
   b. Lethality assessment.
   c. Problem solving.
   d. Recognizing indicators of presenting problems.

Examples
13.c. May include suicide risk, mental illness, abuse, domestic violence, addiction, or homelessness.
Information Call Center

4.D. 14. In an information call center program, written procedures identify the process for:
   a. Determining eligibility for inclusion of resources in the community resource database.
   b. Regularly updating the database.
   c. Tracking requests to identify the community services that are:
      (1) Most needed.
      (2) Not available.

Intent Statements
The program identifies the criteria and process to be used to add or delete resources from its referral list.

Examples
This may include customer feedback, community history and recognition, proven ability to deliver services, funding resources, etc.

4.D. 15. The information call center program implements a policy defining expectations regarding:
   a. Nonendorsement of specific referrals.
   b. Fair and equitable caller-driven referrals.

Intent Statements
The referral policy identifies the program’s expectations regarding endorsement of select providers when choice exists and expectations relative to referrals that may reflect a potential conflict of interest.

4.D. 16. When applicable, the information call center program has procedures for:
   a. A referral process that provides choice to the caller.
   b. Warm transfer.

Examples
16.b. Transferring care from one provider to another involving person-to-person contact as opposed to sending a file.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written procedures related to the provision and parameters of services
- Written training plan for persons providing services
- Written procedures that match resources to service needs
- Written procedures for screening and responses to calls
- Written procedures for involvement of social support systems, including family members, and identified legal representatives
- Written statements describing crises resolutions, if applicable
- Written agreements with secondary service providers, if applicable
- Written procedures related to adding/deleting resources from the referral list and tracking requests for community services
- Policy defining expectations regarding nonendorsement of specific referrals and fair and equitable referrals
- Records of the persons served
E. Diversion/Intervention (DVN)

Description

Diversion/Intervention programs may include programs traditionally thought of as intervention that focus on changing outcomes for persons served and targeting antecedents of the problem. Diversion/Intervention programs utilize strategies designed to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Within the child welfare field, examples include alternative response, differential response, or multiple response systems. Diversion/Intervention programs may serve persons on a voluntary and/or involuntary basis. Programs that serve persons on an involuntary basis are designed to implement special strategies for engaging this population.

Diversion programs may include programs such as juvenile justice/court diversion, substance abuse diversion, truancy diversion, DUI/OWI classes, report centers, home monitoring, after-school tracking, anger management, and building healthy relationships.

Intervention programs target persons who are exhibiting early signs of identified problems and are at risk for continued or increased problems.

Applicable Standards

An organization seeking accreditation for a diversion/intervention program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section) must be applied along with standards from this subsection. If an organization is seeking accreditation for a diversion/intervention program for children or adolescents, the standards in Section 5.C. do not apply.

Examples

The program can demonstrate conformance to this standard through staff member interviews and documentation of skills and training in personnel files.

4.E. The program collaborates with other programs and stakeholders within the community to:
   a. Ensure that agencies are knowledgeable of each others’ services.
   b. Assist with the process of referrals.
   c. Coordinate community planning and development services.

Intent Statements

The program works collaboratively with other prevention, diversion, intervention, treatment, and community services to coordinate with and avoid overlapping use of community resources.

Examples

Collaboration can be demonstrated by:
- The use of the program's services by other organizations.
- Memberships on planning councils.
- Participation in multiagency United Way and other community organizations or public health activities such as health fairs.
- Participation in communitywide health education activities.

4.E. The program provides applicable information in one or more of the following areas:
   a. Mental health.
   b. Alcohol, tobacco, and other drug use.
   c. Child abuse and neglect.
   d. Suicide prevention.
   e. Violence prevention.
   f. Health and wellness.
   g. Social and community issues.
   h. Internet safety.
   i. Acceptance of cultural diversity.
   j. Effective parenting.
Examples

Information may be provided through:
- Sponsorship or participation in community events and activities.
- Participation in health fairs.
- Public service announcements.
- Community seminars and workshops.

Specific topic areas could include:
- 3.a. Stress management education; teen help lines.
- 3.b. Education regarding tobacco use, substance reduction, MADD/SADD groups, prescription drug abuse, and drug-free workplace programs.
- 3.e. Domestic violence, including interpersonal, family, and intimate partner relationships; bullying, gangs, and school-based violence.
- 3.g. Spirituality-based programs; dating issues.

4.E. Diversion/Intervention (DVN)

4. Program activities are:
   a. Culturally relevant.
   b. Age appropriate.
   c. Gender appropriate.
   d. Targeted toward multiple settings within the community.

Examples

4.d. The activities can be directed to:
- Individuals.
- Families.
- Organizations.
- Systems of care.
- The community and the region.

5. The program includes two or more of the following strategies:
   a. Increasing knowledge and raising awareness.
   b. Building skills and competencies.
   c. Increasing involvement in healthful alternatives.
   d. Increasing access to services.
   e. Improving early identification of:
      (1) Needs.
      (2) Referrals.
   f. Influencing behavioral change.
   g. Reducing incidence of problem behaviors.
   h. Changing institutional policies.
   i. Influencing how laws are:
      (1) Developed.
      (2) Interpreted.
      (3) Enforced.
   j. Building the capacity of collaborative partnerships.
   k. Building the capacity of the community to address its needs.
   l. Mentoring.

6. The program has a plan or written logic model that details:
   a. The specific theoretical approaches to be used.
   b. The methodological approaches to be used.
   c. How the approaches will be applied within the community.

Intent Statements

The program is able to document that the approach it uses has a sound theoretical foundation.

Examples

Specific theoretical or methodological prevention approaches could include the use of:
- Health and wellness models.
- Developmental models.
- Risk and resiliency models.
- Public health models.
- Social competency models.
4.E. 7. The program:
   a. Implements procedures for referring persons served to other:
      (1) Health services, as needed.
      (2) Social services, as needed.
   b. Demonstrates that personnel are knowledgeable of current community resources.
   c. Conducts evaluation of its:
      (1) Programs/services.
      (2) Training activities.

Intent Statements
7.a. If, as a result of diversion/intervention services or activities, individuals identify themselves or are identified by family members, significant others, or personnel as needing treatment, program staff members know how to refer these individuals for appropriate services.

4.E. 8. The program:
   a. Utilizes a screening or assessment process to identify individuals for participation or enrollment in the program.
   b. Includes a documented plan for individual outcomes.

Intent Statements
While it is important to accurately determine a participant’s appropriateness for the diversion/intervention program, the screening or assessment may be completed by an external entity.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written plan or logic model that details specific approaches to be used
- Plan for individual outcomes
- Documentation of evaluation of programs/services and training activities

F. Employee Assistance (EA)

Description
Employee assistance programs are work site focused programs designed to assist:

- Work organizations in addressing productivity issues.
- Employee clients in identifying and resolving personal concerns (including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues) that may affect job performance.

Employee Assistance Program Services (EAP Services) may include, but are not limited to, the following:

- Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance and outreach to and education of employees and their family members about availability of EAP services.
- Confidential and timely problem identification and/or assessment services for clients with personal concerns that may affect job performance.
- Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.
- Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.
- Assistance to work organizations in managing provider contracts and in establishing and maintaining relations with service providers, managed care organizations, insurers, and other third-party payers.
- Assistance to work organizations in providing support for employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional behaviors.
Identification of the effects of EAP services on the work organization and individual job performance.

Applicable Standards

An organization seeking accreditation for an employee assistance program must apply the standards in Sections 1 and 2 (please consult grid on page 116 for applicability), along with standards in this subsection and 3.E. Crisis Intervention (CI), Standards 7.–13. If only assessment and referral is provided, Section 2.C. Person-Centered Plan does not apply and Section 3.E. Crisis Intervention (CI), Standards 7.–13. do not apply.

4.F. The program:

a. Facilitates equal access to services by all segments of the host or contracting organization.

b. Fully discloses to the persons served the conditions that may limit confidentiality.

c. Protects the host or contracting organization's proprietary information with professional discretion and integrity.

d. Provides consultation regarding:
   (1) The management of employees.
   (2) Referral of employees with job performance and other behavioral problems.

e. Provides consultation to the host or contracting organization's leadership on issues that may impact employees' well-being.

f. Informs and educates employees.

Examples

1.a. Groups that might be excluded from services include:

- Professional and managerial staff members.
- Sales staff members or employees off site or in remote locations.
- Faculty members of educational institutions.

1.f. Methods to educate and inform employees may include:

- Providing promotional materials.
- Providing activities that encourage the appropriate use of the program.
- Providing employee orientation programs.

4.F. The components of the program are based on:

a. The agreement with the host or contracting organization.

b. An assessment of employee needs.

c. Compliance with regulatory and legislative requirements.

Examples

The design of an employee assistance program addresses issues such as:

- The type of organization.
- The organization's mission.
- The number and distribution of work sites.
- The types of jobs and work products.
- The size of the workforce.
- The size of the organization.
- Collective bargaining agreements.
- Workforce demographics.

2.c. For example, an employee assistance program that provides counseling in addition to assessment services may be defined as an Employee Retirement Income Security Act (ERISA) program.
4.F.3. The program has a written agreement with the host or contracting organization that:
   a. Defines the program’s relationship to the organization.
   b. States the scope of the program’s services.
   c. States the limitations of the program’s services.
   d. Defines the confidentiality guidelines.
   e. Defines the limits under which the employee assistance program functions.
   f. Describes the appropriate role of the program relative to the organization’s corrective and disciplinary procedures.
   g. Delineates the role of the program in all drug-testing programs.
   h. Defines the respective responsibilities and relationships of the program and any managed care functions.
   i. Identifies the criteria for referral for additional services.
   j. Describes the costs of services.
   k. Identifies a liaison from the program.
   l. Identifies a liaison from the organization.
   m. Delineates the ownership of the program records.
   n. Delineates the retention of the program records.
   o. Delineates the types of consultation that will be provided.

Intent Statements
The written agreement includes the issues described and can often be stated in a program policy. However, the policy cannot be confused with operating procedures or other contractual agreements between the host or contracting organization and the provider of the employee assistance program. When the written agreement is developed, it is consistent with the organization’s other policies, such as those addressing disciplinary actions, workers’ compensation, a drug-free workplace, and the ADA, when applicable.

4.F.4. When the written agreement includes a program advisory process within the host or contracting organization, it:
   a. Provides for the involvement of all key segments of the workplace.
   b. Includes representation from the leadership of:
      (1) The organization.
      (2) Labor organizations.
   c. Reflects the employee population’s:
      (1) Genders.
      (2) Ethnicity.
      (3) Cultural diversity.
   d. Describes the program’s scope, purpose, and operation.
   e. Ensures equal access to services by all segments of the organization.

Intent Statements
Program acceptance by the host or contracting organization is enhanced by involving the organization’s leadership, employees, unions, and other key personnel.

Examples
The advisory process can provide advice regarding:
- Goals and objectives.
- Program design and implementation.
- Outcomes management.
- Use of services.
- Confidentiality issues.
- Issues of diversity.
- Advocacy.

4.F.5. The employee assistance program is provided by an identifiable delivery system that includes provisions for:
   a. Making services available in designated areas.
   b. Assigning qualified staff members to the program.
c. Using an environment that supports the program philosophy.

Intent Statements

The intent of this standard is to ensure that employee assistance program services are not delivered through inappropriate channels and do not become integrated into and de-emphasized in either the host or contracting organization’s system or the healthcare delivery system. The system for delivering employee assistance program services is distinct from other divisions of the host or contracting organization and other systems, such as the organization’s department of human resources and the managed care system.

4.F. 6. Each external and consortium program identifies a program liaison from the host or contracting organization.

Intent Statements

Employee assistance program staff members who are external to the host or contracting organization need one designated individual employed by the host or contracting organization to act as the liaison. This individual is often located in the medical or human resources department.

4.F. 7. When considering the addition of new services, the program ensures that the services are consistent with the employee assistance program’s goals and objectives.

Intent Statements

Employee assistance professionals and program staff members are most useful to host or contracting organizations and their employees when they are proactive in identifying and responding to emerging needs. It is suggested that services designed to meet these emerging needs be incorporated into the employee assistance program as long as they do not reduce the effectiveness or perceived neutrality of the employee assistance professionals or program staff members. The employee assistance professionals may assist in the design and location of services for which a need has been identified.

4.F. 8. All employee assistance program personnel:

a. Have an understanding of employee assistance program-related functions.

b. Have training in employee assistance program-related functions.

c. Maintain their skills and abilities.

Examples

8.b. Such training may include:

- Organizational dynamics.
- Employee assistance program practice.
- Mental health issues.
- Alcohol and drug use assessment and treatment.
- Human resources.
- Labor relations issues.

8.c. Knowledge and skills may be obtained and upgraded through a variety of means, including:

- Formal training.
- Inservice training.
- Participation in professional associations.

4.F. 9. Individuals who provide employee assistance services are:

a. Certified employee assistance professionals, or

b. If not certified, have one of the following:

   (1) Supervision by a certified employee assistance professional.

   (2) A training plan that demonstrates progress toward the achievement of competencies in employee assistance.

Intent Statements

The intent of this standard is to ensure that accredited employee assistance programs support individual providers in obtaining and maintaining the unique skills and knowledge base of certified employee assistance professionals.
4.F. Written procedures describe the type of information the host or contracting organization may receive from the program, including:
   a. The circumstances under which information is communicated.
   b. The persons authorized to request or release information.
   c. The need to obtain the consent of the persons served.
   d. The need to adhere to state, provincial, and federal confidentiality guidelines.

Examples
Such information can be included in the written agreement, program policies, contract, or operating procedures of the program.

4.F. The program is prepared to assist the host or contracting organization in the development and implementation of policies regarding:
   a. The threat of workplace violence.
   b. Critical incidents.
   c. Diverse crisis situations.

Intent Statements
If program personnel do not have training and expertise in these areas, the program can contract for these services.

4.F. When appropriate, with the consent of the person served, communication is maintained with a representative of the host or contracting organization throughout the employee assistance process.

Intent Statements
Communication is maintained during all stages, including:
   - Assessment.
   - Referral.
   - Treatment.
   - Reintegration.

4.F. If specified in the written agreement with the host or contracting organization, personnel are trained in:
   a. The scope of the program.
   b. The procedures for referral.

Intent Statements
Personnel include supervisors, management, and union personnel. The intent of training is to encourage supervisors to fulfill their role in early recognition, intervention, and appropriate referral to the employee assistance program. The role of a supervisor is to focus on employees' job performance, not on diagnosis of personal problems. Training may be delivered in a variety of ways depending on the host or contracting organization's corporate culture and other factors affecting the organization.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- A written agreement between the host or contracting organization and the employee assistance program
- The credentials of individuals providing the employee assistance program services
- Written procedures describing the type of information the host or contracting organization may receive
- Policies regarding safety threats
- Documentation of each person's consent
G. Prevention (P)

Description
Prevention programs are proactive and evidence-based/evidence-informed, striving to reduce individual, family, and environmental risk factors, increase resiliency, enhance protective factors, and achieve individual and comprehensive community wellness through a team or collaborative approach. Prevention programs utilize strategies designed to keep individuals, families, groups, and communities healthy and free from the problems related to alcohol or other drug use, mental health disorders, physical illness, parent/child conflict, abuse or neglect, exposure to or experience of violence in the home and community; to inform the general public of problems associated with those issues, thereby raising awareness; or to intervene with at-risk individuals to reduce or eliminate identified concerns. Programs may be provided in the community, school, home, workplace, or other settings.

Organizations may provide one or more of the following types of prevention programs, categorized according to the population for which they are designed:

- **Universal** programs target the general population and seek to increase overall well-being and reduce the overall prevalence of problem behaviors, and include comprehensive, well-coordinated components for individuals, families, schools, communities, and organizations. Universal prevention programs promote positive behavior and include social marketing and other public information efforts.

- **Selected** programs target groups that are exposed to factors that place them at a greater than average risk for the problem. These programs are tailored to reduce identified risk factors and strengthen protective factors.


- **Training** programs provide curriculum-based instruction to active or future personnel in human service programs. Examples of training programs include caseworker training, child welfare supervisory training, foster parent training, leadership training, guardian/guardian ad-litem training, and childcare assistant training.

Applicable Standards
An organization seeking accreditation for a prevention program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 116 for applicability of standards in this section) must be applied along with standards from this subsection.

If the program is strictly a training program and no direct services to persons served are provided, Standard 6. is not applicable.

If an organization is seeking accreditation for a prevention program for children or adolescents, the standards in Section 5.C. do not apply.

4.G. 1. **Services are designed by personnel with demonstrated skill and knowledge in current evidence-informed/evidence-based prevention theory and practice.**

Examples
The program can demonstrate conformance to this standard through staff member interviews and documentation of skills and training in personnel files.

4.G. 2. **The program includes efforts to increase public awareness in one or more of the following areas:**
   a. Mental health.
   b. Alcohol, tobacco, and other drug use.
   c. Child abuse and neglect.
   d. Suicide prevention.
   e. Violence prevention.
   f. Health and wellness.
   g. Social/community issues.
   h. Internet safety.
i. Acceptance of cultural diversity.

j. Effective parenting.

Intent Statements
For training programs, efforts are targeted to prepare personnel to provide services in one or more of the areas identified.

Examples
Public awareness efforts may include:
- Sponsorship of or participation in community events.
- Participation in health fairs.
- Public service announcements.
- Community seminars and workshops.

Specific topic areas could include:
- 2.a. Stress management education; teen help lines.
- 2.b. Education regarding tobacco use, substance reduction, MADD/SADD groups, prescription drug abuse, and drug-free workplace programs.
- 2.e. Domestic violence, including interpersonal, family, and intimate partner relationships; bullying, gangs, and school-based violence.
- 2.g. Spirituality-based programs; dating issues.

4.G. 3. Program activities are:
   a. Culturally relevant.
   b. Age appropriate.
   c. Gender appropriate.
   d. Targeted toward multiple settings within the community.

Examples
3.d. The activities can be directed to:
- Individuals.
- Families.
- Organizations.
- Systems of care.
- The community and the region.

4.G. 4. Universal and selected programs include two or more, and training programs include a.–g., of the following strategies:
   a. Increasing knowledge and raising awareness.
   b. Building skills and competencies.
   c. Increasing awareness of healthy alternatives.
   d. Increasing awareness of available services.
   e. Improving early identification of:
      (1) Needs.
      (2) Referrals.
   f. Influencing behavioral change.
   g. Reducing incidence of problem behaviors.
   h. Changing institutional policies.
   i. Influencing how laws are:
      (1) Developed.
      (2) Interpreted.
      (3) Enforced.
   j. Building the capacity of collaborative partnerships.
   k. Building the capacity of the community to address its needs.

Intent Statements
Prevention, consultation, education, and training services typically employ a variety of strategies.

Examples
4.i. Programs may work to influence development or enforcement of laws such as curfews or laws related to use of seat belts or bicycle helmets.

4.G. 5. The program has a plan or written logic model that details:
   a. The specific theoretical approaches to be used.
   b. The methodological approaches to be used.
   c. How the approaches will be applied within the community.
Intent Statements
The program is able to document that the approach it uses has a sound theoretical foundation.

Examples
Specific theoretical or methodological prevention approaches could include the use of:
- Health and wellness models.
- Developmental models.
- Risk and resiliency models.
- Public health models.
- Social competency models.

4.G. 6. The program:
   a. Implements procedures for referring persons served to other:
      (1) Health services, as needed.
      (2) Social services, as needed.
   b. Demonstrates that personnel are knowledgeable of current community resources.
   c. Conducts evaluation of its:
      (1) Programs/services.
      (2) Training activities.

Intent Statements
6.a. If, as a result of education and awareness activities, individuals identify themselves or are identified by family members or significant others as needing treatment, program staff members know how to refer these individuals for appropriate services.

4.G. 7. Training programs document a written comprehensive curriculum for each course offered that guides the training and includes:
   a. The course philosophy.
   b. The course outline.
   c. Competency-based objectives.
   d. Instructional methods and materials.
   e. The sequence and hours of instruction.
   f. Clinical/practicum expectations, if applicable.
   g. A revision schedule and methodology.

Examples
7.g. The course is reviewed and revised on an annual basis through the use of course evaluation feedback, trainees’ successful completion rate, and subject matter content changes.

4.G. 8. Training programs:
   a. Utilize an expert advisory committee.
   b. Satisfy regulatory requirements leading to certification, as applicable.
   c. Focus on the care of the persons served.
   d. Identify educational and other prerequisite requirements.
   e. Utilize consistent evaluation.
   f. Provide a coordinated, logical learning experience.

Intent Statements
8.c. The focus and emphasis of the training is to provide instruction and tools to the trainees so they will provide quality care to the persons served.

Examples
8.a. A recognized expert/teacher in the field who is external to the program, an external administrator, and an external service provider meet biannually to review the curriculum and the program’s policies and procedures in order to support utilization of the latest research and accepted practices.

8.f. The program provides the theoretical basis of the curriculum prior to teaching the application of that knowledge in a practical, hands-on manner. The trainee learns the stages of grieving and methods of counseling before applying these skills to a person served.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written plan or logic model that details specific approaches to be used
- Documentation of evaluation of programs/services and training activities

H. Supported Living (SL)

Description

Supported living addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of persons living in their own homes (apartments, townhouses, or other residential settings). Supported living services are generally long term in nature, but may change in scope, duration, intensity, or location as the needs and preferences of individuals change over time.

Supported living refers to the support services provided to the person served, not the residence in which these services are provided. A sample of these sites will be visited as part of the interview process of the person served. Although the residence will generally be owned, rented, or leased by the person who lives there, the organization may occasionally rent or lease an apartment when the person served is unable to do so.

Typically, in this situation the organization would co-sign or in other ways guarantee the lease or rental agreement; however, the person served would be identified as the tenant. The home or individual apartment of the person served, even when the organization holds the lease or rental agreement on behalf of the person served, is not included in the survey application or identified as a site on the accreditation outcome.

Note: The term home is used in the following standards to refer to the dwelling of the person served; however, CARF accreditation is awarded based on the services provided. This is not intended to be certification, licensing, or inspection of a site.

Applicable Standards

An organization seeking accreditation for a supported living program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

Note:

- Standard 1.H.7. in Section 1 is not applied to supported living residences.
- Standards 1.H.13. and 1.H.14. in Section 1 are applied to the supported living residence only when the organization owns the home.
If any clarification is needed, please contact a resource specialist in the Behavioral Health customer services unit.

4.H. 1. Based on the needs of the persons served, assistance is offered in securing or maintaining housing that is:
   a. Safe.
   b. Affordable.
   c. Accessible.
   d. Chosen by the individual.

Intent Statements
   Although these services are provided to persons in their own homes, it may or may not be necessary for the provider to offer assistance in locating an appropriate location.

4.H. 2. In-home safety needs of persons served are addressed with respect to:
   a. Environmental risks.
   b. Abuse and/or neglect inflicted by self or others.
   c. Self-protection skills.
   d. Medication management.

Intent Statements
   Health and safety risks may be greater in this type of residential support service. This standard amplifies those in Section 1.H. and should be considered in their context.

4.H. 3. Persons served have input into:
   a. Where they live.
   b. With whom they live.

Intent Statements
   These elements of interdependence and self-determination are fundamental to the concepts of supported living and will enhance satisfaction results for the persons served.

4.H. 4. Persons served determine the décor in their homes.

4.H. 5. Support personnel are available based on the needs of the person served, as identified in the person-centered plan.

Intent Statements
   Supported living services may be up to 24/7/365 support, depending on local regulatory requirements and definitions. This is individualized to each person’s specific needs.

4.H. 6. Support personnel collaborate with the person’s support network, as directed by the person served.

Intent Statements
   This standard defines the amount of control the person served has over the living supports.

4.H. 7. A system is in place to provide access to needed services 24 hours a day, 7 days a week.

Intent Statements
   Refer to Standard 5. above. The extent of service support is determined by the needs of the individual and based on the program plans, local definitions, and regulations.

4.H. 8. Based on the needs and desires of the person served, support is offered in the following areas:
   a. Healthy lifestyles.
   b. Personal care.
   c. Home maintenance.
   d. His or her role as a tenant, when applicable.
   e. Effective self-advocacy and decision making.
   f. Family contact, if desired.
   g. Social life and friendships/relationships.
   h. Community membership and social networks.
   i. Financial stability.
   j. Other identified needs.
Intent Statements

Supported living services may be more inclusive of life needs than traditional residential support for basic food and shelter requirements.

Examples

8.b. This may include assistance with daily needs, personal hygiene, shopping, meal preparation, selection of wardrobe, and/or personal belongings.

4.H. 9. Persons served are provided opportunities to choose and access:
   a. Community activities.
   b. Cultural activities.
   c. Social activities.
   d. Recreational activities.
   e. Spiritual activities.
   f. Employment/income generation activities.
   g. Transportation, when necessary.
   h. Other.

4.H. 10. The organization provides information to residents that includes:
   a. How to access community resources if needed.
   b. Safety issues related to the service delivery site.
   c. Access to emergency care when it is needed.
   d. Specific healthcare procedures and techniques.
   e. Contingency plans in case either the support system or the service provider is unable to deliver care.
   f. A review of how to deal with emergencies and evacuation from the residence.

Note: Standard 10 applies only to programs provided in apartment-type situations where agency staff do not reside at the site.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Records of the persons served
- Person-centered plans
- Progress notes
- Health and safety information
- Procedures manual
SECTION 5

Specific Population Designation Standards

Guidelines for Organizations Seeking a Specific Population Designation

If an organization is required or chooses to add one of the following Specific Population Designations to a core program(s) being surveyed, the standards for these designations will be applied at the time of the survey in addition to the core program standards. See Sections 5.A.–I. for applicable standards.

The Specific Population Designations available are:

- 5.A. Adults with Autism Spectrum Disorder (ASD:A)
- 5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)
- 5.C. Children and Adolescents (CA) (may be required—see following note)
- 5.D. Consumer-Run (CR)
- 5.E. Criminal Justice (CJ) (may be required—see following note)
- 5.F. Eating Disorders (ED) (includes Eating Disorders for Children/Adolescents (EDCA—see following note)
- 5.G. Juvenile Justice (JJ) (may be required—see following note)
- 5.H. Medically Complex (MC) (May be required; includes Medically Complex for Children/Adolescents (MCCA)—see following note)
- 5.I. Older Adults (OA)

NOTE: If children or adolescents (up to age 18) are served in any behavioral health core program (except Crisis or Information Call Centers, Diversion/Intervention, or Prevention) for which the organization is seeking accreditation, the standards in Sections 5.C. Children and Adolescents (CA) or 5.G. Juvenile Justice (JJ) must be applied, except when the Specific Population Designation of 5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C) is applied.

An organization seeking accreditation for an Eating Disorders program for Children/Adolescents (EDCA) must apply the standards in Sections 5.C. and 5.F.

If an organization is seeking accreditation for a Crisis or Information Call Center, Diversion/Intervention, or Prevention program that serves youths under 18 years of age, it is not necessary to apply the standards in Section 5.C. or 5.G., as they are intended for treatment-oriented programs that admit or enroll the persons served.

If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the standards in Section 5.E. Criminal Justice (CJ) (or 5.G. Juvenile Justice (JJ), for populations under 18 not tried as adults) must be applied.

If a core program for which the organization is seeking accreditation is designed primarily to serve persons who meet the definition of medically complex, or the program serves only this target population, the medically complex standards must be applied.

Organizations seeking accreditation for a core program for children/adolescents who meet the definition of medically complex (MCCA) must apply the standards in Sections 5.C. and 5.H.
A. Adults with Autism Spectrum Disorder (ASD:A)

Description

Supports for adults with autism spectrum disorder (ASD:A) enhance accessibility and community membership opportunities for adults with ASD. Education, employment, residential, social, and recreational opportunities; identification from research of successful techniques to apply to service provision including treatment and intervention research; and lifelong planning are means to achieve full inclusion and participation.

Standards for ASD services and supports present a roadmap for successful outcomes in the lives of persons with ASD by encouraging organizational values that focus on individualized, person-centered services for persons to achieve full inclusion and participation as desired in their communities. Services involve families, networks of resources, and education and support communities for older adolescents transitioning to adulthood and adult persons with ASD.

The standards in this section focus on planning for transitions and development of supports as needed for persons with ASD, with the outcomes of employment, further education, community living, and life planning.

Some of the quality results (outcomes) desired by the different stakeholders of ASD services may include:

- Creating and supporting lifelong self-advocacy skills.
- Developing supports and community resources for persons and families.
- Enhancing quality of life by increasing social contacts and support communities.
- Encouraging service provider capacity building by networking with governmental, educational, business/employer, and other community resources.
- Recognizing and sharing reliable evidence-based knowledge, innovations, interventions, and therapies with proven, research-based, and peer-reviewed track records of getting results.
- Planning for transition from school to successful employment and community living supports.
- Individualized, comprehensive life planning that is transferred to other service providers to ensure continuity of service planning and supports.
- Persons served moving toward:
  - Optimal use of natural supports.
  - A social supports network.
  - Self-help.
  - Greater self-sufficiency.
  - Greater ability to make appropriate choices.
  - Greater control of their lives.
  - Increased participation in the community.
  - Employment and/or continued education.

NOTE: The Specific Population Designation of Adults with Autism Spectrum Disorder (ASD:A) is typically applied if the population served is at the age of majority or older.

If the population served is individuals from birth to the age of majority, the standards in Section 5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C) typically would be applied.

CARF allows that there may be services provided to adolescents and adult persons who are technically in transition range from one category to the other and does not require strict adherence to these age cutoffs. This would be identified in the program’s scope of services.

Applicable Standards

If an organization chooses to add the specific population designation for Adults with Autism Spectrum Disorder to an appropriate core program in Section 3 or 4, it must apply the standards in this section in addition to the applicable standards for the core program in Section 3 or 4.
5.A. 1. The program:
   a. Remains current with ASD research findings.
   b. Communicates identified benefits of research to staff and families, as appropriate.
   c. Bases education and services on reputable, evidence-based research findings.
   d. Utilizes peer-reviewed and accepted practices to establish treatments that are helpful to the person and family.
   e. Monitors outcomes of services to evaluate treatment efficacy and monitor possible negative effects of interventions.

Intent Statements
   1.c. and 1.d. Reputable, evidence-based research and peer-reviewed and accepted practices include research that has indicated successful techniques and field recognition from professionals and advocacy organizations.

   Through its active efforts the organization promotes increased community understanding and opportunities for persons with ASD. Persons are part of the community and are included without a label.

Resources
   ■ The publication Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder (PDF file) can be found at: http://autismpdc.fpg.unc.edu/content/ebp-update.

   ■ The goal of the World Health Organization's Parent Skills Training program is to support families who lack access to adequate professional autism care for whatever reason. It involves a system of master trainers and community facilitators who provide parents and other caregivers with evidence-based strategies for working with children who have autism and other developmental disabilities: www.autismspeaks.org/blog/2016/09/12/bringing-who-parent-skills-training-united-states?utm_source=social-media&

   utm_medium=text-link&utm_campaign=espeaks

   ■ Google Scholar (http://scholar.google.com) is a good starting point for locating the latest, most relevant information and abstracts.

5.A. 2. The program:
   a. Acts as an informational resource for community professionals regarding ASD.
   b. Promotes community awareness of ASD that:
      (1) Respects individuals with ASD.
      (2) Supports increased community integration and participation of persons with ASD.
   c. Advocates for resources that are knowledgeable about ASD.

Examples
   2.a. Community professionals may include educators, therapists, and medical personnel. The organization provides opportunities for schools and teachers to receive training on evidence-based practices in ASD, including:

   ■ Strategies for teaching interdependence.
   ■ Building on successes and rewards.
   ■ Establishing educational philosophies that focus on the child and understanding the family.
   ■ Resources for additional support/professional consultation.
   ■ Generalization intervention methods across settings.

   2.b. The organization promotes community awareness, understanding, and acceptance of ASD through education in its newsletter and other media publications, ability awareness celebrations, community trainings, public service announcements, and other events.

   The organization promotes awareness of the contributions of individuals with ASD to their communities and the workforce.

   Educational efforts can help move some focus on “autistic traits” of individuals from the negative to the positive; e.g., persons who are nonverbal...
don’t have lengthy conversations around the water cooler with coworkers. Efforts could also include development of an inclusive-community curriculum that addresses successful transition planning from a student, parent, and community perspective.

The U.S. Centers for Disease Control and Prevention (CDC) launched a campaign to make doctors and parents aware of the need for early diagnosis of autism. The CDC has distributed posters and checklists to doctors that describe developmental milestones for each age and also developed a distribution kit to help volunteers reach local media outlets.

5.A. Initial and ongoing training is provided for staff on:
   a. Understanding ASD.
   b. Evidence-based/generally accepted interventions for ASD.
   c. Needs of families with children with ASD, when appropriate to the ages served.
   d. Supports that are available for families as well as the person with ASD.
   e. Communication techniques.

Intent Statements
Professionals should be knowledgeable about the range of treatment options and supports that may be offered in order to educate families about evidence-based versus nonevidence-based interventions.

Examples
3.a. and 3.e. Includes understanding of relationship-based models; sensory processing, visual-spatial and language/auditory processing issues; and use of alternative means of communication.
3.b. The organization follows new research and new interventions, staying up to date on what is developing in the field and implementing new approaches as evidence-based and accepted interventions change.

5.A. Program personnel providing services demonstrate required competency related to:
   a. The needs of persons with ASD.
   b. The requirements of the job.
   c. Training specific to the service provided.

Intent Statements
The organization identifies the extent of its services and the required expertise of personnel to support the population served.

5.A. Strategies for reasonable accommodations include, as needed, the use of assistive technology or adaptations in:
   a. Communications.
   b. Environmental control.
   c. Mobility, orientation, or destination training.
   d. Education and training.
   e. Activities of daily living.
   f. Employment.
   g. Recreation.
   h. Sensory needs.
   i. Transportation.
   j. Other needs as identified by:
      (1) The person/family served.
      (2) Specialists working with the person/family.

Intent Statements
Assistive technology and other reasonable accommodations enable persons served to have increased access to or participation in life, employment, education, and/or inclusion in the community.

Examples
Assistive technology is considered in all aspects of services, including:
- Diagnosis.
- Treatments.
- Training.
- Transition to school.
- Education.
■ Life planning.
■ Improving communication.

The organization acts as a resource for parents to understand available options and choose appropriate assistive technology based on research and advice from qualified assistive technology professionals. In some instances, families may not have the experience or knowledge necessary to make informed decisions, and the organization helps the families served to choose wisely.

Examples include communication devices, communication “books” and booklets, and sign language; sensory sensitivity accommodations; handheld devices and computers; travel training; cellular phone communication; independent living skills; supported and independent employment including micro-enterprise and part time work; gym and sports activities; and public and other alternative opportunities for travel.

5.j. Might include providing tools for visual supports, such as visual schedules, First Then Visual Schedule, etc. Visit www.autismspeaks.org/family-services/resource-library/visual-tools for additional information and resources.

5.A. 6. If assistive technology services are provided, the assistive technology:

a. Is based on a comprehensive evaluation that considers the person’s needs and preferences.

b. Is individualized to the person.

c. Considers the principle of universal design.

d. Is appropriate to the environment and setting.

e. Identifies resources and assists with financial planning.

f. Sets up training as needed.

g. Includes planning for allocation of resources and related replacement costs.

h. Identifies resources and contacts for repairs and troubleshooting.

Intent Statements

Assistive technology planning is individualized and considers the person’s interests, involves the family in reviews of the home environment and other natural settings, and takes into account long-term costs for servicing and potential replacement. Planning also considers the nature of the disability and factors such as changing medical needs and changes in needs as the person grows older.

Examples

6.c. Includes consideration of adaptations other than technology that could work for families with limited budgets or funding.

6.d. Consideration of the environment and setting includes all functional environments as appropriate to the person, such as the home, childcare providers, preschool or other educational settings, community activities, and vocational or employment settings.

5.A. 7. Assitive technology and adaptations are considered in:

a. Treatments.

b. Training.

c. Transition to/from school, as appropriate.

d. Education.

e. Life planning, as relevant to the needs of the person served and the scope of the program.

f. Improving communication.

Intent Statements

The organization acts as a resource for families to understand available options and choose appropriate assistive technology based on research and advice from qualified assistive technology professionals.

Examples

Leading organizations apply technology that is available for everyday use to expand options for persons served. Today’s technology offers options to assist with cognition, communication, health, organization, and general living. Available tools in the general marketplace help us stay connected, work from anywhere, and be productive. Computers and cell phones come loaded with what was once considered “AT.”
7.c. Assistive technology services include coordination of technology used at home, in the community, and at school to ensure consistency.

5.A. 8. Based upon individual needs and desires, the services facilitate connections for persons and/or families served to community resources that offer:
   a. A variety of life experiences.
   b. Opportunities for community access.
   c. Opportunities for community inclusion.

Intent Statements
The persons served have opportunities to develop or increase social contacts, new supports, and community networks.

Examples
The organization provides individualized services and it supports community membership and inclusion as goals, but the extent is determined by the desires of each person served.

5.A. 9. Information about the person is obtained, maintained, and, with the consent of the person served, shared with other providers or educators when related to services the person is receiving or transition to other services, that includes:
   a. Strengths, abilities, and successes.
   b. Relevant medical information, as available.
   c. Psychological information, as available.
   d. Social information.
   e. Successful strategies to support learning, behavior, communication, and building social networks.
   f. Person-specific situations that should be accommodated.
   g. Key professionals involved in providing services to the individual.

Intent Statements
By sharing the successful experiences, service approaches, and desires of the person served, consistency and greater continuity of services during transitions in the person’s life are possible.

Examples
Information may include individual education plans, individual service plans, individual program plans, consultations, and allied health service reports.
Information may be collected regularly through behavioral data collection and presentation at individual program plan meetings with the individual and other significant stakeholders.
Information includes the “must haves” in the person’s life, e.g., sensory considerations such as low lighting or soft music and personal items important to the person such as a favorite baseball cap.

5.A. 10. As appropriate to the services provided, the program provides or participates in transition planning for the persons served.

Intent Statements
Timely planning for transitions is a critical element to support persons when the environment is changing.

Examples
Preferred practices indicate that if transition-from-school planning begins at least by age fourteen, the likelihood of successful transition is enhanced. In general, transition planning may be better beginning at an even earlier point based on individual needs. Families must also be included in the planning process for transitions as it can be as difficult for the family to transition their young adult into adult services as it is for the individual. This planning is further beneficial at an earlier age because the waiting list for some services may be quite long.

5.A. 11. The services assist persons and/or families served in enhancing their quality of life by providing or connecting them to opportunities to develop and/or increase as desired:
   b. Personal relationships.
c. Community supports.
d. Supports from peer mentors, alumni from the program, or self-advocates with real life experiences.

Intent Statements
The persons and/or families served are included in their communities to the degree they desire.

Examples
Opportunities are based on the unique learning style of each individual and the need for individualized supports. Peer mentors add the dimension of persons with ASD who understand the personal needs of a person with ASD. Families are provided with opportunities to meet with other families who have participated or are participating in the program. Families often benefit from parent-to-parent support that can be accessed from a family support network component.

Based on the level and age of the person served, there could be great variability in availability and involvement of the family or in the desire of the person served to have the family involved.

The organization could assist families served, as desired, to:
■ Develop a personal circle of advocates.
■ Have opportunities for parent-parent supports and networking.
■ Locate referral resources for specialized and generic care.

Examples include developing natural supports at an individual’s place of employment, significant relationships with staff, clergy, other family members, and members of local chapters of advocacy organizations; e.g., Society of America, the Arc, Autism Canada (www.autismcanada.ca), Society for Treatment of Autism (www.autism.ca), and U.S. Autism & Asperger Association (www.usautism.org). The organization may link the family to an appropriate community agency that can assist with this.

State/provincial agency personnel may provide information and training on community resources and benefits planning; funding and program opportunities; foundation grants; referrals to insurance agencies, financial and estate planners, and allied health professional resources in the areas of speech, behavioral, occupational, and physical therapies; and autism-specific resources.

5.A. The services provide information about or referrals to community resources to persons served, as desired, in the areas of:

a. Educational development.
b. Living skills development.
c. Interpersonal relations.
d. Recreation and leisure time opportunities.
e. Vocational development, employment, or career advancement.
f. Access to generic community resources.
g. Housing.
h. Transportation.

Intent Statements
Through providing information about or referrals to supports, the organization facilitates growth and development in the personal lives of persons served. Services enhance opportunities for independent and productive living.

Examples
By addressing these areas, services seek to counter a problem identified in professional journals that “… completion of high school means isolation and restricted social contexts for transitioning youth and young adults on the autism spectrum as they lose access to peer groups.” (Crabtree, L., OT Practice, Volume 16, Issue 12.)

Information might be provided in different ways, such as using an existing community resource directory or a compilation by United Way. This information could give persons access to supports as desired to enhance independent living skills, money management skills, communication skills, social interactions, exercise, community employment opportunities, housekeeping activities, hygiene, food shopping, meal preparation, reduction of maladaptive behaviors,
and use of community resources, e.g., library or gym.

Providers are encouraged to offer safety-and-risk life skills education early and often, suited to the person’s ability and learning styles. For some persons with ASD, learning how to disclose is a key to their personal safety during a high risk situation, such as a sudden interaction with law enforcement professionals. Without disclosure, accommodation would be difficult to get.

Anticipating disruptive behaviors that might occur in the community can facilitate ensuring prior training for staff members, an adequate ratio of personnel to persons served participating in the activity, and advance planning for an emergency situation.

12.a. Services seek to address a problem identified in professional journals that “Many students on the autism spectrum are being admitted to higher education, but they lack the social and organizational skills to be successful.” (Van Bergeijk, E., Kim, A., & Volkmar, F. (2008) Supporting more able students on the autism spectrum: College and Beyond. Journal of Autism and Developmental Disorders, 8.)

12.f. Generic community resources are resources in the community that are used by the general population without disabilities, and may include local, state/provincial, or federal financial resources.

Examples

Quality of life is specific to and defined by each person and/or family served. Skills and supports to enhance quality of life will be determined and their effectiveness reported by persons and families served.

Accessibility to forums of self-determination and decision making is key to meeting the needs of persons with ASD.

Support for advocacy activities may be provided within the organization, through support for participation in activities such as consumer councils, or support for self-facilitation of a person’s individual planning meeting; or in the community, through support for participation in activities sponsored by advocacy groups; or support in self-advocacy to access benefits, services, etc. These examples of self-direction are not the only means by which support for advocacy may be provided.

An important first step is ensuring that persons served feel safe in their environment before they explore opportunities to enhance their advocacy skills. There also must be a strong emphasis on communication, including teaching how to communicate, providing tools with which to communicate, and making sure that communication systems are part of every plan. Self-advocacy does little without the ability to communicate. Likewise, due to prevalent dysfunction in choice-making being one of the characteristics of autism, choice-making may have to be taught through supports and experience.

For some persons who are not capable of participating themselves, this might include significant others, i.e., family, friends, or respite providers. This might include the concept of creating a support circle, as many families are isolated and don’t have anyone other than themselves to support the individual with autism.

13.a. Examples of self-advocacy may include attending and participating in individual program plan meetings, goal development, employment opportunities, participating in community meetings, attending human rights conferences and trainings, membership on human rights committees and other organizational boards, participating in group leisure

Resources

A website offering some suggestions on risk management specific to the population with ASD is [www.autismriskmanagement.com](http://www.autismriskmanagement.com).

5.A. 13. Self-advocacy support services are individualized to each person served and his/her family and include:

   a. Self-advocacy skills training and support systems.
   
   b. Developing new skills and supports on an ongoing basis, including self-determination.

Intent Statements

Support is given to persons and families served for development of their advocacy skills.
activities and travel, participating in political events and voting, and participating in safety committees. Alternative methods, e.g., non-verbal communication, for self-advocacy may be used. Depending on the persons served, efforts may focus on very basic skills such as communication of basic wants and needs.

5.A. As relevant to the desires of the persons served and the scope of the program, life planning:

a. Is updated and adjusted:
   (1) As the life of the person served changes.
   (2) At least every two years.

b. Considers:
   (1) Concerns of the person and family.
   (2) Resources.
   (3) Priorities.
   (4) Expectations.
   (5) Beneficial activities.
   (6) Alternatives.

Intent Statements
As ASD is considered to be a lifelong condition, some persons will need long-term support services. Life planning for these persons documents future expectations for the person served as they transition through life’s stages and the family situation changes.

Examples
A wealth of information is available on the internet by searching “Life planning in ASD” or “ASD life planning.”

Based on the preferences and needs of the person served, life planning services may include:
- Direct guidance or participation to the extent desired by the person served.
- Outreach/facilitation to encourage the active participation of the person served.
- Coordination of, or assistance with, crisis intervention and stabilization services as appropriate.
- Assisting the person served to achieve goals for independence as defined by the person.
- Optimizing resources and opportunities through community linkages and enhanced social support networks.
- Exploring living options reflective of the individual desires of the person.
- Exploring employment, career changes, or educational activities, as desired by the person.
- Planning for anticipated transitions as soon as the person enters services.

The life plan is individualized and person-centered and may include long-term planning considerations such as:
- Support for caregivers, including those who may themselves have special needs related to aging.
- Medical and other healthcare issues.
  Medicaid and Medicare in the United States, provincial/territorial health insurance systems in Canada, and private insurance are critical life-planning concerns.
- Financial and estate planning.
  Wills and trusts and estate planning should also be considered to protect the parent and the child. Appropriate estate planning may be one that provides persons served with access to assets, while simultaneously protecting Supplemental Security Income (SSI) and Medicaid eligibility. Life insurance is an essential part of a complete financial plan and ensures protection in case of the loss of a parent.
- Guardianship.
- Family supports, including sibling supports if applicable.
- Living arrangements, including social, recreational, and community involvement.
  This may include real estate rental or purchase, choice of group home, living with family, and residential staff supports.
- Career or educational development.
  Learning and development is a life-long process. Higher education, community college, vocational education, and individualized training should be part of a life plan.
Independent, competitive employment; supported community employment; sheltered workshops; natural supports; day activities; etc., and all issues affecting life planning. Impairment-related work expenses and targeted tax credits are incentives for employment for both the individual served and the employer.

- Referral to resources for assistance in resolution of family conflicts.
- Implementing the life plan.

The life planning process considers daily living activities including, as appropriate:
- Communication.
- Budgeting.
- Meal planning.
- Personal care.
- Housekeeping and home maintenance.
- Financial services.
- Medical and dental needs.
- Community resources.
- Social skills.
- Recreational skills.

Recreation is an area that contributes to the health, well-being, and quality of life for each individual. Television, gym access, hobbies, travel, the arts, etc., all contribute to a healthy life plan.

- Employment skills.
- Educational opportunities.
- Use of community transportation.
- Spiritual or religious interests.

Developing a way of living and working that brings inner peace, humility, gratitude, joy, and maturity while enhancing the life process and social interactions can be an essential part of the life plan.

- Safety skills.

Some organizations are assisting persons and families served to set up individual communities of supports for the person served as cooperatives. Considerations include:
- Revenues and expenses.
- Financial trends.
- Financial opportunities.
- Specifying the functions and responsibilities of each party in the cooperative.
- Management information.
- Fiscal oversight and financial solvency, including remediation plans when appropriate.

A benefits planning service can educate persons served and their families about long-term earnings, long-range budgeting, tools, and resources for ongoing benefits management.

Some persons may choose volunteerism over employment, and life planning would also apply to this.

Although the persons served are always involved, because the disability is one of deficits in both socialization and communication and many cannot express themselves and do not understand complex or abstract concepts, the inclusion of advocates and/or family is also important.

5.A. 15. The program ensures that individual benefits planning as desired by the person served is:

- Reviewed to stay current with:
  1. Changes in the person's life.
  2. Changes in regulations.
- Updated accordingly.

Intent Statements

At the time of development of or modification to a life plan, determinations are made for eligibility for funding sources, entitlements, and benefits.

Examples

Considerations may include:
- Diagnosis.
- State/provincial agencies and services provided.
- Individual transition plan (residential, vocational considerations).
- Documentation (birth certificate, Social Security (U.S.) or Social Insurance Number (Canada) card, medical diagnoses, allergies, medications, and psychological/behavioral evaluations).
Transportation.
Availability of community resources.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Records of persons served
- Individual service plans
- Progress notes
- Procedures manual
- Organizational newsletters or other communications for parents
- Documented service strategies
- Information about community resources/networks
- Advocacy training materials
- Individual personal scrapbooks of persons served
- Life plans

B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)

Description
Early identification, intervention, treatment planning, and educational strategies for children with autism spectrum disorder (ASD) remain a challenge for families, their physicians, community supports, and educational systems. Early recognition of the condition allows families to receive advice and support to help them adjust to the child’s learning and development challenges and to mobilize resources to provide the best early intervention services for the child.

Services for children and adolescents with ASD are designed to provide to the child/adolescent and family a variety of resources that reflect sound research. The family will have access to results-oriented therapies, education, advocacy, and supports for their child’s optimal progress and to establish a lifetime of positive learning and behaviors. Services involve families, networks of resources, and education and support communities for adolescents transitioning to adulthood. Individuals served under this designation may range from birth to the age of majority, although sometimes services for adolescents transitioning to adulthood are provided by programs that also serve adults. Ages served would be identified in a program’s scope of services.

Organizations with accredited services/supports for children with ASD are a resource for families, community services, and education. With the focus on continuous learning about ASD, the organization can assist parents with:
- Obtaining early intervention screening.
- Obtaining early intervention services.
- Obtaining an evaluation by clinicians experienced in evaluating children with ASD to improve treatment and outcomes.
- Navigating the multiple and complex systems that families need to coordinate, including medical, educational, mental health, disability, and community services.
Connecting to resources to identify and treat medical or other conditions associated with ASD, as they are needed, to improve independence, family well-being, and adaptive behavior.

- Gaining understanding of the core features of ASD and associated conditions.
- Adjusting and adapting to the challenges of raising a child with ASD.
- Understanding the future opportunities, services, and challenges that lay before them as they raise their child.
- Planning for transition to/from school and life planning.
- Building linkages within segments of school systems and across school systems to facilitate successful transitions between placements.
- Providing outcomes information to schools to enhance individualized education plans and employment transition planning.
- Connecting with mentors and parent-to-parent support groups or contacts.
- Connecting with community organizations and support groups dedicated to people with ASD.
- Becoming an advocate for policy changes, as desired.

**NOTE:** The Specific Population Designation of Children/Adolescents with Autism Spectrum Disorder (ASD:C) is typically applied if the population served is individuals from birth to the age of majority. If the population served is individuals at the age of majority or older, the standards in Section 5.A. Adults with Autism Spectrum Disorder (ASD:A) typically would be applied.

CARF allows that there may be services provided to adolescents and adult persons who are technically in transition range from one category to the other and does not require strict adherence to these age cutoffs. This would be identified in the program’s scope of services.

---

### Applicable Standards

If an organization chooses to add the specific population designation for Children/Adolescents with Autism Spectrum Disorder to an appropriate core program in Sections 3 or 4, it must apply the standards in this section in addition to the applicable standards for the core program in Section 3 or 4.

When an organization chooses to add the specific population designation for Children/Adolescents with Autism Spectrum Disorder to an appropriate core program in Section 3 or 4, the standards in Section 5.C. Children and Adolescents do not need to be applied.

---

### 5.B. The program:

- **a.** Remains current with ASD research findings.
- **b.** Communicates identified benefits of research to staff and families, as appropriate.
- **c.** Bases education and services on reputable, evidence-based research findings.
- **d.** Utilizes peer-reviewed and accepted practices to establish treatments that are helpful to the person and family.
- **e.** Monitors outcomes of services to evaluate treatment efficacy and monitor possible negative effects of interventions.

### Intent Statements

1. Reputable, evidence-based research and peer-reviewed and accepted practices include research that has indicated successful techniques and field recognition from professionals and advocacy organizations.

Through its active efforts the organization promotes increased community understanding and opportunities for persons with ASD. Persons are part of the community and are included without a label.

### Resources

- The National Professional Development Center on Autism Spectrum Disorder provides information and resources on evidence-based
practices: http://autismpdc.fpg.unc.edu/evidence-based-practices

- The goal of the World Health Organization’s Parent Skills Training program is to support families who lack access to adequate professional autism care for whatever reason. It involves a system of master trainers and community facilitators who provide parents and other caregivers with evidence-based strategies for working with children who have autism and other developmental disabilities: www.autismspeaks.org/blog/2016/09/12/bringing-who-parent-skills-training-united-states?utm_source=social-media&utm_medium=text-link&utm_campaign=espeaks
- Google Scholar (http://scholar.google.com) is a good starting point for locating the latest, most relevant information and abstracts.

5.B.2. The program:
   a. Acts as an informational resource for community professionals regarding ASD.
   b. Promotes community awareness of ASD that:
      (1) Respects individuals with ASD.
      (2) Supports increased community integration and participation of persons with ASD.
   c. Advocates for resources that are knowledgeable about ASD.

Examples
2.a. Community professionals may include educators, therapists, and medical personnel. The organization provides opportunities for schools and teachers to receive training on evidence-based practices in ASD, including:
   - Strategies for teaching interdependence.
   - Building on successes and rewards.
   - Establishing educational philosophies that focus on the child and understanding the family.

5.B.3. Initial and ongoing training is provided for staff on:
   a. Understanding ASD.
   b. Evidence-based/generally accepted interventions for ASD.
   c. Needs of families with children with ASD, when appropriate to the ages served.
   d. Supports that are available for families as well as the person with ASD.
   e. Communication techniques.

Intent Statements
Professionals should be knowledgeable about the range of treatment options and supports that may be offered in order to educate families about
evidence-based versus nonevidence-based interventions.

Examples

3.a. and 3.e. Includes understanding of relationship-based models; sensory processing, visual-spatial and language/auditory processing issues; and use of alternative means of communication.

3.b. The organization follows new research and new interventions, staying up to date on what is developing in the field and implementing new approaches as evidence-based and accepted interventions change.

5.B. Program personnel providing services demonstrate required competency related to:

a. The needs of persons with ASD.

b. The requirements of the job.

c. Training specific to the service provided.

Intent Statements

The organization identifies the extent of its services and the required expertise of personnel to support the population served.

5.B. Strategies for reasonable accommodations include, as needed, the use of assistive technology or adaptations in:

a. Communications.

b. Environmental control.

c. Mobility, orientation, or destination training.

d. Education and training.

e. Activities of daily living.

f. Employment.

g. Recreation.

h. Sensory needs.

i. Transportation.

j. Other needs as identified by:

(1) The person/family served.

(2) Specialists working with the person/family.

Intent Statements

Assistive technology and other reasonable accommodations enable persons served to have increased access to or participation in life, employment, education, and/or inclusion in the community.

Examples

Assistive technology is considered in all aspects of services, including:

- Diagnosis.
- Treatments.
- Training.
- Transition to school.
- Education.
- Life planning.
- Improving communication.

The organization acts as a resource for parents to understand available options and choose appropriate assistive technology based on research and advice from qualified assistive technology professionals. In some instances, families may not have the experience or knowledge necessary to make informed decisions, and the organization helps the families served to choose wisely.

Examples include communication devices, communication “books” and booklets, and sign language; sensory sensitivity accommodations; handheld devices and computers; travel training; cellular phone communication; independent living skills; supported and independent employment including micro-enterprise and part time work; gym and sports activities; and public and other alternative opportunities for travel.

5.j. Might include providing tools for visual supports, such as visual schedules like First Then Visual Schedule, etc. Visit www.autismspeaks.org/family-services/resouce-library/visual-tools for additional information and resources.

5.B. If assistive technology services are provided, the assistive technology:

a. Is based on a comprehensive evaluation that considers the person’s needs and preferences.

b. Is individualized to the person.

c. Considers the principle of universal design.
d. Is appropriate to the environment and setting.
e. Identifies resources and assists with financial planning.
f. Sets up training as needed.
g. Includes planning for allocation of resources and related replacement costs.
h. Identifies resources and contacts for repairs and troubleshooting.

Intent Statements
Assistive technology planning is individualized and considers the person’s interests, involves the family in reviews of the home environment and other natural settings, and takes into account long-term costs for servicing and potential replacement. Planning also considers the nature of the disability and factors such as changing medical needs and changes in needs as the person grows older.

Examples
6.c. Includes consideration of adaptations other than technology that could work for families with limited budgets or funding.
6.d. Consideration of the environment and setting includes all functional environments as appropriate to the person, such as the home, childcare providers, preschool or other educational settings, community activities, and vocational or employment settings.

7. Assistive technology and adaptations are considered in:
   a. Treatments.
   b. Training.
   c. Transition to/from school, as appropriate.
   d. Education.
   e. Life planning, as relevant to the needs of the person served and the scope of the program.
   f. Improving communication.

Intent Statements
The organization acts as a resource for families to understand available options and choose appropriate assistive technology based on research and advice from qualified assistive technology professionals.

Examples
Leading organizations apply technology that is available for everyday use to expand options for persons served. Today’s technology offers options to assist with cognition, communication, health, organization, and general living. Available tools in the general marketplace help us stay connected, work from anywhere, and be productive. Computers and cell phones come loaded with what was once considered “AT.”

7.c. Assistive technology services include coordination of technology used at home, in the community, and at school to ensure consistency.

5.B. 8. Based upon individual needs and desires, the services facilitate connections for persons and/or families served to community resources that offer:
   a. A variety of life experiences.
   b. Opportunities for community access.
   c. Opportunities for community inclusion.

Intent Statements
The persons served have opportunities to develop or increase social contacts, new supports, and community networks.

Examples
The organization provides individualized services and it supports community membership and inclusion as goals, but the extent is determined by the desires of each person served.

5.B. 9. Information about the person is obtained, maintained, and, with the consent of the person served, shared with other providers or educators when related to services the person is receiving or transition to other services, that includes:
   a. Strengths, abilities, and successes.
   b. Relevant medical information, as available.
c. Psychological information, as available.
d. Social information.
e. Successful strategies to support learning, behavior, communication, and building social networks.
f. Person-specific situations that should be accommodated.
g. Key professionals involved in providing services to the individual.

Intent Statements
By sharing the successful experiences, service approaches, and desires of the person served, consistency and greater continuity of services during transitions in the person’s life are possible.

Examples
Information may include individual education plans, individual service plans, individual program plans, consultations, and allied health service reports.
Information may be collected regularly through behavioral data collection and presentation at individual program plan meetings with the individual and other significant stakeholders.
Information includes the “must haves” in the person’s life, e.g., sensory considerations such as low lighting or soft music and personal items important to the person such as a favorite baseball cap.

5.B. 10. As appropriate to the services provided, the program provides or participates in transition planning for the persons served.

Intent Statements
Timely planning for transitions is a critical element to support persons when the environment is changing.

Examples
Preferred practices indicate that if transition-from-school planning begins at least by age fourteen, the likelihood of successful transition is enhanced. In general, transition planning may be better beginning at an even earlier point based on individual needs. Families must also be included in the planning process for transitions as it can be as difficult for the family to transition their young adult into adult services as it is for the individual. This planning is further beneficial at an earlier age because the waiting list for some services may be quite long.

5.B. 11. The organization provides, arranges for, or has access to early diagnostic services for children with ASD that result in:

a. A comprehensive evaluation that provides diagnosis.
b. Identification of options and referrals for appropriate treatment.

Intent Statements
Comprehensive evaluations give service providers information needed to ensure appropriate planning and services.

Examples
Comprehensive evaluations give guidance for:
- Referrals to appropriate family support services.
Family support services include providing information and education in the basics of autism immediately upon diagnosis to assist parents with understanding the condition and preparing to make informed decisions about treatment options and choices.
- Education plans for families and support systems.
Educational plans are developed with the cooperation of the school district, whenever possible, and the service provider takes an active role in planning for transition to school.
- Developmental plans for therapy and education.
- Medication management planning, if needed.
- Creation of collaborative teams for therapy and support, including as needed dietary support and sensory integration support.
- Treatment planning and intervention for behavior redirection.

Planning considers the needs of the child as well as the family/support system and encourage non-chemical therapeutic interventions.
5.B. 12. Information is available to the family to promote:
   a. Increased awareness and understanding of ASD by parents and siblings.
   b. Referral to and use of appropriate therapies.
   c. Connections to educational and medical resources.
   d. Communications with other families and persons with ASD.
   e. Identification of appropriate community resources.
   f. Involvement and adjustment of family members.
   g. Empowerment of the family to make decisions.
   h. Opportunities for family members and caregivers to learn and carry over treatment techniques and learn about appropriate environments for children with ASD.

Intent Statements
Information is available to assist parents and families in greater understanding to facilitate informed decision making and supporting their child with ASD.

Examples
12.h. The family is an essential member of the team, providing coaching and empowering family inclusion through communication, behavior, and environmental interventions.

5.B. 13. Mentor services for families are offered or referred, as available, for:
   a. Training in advocacy.
   b. Accessing local community resources.
   c. Understanding the importance of certifications and training of support staff.
   d. Creating a community of supports and locating qualified service providers.
   e. Understanding research findings on ASD.
   f. Connecting to parent and sibling groups.

Intent Statements
Mentors help parents and families understand the active role they need to take in the implementation of professional support services and how to become effective advocates for their child with ASD.

Examples
Mentors are individuals with expertise because they have had the same or similar experience.

5.B. 14. The program:
   a. Promotes family-centered care.
   b. Provides or refers for family education programs on parenting techniques and family well-being.
   c. Coordinates a system of supports for family members.
   d. Assists with planning for educational transition.
   e. Promotes a life-span perspective on ASD needs and planning.

Examples
The program is knowledgeable about state/provincial ASD guidelines, if applicable, and IDEA services that are available for children from birth through age 21. The program coordinates with and helps families advocate for those services to which their child is entitled.

14.c. Supports for family members may include networking opportunities, advocacy training, respite care services, support groups, mentor services to assist families with psychological adjustment and coping with stress that may result from an ASD diagnosis, and integrating various services the family is receiving.

14.d. The organization works with schools and other organizations to develop collaborative training agendas for teachers and others who work with children with ASD.

14.e. Promoting a life-span perspective on ASD may include assisting children with ASD, when they are old enough and depending on their level
of cognitive function, in understanding their condition and learning effective techniques to minimize its impact in their lives. Life-span issues may also include assisting parents with planning for their long-term needs and the challenges involved in having an adult child with ASD.

5.B. 15. When a child begins school, services provide advocacy, if requested and with family consent, to educational staff about the family's knowledge about their child.

Intent Statements
Family insight is important and valuable. Emphasis should be placed on developing a working relationship between the family and the school system.

Examples
It is important to develop understanding among school staff about what will succeed with a specific child. The family can provide information about the strengths and needs of the child; the family's interests, priorities, and needs; current behavioral and emotional goals; and specific behavioral interventions that work for the child.

5.B. 16. When partnering with the education system, the program shares to the extent possible its knowledge of the child to give guidance to developing the most effective individual educational model, including the effectiveness of treatment approaches and assistive technology being used.

Intent Statements
The organization identifies the current scholastic level and educational needs of the child, including functional assessments of behavior, communication, social skills, and family involvement, and works in cooperation with the family and school system to determine appropriate, individualized learning models.

Examples
If there are medical and psychological records, the program could assist the family to procure these records from the entity that provided the services. Learning models are developed to ensure adequate levels of direct instruction and effective behavioral interventions as needed to provide educational benefit and improvement of social and communication skills.

Considerations include:
- The child's strengths, needs, abilities, and preferences.
- Successful environmental accommodations and adaptations.
- Appropriate level placements.
- Instructional adaptations.
- Accommodations.
- Assistive technology.
- Opportunities for the generalization of skills.
- Language and learning strategies to improve functional skills.
- Sensory issues and appropriate interventions and supports, including ergonomics and body mechanics as well as environmental issues.

Health and safety risks are also considered, and strategies to reduce such risks are implemented.

5.B. 17. Opportunities for education of the child’s peers, when appropriate and desired, are provided.

Intent Statements
Educational opportunities for peers are individualized and are based on the preferences of the family.

Examples
Education may include understanding the social and emotional needs of the child with ASD and learning strategies for developing friendships and supporting development of social skills. Education of parents and siblings of peers who befriend the child with ASD may also be provided as appropriate.

The child's parents are involved and give their consent and input regarding information about the child to be shared with peers or others.
Curriculum might include topics such as:
- Learning about the strengths and difficulties of the child with ASD.
- How to become a mentor or friend.
- Understanding why the child with ASD needs accommodations.
- Actual skills for peers to develop and use.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Records of persons served
- Individual service plans
- Progress notes
- Procedures manual
- Organizational newsletters or other communications for parents
- Documented service strategies
- Information about community resources/networks
- Advocacy training materials
- Individual personal scrapbooks of persons served
- Life plans

C. Children and Adolescents (CA)

Description
Programs for children and adolescents consist of an array of behavioral health services designed specifically to address the treatment needs of children and adolescents. Such programs tailor their services to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

Applicable Standards
If children or adolescents (up to age 18 unless legally emancipated) are served in any core program other than Call Centers, Comprehensive Suicide Prevention, Diversion/Intervention, or Prevention, the standards in this section or Section 5.G. Juvenile Justice (JJ) must be applied in addition to the standards in Sections 1 and 2 and the core program standards in which the organization is seeking accreditation. An organization cannot be accredited for children and adolescents alone, but rather must select at least one core program to which it wants this designation applied.

If an organization serves children and adolescents in an assessment and referral program that provides only telephone assessments, only Standards 5.C.1., 5.C.2., and 5.C.8. in this section are applicable.

When an organization chooses to add the specific population designation for Children/Adolescents with Autism Spectrum Disorder to an appropriate core program in Section 3 or 4, the standards in Section 5.C. Children and Adolescents do not need to be applied.

NOTE: Legal emancipation generally occurs through marriage, a court order, or specific rules of the Indian Child Welfare Act.
1. Assessments of each child or adolescent served include information on his or her:
   a. Developmental history, such as developmental age factors, motor development, and functioning.
   b. Medical or physical health history.
   c. Culture/ethnicity.
   d. Treatment history.
   e. School history.
   f. Language functioning, including:
      (1) Speech functioning.
      (2) Hearing functioning.
   g. Visual functioning.
   h. Immunization record.
   i. Learning ability.
   j. Intellectual functioning.
   k. Family relationships.
   l. Interactions with peers.
   m. Environmental surroundings.
   n. Prenatal exposure to alcohol, tobacco, or other substances.
   o. History of use of alcohol, tobacco, or other substances.
   q. When applicable, parents'/guardians':
      (1) Ability/willingness to participate in services.
      (2) Strengths.
      (3) Preferences.

Intent Statements
In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, or Detoxification), the amount of information collected may be limited by time or the condition of the person served. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

1.f.–g. Speech, hearing, and visual functioning are often included in yearly physical exams and/or in schools. Source documents are not required; however, any identified needs of the child/youth should consider whether language and/or visual functioning is a contributing factor.

1.h. The assessment includes a determination of the status of the child's immunization. A copy of the immunization record is not required. Organizations can note when children and adolescents are enrolled in school settings where verification of immunization is legally required.

1.k. Information about family relationships includes siblings as well as extended family. Family relationship information would also document changes in the family constellation and persons moving into or out of the home.

1.m. Environmental surroundings include family moves and changes in placements for children placed out of the home.

2. The assessments are appropriate with respect to the child's or adolescent's:
   a. Age.
   b. Development.
   c. Culture.
   d. Education.

3. When the services disrupt the child's or adolescent's day-to-day educational environment, the program provides or make arrangements for the continuity of his or her education.

Examples
Arrangements could include:
- Use of a facility-based school.
- Use of a private school at the organization.
- Use of on-site educators from a local school system.
- Coordination with home school services.
- Coordination and monitoring of assignments.
- Coordination with the community school to facilitate reintegration.

4. Based on the needs of each child or adolescent, or as required by law, an educational specialist is a member of the team.
Intent Statements
When applicable, the educational specialist assists in the planning, implementing, and evaluating of the child’s or adolescent’s educational activities. The educational specialist can be available when needed and is not required to attend all team meetings. Please refer to Standard 2.A.21. for the functions of the team.

5.C. If educational services are provided, they:
   a. Are appropriate to the person served.
   b. Meet applicable federal, provincial, and state requirements.
   c. Include provisions for:
      (1) Evaluation.
      (2) Group instruction.
      (3) Individual instruction.

Intent Statements
Educational services should be appropriate to the developmental and clinical needs of each child and adolescent served.

5.C. Based on the needs of the children or adolescents served, the program includes the development of:
   a. Community living skills.
   b. Social skills.
   c. Social supports.
   d. Vocational skills.

5.C. The environment is configured appropriately to meet the needs of children and adolescents, including:
   a. The physical plant.
   b. The furniture.
   c. The equipment.

Intent Statements
The location in which services are provided reflects the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the children or adolescents served.

Examples
Considerations include the provision of:
- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and video equipment.

5.C. The organization implements a policy and procedures for obtaining criminal background checks on all persons providing direct services to children or adolescents.

Intent Statements
Background checks may include fingerprinting and FBI criminal history checks. Persons providing direct services include personnel, students, interns, volunteers, or contracted providers of direct services. The provision of direct services includes transportation.

Canadian Considerations
In Canada, depending on provincial/territorial/tribal requirements, a criminal record check and a child welfare information system check would be required to meet this standard.

Examples
Background checks may be conducted prior to employment for new personnel, at the time of job change when beginning to work with children or adolescents, or prior to an accreditation survey for existing personnel.

5.C. For residential services provided in congregate facilities or sites that are owned, rented, or leased by the organization, staff support is available on site 24 hours a day, 7 days per week.

Intent Statements
Residential services may include group homes, residential treatment, child caring institutions, inpatient facilities, or residential detoxification programs. Treatment or therapeutic foster care that is provided in facilities that are owned, rented, or leased by the organization is also included. Staff members are in the residential facility around the clock and able to respond to emergencies quickly. If there are times when no persons are served in the facility (such as during
5.C. 10. If residential services are provided, the program provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:
   a. Family members and significant others.
   b. Peers.

5.C. 11. The program does not exclude children or adolescents from services solely on the basis of their juvenile justice status.

Intent Statements
Although specific behaviors may be identified by a program as exclusionary admission criteria, children and adolescents cannot be excluded from services solely because they are involved in the juvenile justice system.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Assessments of the children or adolescents served
- Filed, current information on law pertaining to educational specialists and educational services
- Staffing pattern chart for residential, or 24/7 programs
- Policy related to background checks on all personnel

D. Consumer-Run (CR)

Description
Improvement of the quality of an individual’s situation requires a focus on the person served and his or her identified strengths, abilities, needs, and preferences. The program is designed around the identified needs and desires of the persons served, is responsive to their expectations, and is relevant to their maximum participation in the environments of their choice. The person served participates in decision making and planning that affects his or her life. Efforts to include the person served in the direction of the program or delivery of applicable services are evident. The service environment reflects identified cultural needs and diversity. The person served is given information about the purposes of the program.

Applicable Standards
These standards would be applied to consumer-run programs in place of the current standards in Sections 2.A.–D., G., and H.

5.D. 1. The program’s policies and procedures for membership or acceptance into services identify:
   a. Criteria for the order of acceptance of any person awaiting service.
   b. The position or entity responsible for making acceptance decisions.
   c. Opportunities for individuals to learn about the program and its services.

Intent Statements
These policies may be established based on local referral policies and the mission of the program. These policies and procedures reduce the possibility that subjective judgment will be used to determine if the program is applicable to a person’s needs. They ensure fair access for all applicants and referrals, in keeping with the program’s commitment to be accessible. The intent is to provide information for persons to make informed choices.
Section 5.D. Consumer-Run (CR)

5.D. 2. The membership/acceptance criteria are presented in an understandable manner.

Intent Statements
It is important to consider the comprehension levels and language skills of those applying.

Examples
Written materials in the person’s primary language, large-print written materials, videos, and face-to-face presentations are some of the ways to present information in an understandable manner.

5.D. 3. When a person is found ineligible:
   a. The person is informed as to the reason(s).
   b. The referral source is informed as to the reason(s).
   c. The person is given information about potential alternative services.
   d. The program maintains documentation of these actions.

Intent Statements
Reasons for ineligibility may be provided verbally or in writing.

3.d. The program gathers data on persons found ineligible for services. Through the program’s performance improvement system, this information is used to strategically position the program to identify and develop services to meet the needs of unserved or underserved populations in the community.

5.D. 4. Prior to participation in the program, the program ensures that all persons involved are aware of their responsibilities regarding services/activities.

Intent Statements
The persons accepted for services, their family members, staff members, funders, and others, as appropriate, are given information about their rights and responsibilities.

5.D. 5. As required by funding sources and for legal reasons, signed informed consent for services is:
   a. Obtained.
   b. Retained.

Intent Statements
Programs are encouraged to check with local authorities regarding legal requirements to determine when signed informed consent is required. Signed informed consent is documented. Staff members are familiar and comply with informed consent procedures and requirements.

5.D. 6. The persons participating in activities or receiving services are given information about:
   a. Planning of the services to be delivered or activities in which to participate.
   b. Setting their individual service goals, when applicable.
   c. How progress on service goals will be communicated with the persons served.

Intent Statements
The result is that the persons served are knowledgeable about the person-centered planning process and their active role in or possible direction of the process, including the sharing of information on progress toward and/or achievement of goals.

5.D. 7. As appropriate, the following needs are addressed:
   a. Assistive technology.
   b. Reasonable accommodations.
   c. Identified health risks.
   d. Identified safety risks.

Intent Statements
Reasonable accommodations are necessary to fully access services and enable the person served to participate in the program. Technology needs are addressed in the person-centered plan. The program considers reasonable accommodations and uses assistive technology to convey information about services.
As part of a program’s risk management, any health or safety risks identified during the planning process should be addressed to limit an individual’s exposure to adverse consequences.

Examples
The program may provide assistive technology, or it may be provided by referral to other local resources.

Accommodations and technology may entail the use of communication devices, videos and audio recordings, pictures, and materials in each person’s primary language.

5.D. 8. If a person participating in activities or receiving services needs services that are not available through the program, referrals to other providers are suggested.

Intent Statements
The program may not be able to provide all services a person may want or need. If this is the case, the program refers the person to other services outside the program and coordinates these services with those provided by the program.

Examples
The program may maintain listings or demonstrate knowledge of agencies and programs to which it can refer individuals, if so requested or needed. As a good practice, a program should have a procedure in place to ensure that individuals are satisfied with the services they receive elsewhere as a result of these referrals and that the agencies and programs receiving its referrals are quality driven and person centered.

5.D. 9. Persons served are given opportunities to enhance their advocacy skills through:
   a. Training.
   b. Support for systems advocacy activities.
   c. Support for self-advocacy activities.
   d. Linkage with self-advocacy programs.
   e. Other appropriate means, if applicable.

Examples
Support for advocacy activities may be provided within the program through support for participation in activities, such as consumer-councils, in the community through support for participation in activities sponsored by advocacy groups, or through support for self-advocacy to access benefits and/or services.

Applicable Standards
The following six standards (5.D.10.–15.) do not apply in a drop-in center or consumer-run program that does not provide direct services.

5.D. 10. The following information is used in the development of the person-centered plan:
   a. Relevant medical history.
   b. Relevant psychological information.
   c. Relevant social information.
   d. Information on current and previous direct services and supports.
   e. Other issues, as necessary.

Intent Statements
This standard does not require that each person have a physical or psychological evaluation. The program has a procedure in place to determine relevancy based on the individual’s situation and services provided by the program. The person-centered plans demonstrate that this information has been considered in development of the person-centered plans.

5.D. 11. A coordinated person-centered plan is based on the person’s:
   a. Strengths.
   c. Abilities.
   d. Preferences.
   e. Desired outcomes.
   f. Cultural background and diversity.
   g. Other issues important to the person served.
**Intent Statements**

The program may use consumer self-assessments and/or person-centered planning to obtain this information. Person-centered plans may be under the authority of a referral agency. In these cases, the program demonstrates how it accesses these plans and how it uses them to achieve individualized services and person-focused outcomes. Plans are highly individualized, reflecting the diversity of the persons served.

5.D. **12. A coordinated person-centered plan:**

a. Is developed with the input of the person served.

b. Identifies:

   (1) Overall goals.
   (2) Specific measurable objectives.
   (3) Methods/techniques to be used to achieve the objectives.
   (4) Those responsible for implementation.
   (5) Barriers to an individual’s goals.
   (6) Strengths, supports, or solutions to overcome barriers.

c. Is reviewed on a regular basis with respect to expected outcomes.

d. Is revised, as appropriate:

   (1) Based on the satisfaction of the person served.
   (2) To remain meaningful to the person served.
   (3) Based on the changing needs of the persons served.

**Intent Statements**

The program establishes a schedule for periodic review of the plan. The plan focuses on outcomes and results, and regular review is essential to ensure that goals are achievable and remain meaningful to the person served. Plans are essential for all members of the team to perform their functions and to ensure continuity of services when new staff members are hired.

5.D. **13. The goals and objectives of the person-centered plan are communicated in a manner that is understandable:**

a. To the person served.

b. To the person(s) responsible for implementing the plan.

**Intent Statements**

The program ensures that all persons involved understand the plans and their own involvement in achieving the goals and objectives.

**Examples**

Understanding by persons served may be demonstrated through interviews, records, or checklists.

5.D. **14. A discharge summary is prepared for each person served who leaves a program.**

**Intent Statements**

A discharge summary typically describes the person’s progress toward or achievement of goals, as identified in his or her person-centered plan, the services provided, and the reasons for discharge. The summary also lists recommendations for services or supports needed to assist the person served to achieve his or her identified goals and may suggest referrals to other services.

5.D. **15. A complete record is maintained for each person served.**

**Intent Statements**

The program determines which information should be kept in the records of the persons served. The record communicates information that is complete, clear, and current. Funders and referral agencies may require that certain information be maintained. The program also complies with its own service delivery design...
for the development of the record. Electronic records are acceptable.

Examples

The record may include demographic data; names of personal representatives, such as parents, guardians, and advocates; referral reports; functional abilities; medical information, such as medications taken and name of physician; person-centered plans; release forms; consent forms; follow-up reports; exit summaries; progress reports; and referrals to other resources.

The program may find it helpful to keep an orientation checklist in each person's record so that documentation can be made when items are shared with the individual, such as rights and responsibilities, setting goals and planning services, and securing/retaining benefits.

Working files can be used if security of files is maintained.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Records of the persons receiving services
- Acceptance policies and procedures
- Entrance criteria
- Criteria for the order of acceptance
- Information regarding referrals of persons who are ineligible
- Handbook and information regarding responsibilities in services
- Information regarding basic entitlements
- Orientation checklist, information, etc.
- Person-centered plans
- Information regarding reasonable accommodations and assistive technology used, if applicable
- Release-of-information forms
- Informed consent information
- Documentation of advocacy training or curriculum
- Referral information
- Discharge summary report
Section 5.E. Criminal Justice (CJ)

E. Criminal Justice (CJ)

Description
Criminal justice programs serve special populations comprised of accused or adjudicated individuals referred from within the criminal justice system who are experiencing behavioral health needs, including alcohol or other drug abuse or addiction, or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, in community-based or institutional settings, or in sex offender programs. Institutional settings may include jails, prisons, and detention centers. The services are designed to maximize the person's ability to function effectively in the community. The criminal justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large. Criminal justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/DWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Applicable Standards
If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the Criminal Justice (or Juvenile Justice, for populations under 18 not tried as adults) standards must be applied. Organizations seeking accreditation in criminal justice must apply the standards in Sections 1 and 2 and one or more of the service-specific core programs in Sections 3 or 4 as well as these standards. For example, a criminal justice program providing treatment through a therapeutic community model would apply the standards in Sections 1 and 2 as well as 3.T.

Therapeutic Communities (TC) and 5.E. Criminal Justice (CJ).

5.E. 1. Treatment programs within a correctional setting include:
   a. Partnering with correctional personnel who have decision-making authority.
   b. Identification of personnel assigned as liaison for ongoing communication.

5.E. 2. Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, criminal justice behavioral health services.

Intent Statements
In addition to the standards in Section 2 related to the team providing services, this standard provides more specific guidance as to the competencies of team members providing services in a criminal justice setting who are directly involved in the participatory process of defining, refining, and assisting a person served in meeting his or her goals.

5.E. 3. All members of the team:
   a. Have access to the confidential information that is required for the team members to perform their function.
   b. Are bound by applicable state, federal, and provincial confidentiality laws.

Intent Statements
The intent is for all parties to engage in collaborative information sharing to the greatest extent possible within identified laws, rules, and regulations.

5.E. 4. The person served is provided with a description of the relationship between the criminal justice entity and the program, including:
   a. The extent and limitations of confidentiality and sanctions.
b. The possible implications of having a criminal justice member on the team.

Intent Statements
The team involves a blend of behavioral health providers and criminal justice personnel, such as correctional officers, control agents, guards, and probation and parole officers. Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team. Although exceptions may exist in a correctional setting, the person served has the option of refusing to have the criminal justice system actively involved in the treatment process.

Examples
4.b. The staff members of the program might discuss such issues as:

- Access to confidential records.
- Action the criminal justice member may be forced to take based on information provided by the team.
- The impact on the therapeutic relationship.

5.E. 5. Training:

a. Is provided to personnel prior to the delivery of services.

b. Includes regular interdisciplinary cross-training related to clinical and criminal justice issues.

c. Includes such topics as:

1. The requirements imposed on personnel from the criminal justice system who participate on the treatment team.

2. Safeguards that are available to workers.

3. Safety and security practices specific to the setting.


5. Correctional boundaries.

6. Specialized clinical needs, including dual diagnoses.

7. Therapeutic community practices and methodologies, when that core program is provided.

5.E. 6. The criminal justice program conducts or obtains a timely assessment for each person served that includes:

a. A detailed history of the person's criminal behavior, including:

(1) Arrests.

(2) Convictions.

(3) Violations of parole and/or probation.

(4) Prior incarcerations.

(5) Pending cases.

b. Information on the person's participation in organizations or groups that encourage criminal behavior.

c. The relationship between the person's behavioral health and his or her criminal activity.

d. Risk to self, other persons served, personnel, and/or community.

e. Risk for reoffending.

f. Triggers for recidivism.

Intent Statements
In conducting an assessment in a criminal justice setting, a program emphasizes the collection of information related to criminal behavior.
Section 5.E. Criminal Justice (CJ)

5.E. 7. When applicable and/or permitted, family members and/or significant others are:
   a. Identified.
   b. Located.
   c. Contacted.
   d. Offered and, when possible, engaged in services.

Intent Statements
Family members include children, when applicable. In certain situations, such as under specific contracts for service, contact with family members may not be permitted.

5.E. 8. The person-centered plan of the person served includes:
   a. A discussion of the impact of his or her behavior on:
      (1) Applicable victims.
      (2) Family members, including children.
      (3) Friends or significant others.
      (4) The community.
      (5) The person served.
   b. Goals that address the responsibility of the person served to engage in activities that help to restore or repair damage done to individuals or the larger community when he or she committed criminal acts.

5.E. 9. When a criminal justice program provides behavioral health services in a prison or jail setting, it provides or advocates for access to a full range of services based on the person’s:
   a. Strengths.
   b. Needs, including risk of:
      (1) Recidivism.
      (2) Relapse.
   c. Preferences.

Intent Statements
The intent of this standard is to ensure access to treatment-related services for individuals incarcerated in correctional settings. The services used will depend on the needs and preferences of the persons served.

Examples
The services could include:
- Screening and assessment.
- Crisis intervention.
- Case management, including referral to other services needed.
- Crisis stabilization.
- Outpatient treatment.
- Day treatment.
- Medication management.
- Inpatient and/or residential treatment.
- Aftercare.

5.E. 10. When the program provides behavioral health services in a prison or jail setting, the transition plan refers the person served for:
   a. Reentry services within the other correctional systems when appropriate.
   b. Identified continuing care in the community in which he or she will reside when released from custody.
   c. In-prison continuing care or aftercare maintenance services, when available.

Examples
10.b. Continuing care may include connecting the person served with ongoing treatment services, as needed, or support groups (such as AA/NA) to assist with successful transition. Following treatment in a therapeutic community provided in a correctional facility, transition to a community-based therapeutic community is the treatment of choice, when available.
Section 5.E. Criminal Justice (CJ)

5.E. 11. Predischarge transition plans are:
   a. Developed:
      (1) With the active involvement of the person served.
      (2) Cooperatively by treatment program and correctional institution staff.
   b. Based on a comprehensive needs and risk assessment.
   c. Written at least 30 days prior to discharge.
   d. When applicable, effectively communicated to continuing care providers.

5.E. 12. The predischarge plan addresses:
   a. The personal restoration plan of the person served.
   b. A transition that offers continuity of care.
   c. Transition for the person served to a level of care congruent with his or her:
      (1) Current treatment program.
      (2) Specific needs, including:
         (a) Level of criminality/threat to the safety of the larger community.
         (b) Risk of relapse/recidivism.
      (3) Available resources.
   d. Continuation of needed treatment upon discharge.
   e. Expectations regarding ongoing legal requirements.

Applicable Standards
If an organization has a criminal justice educational component in its program, Standards 13.–14. also apply.

5.E. 13. The curriculum-based program component for each person served:
   a. Addresses issues specific to his or her individual needs.
   b. Is consistent with his or her cognitive and learning abilities.
   c. Is consistent with the program’s philosophy of treatment.
   d. Includes provisions for:
      (1) Evaluation.
      (2) Group instruction.
      (3) Individual instruction.
   e. Meets applicable federal, provincial, and state requirements.

Intent Statements
13.b. The intent of this standard is to ensure that the assessment has included cognitive, behavioral, and learning abilities and that reading materials, assignments, and the requirements for participation take into consideration the learning abilities and styles of the person served. This standard includes ensuring that reasonable accommodations are available for persons with special educational needs.

13.c. Because many of the criminal justice educational services are provided as part of or within a treatment program, this standard encourages the organization to ensure that the educational plan for each person served is consistent with the philosophy of the treatment program.

Examples
Based on the needs of the persons served and the resources available, the organization is encouraged to include the following topics in its educational programs:

- Substance abuse treatment, relapse prevention, and recovery.
- Physical health issues or consequences and communicable diseases.
- Community resources and community integration.
- The possible relationship between substance abuse and/or mental illness and criminal behavior.
- Violence prevention.
Family reunification.
Parenting skills, when applicable.
Culture-specific issues.
Interpersonal and relationship skills.
Communication skills.
Life-skills training.
Job readiness.
Problem solving.
Conflict resolution.
Anger management.

5.E. Based on the needs of the person served, the educational program addresses the development of:

a. Community living skills.
b. Social skills.
c. Social supports.
d. Vocational skills.

Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written assessments for each person served
- Written individual person-centered plans
- Written service agreements
- Transition or discharge plans
- Curriculum for or records of staff training
- Educational plans for the person served

F. Eating Disorders (ED)

Description

Standards for eating disorder programs apply to residential, inpatient, and partial hospitalization programs that offer treatment to patients under the supervision of a licensed healthcare professional who has access to a licensed physician. Patients served in these programs have been diagnosed with eating disorders according to the current DSM, ICD-9 or ICD-10, including Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified. Symptom management and interruption requires an intensity of service delivery that is beyond an outpatient level of care.

The standards consider the individual’s biopsychosocial needs and strengths as well as the needs and strengths of family members. Services maximize the person’s ability to function effectively within their family, school, and community environment and to achieve and maintain an optimal state of health to enhance their quality of life.

Services provided also consider any culturally specific issues relevant to the individual and his or her family/caregivers as appropriate. Services to persons with eating disorders can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. However, programs serving persons with eating disorders within larger general medical or psychiatric units, similar to exclusive programs, must demonstrate programming that is specialty- and evidence-based and demonstrate that staff are specialty-trained and competent to provide eating disorder treatment. Exclusive programs and programs within larger general psychiatric or medical units must also demonstrate that services are designed based on the needs and expectations of the persons served and their legal guardians/caregivers.

For example, they can be informed by the World Wide Charter on Action for Eating Disorders (www.aedweb.org/source/charter/documents/WWCharter4.pdf). The charter describes the
following rights of persons with eating disorders and carers:

- Right to communication and partnership with healthcare professionals
- Right to comprehensive assessment and treatment planning
- Right to accessible, high-quality, fully funded specialized care
- Right to respectful, fully informed, age-appropriate, safe levels of care
- Right of carer(s) to be informed, valued, and respected as a treatment resource
- Right of carer(s) to accessible, appropriate support and education resources

Some examples of the quality results desired by different stakeholders of these services include:

- Replacing the person's connection with the eating disorder with satisfying, supportive and meaningful relationships and the use of healthy coping strategies.
- Effective transitions between levels of care or transition to community living.
- Development of an effective and efficient network of community support services including access to therapies, medical supports, and other school, work, and community-based resources.
- Achievement of goals in health, education, work, and activities of daily living.
- Personal and family development.
- Maintenance of recovery and improved functioning.

**Applicable Standards**

Organizations seeking accreditation as an eating disorders program must apply the standards in Sections 1 and 2, the core program standards in Inpatient Treatment (3.J.), Partial Hospitalization (3.P.), or Residential Treatment (3.Q.), and the standards in this section.

**NOTE:** An organization seeking accreditation for an Eating Disorders program for Children/Adolescents (EDCA) must also apply the standards in Section 5.C.
Section 5.F. Eating Disorders (ED)

5.F. 2. An initial assessment (admission process):
   a. Is completed within 72 hours.
   b. Includes:
      (1) A comprehensive medical assessment provided by a medical clinician.
      (2) A multi-axial diagnostic assessment.
      (3) A psychiatric evaluation.
      (4) A nutritional assessment.
      (5) Psychological assessment.

5.F. 3. A comprehensive assessment is completed within seven days.

5.F. 4. The person-centered plan:
   a. Is developed within the following timeframes:
      (1) An initial within 72 hours of admission.
      (2) A complete within seven days.
   b. Includes a diagnosis according to the current DSM and ICD-9.
   c. Is signed by the:
      (1) Person served or his or her legal representative.
      (2) Treatment team.
   d. Is reviewed by the treatment team at least every seven days.

5.F. 5. The transition plan:
   a. Includes identification of the recommended level of care based on current risk assessment.
   b. Is provided to after-care providers:
      (1) With written consent of the person served.
      (2) Initially, either verbally or in writing, within 48 hours to:
         (a) The primary care provider of the person served.
         (b) Receiving mental health therapists or programs.
      (3) In written form within two weeks of discharge.

5.F. 6. The provision of services includes:
   a. Care delivered by licensed professionals in each of the following four core areas:
      (1) Psychological.
      (2) Medical/nursing.
      (3) Nutritional.
      (4) Psychiatric.
   b. At a minimum, weekly delivery of the following core care components to each person served:
      (1) Individual therapy.
      (2) Group therapy.
      (3) Family therapy.
      (4) Medical monitoring.
      (5) Medication monitoring, as applicable.
      (6) Milieu therapy.
   c. Nutritional counseling provided by a registered dietician trained and experienced in eating disorders for the applicable age group.
   d. Services provided by staff with a minimum of six continuing education hours per year devoted to eating disorders.
Intent Statements

6.a. Care is delivered by persons knowledgeable or experienced in the area of working with persons with eating disorders.

Examples

Current evidence in eating disorder research supports the use of cognitive-behavioral treatment (CBT) and interpersonal therapy (IPT) for adults with bulimia nervosa, and family-based treatment for adolescents (under 19 years of age with less than three years duration of illness) with anorexia nervosa and bulimia nervosa, as well as the use of the principles of CBT and supportive clinical management (SCM) for adults.

6.b.(3) If the person served chooses to not have his/her family involved in the treatment process, this standard would not be applicable.

6.b.(6) Milieu therapy includes day-to-day milieu management and support.

5.F. 7. The program implements nutritional practices that:
   a. Promote growth and development in the applicable age group(s) of the person served.
   b. Support regular and consistent weight gain (or loss, when applicable).
   c. Measure improvement in symptomatic eating behavior and/or urges.
   d. Include:
      (1) A physician to prescribe the diet.
      (2) A registered dietician to:
         (a) Provide the following:
            (i) Assessment.
            (ii) Education.
            (iii) Counseling.
         (b) Design, implement and manage safe and effective nutrition-related strategies to:
            (i) Enhance growth and development.
            (ii) Promote recovery from disordered eating.
            (iii) Reduce disturbances in body image.
            (iv) Promote lifelong health.

Examples

7.b. Weight loss may be applicable when the person served has concurrent obesity.

7.c. May include restricting, binge eating, purging, etc.

5.F. 8. Based on the needs of the persons served, the program’s outcomes measures include the following:
   a. Regular and consistent weight gain (or loss, when applicable).
   b. Measurable improvement in symptomatic eating behavior and/or urges.
   c. Eating disorder diagnostic symptoms regarding preoccupation with:
      (1) Weight.
      (2) Shape.
      (3) Body image.
   d. Improvement as measured by the standardized eating disorder assessments chosen to record admission and discharge status.
   e. When possible, measurement of outcomes at twelve months post discharge.

Examples

8.b. Restricting, binging, purging.

8.d. Eating Disorder Examination Questionnaire (EDEQ)-6 and Eating Disorder Quality of Life. Programs are encouraged to routinely include additional measures of mood and other comorbid symptoms, such as the Beck Depression Inventory, at admission and discharge.

5.F. 9. Persons served in a partial hospitalization program are provided therapeutic services:
   a. At least six hours per day.
   b. At least five days per week.
Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.
- Records of persons served
- Screening forms or procedures
- Assessment forms or procedures
- Individual plans of persons served
- Evidence of service provision by professionals with appropriate licenses/credentials
- Nutritional guidelines and diets
- Transition plans of persons served
- Outcomes measures used
- Procedures for gathering outcomes information

G. Juvenile Justice (JJ)

Description
Juvenile justice programs serve special populations comprised of accused or adjudicated juveniles referred from within the juvenile justice system who are experiencing behavioral health needs including alcohol or other drug abuse or addiction or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, or in community-based or institutional settings. Institutional settings may include juvenile detention centers, jails, prisons, or other delinquency-focused settings. The services are designed to maximize the person’s ability to function effectively in the community. The juvenile justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

Juvenile justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/OWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Applicable Standards
If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the Juvenile Justice standards must be applied. Organizations seeking accreditation in juvenile justice must apply the standards in Sections 1 and 2 and one or more of the service-specific core programs in Section 3 or 4 as well as these standards. For example, a juvenile justice program providing treatment through a therapeutic community model would apply the standards in Sections 1 and 2 as well as 3.T. Therapeutic Communities (TC) and 5.G. Juvenile Justice (JJ).
5.G. 1. Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, juvenile justice behavioral health services.

Intent Statements
In addition to Standard 2.A.21. related to the team providing services, this standard provides more specific guidance as to the competencies of team members providing services in a juvenile justice setting who are directly involved in the participatory process of defining, refining, and assisting a person served in meeting his or her goals.

5.G. 2. All members of the team:
   a. Have access to the confidential information that is required for the team members to perform their function.
   b. Are bound by applicable state, federal, and provincial confidentiality laws.

Intent Statements
2.a. Access to clinical records can include access to information such as:
   ■ Person-centered plans.
   ■ Custody records.

5.G. 3. The person served is provided with a description of the relationship between the juvenile justice entity and the program, including:
   a. The extent and limitations of confidentiality and sanctions.
   b. The possible implications of having a juvenile justice member on the team.

Intent Statements
The team involves a blend of behavioral health providers and juvenile justice personnel, such as detention officers, control agents, guards, and probation and parole officers. Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team.

The person served has the option of refusing to have the juvenile justice system actively involved in the treatment process.

Examples
3.b. The staff members of the program might discuss such issues as:
   ■ Access to confidential records.
   ■ Action the juvenile justice member may be forced to take based on information provided by the team.
   ■ The impact on the therapeutic relationship.

5.G. 4. Training:
   a. Is provided to personnel prior to the delivery of services.
   b. Includes regular interdisciplinary cross-training related to clinical and juvenile justice issues.
   c. Includes such topics as:
      (1) The requirements imposed on personnel from the juvenile justice system who participate on the treatment team.
      (2) Safeguards that are available to workers.
      (3) Safety practices specific to the setting.

Intent Statements
4.a. Behavioral health professionals who work in juvenile justice settings encounter a unique service delivery system with both opportunities and challenges. The intent of this standard is to ensure that individuals new to this type of setting receive full and complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work.

4.b. Interdisciplinary cross-training refers to juvenile justice staff members providing juvenile justice training to clinical staff members and also to clinical staff members providing clinical training to juvenile justice staff members.
5.G. The juvenile justice program conducts a timely assessment for each person served that includes:
   a. A detailed history of the person’s criminal behavior, including:
      (1) Arrests.
      (2) Convictions.
      (3) Violations of parole and/or probation.
      (4) Prior incarcerations.
      (5) Pending cases.
   b. Information on the person’s participation in organizations or groups that encourage criminal behavior.
   c. The relationship between the person’s behavioral health and his or her criminal activity.
   d. Risk to self, other persons served, personnel, and/or community.

Intent Statements
In conducting an assessment in a juvenile justice setting, a program emphasizes the collection of information related to delinquent or criminal behavior.

5.G. Assessments include information on each juvenile’s:
   a. Developmental history, such as developmental age factors, motor development, and functioning.
   b. Medical or physical health history.
   c. Culture.
   d. Treatment history.
   e. School history.
   f. Language functioning, including:
      (1) Speech functioning.
      (2) Hearing functioning.
   g. Visual functioning.
   h. Immunization record.
   i. Learning ability.
   j. Intellectual functioning.
   k. Family relationships.
   l. Interactions with peers.
   m. Environmental surroundings.
   n. Prenatal exposure to alcohol, tobacco, or other drugs.
   o. History of use of alcohol, tobacco, or other drugs.
   q. Ability/willingness of parent(s)/guardian to participate in services.

Intent Statements
In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, or Detoxification), the amount of information collected may be limited by time or the condition of the person served. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

6.h. The assessment includes a determination of the status of the juvenile’s immunization. A copy of the immunization record is not required. Organizations can note when juveniles are enrolled in school settings where verification of immunization is legally required.

5.G. The assessments are appropriate with respect to the juvenile’s:
   a. Age.
   b. Development.
   c. Culture.
   d. Education.

5.G. When applicable and/or permitted, family members and/or significant others are:
   a. Identified.
   b. Located.
   c. Engaged in services.

5.G. When a juvenile justice program provides behavioral health services in a correctional setting, it provides or advocates for access to a full range of services based on the person’s:
   b. Preferences.
Intent Statements

The intent of this standard is to ensure access to treatment-related services for individuals placed in detention or other correctional settings. The services used will depend on the needs and preferences of the persons served.

Examples

The services could include:

- Screening and assessment.
- Crisis intervention.
- Case management, including referral to other services needed.
- Crisis stabilization.
- Outpatient treatment.
- Medication management.
- Inpatient and/or residential treatment.
- Aftercare.

5.G. 10. When the program provides behavioral health services in a correctional setting, the transition plan refers the person served for:

a. Transitional services within the other juvenile justice systems when appropriate.

b. Continuing care in the community in which he or she will reside when released from custody.

5.G. 11. Predischarge transition plans are:

a. Developed:
   (1) With the active involvement of the person served.
   (2) Cooperatively by treatment program and correctional institution staff.

b. Based on a comprehensive needs assessment.

c. Written at least 30 days prior to discharge.

5.G. 12. Based on the needs of each child or adolescent, or as required by law, an educational specialist is a member of the team.

Intent Statements

The educational specialist can be available when needed and is not required to attend all team meetings. Please refer to Standard 2.A.21. for the functions of the team.

5.G. 13. When the services disrupt the juvenile’s day-to-day educational environment, the program provides or makes arrangements for the continuity of his or her education.

Examples

Arrangements could include:

- Use of a facility-based school.
- Use of a private school at the organization.
- Use of on-site educators from a local school system.
- Coordination with home school services.
- Coordination and monitoring of assignments.
- Coordination with the community school to facilitate reintegration.

5.G. 14. The curriculum-based program component for each person served:

a. Addresses issues specific to his or her individual needs.

b. Is consistent with his or her cognitive and learning abilities.

c. Is consistent with the program’s philosophy of treatment.

d. Includes provisions for:
   (1) Evaluation.
   (2) Group instruction.
   (3) Individual instruction.

e. Meets applicable federal, provincial, and state requirements.

Intent Statements

14.b. The intent of this standard is to ensure that the assessment has included cognitive and learning abilities and that reading materials,
assignments, and the requirements for participation take into consideration the learning abilities of the person served. This standard includes ensuring that reasonable accommodations are available for persons with special educational needs.

14.c. Because many of the juvenile justice educational services are provided as part of or within a treatment program, this standard encourages the organization to ensure that the educational plan for each person served is consistent with the philosophy of the treatment program.

Examples
The organization is encouraged to include the following topics in its educational programs:

- Substance abuse treatment, relapse prevention, and recovery.
- Physical health issues or consequences and communicable diseases.
- Community resources and community integration.
- Violence prevention.
- Culture-specific issues.
- Interpersonal and relationship skills.
- Life-skills training.
- Problem solving.
- Conflict or anger management.

5.G. 15. Based on the needs of the person served, the educational program addresses the development of:

a. Community living skills.
b. Social skills.
c. Social supports.
d. Vocational skills.

In detention or correctional settings, staff support may be provided by an organization other than the one providing the behavioral health services.

5.G. 17. If residential services are provided, the program provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:

a. Family members and/or significant others.
b. Peers.
c. Others.

5.G. 18. The environment is configured to meet the needs of juveniles, including:

a. The physical plant.
b. The furniture.
c. The equipment.

Examples
Considerations include the provision of:

- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and video equipment.

5.G. 19. The organization implements a policy(ies) and procedures for:

a. Obtaining criminal background checks on all persons providing direct services to juveniles.
b. Acting on the results of the background checks.

Intent Statements
Background checks may include fingerprinting and FBI criminal history checks. Persons providing direct services include personnel, students, interns, volunteers, or contracted providers of direct service. The provision of direct services includes transportation.

Examples
Background checks may be conducted prior to employment for new personnel, at the time of job change when beginning to work with children or
adolescents, or prior to an accreditation survey for existing personnel.

### Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Curriculum for or records of staff training
- Written service agreements
- Transition or discharge plans
- Person-centered plans
- Educational plans for the person served
- Assessments of the children or adolescents served
- Filed, current information on law pertaining to educational specialists and educational services
- Staffing pattern chart for residential, or 24/7 programs
- Policies related to background checks on all personnel

### H. Medically Complex (MC)

#### Description
Medically complex standards are applied to programs that serve a specific population of persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to his or her health status.

These standards consider the individual’s overall medical condition, including acuity, stability, impairments, activity limitations, participation restrictions, psychological status, behavioral status, placement, and long-term outcomes expectations. Appropriate medical consultation occurs specific to each person served in addition to medical consultation related to policies and procedures.

Services to persons with medically complex conditions can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. The services within the program are designed based on the needs, desires, and expectations of the persons served and their legal guardian/caregivers to maximize the ability to function effectively within their family (or placement), school, and/or community environments and to achieve and maintain an optimal state of health to enhance their quality of life. The services provided also
consider any culturally specific issues relevant to the individual and his or her family/caregivers as appropriate. The service plan supports all transitions in the person's life and is changed as necessary to meet his or her identified needs as well as the needs of the family/caregivers.

Some examples of the quality results desired by the different stakeholders of these services include:

- Development of an effective and efficient network of community support services including access to therapies, medical supports, and guidance.
- Satisfying and meaningful relationships.
- Achievement of goals in health, education, and activities of daily living.
- Being able to choose and pursue meaningful activities in the least restrictive environment possible to achieve personal satisfaction in life activities.
- Maintenance of health and well-being.
- Restored or improved functioning.
- Enhanced quality of life.
- Personal and family development.
- Transitions between levels of care or transition to independence.
- End-of-life services and supports for the person, his or her family/caregiver, legal guardian, and/or other significant persons in the individual's life to assist with meaningful closures.

Note: An organization seeking accreditation for a core program for children/adolescents who meet the definition of medically complex (MCCA) must apply the standards in Sections 5.C. and 5.H.

5.H. The program description of services available for this population includes the following, as applicable:

- Medical acuity issues.
- Medical stability issues.
- Psychological issues.
- Behavioral issues.
- Activity limitations.
- Participation restrictions.
- Long-term planning criteria.
- Intended discharge environments.
- Environmental modifications.
- Adaptive equipment.
- Respite.

Intent Statements

1.a. Medical acuity issues refers to the services that are considered urgent and require immediate attention.

1.b. Medical stability issues refers to the overall medical condition of the person served at a given point in time.

5.H. The program collaborates with:

- Healthcare providers who provide specialized medical, psychological/behavioral, and other therapeutic care to the person served.
- Other providers who provide specialized care to the person served.

Examples

2.b. Other providers may include child care, recreation, and education.
5.H. 3. Services are managed by an individual who has:
   a. The education, training, and experience needed to meet the needs of persons with medically complex needs.
   b. The competencies needed to manage the services.

Intent Statements
The program identifies the background and competencies required based on the scope of services provided.

Examples
Based on the services provided, the individual’s education, training, and experience may be in areas such as healthcare or nursing, health advocacy, health aspects of disabilities, health problems commonly co-occurring with developmental or medical disabilities, palliative care, or medication management.

Job descriptions identify qualifications needed and ensure compliance with applicable guidelines and legal requirements. Applicable laws and national/professional organizations may be excellent resources for establishing qualifications.

5.H. 4. The program informs the primary care physician(s) of the progress of each person served toward his or her individual goals regarding:
   a. Assessments.
   b. Significant changes.
   c. Discharge/transition.

Intent Statements
Communication with primary care physicians is critical when providing services to persons with medically complex needs, especially when the primary care physician is not directly involved with the services provided.

The physician(s) to be notified are identified by the person served and/or by a residential facility.

Examples
4.b. Examples of significant changes in the status of the person served include an acute illness that precipitates transfer to another level of care, a fall that results in significant injury, or death.

5.H. 5. The service delivery team includes specialists, as appropriate.

Intent Statements
In addition to the primary care physician, there may be an array of other professionals or specialists that would be included on the service delivery team.

Examples
The survey team will look for conformance to this standard through review of records (documentation of input into team decisions, attendance at team meetings, and phone conversations) and interviews with persons served, families, personnel, and payers.

Team member involvement can be accomplished by a variety of methods such as conference calls; sharing information via fax, messenger, or mail; and ongoing conversations between team members.

Additional individuals on the service delivery team could include:
- An audiologist.
- A behavior analyst. (A behavior analyst is a psychologist in the distinct specialty of applied behavior analysis. A behavior analyst conducts functional assessments and analyses of behavior and its environmental influences. This individual designs and implements programs using the principles of learning and motivation to effect the acquisition of desired instrumental and social behaviors.)
- A case manager/care coordinator, internal or external.
- A spiritual advisor.
- A child life specialist. (A child life specialist has competence in the areas of growth and development, family dynamics, play and activities, interpersonal communication, developmental observation and assessment, the learning process, the group process, behavior management, the reactions of children to hospitalization and to illness, interventions to prevent emotional trauma,
collaboration with other healthcare professionals, a basic understanding of child/youth illnesses and medical terminology, and supervisory skills.)

- A child psychologist.
- A creative arts therapist. (Includes music therapists, art therapists, dance therapists, drama therapists, and poetry therapists.)
- A developmental specialist. (An individual who is competent in child/youth development and could include, but is not limited to, a pediatrician, child psychologist, social worker, special educator, or child life specialist.)
- A driving instructor.
- An educational specialist. (A special or regular education teacher.)
- A neuropsychologist.
- An occupational therapist.
- An orthotist.
- A pediatric nurse practitioner.
- A pediatric physiatrist.
- A pharmacist.
- A physical therapist.
- A physiotherapist/physical therapist.
- A primary care physician.
- A physician extender (assistant).
- A prosthetist.
- A qualified alcoholism and other drug abuse counselor. (An individual with experience and training in the treatment of alcoholism and other drug abuse.)
- A registered dietitian.
- A registered nurse. (May include a registered nurse with rehabilitation experience.)
- A rehabilitation engineer.
- A rehabilitation nurse.
- A rehabilitation physician.
- A respiratory therapist.
- A school guidance counselor.
- A social worker.
- A speech-language pathologist.
- A therapeutic recreation specialist.
- A vocational specialist.

5.H. 6. Personnel demonstrate competencies in the following areas:
- a. Developmental stages.
- b. Physical impairments.
- c. Behavioral needs.
- d. Day-to-day needs.
- e. Grief and end-of-life support concerns.

Examples
6.d. May include nutritional needs or medication administration.

5.H. 7. The program promotes a positive, therapeutic approach to behavior management, as applicable, that addresses:
- a. Instruction and guidance to the person regarding desired behaviors that:
  (1) Build on current strengths.
  (2) Promote resiliency.
- b. Environmental factors to enhance the desired behaviors of the person.
- c. Environmental modifications.
- d. Use of medications.

Examples
7.c. Environmental modifications might include the use of noise-reduction materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and doorbells; limiting or controlling where and when people may visit persons served; reducing noxious stimuli such as bright sunlight or odors; and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

5.H. 8. As appropriate to the scope of the program, end-of-life planning:
- a. Is directed by the wishes/desires of the person served and/or legal guardian.
- b. Includes advocacy of hospice, palliative care, or other end-of-life choices as needed.
Section 5.H. Medically Complex (MC)

c. Includes spiritual or religious elements, if desired by the person served and/or legal guardian.

d. Includes the guidance of a medical professional, if desired by the person served and/or legal guardian.

e. Is communicated to applicable service providers in the required format, if applicable.

Intent Statements

Persons served, families/support systems, and personnel have opportunities to talk about end-of-life issues and participate in planning the memorial service and creating end-of-life protocols.

Examples

Families/support systems should be involved in the development of advance directives and in identifying the extent to which medical intervention is to be administered.

Whenever possible, no one dies alone. Support and presence are planned for each individual served so that he or she does not die alone.

The person served and his or her family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do-not-resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to an individual's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or family/support systems.

Some organizations do not choose to have a memorial service, but they may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

5.H. 9. The program has a written philosophy of health and wellness for the persons served that:

a. Is designed to:
   (1) Meet their interests.
   (2) Align with their cognitive capabilities.
   (3) Reflect their choices.
   (4) Promote their personal growth.
   (5) Enhance their self-image.
   (6) Improve or maintain their functional levels whenever possible.

b. Is implemented to:
   (1) Address:
      (a) Function.
      (b) Quality of life.
   (2) Promote healthy aging and well-being.

c. Addresses aging in place.

d. Is shared with:
   (1) The persons served.
   (2) Families/support systems.
   (3) Personnel.

Examples

A program's philosophy may be documented separately or included in other documents such as a program plan or marketing materials. An emphasis might be placed on:

- Maximizing or maintaining independence of persons served.

- How changing acuity needs will be addressed.

9.b.(1)(a)–(b) A program's philosophy addresses how it intends to provide services that promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the persons served.

5.H. 10. The primary assessment for each person served in the program includes the identification of:

a. Presenting health risks.

b. Health goals.

c. Expected health benefits.
5.H. 11. Based on the initial and ongoing assessments, the person-centered plan of care addresses needs in the following areas, as appropriate:
   a. Adjustment of the person to activity limitations.
   b. Adjustment of the family to activity limitations.
   c. Advance directives.
   d. Assistive technology.
   e. Bereavement.
   f. Communication.
   g. Community reintegration.
   h. Environmental modifications.
   i. Growth and development.
   j. Sexuality.
   k. Wellness.

Examples
11.c. Advance directives may relate to organ donation and orders not to resuscitate.
Considerations include religion, legal parameters, how orders should be documented, and who is responsible for making a DNR decision.

5.H. 12. The person-centered plan of care:
   a. Specifically addresses how services will be provided in a manner that ensures the safety of the person served.
   b. Identifies the services provided by skilled healthcare providers.

5.H. 13. Wellness for the person served is promoted through activities that:
   a. Are purposeful.
   b. Include daily:
      (1) Structured activities.
      (2) Unstructured activities.
   c. Are designed to:
      (1) Meet their interests.
      (2) Align with their cognitive capabilities.
      (3) Reflect their choices.
   (4) Promote their personal growth.
   (5) Enhance their self-image.
   (6) Improve or maintain their functional levels whenever possible.
   d. Allow for group interaction.
   e. Allow for autonomy, as applicable.
   f. Include opportunities for community integration.
   g. Are evident in the person-centered plan for each person served.

5.H. 14. The environment where services are provided addresses the behavioral and cognitive needs of the person served in terms of:
   a. Agitation.
   b. Cueing.
   c. Distractibility.
   d. Elopement risks.
   e. Equipment safety.
   f. Level of responsiveness.
   g. Orientation.
   h. Physical safety.
   i. Physically aggressive behaviors.
   j. Self-injurious behaviors.
   k. Sexual behaviors.

5.H. 15. The environment where services are provided supports:
   a. Wellness activities.
   b. Initiation of the wellness/health services.
   c. Transition from the wellness/health services.

Intent Statements
The environment where services are provided includes adequate resources, materials, and space to allow for health and wellness activities. The program identifies how persons served are included or removed from those activities.
Section 5.H. Medically Complex (MC)

5.H. 16. When applicable, the living environment provided for the person served is:
   a. Developed based on input from the person served and family/guardian.
   b. Modified as needed based on input from the person served and family/guardian.
   c. Inclusive.
   d. Integrated into the community.
   e. Physically supportive to meet the needs of the persons living in the residence.
   f. Psychologically supportive to meet the:
      (1) Emotional needs of the person served.
      (2) Social needs of the person served.

5.H. 17. When applicable, individual possessions and decorations reflecting the choices by the person served are evident in his or her living environment.

5.H. 18. As appropriate based on scheduling, the program provides:
   a. Daily access to at least three nutritious meals (or equivalent per doctor/dietician) or enteral feedings in a program that provides 24-hour care.
   b. Access to snacks consistent with personal choice and timing, unless contraindicated by the person-centered plan or medical condition.

5.H. 19. The education and training program for the person served:
   a. Is:
      (1) Developmentally appropriate.
      (2) Age appropriate.
   b. Includes:
      (1) Knowledge of:
         (a) Ability.
         (b) Activity.
         (c) Participation.
      (2) Ability to describe and discuss any activity limitations in an age-appropriate fashion.
      (3) Conflict resolution.
      (4) Negotiation skills.
      (5) Assertiveness training.
      (6) Advocacy training.
      (7) Preparation for adolescence/adulthood.
      (8) Outcomes of decisions.

5.H. 20. When a person served dies, opportunities are provided to other persons in the program, family/support systems, and personnel to:
   a. Express grief and remembrance.
   b. Develop and participate in:
      (1) Memorial services.
      (2) Memorial rituals.
      (3) Other forms of grief expression, as desired.
Documentation Examples

The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written program description of services
- Documentation of end-of-life planning, as appropriate
- Written philosophy of health and wellness for the persons served
- Assessments for the persons served
- Written individual person-centered plans

I. Older Adults (OA)

Description

Programs for older adults consist of an array of services designed specifically to address the behavioral health needs of this population. Such programs tailor their services to the particular needs and preferences of older adults and their families/support systems. Services are provided in environments appropriate to their needs. Personnel are trained to effectively address the complex needs of older adults.

Applicable Standards

If an organization serves older adults and chooses to add the Specific Population Designation for Older Adults to a core program in Section 3 or 4, the standards in this section must be applied in addition to the standards in Section 1 and 2 and the core program standards in Section 3 or 4, except for Call Centers, Diversion/Intervention, Prevention, and Comprehensive Suicide Prevention programs.

Organizations that serve older adults are not required to apply these standards to the core programs for which they are seeking accreditation.

5.I. 1. The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served that:

   a. Includes information obtained from:
      (1) The person served.
      (2) Family members/legal representatives, when applicable and permitted.
(3) Other collateral sources, when applicable and permitted.

(4) External sources, when the need for specified assessment not able to be provided by the program is identified.

b. Addresses the following areas:
   (1) Abuse, neglect, and/or exploitation.
   (2) Addiction.
   (3) Behavioral.
   (4) Cognition.
   (5) Communication.
   (6) Comorbidities.
   (7) Family roles and responsibilities.
   (8) Function.
   (9) Goals for living situation.
   (10) Grief and loss.
   (11) Medications, including systems for medication adherence.
   (12) Nutrition.
   (13) Physical status.
   (14) Risks.
   (15) Safety of the home environment, including:
      (a) Assistive devices and equipment.
      (b) Emergency plans.
      (c) Other persons in the home.
      (d) Pets.
      (e) Physical environment.
   (16) Sexuality.
   (17) Significant life events.
   (18) Social status.
   (19) Spirituality.
   (20) Vocational status.
   (21) Other areas, as appropriate to the needs of the person served.

Intent Statements

In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, or Detoxification) the amount of information collected may be limited by time or the condition of the person served. The intent of this standard is to collect an adequate amount of information to provide appropriate and safe services that meet the unique needs of this population.

Examples

1.b.(2) This may include substance misuse, process addictions, gambling, and spending/shopping.

1.b.(3) The assessment process addresses problematic or excessive behaviors impacting the person's functioning.

1.b.(4) This includes a description of the person's memory and thinking abilities.

1.b.(6) Comorbidities in this context could include mental health, physical health, and substance misuse/abuse/addiction.

1.b.(7) This may include whether the person is functioning in a family role that is satisfying and that the person views as appropriate and if the person has financial responsibilities for other family members either in or out of the home.

1.b.(8) This would describe the person's ability to perform functions of daily living.

1.b.(10) Older adults often experience significant losses of life partners, children, and close friends, and grief may be unexpressed.

1.b.(13) There could be a general description of overall physical condition, but there are a number of typical conditions that impact older adults and should be considered in planning for care. These include vision and hearing difficulties, ambulation restrictions or need for assistive devices, fall risks, and incontinence.

1.b.(14) There are a number of risks to this population that should be considered, such as abuse, falls, driving, violence in the home, financial or other exploitation, and suicide.

1.b.(16) The program considers the person's current sexual behaviors/status and how these may impact current functioning.

1.b.(17) There are a number of significant life events that can create grief and loss issues as well as trauma. These can include retirement, change of residence, loss of independence, loss of loved ones and pets, recent diagnosis of serious illness, and experiences of war or disasters.

1.b.(18) The program considers how the person interacts with friends and social networks, types
of recreation and leisure activities engaged in, and volunteer or other activities.

5.1. 2. To ensure that the family/support system is involved as desired by the person served, the program conducts assessments that consider:
   a. The family/support system's:
      (1) Ability and willingness to support and participate in the person-centered plan.
      (2) Ability and willingness to serve in a supportive role.
      (3) Composition.
      (4) Geography.
      (5) Education/information needs.
      (6) Expectations of the program.
      (7) Interactions.
      (8) Responsibilities.
      (9) Contingency plans for care.
   b. Other factors that might influence the plan of care.

Intent Statements
Involvement of immediate or extended family members or their proxies often assists programs to effectively keep persons served living the most independent lives possible. Programs seek to assess the quality and safety of the person’s support network as well as the ability to function as appropriate support.

Examples
2.a.(7) The program determines how the members of the family/support system interact with each other and how the program can interact in a manner to be most effective in supporting the family/support system.

5.1. 3. Care coordination includes sharing information:
   a. With the following providers involved in the care of the person served, as applicable:
      (1) Primary care.
      (2) Behavioral health.
      (3) Hospital and other inpatient settings.
      (4) Medical specialty.
      (5) Others, when applicable.
   b. At the following times:
      (1) Entry to the program.
      (2) Significant changes in status of the person served.
      (3) Transition/discharge.
   c. In accordance with applicable laws and authorizations.

Intent Statements
Older adults often have a complex constellation of care providers, including healthcare and social service organizations, which may not communicate effectively with each other. To the degree allowed by applicable laws, the program assists the person served by bridging communication gaps between providers and educating providers about needed services.

5.1. 4. The program provides an organized education program that:
   a. Is appropriate to the needs of:
      (1) Persons served.
      (2) Families/support systems.
   b. Addresses the following topics, as appropriate:
      (1) Abuse, neglect, and exploitation.
      (2) Addiction.
      (3) Caregiver stress.
      (4) Cognitive decline.
      (5) Communication with care providers.
      (6) Falls.
      (7) Interaction between behavioral health issues and comorbidities.
      (8) Importance of having a primary care provider.
      (9) Loss and bereavement.
      (10) Nutrition.
      (11) Psychoeducation about the diagnosis.
      (12) Risk of suicide.
      (13) Self-advocacy.
(14) Sexuality.
(15) Wellness.

Intent Statements

These educational services are provided as appropriate to the needs of the persons served and the intensity of service provided.

5. The program provides, arranges, or assists with arrangements for education on medication, as appropriate:
   a. To:
      (1) Persons served.
      (2) Families/support systems.
   b. That addresses:
      (1) Actions to take in case of an emergency.
      (2) Medication management.
      (3) Disposal.
      (4) Identification, including why each medication is prescribed.
      (5) Implications for management of multiple medications.
      (6) Implications of abrupt discontinuation.
      (7) Obtaining medication.
      (8) Over-the-counter medications, supplements, and vitamins.
      (9) Side effects.
      (10) Storage.
      (11) Understanding the education provided.

6. Based on identified needs, the program provides information to the persons served and their families/support systems on:
   a. Financial resources.
   b. Healthcare benefits.
   c. Service options available in the community.

Examples

6.b. As appropriate, persons served are provided with information about benefits such as Medicare, Medicare Advantage Plans or Part B Plans, VA benefits, or other private insurance benefits.

7. As appropriate to the scope of the program, planning end-of-life care:
   a. Is directed by the wishes/desires of the person served and/or legal representative.
   b. Includes advocacy of hospice, palliative care, or other end-of-life choices as needed.
   c. Includes cultural, ethnic, religious, or spiritual elements, if desired by the person served and/or legal representative.
   d. Includes the guidance of a medical professional, if desired by the person served and/or legal representative.
   e. Is communicated to applicable service providers in the required format, if applicable.

Intent Statements

Persons served, families/support systems, and personnel have opportunities to talk about end-of-life issues and participate in planning of memorial services and creating end-of-life protocols.

Examples

Families/support systems are involved in the development of advance directives and in identifying the extent to which medical intervention is to be administered.

Whenever possible, no one dies alone. Support and presence are planned for each individual served so that he or she does not die alone.

The person served and his or her family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs), and care planning includes these preferences.

Memorial gardens may be developed on the organization’s property in remembrance of those lost.
Memorials that reflect persons served who have died may be evident throughout the organization.

Do-not-resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify any issues related to an individual's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or families/support systems.

**Resources**

A resource for preparing for the end of life is [http://nihseniorhealth.gov/endoflife/preparingfortheendoflife/01.html](http://nihseniorhealth.gov/endoflife/preparingfortheendoflife/01.html).

5.I. **8.** The environment is configured appropriately to meet the needs of older adults, including the:
   a. Physical plant.
   b. Furniture.
   c. Equipment and supplies.

**Intent Statements**

The program considers issues of lighting, carpets, handrails, toilets, placement and types of furnishings, as well as equipment needed to ensure the safety of persons served such as walkers, wheelchairs, raised toilet seats, incontinence supplies, pocket talkers, etc.

5.I. **9.** The organization implements a policy and procedure for obtaining criminal background checks on all personnel providing direct services to older adults.

**Intent Statements**

Direct support workers are appropriately screened before being allowed to provide services.

**Examples**

Background checks may include fingerprinting, FBI criminal history checks, child abuse and neglect registry, sex offender registries, or other appropriate methods available.

**Resources**

The Dru Sjodin National Sex Offender Public Website ([www.nsopw.gov](http://www.nsopw.gov)), coordinated by the U.S. Department of Justice, is a cooperative effort between jurisdictions hosting public sex offender registries (“Jurisdictions”) and the federal government and is offered free of charge to the public. These Jurisdictions include the 50 states, U.S. Territories, the District of Columbia, and participating tribes. The web site provides an advanced search tool that allows a user to submit a single national query to obtain information about sex offenders; a listing of public registry web sites by state, territory, and tribe; and information on sexual abuse education and prevention. The criteria for searching are limited to what each individual Jurisdiction may provide. Also, because information is hosted by each Jurisdiction and not by the federal government, search results should be verified by the user in the Jurisdiction where the information is posted. Users are advised to visit the corresponding Jurisdiction web sites for further information and/or guidance, as appropriate.

5.I. **10.** The program provides documented training to direct service personnel on topics unique to working with older adults:
   a. At:
      (1) Orientation.
      (2) Regular intervals.
   b. That includes, at a minimum, the following topics:
      (1) Addiction.
      (2) Aging.
      (3) Bereavement.
      (4) Cognitive decline.
      (5) Interaction between behavioral health issues and comorbidities.
      (6) Mental illness.
      (7) Respecting autonomy.
      (8) Substance use.
      (9) Other, as appropriate.

**Intent Statements**

Direct service personnel are those who interact with persons served for the purpose of providing or supporting a service in a program.
Examples
10.b.(2) There are many typical age-related changes that may occur in older adults, such as cognitive decline, dementia, degenerative diseases, decreases in sexual activity and intimacy, organ failures, and incontinence. Personnel are knowledgeable in typical and atypical symptoms.

10.b.(3) Personnel are able to distinguish between loss, grief, and depression. They are also skilled at recognizing and caring for their own issues of loss that can be associated with the death of persons served.

Intent Statements
Older adults often have difficulty engaging in services for a variety of reasons, which may include transportation challenges, stigma issues, and inability to establish rapport with program personnel. Based on the type and intensity of services offered, the program identifies a method to define meaningful engagement in service and collects data for the purpose of performance improvement.

Documentation Examples
The following are examples of the types of documents and other information you should have available to demonstrate conformance to the standards in this section. Note that for some items, evidence of conformance is not required to be in writing. See Appendix A for more information on standards that specifically require written documentation.

- Written program description
- Individual plans of persons served
- Assessments of persons served and families/support systems
- Documentation of end-of-life planning, as appropriate
- Information provided to persons served and families/support systems
- Policy and procedure for obtaining criminal background checks on all personnel providing direct services to older adults
- Documentation of training for all direct service personnel
APPENDIX A

Required Written Documentation

The following tables list standards that explicitly require some form of written evidence in order to achieve full conformance.

When interpreting CARF standards, the following terms always indicate the need for written evidence: policy, plan, documented, documentation, and written. Other terms may also indicate the need for specific written information.

This list of standards is not inclusive of all the documentation that will be reviewed during the survey of your organization.

NOTE: This appendix is available in an editable electronic format at www.carf.org/Documentation_and_Time_Lines or through the Resources section in Customer Connect (https://customerconnect.carf.org).

Section 1. ASPIRE to Excellence®

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.A. Leadership</strong></td>
<td></td>
</tr>
<tr>
<td>1.A.5.a.</td>
<td>Cultural competency and diversity plan</td>
</tr>
<tr>
<td>1.A.6.a., b.</td>
<td>Written ethical codes of conduct and written procedures to deal with allegations of violations of ethical codes</td>
</tr>
<tr>
<td>1.A.7.a.</td>
<td>For U.S. organizations receiving federal funds, policy on corporate compliance adopted by organization leadership</td>
</tr>
<tr>
<td>1.A.7.b.</td>
<td>For U.S. organizations receiving federal funds, written procedures that address exclusion of individuals and entities from federally funded healthcare programs.</td>
</tr>
<tr>
<td>1.A.7.c.(1)</td>
<td>For U.S. organizations receiving federal funds, documentation of staff member designated to serve as the organization’s compliance officer</td>
</tr>
<tr>
<td>1.A.9.a.</td>
<td>Written procedures related to organizational fundraising, if applicable</td>
</tr>
<tr>
<td><strong>1.B. Governance (Optional)</strong></td>
<td></td>
</tr>
<tr>
<td>1.B.1.</td>
<td>Governance policies to facilitate ethical governance, assure stakeholders that governance is active and accountable, and meet legal requirements</td>
</tr>
<tr>
<td>1.B.2.</td>
<td>Governance policies regarding board selection, orientation, development, education, leadership, structure, and performance</td>
</tr>
<tr>
<td>1.B.5.</td>
<td>Governance policies addressing executive leadership development and evaluation, including a written performance review and succession plan</td>
</tr>
</tbody>
</table>
## Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.B.6.</strong> Governance policies, written statements, and documented processes addressing executive compensation</td>
<td></td>
</tr>
<tr>
<td><strong>1.C. Strategic Planning</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.C.2.a.–c.</strong> Strategic plan</td>
<td></td>
</tr>
<tr>
<td><strong>1.E. Legal Requirements</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.E.2.</strong> Written procedures to guide personnel in responding to subpoenas, search warrants, investigations, and other legal actions</td>
<td></td>
</tr>
<tr>
<td><strong>1.E.3.</strong> Policies and written procedures on records</td>
<td></td>
</tr>
<tr>
<td><strong>1.F. Financial Planning and Management</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.F.2.a., b.(1), b.(3)</strong> Written budgets</td>
<td></td>
</tr>
<tr>
<td><strong>1.F.4.e.</strong> If appropriate, financial solvency remediation plans</td>
<td></td>
</tr>
<tr>
<td><strong>1.F.6.a.</strong> Fiscal policies and written procedures including internal control practices</td>
<td></td>
</tr>
<tr>
<td><strong>1.F.7.b.</strong> Review of representative sample of bills of persons served, if applicable</td>
<td></td>
</tr>
<tr>
<td><strong>1.F.9.</strong> Written procedures regarding managing funds of persons served, if applicable</td>
<td></td>
</tr>
<tr>
<td><strong>1.F.10.</strong> Annual review or audit of financial statements by an independent, authorized accountant; any recommendations that resulted from the review or audit and management's response, if applicable</td>
<td></td>
</tr>
<tr>
<td><strong>1.G. Risk Management</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.G.1.a.</strong> Risk management plan</td>
<td></td>
</tr>
<tr>
<td><strong>1.G.3.</strong> Written procedures regarding communications, including media relations and social media</td>
<td></td>
</tr>
<tr>
<td><strong>1.H. Health and Safety</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.H.2.</strong> Written procedures to promote the safety of persons served and personnel</td>
<td></td>
</tr>
<tr>
<td><strong>1.H.4.</strong> Documentation of competency-based training in health and safety for personnel at orientation and at least annually</td>
<td></td>
</tr>
<tr>
<td><strong>1.H.5.</strong> Written emergency and evacuation procedures</td>
<td></td>
</tr>
<tr>
<td><strong>1.H.7.d.</strong> Written evidence of unannounced tests of each emergency procedure, including analyses</td>
<td></td>
</tr>
</tbody>
</table>
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.H.9.</td>
<td>Written procedures regarding critical incidents</td>
</tr>
<tr>
<td>1.H.10.b.</td>
<td>Written analysis of critical incidents</td>
</tr>
<tr>
<td>1.H.12.h.</td>
<td>Written emergency procedures related to transportation services</td>
</tr>
<tr>
<td>1.H.13.b.</td>
<td>External health and safety inspection reports</td>
</tr>
<tr>
<td>1.H.15.</td>
<td>Written procedures concerning hazardous materials, if applicable</td>
</tr>
</tbody>
</table>

#### 1. Workforce Development and Management

| 1.I.1. | Documentation of the composition of the organization's workforce |
| 1.I.3.b. | Written job descriptions |
| 1.I.4. | Written procedures related to verification of backgrounds, credentials, and fitness for duty, if required, of the workforce |
| 1.I.6.d.(1) | Policies and written procedures related to workforce engagement |
| 1.I.8. | Written procedures for performance appraisals |

#### 1.J. Technology

| 1.J.2.b. | Technology and system plan |
| 1.J.3. | Policies related to technology that address all elements identified in the standard |
| 1.J.4.c. | Written evidence of tests of the organization's procedures for business continuity/disaster recovery, including the analysis |
| 1.J.5. | Documentation of personnel training on cybersecurity and the technology used in performance of job duties |
| 1.J.6. | Written procedures related to use of information and communication technologies to deliver services, and to confirm technology and equipment is available and functions, if applicable |

#### 1.K. Rights of Persons Served

| 1.K.1. | Policies on the rights of persons served |
| 1.K.3.a. | Policy and written procedure by which persons served may make a formal complaint |
| 1.K.3.b. | Complaint forms, if applicable |
| 1.K.3.c. | Documentation of formal complaints |
| 1.K.4.b. | Documented analysis of all formal complaints |
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.L. Accessibility</td>
<td></td>
</tr>
<tr>
<td>1.L.2.</td>
<td>Accessibility plan</td>
</tr>
<tr>
<td>1.L.3.d.</td>
<td>Documentation of requests for reasonable accommodations</td>
</tr>
<tr>
<td>1.M. Performance Measurement and Management</td>
<td></td>
</tr>
<tr>
<td>1.M.1.</td>
<td>Written description of performance measurement and management system</td>
</tr>
<tr>
<td>1.M.3.d.(2)</td>
<td>Written service delivery objectives, performance indicators, and performance targets for each program seeking accreditation</td>
</tr>
<tr>
<td>1.N. Performance Improvement</td>
<td></td>
</tr>
<tr>
<td>1.N.1.b. and c.</td>
<td>Written performance analysis</td>
</tr>
<tr>
<td>1.N.1.c.(2)</td>
<td>Performance improvement action plan</td>
</tr>
</tbody>
</table>

### Section 2. General Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A. Program/Service Structure</td>
<td></td>
</tr>
<tr>
<td>2.A.1.a.</td>
<td>Scope of services</td>
</tr>
<tr>
<td>2.A.3.</td>
<td>Entry, transition, and exit criteria</td>
</tr>
<tr>
<td>2.A.8.</td>
<td>Written procedures related to mobile unit services</td>
</tr>
<tr>
<td>2.A.9.</td>
<td>Written program description that guides service delivery</td>
</tr>
<tr>
<td>2.A.11.</td>
<td>Policies and written procedures addressing positive approaches to behavioral interventions, when applicable</td>
</tr>
<tr>
<td>2.A.12.a.</td>
<td>Written procedures governing the use of special treatment interventions and restrictions of rights</td>
</tr>
<tr>
<td>2.A.18.</td>
<td>Written procedures that specify the program provides or arranges for crisis intervention services</td>
</tr>
<tr>
<td>2.A.21.e.</td>
<td>Documented attendance of participants at team meetings and results of team meetings</td>
</tr>
<tr>
<td>2.A.23.</td>
<td>Policy and written procedures for supervision of direct service personnel</td>
</tr>
</tbody>
</table>
### Section 2. General Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A.24.</td>
<td>Documented ongoing supervision of clinical or direct service personnel</td>
</tr>
<tr>
<td>2.A.25.</td>
<td>Policies that address the handling of items brought into the program by persons served, personnel, and visitors, and that address the use of tobacco products in all locations and in all vehicles owned or operated by the organization</td>
</tr>
<tr>
<td>2.A.26.</td>
<td>Written procedures that address the use of drug screening, for programs that treat persons with substance use disorders</td>
</tr>
<tr>
<td>2.A.27.</td>
<td>Policies and procedures that are inclusive of a peer workforce</td>
</tr>
<tr>
<td>2.A.30.</td>
<td>Documented competency-based training for peer support specialists</td>
</tr>
<tr>
<td>2.A.31.</td>
<td>Ethical codes of conduct specifically address boundaries related to peer support services</td>
</tr>
</tbody>
</table>

#### 2.B. Screening and Access to Services

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.B.3.</td>
<td>Policies and written procedures related to screening</td>
</tr>
<tr>
<td>2.B.4.</td>
<td>Documented screening, when conducted by the organization</td>
</tr>
<tr>
<td>2.B.7.a. and c.</td>
<td>Waiting list documentation, if applicable</td>
</tr>
<tr>
<td>2.B.8.</td>
<td>Documented orientation for each person served</td>
</tr>
<tr>
<td>2.B.13.</td>
<td>Information gathered and recorded in the assessment process</td>
</tr>
<tr>
<td>2.B.14.</td>
<td>Written interpretive summary from assessment process</td>
</tr>
</tbody>
</table>

#### 2.C. Person-Centered Plan

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.C.1.</td>
<td>Written person-centered plan for each person served</td>
</tr>
<tr>
<td>2.C.2.</td>
<td>Specific components of person-centered plan for each person served</td>
</tr>
<tr>
<td>2.C.3.</td>
<td>Written procedures that identify timeframes for reviewing and modifying person-centered plans</td>
</tr>
<tr>
<td>2.C.4.</td>
<td>Personal safety plan, completed when assessment identifies potential risks for suicide, violence, or other risky behaviors</td>
</tr>
<tr>
<td>2.C.5.a.</td>
<td>When a person served has concurrent disorders or disabilities and/or comorbidities, the person-centered plan addresses these conditions in an integrated manner</td>
</tr>
<tr>
<td>2.C.6.b.</td>
<td>Signed, dated progress notes</td>
</tr>
</tbody>
</table>
### Section 2. General Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.D. Transition/Discharge</strong></td>
<td></td>
</tr>
<tr>
<td>2.D.1.</td>
<td>Written procedures for referrals, transfers, inactive status, discharge, and follow-up</td>
</tr>
<tr>
<td>2.D.3.</td>
<td>Written transition plan</td>
</tr>
<tr>
<td>2.D.4.a.</td>
<td>Written transition plan is developed with the identified sources</td>
</tr>
<tr>
<td>2.D.6.</td>
<td>Written discharge summary for all persons leaving services</td>
</tr>
<tr>
<td><strong>2.E. Medication Use</strong></td>
<td></td>
</tr>
<tr>
<td>2.E.1.</td>
<td>Policy that identifies the scope of medication services for each program seeking accreditation</td>
</tr>
<tr>
<td>2.E.2.</td>
<td>Documentation of training and education regarding medications provided to direct service personnel, persons served, and others, as specified in the standard</td>
</tr>
<tr>
<td>2.E.3.</td>
<td>Written procedures for medications physically controlled by the program</td>
</tr>
<tr>
<td>2.E.4.</td>
<td>Documentation of all medications for each person served</td>
</tr>
<tr>
<td>2.E.6.</td>
<td>Written procedures for administering or prescribing of medications</td>
</tr>
<tr>
<td>2.E.8.</td>
<td>Written procedures for prescribing of medications</td>
</tr>
<tr>
<td>2.E.9.</td>
<td>Documented peer review related to prescribing of medications</td>
</tr>
<tr>
<td><strong>2.F. Promoting Nonviolent Practices</strong></td>
<td></td>
</tr>
<tr>
<td>2.F.1.</td>
<td>Policy for each program that identifies how it will respond to unsafe behaviors of persons served and whether, and under what circumstances, seclusion and restraints are used</td>
</tr>
<tr>
<td>2.F.2.</td>
<td>Documentation of competency-based training for all direct service personnel that addresses prevention of unsafe behaviors</td>
</tr>
<tr>
<td>2.F.3.</td>
<td>Policies on use of seclusion and restraint</td>
</tr>
<tr>
<td>2.F.4.</td>
<td>Documentation of competency-based training for all personnel involved in the direct administration of seclusion or restraint</td>
</tr>
<tr>
<td>2.F.5.</td>
<td>Plan to eliminate the use of seclusion and restraint</td>
</tr>
<tr>
<td>2.F.6.</td>
<td>Written procedures for seclusion and restraint that include identified protocols</td>
</tr>
<tr>
<td>2.F.7.</td>
<td>Written procedures that address risk assessments of each person served and, when applicable, identification of actions to be taken by personnel to de-escalate unsafe behaviors</td>
</tr>
</tbody>
</table>
### Appendix A. Required Written Documentation

#### Section 2. General Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.F.8.</td>
<td>Documentation in the record of each person served when seclusion or restraint is used</td>
</tr>
<tr>
<td>2.F.9.</td>
<td>Written procedures regarding orders for the use of seclusion and restraint</td>
</tr>
<tr>
<td>2.F.11.c.</td>
<td>Documentation of debriefing following the use of seclusion or restraint</td>
</tr>
<tr>
<td>2.F.12.</td>
<td>Written procedure that addresses leadership review of all uses of seclusion and restraint</td>
</tr>
<tr>
<td>2.F.13.</td>
<td>Documented analysis of the program's use of seclusion and restraint</td>
</tr>
</tbody>
</table>

#### 2.G. Records of the Persons Served

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.G.1.</td>
<td>Policies regarding information to be transmitted to other individuals or agencies and forms to authorize release of information</td>
</tr>
<tr>
<td>2.G.2.</td>
<td>Individual record of each person served</td>
</tr>
<tr>
<td>2.G.3.</td>
<td>All documents that require signatures have original or electronic signatures</td>
</tr>
<tr>
<td>2.G.4.</td>
<td>Individual record for each person served contains the identified elements</td>
</tr>
<tr>
<td>2.G.5.</td>
<td>Entries to the records of the persons served follow the organization's policy on timeframes for entries</td>
</tr>
</tbody>
</table>

#### 2.H. Quality Records Management

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.H.1.</td>
<td>Documented quarterly records review</td>
</tr>
</tbody>
</table>

#### Section 3. Core Treatment Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.A. Assertive Community Treatment (ACT)</td>
<td></td>
</tr>
<tr>
<td>3.A.9.</td>
<td>Treatment plan, reviewed quarterly and modified as necessary</td>
</tr>
<tr>
<td>3.A.11.e.</td>
<td>Written emergency procedures for crisis intervention services</td>
</tr>
<tr>
<td>3.A.19.b.</td>
<td>Regular review and documentation of symptoms as well as the response of persons served to prescribed medication treatment</td>
</tr>
<tr>
<td>3.A.29.</td>
<td>Documentation of information shared at organizational staff meetings</td>
</tr>
</tbody>
</table>
## Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.A.36.</td>
<td>Documentation of discharge, completed by identified member(s) of the treatment team</td>
</tr>
<tr>
<td>3.A.37.</td>
<td>Signed discharge documentation</td>
</tr>
<tr>
<td><strong>3.D. Court Treatment (CT)</strong></td>
<td></td>
</tr>
<tr>
<td>3.D.1.b.</td>
<td>Policies for screening, eligibility, and case processing</td>
</tr>
<tr>
<td>3.D.4.</td>
<td>Written assessment for each person served that includes the identified elements</td>
</tr>
<tr>
<td>3.D.9.</td>
<td>Written procedures specifying that the program provides or arranges for the identified services when needed</td>
</tr>
<tr>
<td>3.D.11.</td>
<td>Records of the persons served that document, on an ongoing basis, the specific treatment interventions provided</td>
</tr>
<tr>
<td>3.D.18.</td>
<td>Updated transition plan and status tracking/monitoring, for persons sanctioned to an external setting for 30 days or more</td>
</tr>
<tr>
<td>3.D.21.</td>
<td>Person-centered plan for persons receiving education and training services</td>
</tr>
<tr>
<td><strong>3.E. Crisis Intervention (CI)</strong></td>
<td></td>
</tr>
<tr>
<td>3.E.1.</td>
<td>Written procedure for timely engagement of the person served</td>
</tr>
<tr>
<td>3.E.2.</td>
<td>Written crisis assessment that includes the identified elements</td>
</tr>
<tr>
<td>3.E.3.</td>
<td>Initial crisis intervention plan</td>
</tr>
<tr>
<td>3.E.7.</td>
<td>Written emergency procedures addressing the identified elements</td>
</tr>
<tr>
<td>3.E.11.</td>
<td>Written procedures that guide access to inpatient services or less restrictive alternatives</td>
</tr>
<tr>
<td><strong>3.F. Crisis Stabilization (CS)</strong></td>
<td></td>
</tr>
<tr>
<td>3.F.2.</td>
<td>Initial crisis stabilization plan</td>
</tr>
<tr>
<td>3.F.5.</td>
<td>Documented daily therapeutic interventions</td>
</tr>
<tr>
<td><strong>3.H. Detoxification/Withdrawal Management (DTX)</strong></td>
<td></td>
</tr>
<tr>
<td>3.H.1.</td>
<td>Documented admission criteria that address all areas identified in the standard</td>
</tr>
<tr>
<td>3.H.3.b.</td>
<td>Documented medical evaluation obtained within 24 hours of admission for each person served</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.H.4.c.</td>
<td>Safety plans for persons served, when risks are identified</td>
</tr>
<tr>
<td>3.H.7.b.</td>
<td>Written agreement with medical director that outlines his/her responsibilities</td>
</tr>
<tr>
<td>3.H.7.d.(4)</td>
<td>Written treatment protocols</td>
</tr>
<tr>
<td>3.H.15.</td>
<td>Written procedures for transfer to emergency medical services that include all elements identified in the standard</td>
</tr>
<tr>
<td>3.H.16.</td>
<td>Documentation of competency-based training provided to direct service personnel at orientation and regular intervals that includes the topics identified in the standard</td>
</tr>
<tr>
<td>3.H.17.</td>
<td>Documentation that a review of medical services provided is conducted at least annually</td>
</tr>
<tr>
<td>3.H.21.</td>
<td>Written procedures for searches of persons served, belongings, and the physical facility</td>
</tr>
<tr>
<td>3.H.22.</td>
<td>Written procedures that address visitation, mail, telephone use, and use of personal electronics</td>
</tr>
<tr>
<td>3.H.28.</td>
<td>Written procedures that address drug-screening practices</td>
</tr>
</tbody>
</table>

**3.1. Health Home (HH)**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.I.1.</td>
<td>Written program description</td>
</tr>
<tr>
<td>3.I.7.a.</td>
<td>Person-centered plans for persons served</td>
</tr>
<tr>
<td>3.I.9.</td>
<td>Documented cross-training of direct service personnel at orientation and regular intervals</td>
</tr>
</tbody>
</table>

**3.4. Inpatient Treatment (IT)**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.J.2.c.</td>
<td>Personal safety plans for persons served when risks are identified</td>
</tr>
<tr>
<td>3.J.3.b.</td>
<td>Preliminary treatment plans for persons served based on initial assessments</td>
</tr>
<tr>
<td>3.J.4.b.</td>
<td>Written agreement with medical director that outlines his/her responsibilities</td>
</tr>
<tr>
<td>3.J.6.</td>
<td>Written daily schedule of activities</td>
</tr>
<tr>
<td>3.J.8.</td>
<td>Formal written arrangements for medical consultative services, ancillary medical services, pharmacy services, emergency medical services, and other services, as appropriate</td>
</tr>
<tr>
<td>3.J.14.</td>
<td>Written procedures for searches of persons served and belongings</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.J.15.</td>
<td>Written procedures that address visitation, mail, telephone use, and use of personal electronics</td>
</tr>
<tr>
<td>3.J.18.</td>
<td>Documentation of competency-based training for direct service personnel</td>
</tr>
<tr>
<td><strong>3.K. Integrated Behavioral Health/Primary Care (IBHPC)</strong></td>
<td></td>
</tr>
<tr>
<td>3.K.1.</td>
<td>Written program description that includes the identified elements</td>
</tr>
<tr>
<td>3.K.2.b.</td>
<td>Written procedures for colocation and coordination</td>
</tr>
<tr>
<td>3.K.11.</td>
<td>Written screening procedures</td>
</tr>
<tr>
<td>3.K.12.</td>
<td>Written procedures for intake assessments</td>
</tr>
<tr>
<td>3.K.13.</td>
<td>Individualized integrated plan regarding medical and behavioral health</td>
</tr>
<tr>
<td>3.K.14.</td>
<td>Written procedures for follow-through process in response to the initial assessment</td>
</tr>
<tr>
<td>3.K.15.</td>
<td>Written procedures for ongoing communication and collaboration</td>
</tr>
<tr>
<td><strong>3.L. Intensive Family-Based Services (IFB)</strong></td>
<td></td>
</tr>
<tr>
<td>3.L.2.</td>
<td>Written assessment of how each family functions</td>
</tr>
<tr>
<td>3.L.6.</td>
<td>Policy that demonstrates a commitment to having an identified person/team working consistently with the family</td>
</tr>
<tr>
<td>3.L.8.</td>
<td>File of current community resources for appropriate referral of persons served</td>
</tr>
<tr>
<td>3.L.10.</td>
<td>Contingency plan for crises</td>
</tr>
<tr>
<td>3.L.13.</td>
<td>Plan for access to qualified professionals 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td><strong>3.M. Intensive Outpatient Treatment (IOP)</strong></td>
<td></td>
</tr>
<tr>
<td>3.M.8.</td>
<td>Review of individualized plans for persons served at least monthly</td>
</tr>
<tr>
<td><strong>3.N. Office-Based Opioid Treatment Program (OBOT)</strong></td>
<td></td>
</tr>
<tr>
<td>3.N.2.f.</td>
<td>Written treatment protocols for special populations served</td>
</tr>
<tr>
<td>3.N.2.g.</td>
<td>Written protocols for laboratory studies</td>
</tr>
<tr>
<td>3.N.3.</td>
<td>Written interpretive summaries of assessments for persons served that address the six dimensions of ASAM or similar criteria</td>
</tr>
<tr>
<td>3.N.4.</td>
<td>Written procedures for induction, stabilization, and maintenance</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.N.5.</td>
<td>Written procedures for medication monitoring</td>
</tr>
<tr>
<td>3.N.6.</td>
<td>Written procedures for pharmacy services</td>
</tr>
<tr>
<td>3.N.7.</td>
<td>Documentation of training and education provided to persons served</td>
</tr>
<tr>
<td>3.N.8.</td>
<td>Documentation of training and education provided to direct service personnel at orientation and regular intervals</td>
</tr>
<tr>
<td><strong>3.P. Partial Hospitalization (PH)</strong></td>
<td></td>
</tr>
<tr>
<td>3.P.3.b.</td>
<td>Schedule of activities</td>
</tr>
<tr>
<td>3.P.9.a.</td>
<td>Primary assessment of person served that includes the identified elements</td>
</tr>
<tr>
<td>3.P.10.</td>
<td>Person-centered plan, completed within seven days of admission and reviewed as identified</td>
</tr>
<tr>
<td><strong>3.Q. Residential Treatment (RT)</strong></td>
<td></td>
</tr>
<tr>
<td>3.Q.4.c.</td>
<td>Personal safety plans for persons served when risks are identified</td>
</tr>
<tr>
<td>3.Q.6.a.</td>
<td>Written daily schedule of activities</td>
</tr>
<tr>
<td>3.Q.10.</td>
<td>Written procedures for searches of persons served and belongings</td>
</tr>
<tr>
<td>3.Q.11.</td>
<td>Written procedures that address visitation, mail, telephone use, and use of personal electronics</td>
</tr>
<tr>
<td>3.Q.14.</td>
<td>Documentation of competency-based training for direct service personnel at orientation and regular intervals</td>
</tr>
<tr>
<td>3.Q.17.</td>
<td>Documented monthly review of person-centered plans for each person served</td>
</tr>
<tr>
<td><strong>3.R. Specialized or Treatment Foster Care (STFC)</strong></td>
<td></td>
</tr>
<tr>
<td>3.R.2.</td>
<td>Documentation of training provided to personnel and foster care providers at orientation and regular intervals</td>
</tr>
<tr>
<td>3.R.3.</td>
<td>Documentation of training provided to foster care providers includes the type, dates, and length of training</td>
</tr>
<tr>
<td>3.R.7.</td>
<td>Comprehensive plan for the selection of providers</td>
</tr>
<tr>
<td>3.R.8.c.</td>
<td>Assessment of the appropriateness of the match for children/youths with available foster care providers</td>
</tr>
<tr>
<td>3.R.9.</td>
<td>Written agreement that defines the expectations of the organization and the foster care provider</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.S. Student Counseling (SC)</td>
<td></td>
</tr>
<tr>
<td>3.S.1.</td>
<td>Written person-centered plan for each person served</td>
</tr>
<tr>
<td>3.S.10.</td>
<td>Discharge summaries for persons who leave the program</td>
</tr>
<tr>
<td>3.S.11.</td>
<td>Records of persons served</td>
</tr>
<tr>
<td>3.S.12.</td>
<td>Written procedures for ongoing communication and collaboration with relevant stakeholders within the educational organization</td>
</tr>
<tr>
<td>3.S.13.</td>
<td>Plan and written procedures that guide the program's response when a potential threat to personal or campus safety is identified</td>
</tr>
<tr>
<td>3.T. Therapeutic Communities (TC)</td>
<td></td>
</tr>
<tr>
<td>3.T.1.</td>
<td>Written program plan that includes the identified elements</td>
</tr>
<tr>
<td>3.T.10.</td>
<td>At least a quarterly review of each person's plan, goals, objectives, and progress</td>
</tr>
<tr>
<td>3.T.11.a.</td>
<td>Written schedule of activities</td>
</tr>
<tr>
<td>3.T.20.</td>
<td>In a correctional setting, written procedure for review of rule infractions</td>
</tr>
</tbody>
</table>

### Section 4. Core Support Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.A. Assessment and Referral (AR)</td>
<td></td>
</tr>
<tr>
<td>4.A.1.</td>
<td>Policies for assessment and referral that include the identified elements</td>
</tr>
<tr>
<td>4.A.3.</td>
<td>Written summary of assessment and referral(s), provided to person served or legal representative when requested</td>
</tr>
<tr>
<td>4.B. Community Housing (CH)</td>
<td></td>
</tr>
<tr>
<td>4.B.2.h.</td>
<td>Policies related to visitors, guests, and pets</td>
</tr>
<tr>
<td>4.C. Comprehensive Suicide Prevention Program (CSPP)</td>
<td></td>
</tr>
<tr>
<td>4.C.1.</td>
<td>Documentation of environmental scan</td>
</tr>
<tr>
<td>4.C.2.</td>
<td>Program plan</td>
</tr>
<tr>
<td>4.C.4.</td>
<td>Written procedures for referrals</td>
</tr>
<tr>
<td>4.C.5.</td>
<td>Written procedures for crisis intervention</td>
</tr>
</tbody>
</table>
### Section 4. Core Support Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.C.6.</td>
<td>Documentation of competency-based training for personnel at orientation and regular intervals</td>
</tr>
<tr>
<td><strong>4.D. Call Centers (CC)</strong></td>
<td></td>
</tr>
<tr>
<td>4.D.1.</td>
<td>Written procedures for the program</td>
</tr>
<tr>
<td>4.D.2.a.–c.</td>
<td>Written training plan</td>
</tr>
<tr>
<td>4.D.4.</td>
<td>Written procedures to ensure access during identified hours of operation</td>
</tr>
<tr>
<td>4.D.6.</td>
<td>Written procedures for the identified elements</td>
</tr>
<tr>
<td>4.D.7.</td>
<td>Written procedures for involvement of social support systems, including family members and identified legal representatives</td>
</tr>
<tr>
<td>4.D.11.b.</td>
<td>Written agreements, when a crisis response program uses a secondary provider for roll-over call answering or 24/7 coverage</td>
</tr>
<tr>
<td>4.D.14.</td>
<td>Written procedures for the identified elements</td>
</tr>
<tr>
<td>4.D.15.</td>
<td>Policy defining expectations regarding non-endorsement of specific referrals and fair and equitable caller-driven referrals</td>
</tr>
<tr>
<td><strong>4.E. Diversion/Intervention (DVN)</strong></td>
<td></td>
</tr>
<tr>
<td>4.E.6.</td>
<td>Plan or written logic model that details the specific theoretical and methodological approaches to be used and how the approaches will be applied within the community</td>
</tr>
<tr>
<td>4.E.8.b.</td>
<td>Documented plan for individual outcomes</td>
</tr>
<tr>
<td><strong>4.F. Employee Assistance (EA)</strong></td>
<td></td>
</tr>
<tr>
<td>4.F.3.</td>
<td>Written agreement with host or contracting organization</td>
</tr>
<tr>
<td>4.F.9.b.(2)</td>
<td>Training plan for personnel not certified</td>
</tr>
<tr>
<td>4.F.10.</td>
<td>Written procedures that describe the type of information the host or contracting organization may receive from the program</td>
</tr>
<tr>
<td><strong>4.G. Prevention (P)</strong></td>
<td></td>
</tr>
<tr>
<td>4.G.5.</td>
<td>Plan or written logic model that details the specific theoretical and methodological approaches to be used and how the approaches will be applied within the community</td>
</tr>
<tr>
<td>4.G.7.</td>
<td>Written comprehensive curriculum for each course offered</td>
</tr>
</tbody>
</table>
### Section 5. Specific Population Designations

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.A. Adults with Autism Spectrum Disorder (ASD:A)</strong></td>
<td></td>
</tr>
<tr>
<td>5.A.9.</td>
<td>Information about persons served is obtained, maintained, and shared with other providers or educators, when related to services the person is receiving or transition to other services</td>
</tr>
<tr>
<td><strong>5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)</strong></td>
<td></td>
</tr>
<tr>
<td>5.B.9.</td>
<td>Information about persons served is obtained, maintained, and shared with other providers or educators, when related to services the person is receiving or transition to other services</td>
</tr>
<tr>
<td><strong>5.C. Children and Adolescents (CA)</strong></td>
<td></td>
</tr>
<tr>
<td>5.C.1.</td>
<td>Assessments of each child/adolescent served that include the identified elements</td>
</tr>
<tr>
<td>5.C.8.</td>
<td>Policy for obtaining criminal background checks for all persons providing direct services to children or adolescents</td>
</tr>
<tr>
<td><strong>5.D. Consumer-Run (CR)</strong></td>
<td></td>
</tr>
<tr>
<td>5.D.1.</td>
<td>Policies and procedures for membership or acceptance into services</td>
</tr>
<tr>
<td>5.D.2.</td>
<td>Membership/acceptance criteria</td>
</tr>
<tr>
<td>5.D.3.d.</td>
<td>Documentation of actions taken when a person is found ineligible</td>
</tr>
<tr>
<td>5.D.5.</td>
<td>Signed informed consent for services obtained and maintained as required</td>
</tr>
<tr>
<td>5.D.11.</td>
<td>Coordinated person-centered plan for each person served based on the identified elements</td>
</tr>
<tr>
<td>5.D.12.</td>
<td>Coordinated person-centered plan for each person served that includes the identified elements</td>
</tr>
<tr>
<td>5.D.14.</td>
<td>Discharge summary for each person who leaves the program</td>
</tr>
<tr>
<td>5.D.15.</td>
<td>Complete record maintained for each person served</td>
</tr>
<tr>
<td><strong>5.E. Criminal Justice (CJ)</strong></td>
<td></td>
</tr>
<tr>
<td>5.E.6.</td>
<td>Timely assessment for each person served that includes the identified elements</td>
</tr>
<tr>
<td>5.E.8.</td>
<td>Person-centered plan for each person served that includes the identified elements</td>
</tr>
</tbody>
</table>
### Section 5. Specific Population Designations (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.E.10.</td>
<td>When the program provides behavioral health services in a prison or jail setting, a transition plan that includes the identified elements</td>
</tr>
<tr>
<td>5.E.11.</td>
<td>Predischarge transition plans that include the identified elements</td>
</tr>
<tr>
<td>5.E.12.</td>
<td>Predischarge transition plans that address the identified elements</td>
</tr>
<tr>
<td></td>
<td><strong>5.F. Eating Disorders (ED)</strong></td>
</tr>
<tr>
<td>5.F.4.</td>
<td>Person-centered plan for each person served that includes all of the listed requirements</td>
</tr>
<tr>
<td>5.F.5.</td>
<td>Transition plan for each person served that includes all of the listed requirements</td>
</tr>
<tr>
<td></td>
<td><strong>5.G. Juvenile Justice (JJ)</strong></td>
</tr>
<tr>
<td>5.G.5.</td>
<td>Timely assessments for each person served that include the identified elements</td>
</tr>
<tr>
<td>5.G.6.</td>
<td>Assessments that include the identified information</td>
</tr>
<tr>
<td>5.G.10.</td>
<td>When the program provides behavioral health services in a correctional setting, a transition plan that includes the identified elements</td>
</tr>
<tr>
<td>5.G.11.</td>
<td>Predischarge transition plans</td>
</tr>
<tr>
<td>5.G.19.</td>
<td>Policy on obtaining criminal background checks on all persons providing direct services to juveniles</td>
</tr>
<tr>
<td></td>
<td><strong>5.H. Medically Complex (MC)</strong></td>
</tr>
<tr>
<td>5.H.1.</td>
<td>Program description of services that includes the identified elements</td>
</tr>
<tr>
<td>5.H.9.</td>
<td>Written philosophy of health and wellness for the persons served</td>
</tr>
<tr>
<td>5.H.10.</td>
<td>Primary assessment for each person served that includes identification of presenting health risks, health goals, and expected health benefits</td>
</tr>
<tr>
<td>5.H.11.</td>
<td>Based on initial and ongoing assessments, a person-centered plan of care for each person served that addresses identified needs</td>
</tr>
<tr>
<td>5.H.12.</td>
<td>Person-centered plans of care that address how services will be provided to ensure the safety of the person served and that identify the services provided by skilled healthcare providers</td>
</tr>
</tbody>
</table>
### Appendix A. Required Written Documentation

#### Section 5. Specific Population Designations (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.H.13.g.</td>
<td>Activities to promote wellness evident in the person-centered plan for each person served</td>
</tr>
</tbody>
</table>

**5.I. Older Adults (OA)**

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.I.1.</td>
<td>Documented assessments of persons served</td>
</tr>
<tr>
<td>5.I.9.</td>
<td>Policy for obtaining criminal background checks on all personnel providing direct services to older adults</td>
</tr>
<tr>
<td>5.I.10.</td>
<td>Documented training to direct service personnel on topics unique to working with older adults</td>
</tr>
</tbody>
</table>
APPENDIX B

Operational Timelines

The following tables list CARF standards that require activities be conducted at specific time intervals. The documents assembled as part of survey preparation should provide evidence that these activities occur.

Standards that specify an activity be conducted at least or no less than a specific time period are listed in the table for the maximum timeframe within which they may occur. During an original survey the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey.

Standards that require a policy that includes a timeframe, such as for the reporting of complaints or recording information into the records of the persons served, are not included in this appendix. Standards that require activities be conducted on an ongoing or as needed basis are also not included here.

The timelines for the standards listed in the last table, Activities to be Conducted at a Frequency Determined by the Organization, may be influenced by various factors, such as local regulations or the needs of the organization and the persons served—e.g., verification of backgrounds, credentials, and fitness for duty of members of the workforce, or data collected about persons served at appropriate intervals during services. For these standards, you should identify the frequency at which these activities are scheduled. The surveyors will want to see evidence that you are following your identified timelines.

**NOTE:** This appendix is available in an editable electronic format at www.carf.org/Documentation_and_Time_Lines or through the Resources section in Customer Connect (https://customerconnect.carf.org).

### Activities to be Conducted at Least Every Two Years

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.A. Adults with Autism Spectrum Disorder (ASD:A)</td>
<td></td>
</tr>
<tr>
<td>5.A.14.</td>
<td>Life planning for persons served is updated and adjusted</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Annually

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1. ASPIRE to Excellence*</td>
<td></td>
</tr>
<tr>
<td>1.A.3.k.</td>
<td>Review of the organization's policies, as guided by leadership</td>
</tr>
<tr>
<td>1.A.5.c.</td>
<td>Cultural competency and diversity plan reviewed for relevance</td>
</tr>
</tbody>
</table>
### Activities to be Conducted at Least Annually (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.B.2.g.(3), (5)–(6)</td>
<td>Board conducts self-assessment of the entire board; written conflict-of-interest and ethical code of conduct declarations signed</td>
</tr>
<tr>
<td>1.B.5.a.–b.</td>
<td>Review of executive leadership performance and executive leadership succession plan</td>
</tr>
<tr>
<td>1.B.6.e.(6)</td>
<td>Review of executive compensation records</td>
</tr>
<tr>
<td>1.B.7.</td>
<td>Review of governance policies</td>
</tr>
<tr>
<td>1.C.2.d.</td>
<td>Strategic plan reviewed for relevance</td>
</tr>
<tr>
<td>1.F.2.</td>
<td>Budgets are prepared and approved</td>
</tr>
<tr>
<td>1.F.10.</td>
<td>Review or audit of the financial statements of the organization by an independent accountant authorized by the appropriate authority</td>
</tr>
<tr>
<td>1.G.1.b.(1)</td>
<td>Risk management plan reviewed for relevance</td>
</tr>
<tr>
<td>1.G.2.a.(2)</td>
<td>Review of organization's insurance package for adequacy</td>
</tr>
<tr>
<td>1.G.4.d.</td>
<td>Review of contracted services, if applicable</td>
</tr>
<tr>
<td>1.H.4.b.</td>
<td>Personnel receive competency-based training in health and safety practices, identification of unsafe environmental factors, emergency and evacuation procedures, identification and reporting of critical incidents, reducing physical risks, workplace violence, and, if appropriate, medication management</td>
</tr>
<tr>
<td>1.H.7.</td>
<td>Unannounced tests of each emergency procedure, including complete actual or simulated physical evacuation drills as relevant to the procedure, on each shift at all locations</td>
</tr>
<tr>
<td>1.H.10.</td>
<td>Written analysis of all critical incidents conducted by or provided to leadership</td>
</tr>
<tr>
<td>1.H.12.l.</td>
<td>If transportation services are contracted, contract reviewed against Standards 1.H.12.a.–k.</td>
</tr>
<tr>
<td>1.H.13.</td>
<td>Comprehensive external health and safety inspection conducted, resulting in a written report</td>
</tr>
<tr>
<td>1.J.4.</td>
<td>Test and analysis of the organization's procedures for business continuity and disaster recovery</td>
</tr>
<tr>
<td>1.K.2.a.(3)</td>
<td>Rights of persons served shared with persons served who have been in the program longer than one year</td>
</tr>
<tr>
<td>1.K.4.</td>
<td>Written analysis of all formal complaints that documents whether formal complaints were received, trends, areas needing performance improvement, actions to be taken, and actions taken or changes made</td>
</tr>
<tr>
<td>1.L.2.b.</td>
<td>Accessibility plan reviewed for relevance</td>
</tr>
</tbody>
</table>
## Activities to be Conducted at Least Annually (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.N.1.</td>
<td>Written analysis of performance indicators that identifies areas needing improvement, results in an action plan to address the improvements needed, and identifies actions taken or changes made.</td>
</tr>
<tr>
<td>2.A. Program/Service Structure</td>
<td></td>
</tr>
<tr>
<td>2.A.1.c.</td>
<td>Review of scope of services</td>
</tr>
<tr>
<td>2.E. Medication Use</td>
<td></td>
</tr>
<tr>
<td>2.E.2.a.(2)</td>
<td>Training and education regarding medications provided to direct service personnel</td>
</tr>
<tr>
<td>2.E.9.a.(1)</td>
<td>Documented peer review of medication prescribing</td>
</tr>
<tr>
<td>2.F. Promoting Nonviolent Practices</td>
<td></td>
</tr>
<tr>
<td>2.F.2.b.</td>
<td>Documented competency-based training of direct service personnel on prevention of unsafe behaviors</td>
</tr>
<tr>
<td>2.F.4.b.</td>
<td>Documented, competency-based training of all personnel involved in the direct provision of seclusion or restraint</td>
</tr>
<tr>
<td>2.F.5.c.</td>
<td>Review of plan to eliminate use of seclusion and restraint</td>
</tr>
<tr>
<td>2.F.13.a.</td>
<td>Documented analysis of the program's use of seclusion and restraint</td>
</tr>
<tr>
<td>3.A. Assertive Community Treatment (ACT)</td>
<td></td>
</tr>
<tr>
<td>3.A.2.c.</td>
<td>ACT team reviews capacity to provide integrated treatment services</td>
</tr>
<tr>
<td>3.H. Detoxification/Withdrawal Management (DTX)</td>
<td></td>
</tr>
<tr>
<td>3.H.19.b.</td>
<td>Addresses performance in relationship to an established target for successful transitions of the persons served into ongoing treatment services post discharge</td>
</tr>
<tr>
<td>3.I. Health Home (HH)</td>
<td></td>
</tr>
<tr>
<td>3.I.6.</td>
<td>Annual health assessments for persons served</td>
</tr>
<tr>
<td>3.I.11.b.</td>
<td>Addresses performance in relationship to established targets for medical status, behavioral status, and functional outcomes of the persons served</td>
</tr>
<tr>
<td>3.J. Inpatient Treatment (IT)</td>
<td></td>
</tr>
<tr>
<td>3.J.19.b.</td>
<td>Addresses performance in relationship to an established target</td>
</tr>
<tr>
<td>5.I. Older Adults (OA)</td>
<td></td>
</tr>
<tr>
<td>5.I.12.b.</td>
<td>Addresses performance in relationship to an established target regarding engagement of persons served in services; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and personnel</td>
</tr>
</tbody>
</table>
### Activities to be Conducted at Least Semiannually

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence®</strong></td>
<td></td>
</tr>
<tr>
<td>1.H.14.</td>
<td>Comprehensive health and safety self-inspections conducted on each shift, resulting in a written report</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Quarterly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence®</strong></td>
<td></td>
</tr>
<tr>
<td>1.F.7.</td>
<td>Review of representative sample of bills of the persons served that addresses whether bills are accurate, trends, areas needing improvement, and actions to be taken</td>
</tr>
<tr>
<td><strong>2.H. Quality Records Management</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.A. Assertive Community Treatment (ACT)</strong></td>
<td></td>
</tr>
<tr>
<td>3.A.9.</td>
<td>Review of treatment plan of persons served in an Assertive Community Treatment program</td>
</tr>
<tr>
<td><strong>3.T. Therapeutic Communities (TC)</strong></td>
<td></td>
</tr>
<tr>
<td>3.T.10.</td>
<td>Review of plan of services, goals, and progress toward goals for persons served in a Therapeutic Community</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Monthly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1. ASPIRE to Excellence®</strong></td>
<td></td>
</tr>
<tr>
<td>1.F.3.c.</td>
<td>Review of actual financial results</td>
</tr>
<tr>
<td>1.F.9.g.</td>
<td>If responsible for funds of the persons served, monthly account reconciliation provided to persons served</td>
</tr>
<tr>
<td><strong>3.D. Court Treatment (CT)</strong></td>
<td></td>
</tr>
<tr>
<td>3.D.17.</td>
<td>Review of person-centered plan for persons served in a Court Treatment program</td>
</tr>
</tbody>
</table>
## Appendix B. Operational Timelines

### Activities to be Conducted at Least Monthly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.M. Intensive Outpatient Treatment (IOP)</td>
<td>Review of person-centered plan for persons served in an Intensive Outpatient Treatment program</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Every Two Weeks

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.P. Partial Hospitalization (PH)</td>
<td>Review of person-centered plan for persons served in a Partial Hospitalization program</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at Least Weekly

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.P. Partial Hospitalization (PH)</td>
<td>Weekly meetings with persons served in a Partial Hospitalization program</td>
</tr>
</tbody>
</table>

### Activities to be Conducted Daily

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.A. Assertive Community Treatment (ACT)</td>
<td>Daily staff meetings of team members in Assertive Community Treatment programs</td>
</tr>
<tr>
<td>3.F. Crisis Stabilization (CS)</td>
<td>Documented daily therapeutic interventions occur between the persons served and a qualified behavioral health practitioner</td>
</tr>
<tr>
<td>3.H. Detoxification/Withdrawal Management (DTX)</td>
<td>Daily determination by physician of the medical necessity of the person served to remain in the inpatient detoxification/withdrawal management treatment program</td>
</tr>
</tbody>
</table>
### Activities to be Conducted Daily (Continued)

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.J. Inpatient Treatment (IT)</td>
<td>3.J.12. In programs where persons served have been committed to inpatient treatment through legal processes, daily determination by physician of the medical necessity of the person served to remain in the inpatient treatment program</td>
</tr>
<tr>
<td>3.T. Therapeutic Communities (TC)</td>
<td>3.T.11.c. Daily access to nutritious meals and snacks in Therapeutic Communities</td>
</tr>
<tr>
<td>4.B. Community Housing (CH)</td>
<td>4.B.2.e. Daily access to nutritious meals and snacks in Community Housing programs</td>
</tr>
</tbody>
</table>

### Activities to be Conducted at a Frequency Determined by the Organization

<table>
<thead>
<tr>
<th>Related Standard</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1. ASPIRE to Excellence®</td>
<td>1.B.2.g.(4) Periodic self-assessment of individual members of board</td>
</tr>
<tr>
<td></td>
<td>1.H.12.b. Regular review of driving records of all drivers</td>
</tr>
<tr>
<td></td>
<td>1.H.12.k. Maintenance of vehicles owned or operated by the organization according to manufacturer’s recommendations</td>
</tr>
<tr>
<td></td>
<td>1.I.4.c.(2) Verification of workforce backgrounds, credentials, and fitness for duty throughout employment</td>
</tr>
<tr>
<td></td>
<td>1.I.7.c. Timeframes/frequencies related to the competency assessment process</td>
</tr>
<tr>
<td></td>
<td>1.I.8.e. Timeframes/frequencies related to the performance appraisal process</td>
</tr>
<tr>
<td></td>
<td>1.M.5.b., d. Data collected on the persons served at appropriate intervals during services and at points in time following services</td>
</tr>
<tr>
<td>2.C. Person-Centered Plan</td>
<td>2.C.3. Person-centered plan reviewed and modified in accordance with written procedures that identify required timeframes</td>
</tr>
<tr>
<td>3.A. Assertive Community Treatment (ACT)</td>
<td>3.A.19.b. The ACT team psychiatrist regularly reviews and documents the symptoms and the response of the persons served to the prescribed medication treatment</td>
</tr>
<tr>
<td>Related Standard</td>
<td>Activity</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3.D. Court Treatment (CT)</td>
<td>Regular interdisciplinary joint cross-training related to clinical and criminal justice issues</td>
</tr>
<tr>
<td>3.H. Detoxification/Withdrawal Management (DTX)</td>
<td>Personnel training at regular intervals</td>
</tr>
<tr>
<td>3.H.16.a.(2)</td>
<td></td>
</tr>
<tr>
<td>3.I. Health Home (HH)</td>
<td>Cross training of direct service personnel and orientation and regular intervals</td>
</tr>
<tr>
<td>3.I.9.a.(2)</td>
<td></td>
</tr>
<tr>
<td>3.N. Office-Based Opioid Treatment Program (OBOT)</td>
<td>Training and education provided to direct service personnel at regular intervals</td>
</tr>
<tr>
<td>3.N.8.a.(2)</td>
<td></td>
</tr>
<tr>
<td>3.Q. Residential Treatment (RT)</td>
<td>Regular meetings between persons served and program personnel in Residential Treatment programs</td>
</tr>
<tr>
<td>3.Q.6.g.</td>
<td></td>
</tr>
<tr>
<td>3.Q.14.</td>
<td>Competency-based training at regular intervals for direct service personnel in de-escalation techniques, risk assessment, and trauma-informed approaches</td>
</tr>
<tr>
<td>3.R. Specialized or Treatment Foster Care (STFC)</td>
<td>Competency-based training at regular intervals for personnel and specialized or treatment foster care providers</td>
</tr>
<tr>
<td>3.R.2.b.(2)</td>
<td></td>
</tr>
<tr>
<td>3.S. Student Counseling (SC)</td>
<td>Regular review of person-centered plans of persons served in Student Counseling programs</td>
</tr>
<tr>
<td>3.S.1.f.</td>
<td></td>
</tr>
<tr>
<td>4.B. Community Housing (CH)</td>
<td>Regular meetings between persons served and staff members in Community Housing programs</td>
</tr>
<tr>
<td>4.B.2.a.</td>
<td></td>
</tr>
<tr>
<td>4.C. Comprehensive Suicide Prevention Program (CSPP)</td>
<td>Competency-based training for personnel at regular intervals</td>
</tr>
<tr>
<td>4.C.6.a.(2)</td>
<td></td>
</tr>
<tr>
<td>4.D. Call Centers (CC)</td>
<td>Regularly updating the database</td>
</tr>
<tr>
<td>5.I. Older Adults (OA)</td>
<td>Training at regular intervals for direct service personnel on topics unique to working with older adults</td>
</tr>
<tr>
<td>5.I.10.a.(2)</td>
<td></td>
</tr>
</tbody>
</table>
The following tables list the standards that require an organization to provide some form of education or training to personnel, persons served, and/or other stakeholders. Some standards require specifically qualified or trained personnel to provide certain services or require an organization to verify or ensure that personnel have appropriate qualifications, education, and/or training but do not require the organization to directly provide the requisite education or training. Such standards are not included in this appendix. Please contact your resource specialist with any questions.

**Note:** This appendix is available in an editable electronic format at www.carf.org/Documentation_and_Time_Lines or through the Resources section in Customer Connect (https://customerconnect.carf.org).

### Section 1. ASPIRE to Excellence®

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.A.6.c.</td>
<td>Education on ethical codes of conduct</td>
<td>Personnel and other stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.7.d.</td>
<td>Training on corporate compliance</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.8.</td>
<td>Education to stay current in the field</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.A.9.b.</td>
<td>Training related to fundraising written procedures, if applicable</td>
<td>Personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>B. Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.B.2.d.</td>
<td>Board education</td>
<td>Board members</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>F. Financial Planning and Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.F.6.b.</td>
<td>Training related to fiscal policies and written procedures</td>
<td>Appropriate personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>H. Health and Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.H.3.</td>
<td>Education designed to reduce identified physical risks</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.H.4.a.(1) and b.(1)</td>
<td>Training in health and safety practices</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(2) and b.(2)</td>
<td>Training in identification of unsafe environmental factors</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
</tbody>
</table>
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.H.4.a.(3) and b.(3)</td>
<td>Training in emergency procedures</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(4) and b.(4)</td>
<td>Training in evacuation procedures, if appropriate</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(5) and b.(5)</td>
<td>Training in identification of critical incidents</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(6) and b.(6)</td>
<td>Training in reporting of critical incidents</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(7) and b.(7)</td>
<td>Training in medication management, if appropriate</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(8) and b.(8)</td>
<td>Training in reducing physical risks</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.4.a.(9) and b.(9)</td>
<td>Training regarding workplace violence</td>
<td>Personnel</td>
<td>Yes</td>
<td>Upon hire and at least annually</td>
</tr>
<tr>
<td>1.H.7.c.(4)</td>
<td>Necessary education and training of personnel regarding emergency procedures</td>
<td>Personnel</td>
<td>No</td>
<td>As needed</td>
</tr>
<tr>
<td>1.H.10.b.(5)</td>
<td>Necessary education and training of personnel regarding critical incidents</td>
<td>Personnel</td>
<td>No</td>
<td>As needed</td>
</tr>
<tr>
<td>1.H.11.b.(1)</td>
<td>Training regarding infections and communicable diseases</td>
<td>Personnel, persons served, and other stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.H.12.g.</td>
<td>Training of drivers regarding the organization’s transportation procedures and unique needs of persons served</td>
<td>Personnel with driving responsibilities</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### I. Workforce Development and Management

| 1.I.5.b. | On-the-job training included in onboarding and engagement activities | Personnel | No | None specified |
| 1.I.7.f. | Education and training included in workforce development activities | Personnel | No | None specified |
### Section 1. ASPIRE to Excellence® (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>J. Technology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.J.4.c.</td>
<td>Necessary education and training of personnel regarding business continuity/disaster recovery procedures</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.J.5.a.</td>
<td>Training on cybersecurity</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>1.J.5.b.</td>
<td>Training on the technology used in performance of job duties</td>
<td>Personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>1.J.7.</td>
<td>Training in equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting</td>
<td>Personnel who deliver services via information and communication technologies</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>1.J.8.</td>
<td>Instruction and training in equipment features, set up, use, and troubleshooting</td>
<td>Persons served, families/support systems, and others, as appropriate</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### Section 2. General Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.A. Program/Service Structure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.A.16.</td>
<td>Information and education relevant to the needs of the persons served</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.20.a.</td>
<td>Training that includes areas that reflect the specific needs of the persons served</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.20.b.</td>
<td>Training that includes clinical skills that are appropriate for the position</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.20.c.</td>
<td>Training that includes person-centered plan development</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.20.d.</td>
<td>Training that includes interviewing skills</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.20.e.</td>
<td>Training that includes program-related research-based treatment approaches</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
</tbody>
</table>
### Section 2. General Program Standards  (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.A.20.f.</td>
<td>Training that includes identification of clinical risk factors, including suicide,</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td></td>
<td>violence, and other risky behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.A.29.b.</td>
<td>Training on the role of peer support specialists</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>2.A.30.</td>
<td>Documented competency-based training</td>
<td>Peer support specialists</td>
<td>Yes</td>
<td>None specified</td>
</tr>
</tbody>
</table>

**2.B. Screening and Access to Services**

| 2.B.8.d.(3) | Education regarding advance directives                                               | Persons served                        | No               | At orientation     |

**2.E. Medication Use**

| 2.E.2.a.    | Training and education regarding medications                                         | Direct service personnel               | No               | At orientation and at least annually |
| 2.E.2.b.    | Training and education regarding medications                                         | Persons served and, when applicable,  | No               | None specified      |

**2.F. Promoting Nonviolent Practices**

| 2.F.2.      | Training that addresses prevention of unsafe behaviors and includes all areas identified in the standard | All direct service personnel           | Yes              | At orientation and at least annually |
| 2.F.4.      | Training that addresses use of seclusion and restraint and includes all areas identified in the standard | All personnel involved in the direct administration of seclusion or restraint | Yes              | At orientation and at least annually |
### Section 3. Core Treatment Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.A. Assertive Community Treatment (ACT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.A.22.a.</td>
<td>Education provided by the ACT team about the illness/disorder of the persons served</td>
<td>Families and other major supports of the persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.A.22.b.</td>
<td>Education provided by the ACT team about the strengths and abilities of the persons served</td>
<td>Same as above</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.A.22.c.</td>
<td>Education provided by the ACT team about, when applicable, the role of the family in the therapeutic process</td>
<td>Same as above</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td><strong>3.D. Court Treatment (CT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.D.14.b.</td>
<td>Interdisciplinary joint cross-training related to clinical and criminal justice issues</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services and regularly</td>
</tr>
<tr>
<td>3.D.14.c.(1)</td>
<td>Training on the requirements imposed on personnel from the criminal justice system who participate on the treatment team</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services and regularly</td>
</tr>
<tr>
<td>3.D.14.c.(2)</td>
<td>Training on safeguards that are available to personnel</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services and regularly</td>
</tr>
<tr>
<td><strong>3.E. Crisis Intervention (CI)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.E.6.</td>
<td>Training or certification in first aid and CPR</td>
<td>Personnel providing mobile services</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td><strong>3.H. Detoxification/Withdrawal Management (DTX)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.H.14.</td>
<td>Training in first aid, CPR, and use of emergency equipment</td>
<td>Personnel providing direct services</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>3.H.16.</td>
<td>Training that includes risk assessment, detoxification/withdrawal management protocols, and withdrawal syndromes</td>
<td>Personnel providing direct services</td>
<td>No</td>
<td>At orientation and regular intervals</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.H.28.</td>
<td>Education on drug-screening practices</td>
<td>Persons served, families/support systems, and personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.I. Health Home (HH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.I.8.</td>
<td>Education and training program that addresses all areas identified in the standard</td>
<td>Persons served and families/support systems</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.I.9.</td>
<td>Cross training that addresses the most common conditions prevalent in the population served, including physical health conditions, mental health conditions, and substance use disorders</td>
<td>Direct service personnel</td>
<td>No</td>
<td>At orientation and regular intervals</td>
</tr>
<tr>
<td>3.J. Inpatient Treatment (IT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.J.16.</td>
<td>Training in first aid, CPR, and the use of emergency equipment</td>
<td>Direct service personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.J.18.</td>
<td>Training in de-escalation techniques, risk assessment, and trauma-informed approaches</td>
<td>Direct service personnel</td>
<td>Yes</td>
<td>At orientation and regular intervals</td>
</tr>
<tr>
<td>3.K. Integrated Behavioral Health/Primary Care (IBHPC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.K.9.a.</td>
<td>Education that includes wellness</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.K.9.b.</td>
<td>Education that includes resilience and recovery</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.K.9.c.</td>
<td>Education that includes the interaction between mental and physical health</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.K.9.d.</td>
<td>Education that includes self-management of identified medical conditions and behavioral health concerns</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.M. Intensive Outpatient Treatment (IOP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.M.3.</td>
<td>Education on wellness and recovery</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>
### Section 3. Core Treatment Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.N. Office-Based Opioid Treatment Program (OBOT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.N.8.</td>
<td>Training and education on chronic disease model of addiction, behaviors associated with addiction, concepts of medications for addiction treatment, overdose prevention and response, and specimen collection for drug testing</td>
<td>Direct service personnel</td>
<td>No</td>
<td>At orientation and regular intervals</td>
</tr>
<tr>
<td>3.N.9.</td>
<td>Education about opioid use, including addiction, treatment, and stigma-reducing language</td>
<td>Stakeholders in the community</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.O. Outpatient Treatment (OT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.O.2.</td>
<td>Education on wellness and recovery</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>3.Q. Residential Treatment (RT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.Q.12.</td>
<td>Training in first aid, CPR, and the use of emergency equipment</td>
<td>Direct service personnel</td>
<td>Yes</td>
<td>None specified</td>
</tr>
<tr>
<td>3.Q.14.</td>
<td>Training in de-escalation techniques, risk assessment, and trauma-informed approaches</td>
<td>Direct service personnel</td>
<td>Yes</td>
<td>At orientation and regular intervals</td>
</tr>
<tr>
<td>3.R. Specialized or Treatment Foster Care (STFC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.R.2.</td>
<td>Training that covers all areas listed in the standard</td>
<td>Personnel</td>
<td>Yes</td>
<td>At orientation and regular intervals</td>
</tr>
<tr>
<td>3.S. Student Counseling (SC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.S.5.</td>
<td>Education on wellness and recovery</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### Section 4. Core Support Program Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.C. Comprehensive Suicide Prevention Program (CSPP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.C.3.d.</td>
<td>Education and training based on stakeholder needs and interests</td>
<td>Stakeholders</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.C.6.</td>
<td>Training for personnel, based on roles and responsibilities, that includes all topics listed in the standard</td>
<td>Personnel</td>
<td>Yes</td>
<td>At orientation and regular intervals</td>
</tr>
</tbody>
</table>
### Section 4. Core Support Program Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.D. Call Centers (CC)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.D.2.a.–c.</td>
<td>Training that is guided by a written training plan, a detailed curriculum, and a post-training assessment of competency</td>
<td>Persons providing services</td>
<td>Yes</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>4.D.2.d.(1) and (2)</td>
<td>Training that is guided by mechanisms for modeling and evaluation</td>
<td>Persons providing services</td>
<td>Yes</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td>4.D.2.e.(1) and (2)</td>
<td>Training that is guided by updating to reflect current community issues or trends and field trends or research</td>
<td>Persons providing services</td>
<td>Yes</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td><strong>4.F. Employee Assistance (EA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.F.1.f.</td>
<td>Informing and education of employees of the host or contracting organization</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.F.8.b.</td>
<td>Training in employee assistance program-related functions</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.F.13.a.</td>
<td>If specified in the written agreement, training in the scope of the program</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>4.F.13.b.</td>
<td>If specified in the written agreement, training in the procedures for referral</td>
<td>Personnel</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>

### Section 5. Specific Population Designation Standards

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.A. Adults with Autism Spectrum Disorder (ASD:A)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.A.3.</td>
<td>Training on ASD that covers all areas listed in the standard</td>
<td>Personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td><strong>5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.B.3.</td>
<td>Training on ASD that covers all areas listed in the standard</td>
<td>Personnel</td>
<td>No</td>
<td>Initial and ongoing</td>
</tr>
<tr>
<td><strong>5.D. Consumer-Run (CR)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.D.9.a.</td>
<td>Opportunities to enhance advocacy skills through training</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>
### Section 5. Specific Population Designation Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.E. Criminal Justice (CJ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.E.5.b.</td>
<td>Regular interdisciplinary cross-training related to clinical and criminal justice issues</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services and regularly</td>
</tr>
<tr>
<td>5.E.5.c.(1)</td>
<td>Training includes the requirements imposed on personnel from the criminal justice system who participate on the treatment team</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(2)</td>
<td>Training on safeguards that are available to workers</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(3)</td>
<td>Training on safety and security practices specific to the setting</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(4)</td>
<td>Training on clinical boundaries</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(5)</td>
<td>Training on correctional boundaries</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(6)</td>
<td>Training on specialized clinical needs, including dual diagnoses</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.5.c.(7)</td>
<td>Training on therapeutic community practices and methodologies, when that core program is provided</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services</td>
</tr>
<tr>
<td>5.E.13.</td>
<td>Curriculum-based program component for each person served that meets all requirements listed in the standard</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>5.E.14.</td>
<td>Educational program the addresses development of community living skills, social skills and supports, and vocational skills</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
</tbody>
</table>
### Section 5. Specific Population Designation Standards (Continued)

<table>
<thead>
<tr>
<th>Standard(s)</th>
<th>Training Requirements</th>
<th>Provided To</th>
<th>Competency-Based</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.G. Juvenile Justice (JJ)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.G.4.</td>
<td>Regular interdisciplinary cross-training related to clinical and juvenile justice issues, requirements imposed on personnel from the juvenile justice system who participate on the treatment team, safeguards available to workers, and safety practices specific to the setting</td>
<td>Personnel</td>
<td>No</td>
<td>Prior to the delivery of services and regularly</td>
</tr>
<tr>
<td>5.G.14.</td>
<td>The curriculum-based program component for each person served that meets all requirements listed in the standard</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td>5.G.15.</td>
<td>Educational program the addresses the development of community living skills, social skills and supports, and vocational skills</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td><strong>5.H. Medically Complex (MC)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.H.19.</td>
<td>Education and training program that is developmentally and age appropriate and includes all elements listed in the standard</td>
<td>Persons served</td>
<td>No</td>
<td>None specified</td>
</tr>
<tr>
<td><strong>5.I. Older Adults (OA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.I.10.</td>
<td>Training on topics unique to working with older adults that includes all elements listed in the standard</td>
<td>Direct service personnel</td>
<td>No</td>
<td>Orientation and regular intervals</td>
</tr>
</tbody>
</table>
GLOSSARY

NOTE: This glossary has been prepared for use with all CARF standards manuals. Terms have been selected for definition because they are subject to a wide range of interpretation and therefore require clarification of their usage in CARF’s standards and materials. The glossary does not define practices or disciplines.

CARF has not attempted to provide definitions that will be universally applicable. Rather, the intention is to define the meanings of the terms as they are used by CARF.

These definitions apply to all programs and services seeking accreditation. In some instances, glossary terms are used differently in different standards manuals. In such cases, the applicable manual is noted in parentheses after the term heading and before the definition.

Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Acquired brain injury: Acquired brain injury (ABI) is an insult to the brain that affects its structure or function, resulting in impairments of cognition, communication, physical function, or psychosocial behavior. ABI includes both traumatic and nontraumatic brain injury. Traumatic brain injuries may include open head injuries (e.g., gun shot wound, other penetrating injuries) or closed head injuries (e.g., blunt trauma, acceleration/deceleration injury, blast injury). Nontraumatic brain injuries may include those caused by strokes, nontraumatic hemorrhage (e.g., ruptured arterio-venous malformation, aneurysm), tumors, infectious diseases (e.g., encephalitis, meningitis), hypoxic injuries (e.g., asphyxiation, near drowning, anesthetic incidents, hypovolemia), metabolic disorders (e.g., insulin shock, liver or kidney disease), and toxin exposure (e.g., inhalation, ingestion). ABI does not include brain injuries that are congenital, degenerative, or induced by birth trauma.

Acquired impairment: An impairment that has occurred after the completion of the birthing process.

Acquisition: The purchase by one legal entity of some or all of the assets of another legal entity. In an acquisition, the purchasing entity may or may not assume some or all of the liabilities of the selling entity. Generally, the selling entity continues in existence.

Activities of daily living (ADL): The instructional area that addresses the daily tasks required to function in life. ADL encompass a broad range of activities, including maintaining personal hygiene, preparing meals, and managing household chores.

Activity: The execution of a task or action by an individual. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

Activity limitations: Difficulties an individual may have in executing activities. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

Adaptive equipment: Equipment or devices, such as wheelchairs, walkers, communication devices, adapted utensils, and raised toilet seats, that help persons perform their activities of daily living.

Adjudicated: (Behavioral Health, Child and Youth Services) Sentenced by a juvenile court or criminal court.

Administration: The act of managing or supporting management of an organization’s business affairs. Business affairs include activities such as strategic planning, financial planning, and human resources management.
**Administrative location:** Sites where the organization carries out administrative operations for the programs or services seeking accreditation and/or personnel who provide the programs or services seeking accreditation are located.

**Adolescence:** The period of life of an individual between childhood and adulthood, beginning at puberty and ending when one is legally recognized as an adult in one's state or province.

**Advance directives:** Specific instructions given by a person served to a care provider regarding the level and extent of care he or she wishes to receive. The intent is to aid competent adults and their families to plan and communicate in advance their decisions about medical treatment and the use of artificial life support. Included is the right to accept or refuse medical or surgical treatment. Includes psychiatric advance directives where allowed by law.

**Adverse events:** An untoward, undesirable, and usually unanticipated event such as a death of a person served, an employee, a volunteer, or a visitor in a provider organization. Incidents such as a fall or improper administration of medications are also considered adverse events even if there is no permanent effect on the individual or person served.

**Advocacy services:** Services that may include one or more of the following for persons with disabilities or other populations historically in need of advocacy:
- Personal advocacy: one-on-one advocacy to secure the rights of the person served.
- Systems advocacy: seeking to change a policy or practice that affects the person served.
- Legislative advocacy as permitted by law: seeking legislative enactments that would enhance the rights of and/or opportunities for the person served.
- Legal advocacy: using the judicial and quasi-judicial systems to protect the rights of the person served.
- Self-advocacy: enabling the person served to advocate on his/her own behalf.

**Affiliation:** A relationship, usually signified by a written agreement, between two organizations under the terms of which one organization agrees to provide specified services and personnel to meet the needs of the other, usually on a scheduled basis.

**Affirmative enterprises:** Operations designed and directed to create substantial economic opportunities for persons with disabilities.

**Assessment:** Process used with the person served to collect information related to his or her history and strengths, needs, abilities, and preferences in order to determine the diagnosis, appropriate services, and/or referral.

**Assistive technology:** Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase or improve functional capabilities of individuals.

**Aversive conditioning:** Procedures that are punishing, physically painful, emotionally frightening, deprivational, or put a person served at medical risk when they are used to modify behaviors.

**Behavioral health:** A category of medicine and rehabilitation that combines the areas of alcohol and other drug services, mental health, and psychosocial rehabilitation.

**Board:** See Governing board.

**Catastrophe:** A disaster or accident that immediately impacts an organization’s ability to provide its programs or services or significantly impacts how the programs or services will be provided in the future.

**Child/adolescent:** An individual up to the age at which one is legally recognized as an adult according to state or provincial law.

**Commensurate wage:** A wage that is proportionate to the prevailing wage paid to experienced workers in the vicinity for essentially the same type of work. It is based on the quantity and quality of work produced by the worker with a disability compared to the work produced by experienced workers.


**Communication skills:** The instructional area that teaches the use of adaptive skills and assistive technology for accomplishing tasks such as reading, writing, typing, managing finances, and storing and retrieving information.

**Community integration:** (Aging Services, Child and Youth Services) Being part of the mainstream of family and local community life, engaging in typical roles and responsibilities, and being an active and contributing member of one's social groups, local town or area, and of society as a whole.

**Community relations plan:** (Opioid Treatment Program) Supports program efforts to help minimize negative impact on the community, promote peaceful coexistence, and plan for change and program growth.

**Community resources:** Services and/or assistance programs that are available to the members of a community. They commonly offer persons help to become more self-reliant, increase their social connectedness, and maintain their human rights and well being.

**Community settings:** Locations in the community that are owned or leased and under the control of another entity, organization, or agency, and where organization personnel go for the purpose of providing services to persons in those locations. Examples include: community job sites that are owned or leased by the employer(s) where the organization may provide employment supports such as job coaching, vocational evaluation, or work adjustment; school settings where services such as early intervention or prevention services may be provided during the school's regular school, pre-school, or after-school program hours; or public or private sites such as libraries, recreational facilities, shopping malls, or museums where services such as community integration, case management, or community support may be provided.

**Comparative analysis:** The comparison of past and present data to ascertain change, or the comparison of present data to external benchmarks. Consistent data elements facilitate comparative analysis.

**Competency:** The criteria established for the adequate skills, knowledge, and capacity required to perform a specific set of job functions.

**Competency-based training:** An approach to education that focuses on the ability to demonstrate adequate skills, knowledge, and capacity to perform a specific set of job functions.

**Computer access training:** The instructional area that teaches the skills necessary to use specialized display equipment in order to operate computers. This includes evaluating the person served with large print, synthetic speech, and Braille access devices in order to perform word processing functions and other computer-related activities.

**Concurrent physician care:** Services delivered by more than one physician.

**Concurrent services:** Services delivered by multiple practitioners to the same person served during the same time period.

**Congenital impairment:** An impairment that is present at the completion of the birthing process.

**Consolidation:** The combination of two or more legal entities into a single legal entity, where the entities unite to form a new entity and the original entities cease to exist. In a consolidation, the consolidated entity has its own name and identity and acquires the assets and liabilities of the disappearing entities.

**Consumer:** The person served. When the person served is legally unable to exercise self-representation at any point in the decision-making process, person served also refers to those persons willing and able to make decisions on behalf of the person served. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the person served, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his or her own interests should be granted the right to choose whether family, significant others, or advocates may participate in the decision-making process. In standards that deal with infants, children, and/or adolescents,
the family may be referenced directly as the family may serve as a person served in such situations.

**Continuum of care/Continuum of services:** A system of services addressing the ongoing and/or intermittent needs of persons at risk or with functional limitations resulting from disease, trauma, aging, and/or congenital and/or developmental conditions. Such a system of services may be achieved by accessing a single provider, multiple providers, and/or a network of providers. The intensity and diversity of services may vary depending on the functional and psychosocial needs of the persons served.

**Contract:** A written agreement between two or more parties that sets forth enforceable obligations between or among the parties.

**Controlled/operated:** The right or responsibility to exercise influence over the physical conditions of a facility where service delivery/administrative operations occur. An organization is considered in control of all facilities where it delivers services to persons who are present at the time of service delivery for the sole purpose of receiving services from the organization (e.g., services provided to students at a school outside of the school's regular school, pre-school, or after-school program hours). An organization is not considered in control of facilities where it delivers services to persons who are present at the time of service delivery for purposes other than receiving services from the organization (e.g., services provided at a school to students who are present at the school to participate in the school's regular school, pre-school, or after-school programs).

**Co-pharmacy:** (Behavioral Health, Child and Youth Services, and Opioid Treatment Program) The use of two or more medications from the same class, e.g., two antidepressant medications or two antipsychotic medications.

**Core values:** The essential and enduring tenets of an organization. They are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those inside the organization.

**Corporate citizenship:** An organization’s efforts, activities, and interest in integrating, contributing, and supporting the communities where it delivers services to better address the needs of persons served.

**Corporate status:** The existence of an entity as a corporation under applicable law. Maintenance of corporate status typically requires ongoing compliance with state requirements.

**Costs:** The expenses incurred to acquire, produce, accomplish, and maintain organizational goals. These include both direct costs, such as those for salaries and benefits, materials, and equipment, and indirect costs, such as those for electricity, water, building maintenance, and depreciation of equipment.

**Cultural competency:** An organization’s ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual’s racial, ethnic, religious, and/or social groups or sexual orientation.

**Culturally normative:** Providing the persons served with an opportunity to experience patterns and conditions of everyday life that match as closely as possible those patterns and conditions typical of the mainstream experience in the local society and community. This requires the use of service delivery systems and settings that adapt to the changing norms and patterns of communities in which the persons served function so as to incorporate the following features:

- Rhythms of the day, week, and year and life cycles that are “normal” or typical of the community.
- A range of choices, with personal preferences and self-determination receiving full respect and consideration.
- A variety of social interactions and settings, including family, work, and leisure settings and opportunities for personal intimacy.
- Normal economic standards.
- Life in housing typical of the local neighborhoods.
**Culture:** The integrated pattern of human behavior that includes the thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, social, or other group.

**Customers:** The persons served, families, communities, funding agencies, employers, etc., who receive or purchase services from the organization.

**Data:** A set of values of qualitative or quantitative variables, e.g., facts, objective information, or statistics collected, assembled, or compiled for reference, analysis and use in decision-making.

**Demonstrate:** To show, explain, or prove by evidence presented in program documentation, interviews, and behavior how an organization or a program consistently conforms to a given standard.

**Debt covenants:** Requirements found in loan documents that require an organization to meet certain predefined performance targets to be measured at predefined time periods. The performance targets can be financial (for example, the organization must maintain a certain level of days with cash on hand) or nonfinancial (an organization must maintain a certain occupancy level).

**Detoxification treatment:** Dispensing an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such period.

**Diversion control plan:** A document that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and must assign specific responsibility to medical and administrative staff for implementation.

**Diversity:** Differences due to cognitive or physical ability, culture, ethnicity, language, religion, economic status, gender, age, or sexual orientation.

**Donated location/space:** Physical space not owned or leased by the organization but made available to the organization without charge for the purposes of delivering services or for administrative operations on an ongoing basis and which the organization controls or operates during the time of service delivery/administrative operations. The location and availability of the space does not vary at the discretion of the donating entity.

**Durability:** Maintenance or improvement over time of outcomes achieved by persons served at the time of discharge.

**Duty of care:** Obligation of governing board members to act with the care that an ordinarily prudent person in a similar position would use under similar circumstances. This duty requires governing board members to perform their duties in good faith and in a manner they reasonably believe to be in the organization's best interest.

**Duty of loyalty:** Obligation of governing board members to refrain from engaging in personal activities that would harm or take advantage of the organization. This duty prohibits governing board members from using their position of trust and confidence to further their private interests. It requires an undivided loyalty to the organization and demands that there be no conflict between a governing board member's corporate duty and self-interest.

**Duty of obedience:** Obligation of governing board members to perform their duties according to applicable statutes and the provisions of the organization's articles of incorporation and bylaws.
Effectiveness: Results achieved and outcomes observed for persons served. Can apply to different points in time (during, at the end of, or at points in time following services). Can apply to different domains (e.g., change in disability or impairment, function, participation in life's activities, work, and many other domains relevant to the organization.)

Efficacy: The ability to produce an effect, or effectiveness.

Efficiency: Relationship between resources used and results or outcomes obtained. Resources can include, for example, time, money, or staff/FTEs. Can apply at the level of the person served, program, or groups of persons served or at the level of the organization as a whole.

Employee-owner: An individual who delivers administration or services on behalf of an organization if such individual is also:
- with respect to a for-profit organization, a person holding an ownership interest in the organization; or
- with respect to a nonprofit organization, a person with the right to vote for the election of the organization's directors, unless that right derives solely from the person's status as a delegate or director.

Entitlements: Governmental benefits available to persons served and/or their families.

Executive leadership: The organization's principal management employee, often referred to as the chief executive officer, president, or executive director. The executive leadership is hired and evaluated directly by the organization's governing board and is responsible for leading management in conducting the organization's business and affairs.

Family/support system: (Aging Services, Continuing Care Retirement Communities, and Medical Rehabilitation) A group of persons of multiple ages bonded by affection, biology, choice, convenience, necessity, or law for the purpose of meeting the individual needs of its members.

Family: (Behavioral Health, Child and Youth Services, Employment and Community Services, Vision Rehabilitation Services) A person's parents, spouse, children, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served.

Family of origin: Birth family or first adoptive parents.

Fee schedule: A listing of prices for services rendered. These prices may be designed for and used with third-party payers, outside funding sources, and/or the persons served, their families, and caregivers.

Functional literacy: The ability to read, comprehend, and assimilate the oral and written language and numerical information required to function in a specific work or community environment. Accommodation strategies for those with reduced functional literacy may include picture instructions and audio or video recordings.

Governance authority: (Medical Rehabilitation, Opioid Treatment Program) The individual or group that provides direction, guidance, and oversight and approves decisions specific to the organization and its services. This is the individual or group to which the chief executive reports.

Governing board: The body vested with legal authority by applicable law to direct the business and affairs of a corporate entity. Such bodies are often referred to as boards of directors, trustees, or governors. Advisory and community relations boards and management committees do not constitute governing boards.

Governmental: Regarding any city, county, state, federal, tribal, provincial, or similar jurisdiction.

Grievance: A perceived cause for complaint.

Home: (Employment and Community Services) The individual's living environment as impacted by the individual's personal articles, friends, roommates, or significant others. Individuals' homes are considered central to their identity.

Host organization: Employer of an individual eligible for employee assistance program services.
**Impairment:** Problems in body function or structure such as a significant deviation or loss. (This definition is from the World Health Organization’s *International Classification of Functioning, Disability, and Health [ICF]*.)

**Independent (board representation):** The absence of conflict of interest by a governing board member with respect to any organizational transaction. A governing board member is typically independent with respect to a transaction if neither the individual nor any related person or entity benefits from the transaction or is subject to the direction or control of a person or entity that benefits from the transaction. (See definition of *unrelated*.) For purposes of the foregoing, direction or control is often evidenced by the existence of an employment relationship or other compensation arrangement.

**Indigenous:** Indigenous people are the descendants—according to a common definition—of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. CARF is using the term *indigenous* as a generic term as defined by the United Nations for many years. Practicing unique traditions, indigenous people retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. In some countries, there may be preference for other terms including tribes, first peoples, or Aboriginals; specific examples include Native Americans, First Nations, Métis, and Inuit.

**Individual plan:** An organized written statement of the proposed service/treatment process to guide a provider and a person served throughout the duration of service/treatment. It identifies the input from the person served regarding goals and objectives and services to be provided, persons responsible for providing services, and input from the person served.

**Information:** Understanding derived from looking at facts; conclusions from looking at data.

**Informed choice:** A decision made by a person served that is based on sufficient experience and knowledge, including exposure, awareness, interactions, or instructional opportunities, to ensure that the choice is made with adequate awareness of the alternatives to and consequences of the options available.

**Integration:** (Behavioral Health, Child and Youth Services) Presence and participation in the mainstream of community life. Participation means that the persons served maintain social relationships with family members, peers, and others in the community who do not have disabilities. In addition, the persons served have equal access to and full participation in community resources and activities available to the general public.

**Integration:** (Aging Services, Continuing Care Retirement Communities, Employment and Community Services, Medical Rehabilitation, Vision Rehabilitation Services) The opportunity for involvement in all aspects of community life. Integration into communities, work settings, and schools provides all individuals opportunities to be active, fully participating members of those communities or environments. In integrated settings, diversity is viewed as a goal; it is recognized that diversity enriches all community members.

**Interdependence:** Movement from dependence toward interdependence may be demonstrated by an increase in self-sufficiency, self-advocacy, or self-determination, with offsetting decreases in artificial or paid services.

**Interdisciplinary:** Characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of a person’s program. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

**Investigation:** A detailed inquiry or systematic examination by a third party into the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization’s entire operations may be affected.
**Joint venture:** A business undertaking by two or more legal entities in which profits, losses, and control are shared, which may or may not involve the formation of a new legal entity. If a new entity is formed, the original entities continue to exist.

**Kinship care:** (Child and Youth Services) Kinship care is the full-time care, nurturing, and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment. (This definition is from the Child Welfare League of America [CWLA].)

**Leadership:** Leadership creates and sustains a focus on the persons served, the organization’s core values and mission, and the pursuit of organizational and programmatic performance excellence. It is responsible for the integration of the organization's core values and performance expectations into its management system. Leadership promotes and advocates for the organization's and community's commitment to the persons served.

**Linkages:** Established connections and networks with a variety of agencies, companies, and persons in the community.

**Living arrangements:** (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.

**Long-term detoxification treatment:** (Opioid Treatment Program) Detoxification treatment for more than 30 days but no more than 180 days.

**Maladaptive behavior:** Behavior that is destructive to oneself, others, or the environment, demonstrating a reduction or lack of the ability necessary to adjust to environmental demands.

**Manual skills:** The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

**Material litigation:** A legal proceeding initiated by a third party concerning the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

**Medical director:** (Opioid Treatment Program) A physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program either by performing them directly or delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

**Medically complex:** (Behavioral Health, Child and Youth Services) Persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to his or her health status.

**Medically fragile:** (Employment and Community Services) An individual who has a serious ongoing illness or a chronic physical condition that has lasted or is anticipated to last at least 12 months or who has required at least one month of hospitalization. Additionally, this
individual may require daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members. Moreover, this individual may require the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.

**Medically supervised withdrawal (MSW):**
A medically supervised, gradual reduction or tapering of dose over time to achieve the elimination of tolerance and physical dependence to methadone or other opioid agonists or partial agonists.

**Medication-assisted treatment:** (Opioid Treatment Program) Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care. (Definition from SAMHSA)

**Medication control:** (Aging Services, Employment and Community Services, Vision Rehabilitation Services) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. This would include medications self-administered by the persons served or the use of samples.

**Medication management:** (Aging Services, Employment and Community Services, Medication Rehabilitation, Vision Rehabilitation Services) The practice of prescribing, administering, and/or dispensing medication by qualified personnel.

It is considered management when personnel in any way effect dosage, including taking pills out of a bottle or blister pack; measuring liquids; or giving injections, suppository, or PRN medications.

**Medication management:** (Opioid Treatment Program) The practice of prescribing, administering, and/or dispensing any medications approved for the treatment of opioid use disorder by qualified medical personnel.

**Medication monitoring:** (Employment and Community Services, Vision Rehabilitation Services) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. The person served must take the medication without any assistance from personnel.

**Medication unit:** (Opioid Treatment Program) A facility that is part of but geographically separate from an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis.

**Medication use:** (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program) The practice of handling, prescribing, dispensing and/or administering medication to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious.

**Mental status:** A person's orientation, mood, affect, thought processes, developmental status, and organic brain function.

**Merger:** The combination of two or more legal entities into a single legal entity, where one entity continues in existence and the others cease to exist. In a merger, the surviving entity retains its name and identity and acquires the assets and liabilities of the disappearing entities.

**Mission:** An organization's reason for being. An effective mission statement reflects people's idealistic motivations for doing the organization's work.

**Natural proportions:** A principle that states that the number of persons served in any given setting, such as a work setting, should be in proportion to the number of persons with disabilities in the general population.

**Natural supports:** (Behavioral Health, Child and Youth Services) Supports provided that assist the persons served to achieve their goals.
of choice and facilitate their integration into the community. Natural supports are provided by persons who are not paid staff members of a service provider but may be initiated or planned, facilitated in partnership with such a provider.

**Natural supports**: (Employment and Community Services, Vision Rehabilitation Services)

Supports that occur naturally in the community, at work, or in a social situation that enable the persons served to accomplish their goals in life without the use of paid supports.

**Offender**: An inmate, detainee, or anyone under the community supervision of a criminal justice agency.

**On-the-job evaluation**: An evaluation performed in a work setting located outside the organization in which a person is given the opportunity to experience the requirements necessary to do a specific job. Real work pressures are exerted by the employer, and the person’s performance is evaluated by the employer and the evaluator.

**Opioid agonist treatment medication**: (Opioid Treatment Program) Any opioid agonist drug approved by the U.S. Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder.

**Organization**: A legal entity that provides an environment within which services or programs are offered.

**Orientation and Mobility (O&M)**: The instructional area that addresses the use of the remaining senses in combination with skill training utilizing protective techniques and assistive devices in order to travel independently in a safe, efficient, and confident manner in both familiar and unfamiliar environments.

**Outcome**: Result or end point of care or status achieved by a defined point following delivery of services.

**Outcomes measurement and outcomes management**: A systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of the individuals’ satisfaction with those results. An outcomes management system measures outcomes by obtaining, aggregating, and analyzing data regarding how well the persons served are functioning after transition/exit/discharge from a specific service. Outcomes measures should be related to the goals that recent services were designed to achieve. Other measures in the outcomes management system may include progress measures that are appropriate for long-term services (longer than six months in duration) that serve persons demonstrating a need for a slower pace in order to achieve gains or changes in functioning.

**Paid work**: Employment of a person served that results in the payment of wages for the production of products or provision of services. Paid work meets the state and/or federal definition of employment.

**Participation**: An individual’s involvement in life situations. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

**Participation restrictions**: Problems an individual may experience in involvement in life situations. (This definition is from the World Health Organization’s International Classification of Functioning, Disability, and Health [ICF].)

**Pathological aging**: Changes due to the impact of disease versus the normal aging process.

**Pediatric medicine**: The branch of medicine dealing with the growth, development, and care of infants, children, and adolescents and with the treatment of their diseases.

**Performance indicator**: A quantitative expression that can be used to evaluate key performance in relation to objectives. It is often expressed as a percent, rate, or ratio. For example, a performance indicator on return to work might be: percentage of clients in competitive employment 90 days after closure.

**Performance target**: Measurable level of achievement identified to show progress toward an overall objective. This could be set internally by the program, organization, or it could be a target established by an external entity. The
performance target could be expressed as a certain percentage, ratio, or number to be reached.

**Periodically**: Occurring at intervals determined by the organization. The organization uses information about and input from the persons served and other stakeholders to determine the frequency of the intervals.

**Person served**: The primary consumer of services. When this person is unable to exercise self-representation at any point in the decision-making process, person served also refers to those willing and able to make decisions on behalf of the primary consumer. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the primary consumer, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his/her own interests should be granted the right to choose whether other members of the family, significant others, or advocates may participate in that decision-making process.

**Personal care**: Services and supports, including bathing, hair care, skin care, shaving, nail care, and oral hygiene; alimentary procedures to assist one with eating and with bowel and bladder management; positioning; care of adaptive personal care devices; and feminine hygiene.

**Personal representative**: An individual who is designated by a person served or, if appropriate, by a parent or guardian to advocate for the needs, wants, and rights of the person served.

**Personnel**: Individuals employed full time or part time or on a contract.

**Personnel: (Behavioral Health, Child and Youth Services, Opioid Treatment Program)** Individuals who provide services in a program on a part- or full-time basis as staff members, independent contractors, volunteers, students, trainees, or interns.

**Persons with severe and persistent mental illness: (Behavioral Health)** Adults with a primary diagnosis of schizophrenia, psychiatric disorders, major affective disorders (such as treatment resistant major depression and bipolar disorder), or other major mental illness according to the current *Diagnostic and Statistical Manual of Mental Disorders*, which may also include a secondary diagnosis.

**Pharmacotherapy**: Any treatment of the persons served with prescription medications, including methadone or methadone-like drugs.

**Plan**: Written direction that is action oriented and related to a specific project or defined goal, either present and/or future oriented. A plan may include the steps to be taken to achieve stated goals, a timeline, priorities, the resources needed and/or available for achieving the plan, and the positions or persons responsible for implementing the identified steps.

**Plan of care**: The document that contains the program that has been designed to meet the needs of the person served. This document is prepared with input from the team, including the person served. The plan is modified and revised, as needed, depending upon the needs of the person served.

**Policy**: Written course of action or guidelines adopted by leadership and reflected in actual practice.

**Polypharmacy: (Behavioral Health, Child and Youth Services, and Opioid Treatment Program)** The use of multiple medications to treat different conditions.

**Predicted outcomes**: The outcomes established by the team at the time of the completion of the initial assessment.

**Preferred practice patterns**: Statements developed as a guideline for blind rehabilitation specialists that specify procedures, clinical indications for performing the procedures, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes.
Prevailing wage: A wage paid to experienced workers in the vicinity who do not have disabilities that impede them in doing the work to be performed. An experienced worker is one who has become proficient in performing a job and is not receiving entry-level wages. Prevailing wage rates must be based on work done using similar methods and equipment. The information to be recorded in documenting prevailing wage rates includes:

- The date of contact with the firm.
- The name, address, and phone number of the firm.
- The individual contacted within the firm.
- The title of the individual contacted.
- The wage range provided.
- A brief description of the work for which information is provided.
- The basis for the conclusion that the wage rate is not based on an entry-level position.

Primary care: Active, organized, structured treatment for a presenting illness.

Private homes: An apartment, duplex, house, or condominium owned or leased by a person served.

If a person served and the organization co-sign a lease for the person served for an apartment, duplex, or townhouse, this living arrangement will be considered a private home. The organization will not technically be considered a lessor of this private home for the person served, but will be considered a financial guarantor for the person served who is leasing his or her own private home.

Procedure: A “how to” description of actions to be taken. Not required to be written unless specified.

Prognosis: The process of projecting:

- The likelihood of a person achieving stated goals.
- The length of time necessary for the person to achieve his or her rehabilitation goals.

- The degree of independence the person is likely to achieve.
- The likelihood of the person maintaining outcomes achieved.

Program: A system of activities performed for the benefit of persons served.

Program sponsor: (Opioid Treatment Program) The person named in the application for certification as responsible for the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any medication units.

Proprietary organization: An organization that is operated for profit.

Publicly operated organization: An organization that is operated by a governmental entity.

Qualified behavioral health practitioner: (Behavioral Health, Child and Youth Services, Opioid Treatment Program) A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services. Persons other than a physician who are designated by a program to order seclusion or restraints must be permitted to do so by federal, state, provincial, or other regulations.

Qualified practitioner: (Child and Youth Services) A person who is certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide human services.

Reasonable accommodations: Modifications or adjustments, which are not unduly burdensome, that assist the persons served or staff members to access benefits and privileges that are equal to those enjoyed by others. Examples taken from the Americans with Disabilities Act include making existing facilities readily accessible to and usable by persons with disabilities; restructuring jobs; modifying work schedules; reassigning persons to vacant positions; acquiring or modifying
equipment or assistive devices; adjusting or modifying examinations, training materials, policies, and procedures; and providing qualified readers or interpreters.

**Regular:** Occurring at fixed, uniform intervals of time determined by the organization. The organization assesses and uses information about and input from the persons served and other stakeholders to determine the frequency necessary.

**Rehabilitation:** The process of providing those comprehensive services deemed appropriate to the needs of persons with disabilities in a coordinated manner in a program or service designed to achieve objectives of improved health, welfare, and realization of the person’s maximum physical, social, psychological, and vocational potential for useful and productive activity. Rehabilitation services are necessary when a person with a disability is in need of assistance and it is beyond the person’s personal capacities and resources to achieve his or her maximum potential for personal, social, and economic adjustment and beyond the capabilities of the services available in the person’s usual daily experience. Such assistance continues as long as the person makes significant and observable improvement.

**Rehabilitative treatment environment:** A rehabilitation setting that provides for:
- The provision of a range of choices, with personal preference and self-determination receiving full respect and consideration.
- A variety of social interactions that promote community integration.
- Treatment of a sufficient volume of persons served to ensure that there is an environment of peer support and mentorship.
- Treatment of a sufficient volume of persons served to support professional team involvement and competence.
- A physical environment conducive to enhancing the functional abilities of the persons served.

**Reliability:** The process of obtaining data in a consistent or reproducible manner.

**Representative sample/sampling:** A group of randomly selected individuals determined through a procedure such that each person has an equal probability of inclusion in the sample. If sampling is used, the sample should reflect the population to which the results are generalized. Although no specific percentage of persons served is required to be included in the sample, general principles of data analysis state that the larger the sample, the less the error that is expected in comparing the sample to the entire population of persons served. The number of persons sampled within each program area or subgroup should be sufficient to give confidence that the characteristics of the sample reflect the distribution of the entire population of persons served.

**Residence:** (Employment and Community Services) The actual building or structure in which a person lives.

**Residential settings:** (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.
**Restraint:** The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person’s freedom of movement. Restraint is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm.

**Risk:** Exposure to the chance of injury or loss. The risk can be external, such as a natural disaster, injury that occurs on the property of a program, or fire. The risk can be internal to the organization and include things such as back injuries while performing job duties, it can involve liability issues such as the sharing of information about a person served without consent, or it can jeopardize the health of those internal or external to the organization due to such things as poor or nonexistent infection control practices.

**Risk factors:** (Behavioral Health) Certain conditions and situations that precede and may predict the later development of behavioral health problems. Examples of risk factors may include poverty, family instability, or poor academic performance. Examples of protective factors may include an internal locus of control, a positive adult role model, and a positive outlook.

**Risk factors:** Aspect of personal behavior or lifestyle, environmental exposure, or variable or condition that increases the likelihood of an adverse outcome.

**Screening:** A face-to-face, computer-assisted, or telephone interview with a person served to determine his or her eligibility for services and/or proper referral for services.

**Seclusion:** The separation of an individual from normal program participation in an involuntary manner. The person served is in seclusion if freedom to leave the segregated room or area is denied. Voluntary time-out is not considered seclusion.

**Sentinel events:** An unexpected occurrence within a CARF-accredited program involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

**Service:** Activities performed for the benefit of persons served.

**Service access:** The organization’s capacity to provide services to those who desire or are in need of receiving it.

**Service referral:** The practice of arranging for a person to receive the services provided by a given professional service unit of the organization or through some other appropriate agent. This arrangement, which is usually made by the individual responsible for the program of the person served, should be documented by notation in the person’s permanent record.

**Short-term detoxification treatment:** (Opioid Treatment Program) Detoxification treatment for no more than 30 days.

**Should:** Inasmuch as CARF is a standards-setting and consultative resource rather than a regulatory or enforcement agency, the term should is used synonymously with the term shall. CARF’s intent is that each applicable standard and each policy within this document will be addressed and met by organizations seeking to become accredited or maintain current accreditation.

**Skilled healthcare provider:** Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist).

**Skilled healthcare provider:** (Behavioral Health, Child and Youth Services) Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist). Can also include specifically trained natural or foster family member knowledgeable in the care of the specific individual.

**Staff member:** A person who is directly employed by an organization on either a full- or part-time basis.

**Stakeholders:** Individuals or groups who have an interest in the activities and outcomes of an organization and its programs and services. They include, but are not limited to, the persons...
served, families, governance or designated authority, purchasers, regulators, referral sources, personnel, employers, advocacy groups, contributors, supporters, landlords, business interests, and the community.

**Strategic planning:** An organization’s directional framework, developed and integrated from a variety of sources, including but not limited to financial planning, environmental scans, and organizational competencies and opportunities.

**Supervisor:** The lead person who is responsible for an employee’s job performance. A supervisor may be a manager or a person with another title.

**Supports:** Individuals significant to a person served and/or activities, materials, equipment, or other services designed and implemented to assist the person served. Examples include instruction, training, assistive technology, and/or removal of architectural barriers.

**Team:** At a minimum, the person served and the primary personnel directly involved in the participatory process of defining, refining, and meeting the person’s goals. The team may also include other significant persons such as employers, family members, and/or peers at the option of the person served and the organization.

**Team integration:** The process of bringing individuals together or incorporating them into a collaborative team. The entire team becomes the dominant culture and decision-making body for the rehabilitation process. There is recognition of and respect for the value of information provided by an individual team member, with a focus on the interdependence and coordination of all team members. Through coordinated communication, there is accountability by the team 24 hours per day, 7 days per week for all decisions made.

**Transition (from school): (Employment and Community Services)** The process of moving from education services to adult services, including living and working in the community.

**Transition:** The process of moving from one level of care or service/support to another, changing from child/adolescent service systems to adult systems, or leaving care or services/supports.

**Transition plan: (Aging Services, Behavioral Health, Child and Youth Services, Opioid Treatment Program)** A document developed with the full participation of the person served that (a) focuses on a successful transfer/transition between program or service phases/levels/steps or (b) focuses on a successful transition to a community living situation. The plan could be part of the individual plan and details how the person served will maintain the gains made during services and support ongoing recovery and/or continued well-being at the next phase/level/step.

**Treatment:** A professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served.

**Unrelated (board representation):** The absence of an affiliation between a governing board member and any person or entity that benefits from any organizational transaction. For purposes of the foregoing, affiliation generally means a relationship that is:

- Familial;
- Characterized by control of at least a 35 percent voting, profits, or beneficial interest by the member; or
- Substantially influenced by the member.

**Validity:** Refers to the appropriateness, meaningfulness, and usefulness of a measure and the inferences made from it. Commonly regarded as the extent to which a test measures what it is intended to measure.

**Value:** The relationship between quality and cost.

**Visit:** Episode of service delivery to one person served on one day by one service or discipline.

**Visual skills:** The instructional area that addresses the needs of persons with partial vision to gain a better understanding of their eye problems through patient education and teaches them how to utilize their remaining vision effectively through the use of low vision techniques. It also includes assessment and training with special optical aids and devices designed to meet the various needs of the persons served. These needs
may include reading, activities of daily living, orientation, mobility, and home repairs.

**Wellness education:** Learning activities that are intended to improve the patient’s health status. These include but are not limited to healthcare education, self-management of medication(s), nutritional instruction, exercise programs, and training in the proper use of exercise equipment.

**Youth:** The time a person is young—generally referring to the time between childhood and adulthood.
INDEX

A

Accessibility
identification of barriers 99
leadership responsibilities 99
plan, requirements 101
requests for reasonable accommodations, requirements 101

Accreditation
allegations 21
certificate 18
conditions 5
decisions 6, 10
disputed 21
nonaccreditation 7
provisional accreditation 7
extension of 20
multiple programs and services 12
overview 8
policies and procedures 5
preliminary 7
preparing for 8, 11
public identification 18
report 16
 suspension of 21

Admission
screening
documentation requirements 131
identification of unsafe substance use 131
urgent and critical needs 131
screening and eligibility criteria, policies and written procedures 131
timeframes between first contact, screening, and admission/referral 130
waiting list
procedures for referral of persons in crisis 132
requirements 132

Annual Conformance to Quality Report (ACQR) 6, 10, 17

Applying for a survey 11

ASPIRE to Excellence
assess the environment 31
effect change 111
implement the plan 55
persons served and other stakeholders—obtain input 53
process diagram 29
review results 103

Assertive community treatment (ACT)
activities of daily living 177
case management services 176
clinical supervision of team members 179
community integration services 176
community interaction 179
crisis intervention services 175
daily staff meetings 178
designated space for 179
description 173
discharge process 179
discharge, documentation 179–180
hours of operation 178
housing, for persons served 177
information shared at staff meetings, documentation of 179
medication management 177
multidisciplinary treatment teams 174
nursing staff 174
outreach and follow-up 178
peer support and consultation 175
psychiatrist, roles and responsibilities 177
service provision 178
services for families 178
services for persons in restrictive settings 178
services provided 176
staff to client ratio 174
substance abuse services 177
support activities 177
### Index

- **team**
  - access to records of persons served 179
  - leader 174
  - psychiatrist or physician specialist 175
  - requirements 174
  - review of capacity 174
  - roles and responsibilities 175
- **treatment plan**
  - review and modification 175
- **vocational services** 178

### Assessment and referral programs
- description 255
- emergency and crisis intervention services 255
- policies and procedures 255
- services provided 255
- written summary 256

### Assessment/screening
- process, requirements 130

### Assessments
- communicating results 134
- conducted by qualified personnel 134
- identification of risks 141
- information gathered and recorded, requirements 135
- interpretive summary 138
- obtaining information 134
- process, requirements 134
- resulting in diagnosis, requirements 134
- timeframes for 134

### Autism spectrum disorder
- adults with ASD
  - assistive technology 287
  - services 287
  - benefits planning 292
  - community awareness of ASD, promoting 285
  - community resources 288
  - community resources, information about and referrals to 289
  - description 284
  - information about persons served, collecting and sharing 288
  - life planning 291
  - outcomes, monitoring 285
- personnel
  - competencies 286
  - training requirements 286
  - reasonable accommodations, use of assistive technology and adaptations 286
  - research, evidence-based and accepted practices 285
  - self-advocacy support services 290
  - services provided 288
  - transition planning 288
- children with ASD
  - assistive technology 297
  - services 296
  - community awareness of ASD, promoting 295
  - community resources 297
  - description 293
  - diagnostic services 298
  - education for peers 300
  - educational system
    - advocacy for families 300
    - sharing information with 300
  - family-centered care 299
  - information about persons served, collecting and sharing 297
  - information for families 299
  - mentor services 299
  - outcomes, monitoring 294

### Behavioral health
- field categories 171, 253, 283

### Behavioral interventions
- policies and written procedures 121

### Billing, quarterly reviews
- 60

### Blended surveys
- 3

---

2019 Behavioral Health Standards Manual
Board
  governance policies 42
  processes 46
  relationship with executive leadership 45
  selection 42

Bomb threats, emergency procedures 67

Budget preparation, requirements 57

C

Call centers
  access to services 266
  assessment and crisis intervention 267
  availability of services 24/7 267
  crisis resolution, documentation of 267
  face-to-face response 266
  personnel
    decision making capability 267
    knowledge and skills 266
    training requirements 266
  policy regrading referrals 268
  procedures
    access to services 266
    for information and referral programs 268
    involvement of family members and social support systems 266
    program operations 265
    referrals and warm transfers 268
    screening and response 266
  referrals, policy 268
  resources database, development and maintenance of 268
  results of screening, documentation of 266
  roll-over call answering 267
  secondary provider 267
  telephone intervention services 266

Cancellation/change, fee 13

CARF
  consultation with 8, 11
  education and training events 11
  mission 1
  publications, ordering 11
  purposes 2
  standards development 2
  standards manuals, ordering 4
  values 1
  vision 1

Case management/services coordination programs
  advocacy 182
  description 180
  intensity 182
  linkages to services and resources 180
  locations 181
  multiple providers 182
  personnel, qualifications 181
  roles and responsibilities 181

Certificate of Accreditation 18

Children and adolescents
  applicable standards 301
  assessments 302
  continuity of education 302
  educational services, requirements 303
  educational specialist, included as team member 302
  eligibility 304
  policies and procedures
    criminal background checks of personnel providing direct services 303
  population designation, description 301
  service environment, requirements 303
  skills development 303
  staff support, availability 303
  visits 304

Community housing programs
  activities 257
  changes in living arrangements 258
  community living components 257
  description 256
  housemates 257
  information provided to residents 260
  in-home safety 258
  maintaining residences during absences 259
  meals and snacks 257
  medication management 258
  ongoing support/services 259
  personnel, availability
    on call 259
    on site 259
  policies
    pets 257
    visitors or guests 257
  residential setting 257
  securing housing, procedures 258
skills development 259
smoking/nonsmoking areas 259
transportation 259
visits 259

Community integration programs
description 183
legal wage guidelines 184
objectives 183
outreach and follow-up 184
personnel, availability 184
persons served, meeting basic needs 184
services/activities, organization 183
times and locations 184

Complaints
from persons served, policy and procedures 98
review and documented analysis of, requirements 98

Comprehensive suicide prevention programs
crisis intervention, written procedures for 263
description 260
education and training for stakeholders 262
environmental scan, requirements 261
evidence-informed prevention activities 262
personnel
  support and resources for 264
  training requirements 263
program plan, required components 261
referred, written procedures for 263
services and resources 262
stakeholder engagement, strategy for 262

Confidentiality 132
authorization to release information 164

Consultation with CARF 8, 11

Consumer-run programs
advocacy skills 306
applicable standards 304
assistive technology 305
criteria for order of acceptance 304
discharge summary 307
ineligibility 305
information provided to persons served 305
informed consent for services 305
membership/acceptance criteria 305
person-centered plan 306–307
policies and procedures 304
reasonable accommodations 305
records of persons served 307
referrals to other providers 306

Contracted services, reviews of 64

Corporate citizenship 35

Corporate compliance
policy 37
procedures 37
reporting 37
requirements 37
risk assessments 37
training for personnel 37

Court treatment programs
alcohol and drug testing 187
assessments 186
case management
  multiple providers 187
  services 186
case management, requirements 187
communication with participants 186
coordination with other services 189
counseling services 187
description 185
education and training services, for persons served 189
eligibility for participation 186
outpatient services 187
person-centered plan
  review, monthly 188
personnel, training 188
policies and procedures
  case processing 186
  eligibility 186
  screening 186
relationship with criminal justice entity 188
team
  access to confidential information 187
  qualifications 187
  working in partnership with judges 188
treatment interventions,
documentation 187
written procedures 187

Criminal justice programs
access to confidential information 309
applicable standards 309
assessments 310
behavioral health services in a prison or jail setting 311
transition plan 311
curriculum-based component 312
description 309
educational program 313
in a correctional setting 309
individual plan 311
involvement of family members 311
predischarge transition plan 312
relationship with criminal justice entity 309
service delivery team 309
training for personnel 310
Crisis intervention programs
access to inpatient services 191
clinical decisions 191
crisis assessment 190
description 190
face-to-face assessment services 190
initial crisis intervention plan 190
mobile services 191
personnel, qualifications 191
procedures
   emergency 191
   engagement of persons served 190
   handling standing orders 191
   identifying personnel trained in
      emergency procedures 191
   involuntary hospitalization 191
   involvement of significant others 191
   mobile services 190
   referrals to emergency medical
      services 191
   screening for medical conditions 191
   qualified behavioral health practitioners,
      availability 191
   services, availability 191
   telephone intervention services 190
Crisis stabilization programs
contact with persons served, documented
therapeutic interventions 193
description 192
hours 192
initial crisis stabilization plan 192
licensed medical personnel, availability 192
personnel, availability 192
referral and linkage to needed services 193
transportation arrangements, for
persons served 193
Critical incidents
procedures 72
written analysis 74
Cultural competency, written plan 33
D
Data
collection 105–107
performance improvement, ensuring
integrity of 104
Day treatment programs
activities
   consistently scheduled 195
   offered 194
availability 194
description 194
interdisciplinary team 195
personnel, consistently assigned 195
psychiatric services 195
treatment services offered 194
Detoxification/withdrawal management
programs
admission
criteria 196
risk assessments 197
ambulatory programs
admission criteria and assessments 204
linkage of persons served to
treatment programs 203
procedures for drug screening 204
assessments, initial and ongoing 198
description 196
inpatient and residential programs
physical facilities, requirements 202
procedures for searches 202
procedures for visitation, mail,
telephone, and use of personal
electronics 203
inpatient programs
daily determination of medical necessity
203
licensed nursing services 203
interdisciplinary team 199
medical director, qualifications and
responsibilities 198
medical evaluations of persons served, requirements 197
performance measurement and improvement 202
personnel training requirements 200–201
physician availability 200
placement of persons served into appropriate services 197
procedures for transfer to emergency medical services 201
program director, qualifications and responsibilities 198
residential programs
service provision by qualified personnel 203
resources, linkages and referrals to 200
review of medical services provided 201
risk assessments 197
services provided 200
treatment protocols 199

**Discharge summary, written** 146

**Disputed accreditation decisions** 21

**Diversion/intervention programs**
activities provided 270
collaboration with other programs and stakeholders 269
description 269
evaluation of programs/services and training activities 271
information provided 269
personnel, knowledge of community resources 271
plan for individual outcomes 271
procedures for referrals to other services 271
program plan, requirements 270
requirements 271
service design, personnel responsible for, qualifications 269
strategies used 270

**Diversity**
of stakeholders, responding to 33

**Documents, falsification of** 18

**E**

**Eating disorders population designation**
admission process 315
assessment 314–315
assessment requirements 315
description 313
nutritional guidelines 316
outcomes measures 316
partial hospitalization provision of therapeutic services 316
person-centered plan, requirements 315
registered dietician, responsibilities 316
screening 314
service provision requirements 315
transition plan, requirements 315

**Emergency procedures**
requirements 67
testing 70

**Employee assistance programs**
addition of new services 274
communication with host/contracting organization 275
components 272
commentaries guidelines 273, 275
description 271
external and consortium programs 274
host/contracting organization communication with 275
equal access to services 273
written agreement with 273
personnel qualifications 274
training plan 274
personnel of host/contracting organization, training for 275
personnel qualifications 274
policies
critical incidents 275
diverse crisis situations 275
workplace violence 275
procedures
information provided to host organization 275
requirements 272
service delivery system 273
written agreement with host/contracting organization 273

**Ethics**
codes of conduct 34
violations, procedures 35
Evacuation  
   procedures, requirements 68  
   route identification, requirements 70  

F  
   Facilities  
      health and safety requirements 66  
   Families  
      participation 123  
   Federal funding  
      corporate compliance 37  
   Fees  
      past due 13  
      requirements 61  
      supplemental survey 20  
      survey 9, 13  
         application 11  
         cancellation 13  
         rescheduling 13  
   Financial  
      audits 62  
      planning and management 57  
      policies and procedures 60  
      related entities, requirements 59  
      results, reporting 58  
      reviews 58  
      solvency, leadership responsibilities 32  
      statements, annual review of, requirements 62  
   Fire, emergency procedures 67  
   First aid  
      access to expertise, equipment, and supplies 71  
      supplies, in vehicles 76  
   Funds of persons served, procedures 61  

G  
   Governance  
      board processes 46  
      description 41  
      executive leadership 45  
      policies 42, 46  
         annual review 47  
         board selection 42  
         executive compensation 46  

H  
   Hazardous materials, procedures for  
      safe handling 79  
   Health and safety  
      leadership responsibilities 32  
      requirements for facilities 66  
      training for personnel 66  
      See also Emergency procedures, Evacuation procedures, and Universal precautions  
   Health home  
      access to program, enhancing 206  
      admission process 208  
      education and training program for persons served and families/support systems 209  
      health assessments for persons served, requirements 208  
      patient registries and health records, used for data collection and analysis 210  
      performance indicators 210  
      person-centered plans for persons served, requirements 209  
      personnel training requirements 209  
      physician services 206  
      program description 205  
      psychiatrist or addictionologist services 206  
      service delivery team, requirements 206  
      service scheduling and availability 206  
      services provided 207  
      written program description, requirements 205  
   Human resources  
      See Workforce development and management  

I  
   Infection control procedures 75  
   Information  
      confidential  
         records 164  
      release of 164  
      requested by CARF 6
Informed consent, policies 96

**Inpatient treatment**
- arrangements for additional services, requirements 213
- assessments 212
- communication with other service providers 215
- daily evaluations by physician 214
- daily schedule of activities 213
- description 212
- discharge, requirements 214
- interaction between persons served and personnel, reducing barriers to 215
- medical director, qualifications and responsibilities 213
- medical evaluations of person served, requirements 212
- nursing services 213
- performance measurement and improvement, indicators and analysis 216
- personal safety plans for persons served 212
- personnel
  - training in first aid, CRP, and use of emergency equipment 215
  - training, competency-based, requirements 215
- procedures
  - searches of persons served and belongings 215
  - visits, mail, telephone, and personal electronics 215
- program facilities, privacy and security 214
- referral sources, engagement with program 214
- risk assessments 212
- searches, procedures for 215
- service delivery team, requirements 213

**Input**
- from personnel 53
- from persons served 53
- from stakeholders 53
  - for budget preparation 58
  - used in planning 54

**Insurance**
- as part of risk management plan 63
- for vehicles and personnel 76

**Integrated behavioral health/primary care**
- behavioral health providers, availability 217
- care coordination responsibilities 219
- cross training 217
- education provided 218
- individualized integrated plan 219
- integrated team approach 217
- medical services, availability 217
- medical staff 217
- performance measurement indicators 220
- policies
  - consent for treatment 218
  - procedures
    - collaboration with external service providers 220
    - communication and collaboration of team members 220
    - communication with persons served 220
    - declining integrated services 218
    - follow-through process 219
    - intake assessments 219
    - screening 219
- program description 216
- provision of services 218
- psychiatrist or psychologist, availability 217
- referral procedures, documented in program description 217
- staffing requirements 218
- written procedures 217
- written program description, requirements 217

**Intensive family-based services**
- assessments
  - of family functioning 221
- collaboration with other programs 222
- contingency plan for crises 222
- description 221
- emergency care services 222
- involvement of family members 221
- monitoring progress toward goals 221
- plan
  - written, for access to qualified professionals 222
- planning
  - child and family centered 221
- policies
  - consistently assigned personnel 221
range of services provided 221
deferrals to community resources 222
respite care 222

**Intensive outpatient treatment programs**
description 223
direct contact hours offered for persons served 223
education on wellness, recovery, and resiliency 223
integration with other services 224
linkage with other resources and supports 224
monthly review of person-centered plan 224
natural supports, identification, development, and use of 224
service locations and times 223
services provided 223

**J**

**Juvenile justice programs**
applicable standards 317
assessments 319
background checks, policies and procedures 321
behavioral health services in a correctional setting 319–320
continuity of education 320
curriculum-based component 320
description 317
educational program, requirements 321
educational specialist 320
involvement of family members 319
predischarge transition plans 320
relationship with juvenile justice entity 318
residential services 321
service environment 321
service team
  - access to confidential information 318
  - requirements 318
training for personnel 318
visits 321

**L**

**Leadership**
analysis of critical incidents 74
development 46

ethics 34
evaluation 46
person-centered philosophy of 31
relationship with board 45
requirements
  - accessibility 99
  - accountability 31
  - responsibilities 31–32, 38
  - roles and responsibilities 33
structure 31
support and involvement in technology assessments and planning 88
use of input from stakeholders 54

**Leadership responsibilities**
compliance with legal and regulatory requirements 32
establishing mission of the organization 32
financial solvency 32
health and safety 32

**Legal requirements**
compliance 32
compliance with obligations 55

**M**

**Media relations**
procedures 64

**Medical consultation**
regarding medically related policies or procedures 122

**Medical director** 122

**Medical emergencies**
procedures 68

**Medically complex**
applicable standards 323
assessments
  - initial and ongoing 327
  - primary, for each person served 326
behavioral management, approach to 325
behavioral and cognitive needs 327
collaboration with other providers 323
communication with primary care physician(s) 324
education and training for persons served 328
end-of-life planning 325
living environment, requirements 328
Index

management of services 324
meals and snacks, provided for persons served 328
memorial services and rituals 328
person-centered plan of care, requirements 327
personnel competencies, requirements 325
population designation, description 322
program description, requirements 323
service delivery team, requirements 324
service environment 327
wellness activities and services 327
written philosophy of health and wellness, requirements 326

Medication use
description 147
documentation of medications used by persons served, requirements 150
peer review of medication prescribing, if applicable 154
poison control center contact information 151
policy on scope of medication services provided 147
training and education provided to personnel and persons served 148
treatment guidelines and protocols for prescribing, if applicable 153
written procedures for administering or prescribing, if applicable 151
written procedures for medication control if applicable 149
written procedures for medication prescribing, if applicable 153

Mission
establishment of, leadership responsibilities 32
Mission of CARF 1

N
Natural disasters, emergency procedures 67
Nonaccreditation 7

O
Office-based opioid treatment programs
assessment process, interpretative summary 227
description 225
education for stakeholders in the community 229
medical director, qualifications and responsibilities 226
retention in program, performance indicator 229
services provided, requirements 225
training and education for persons served 229
training and education for direct service personnel, requirements 229
written procedures
induction, stabilization, and maintenance 227
medication monitoring 228
pharmacy services 228

Older adults specific population designation
assessment process 329, 331
description 329
education on medications 332
education program for persons served 331
end-of-life planning 332
family/support system assessments 331
information provided to persons served 332
information sharing for care coordination 331
medications, education on for persons served 332
memorial services and grief expression, opportunities for participation 334
service delivery, environment 333

Organizational fundraising
personnel training on written procedures 39
written procedures for 39

Orientation
for persons served 132

Outpatient treatment programs
description 230
education on wellness, recovery, and resiliency 230

394
integration with other services 231
linkage with other resources and supports 231
natural supports, identification, development, and use of 231
service locations and times 231
services provided 230
Outstanding debt 13

P

Partial hospitalization programs
admission 233
assessments
  initial 234
availability
  primary medical care 234
  psychiatrist 233
  qualified behavioral health practitioners 233
  registered nurse 233
case management services 234
clinical director, requirements 232
crisis management services 234
description 232
person-centered plan 234
program hours 232
psychiatric services 233
referral to another level of service 235
service provision, requirements 232
therapeutic activities 235
therapeutic environment 232
therapeutic services 234

Peer support services
description 127
design and development 128
ethical codes of conduct 129
peer support specialists
  activities performed by 129
  role 128
  training for 128
personnel training on role of peer support specialists 128
persons served, educational activities for 129
policies and procedures 128
service provision locations and times 129

training
  for peer support specialists 128
  for personnel 128

Performance improvement
  action plan 112
  analysis, annual, requirements 111
description and requirements 111

Performance indicators
  analysis 113
  in relation to targets 111
  measuring 107

Performance information, sharing 113

Performance measurement and management 103
data collection, requirements 105–107
indicators
  measuring 107
  service delivery 108
  system, written description 103

Person(s) served
complaint and appeal procedures 132
disclosure of fees 61
education 123
education, to reduce physical risks 66
funds handled by organization 61
information provided to 123
  regarding performance 113
input from 53
input on technology used by the organization 88
involvement in planning process 139
involvement in survey process 14
legal decision-making authority 119
orientation 132
records 164
  access 96
  safeguarding 56
  rights 96
  evaluation of restrictions 122
  policies 96
  promoting 121
  requirements 98
services coordination for 125
sharing strategic plan with 51
transporting, safety requirements 76
with substance use disorders, drug screening procedures 127

**Person-centered plan**
devlopment 139
for persons with concurrent disabilities and/or comorbidities 142
periodic reviews 141
personal safety plan 141
progress notes 142
requirements 140
service or treatment objectives 140

**Personnel**
clinical or direct service, supervision of 126
competency assessments and training 124
input from 53
resources and education for 38
sharing performance information with 113
training
cybersecurity and use of technology 92
fiscal policies and procedures 60
health and safety 66
infection control procedures 75
information and communication technologies 94
on corporate compliance 37
organizational fundraising procedures 39
transportation of persons served 76

**Plans**
accessibility 101
cultural competency 33
quality improvement (QIP) 6
risk management 63
technology and system 90
to eliminate the use of seclusion and restraint, if applicable 158

**Policies**
confidentiality 132
consent for treatment 218

corporate compliance 37
financial 60
governance 46
annual review of 47
eexecutive compensation 46
health and safety
legal and illegal drugs 126
weapons 126
illegal or legal substances brought into the program 133
informed consent 96
peer support services 128
persons served
corresponding to unsafe behaviors of persons served 156
rights of persons served 96
scope of medication services provided 147
screening, eligibility, and admissions 131
seclusion and restraint 133
seclusion and restraint, use of in programs seeking accreditation 156
supervision of all individuals providing direct services 125
technology use and security 90
use of seclusion and restraint, if applicable 157
use of tobacco products 126, 133
weapons brought into the program 133
workforce development and management 84

**Preliminary Accreditation** 7

**Preparing for a survey** 14

**Prevention programs**
activities provided, requirements 277
description 276
evaluation of programs/services and training activities 278
personnel, knowledge of community resources 278
procedures for referrals to other services 278
program plan, requirements 277
public awareness efforts 276
service design, personnel responsible for, qualifications 276
strategies used 277
training programs
  curriculum, requirements 278
  requirements 278

Procedures
  business continuity/disaster recovery
  plans, testing of 92
  collaboration with external service
  providers 220
  colocation and coordination of integrated
  disciplines 217
  communication and collaboration of
  team members 220
  communication with persons served 220
  corporate compliance 37
  crisis intervention services 123
  critical incidents 72
  declining integrated services 218
  drug screening for persons with substance
  use disorders 127
  emergency
    annual tests 70
    requirements 67
  ethics violations, allegations 35
  evacuation 68
  financial 60
  follow-through process 219
  for medication control, if applicable 149
  formal complaints from persons served 98
  funds of persons served 61
  hazardous materials handling 79
  health and safety
    legal and illegal drugs 126
    weapons 126
  infection control and prevention 75
  leadership review of use of seclusion or
  restraint, if applicable 162
  media relations 64
  medication administering and prescribing,
  if applicable 151
  medication prescribing, if applicable 153
  orders for seclusion and restraint, if
  applicable 161
  organizational fundraising 39
  peer support services 128
  personnel
    performance appraisals 86
    responding to legal actions 56
  persons served
    complaint and appeal 132
    positive behavioral interventions 121
  protocols for use of seclusion and restraint,
  if applicable 159
  records
    confidentiality 56
    of persons served, requirements 56
  referrals and transfers 145
  referrals, transition, discharge, and
  follow-up 143
  regarding information sharing 164
  risk assessments of persons served 159
  safety 66
  screening 219
  screening, eligibility, and admissions 131
  social media 64
  supervision of all individuals providing
  direct services 125
  technology use and security 90
  timeframes for review and updates to
  person-centered plans 141
  universal precautions 75
  use of information and communication
  technologies 93
  use of tobacco products 126
  verifications of personnel backgrounds,
  credentials, and fitness for duty 81
  waiting list
    referrals for persons in crisis 132
  workforce development and
  management 84

Program/service structure
  entry, transition, and exit criteria,
  documented 117
  mobile unit services, requirements 119
  persons found ineligible for services 118
  persons served
    communication mechanisms,
    requirements 119
    resources, provided by organization 117
    scope of services
      documented parameters 117
      information about, requirements 117
    service models and strategies 118

Promoting nonviolent practices
  debriefing process following use of seclusion
  or restraint, requirements 161
description 155
documentation of any use of seclusion and restraint, requirements 160
plan to eliminate use of seclusion and restraint, if applicable 158
policy addressing use of seclusion and restraint, if applicable 157
policy on responding to unsafe behaviors of persons served 156
policy on use of seclusion and restraint 156
review and analysis of the use of seclusion and restraint, requirements 162
risk assessments, written procedures for 159
room used for seclusion or restraint, requirements 161
training for direct service personnel on prevention of unsafe behaviors 157
training for personnel in the use of seclusion and restraint, if applicable 157
written procedures for leadership review of all use of seclusion or restraint 162
protocols for use of seclusion and restraint, if applicable 159
regarding orders for seclusion and restraint, requirements 161

Provisional Accreditation 7
Public identification of accreditation 18
Purposes of CARF 2

Q
Quality Improvement Plan (QIP) 6, 17
submitting 10
Quality records review
review of services provided 166

R
Reasonable accommodations
requests, reviewing and documenting 101
Records
discharge summary
of person served 165
duplicate records, handling of 166
information collected from records review 168
management 166
of persons served, safeguarding 56
organization 164
requested by CARF 6
requirements regarding persons served 164–165
review, requirements 166–167
selection of records for review 167
signatures of persons served 165
timeframes for entries 165

Referrals
procedures for 145

Regulatory requirements
compliance 32

Release of information 165

Reports
accreditation 16
Annual Conformance to Quality 6, 17
corporate compliance 37
external safety inspection, annual 77
financial results 58
internal safety inspection 78
requested by CARF 6

Rescheduling a survey 13

Residential treatment
additional services provided 237
community living components 237
daily activities schedule 237
description 235
engagement of family/support system in program services 237
facilities, privacy and security 238
food services, consultation with dietician 237
individual treatment plans, monthly review 239
integration with surrounding community 239
interaction between persons served and personnel 238
meals and snacks 237
on-site personnel, requirements 236
personal safety plans 236
personnel training competency-based, requirements 239
first aid, CPR, and use of emergency equipment 238
procedures
  searches 238
  visits, mail, telephone, and personal electronics 238
referral sources, engagement with program 239
relationships with community resources 239
risk assessments 236
searches of persons served and belongings, procedures for 238
services provided 235
treatment team, composition of 236
Rights
  of persons served 96
  promoting 121
  of persons served, requirements 98
Risk management
  description 63
  insurance 63
  plan
    annual review of 63
    requirements 63
    reviews of contracted services 64
S
Safety
  inspection
    annual 76
    external 77
    internal 78
    report 77
    self-inspection 78
  procedures 66
  vehicles 76
Scheduling of survey 13
Self-inspections, health and safety 78
Service delivery
  guided by person-centered philosophy 31
  performance goals, setting 108
  performance indicators, requirements 108
  using information and communication technologies
    description and applicable standards for all organizations 93
Services
  coordination, for persons served 125
  design 121
  implementation 121
Social media
  procedures 64
Specialized or treatment foster care
  access to activities 242
  access to professionals 242
  clinical oversight of services and direction of treatment plan 244
  description 240
  personnel, training requirements
    providers, training requirements 241
  placement with siblings 244
  plan
    for access to qualified practitioners 244
    for selection of treatment or foster care providers 242
  processes for identifying, locating, and engaging family members 240
  referral networks 242
  reunification 244
  staff supervision 244
  supervised visits 244
  training
    for care providers, documented 241
Stakeholders
  information provided to 31
  input from 53
Standards manuals
  in alternative formats 4
  ordering 4
Steps to accreditation 8
Strategic plan
  annual review of 50
  requirements 50
  review and updating of, based on performance indicators 113
  sharing of 51
Strategic planning
  considerations 49
  description 49
  technology to support service delivery 49
Student counseling programs
coordination of services with other providers 246
description 245
discharge summary 246
education on wellness and recovery 246
person-centered plan
communication of goals and objectives 246
requirements 245
review and revision 245
personnel, knowledge and competencies 246
plan and written procedures for potential threats to personnel or campus safety 247
procedures
written, communication and collaboration with stakeholders 246
records of persons served 246
service times and locations 246
services offered 246
transition/discharge process coordination 246
Supplemental surveys 19
Supported living programs
access
to activities 281
to services 280
to transportation 281
availability of support personnel 280
description 279
determination of décor in the homes of persons served 280
information, provided to residents 281
input, from persons served 280
medication management 280
persons served, safety needs 280
securing or maintaining housing 280
supports offered 280
Survey
after the survey 16
application 5
application fee 11
application process 11
blended 3
fees 9, 13
multiple programs and services 12
preparing for 8, 11, 14
process 14
schedule 15
selection of program(s)/service(s) 12
supplemental 19
team
language interpreters, providing 13
selecting 9, 13
timeframes 12
Suspension of accreditation 21

T
Team
meetings, frequency 125
responsibilities 125
Technology
alignment with strategic plan 90
business continuity/disaster recovery, testing of procedures 92
considered in strategic planning 49
description 88
for enhancement of and access to services and supports 124
input from persons served, personnel, and stakeholders 88
leadership support and involvement 88
ongoing assessments related to use of 88
personnel training requirements 92
plan, requirements 90
policies and procedures 90
security policies and procedures 90
services provided using information and communication technologies
description and applicable standards for all organizations 93
emergency procedures 95
equipment maintenance 95
personnel training requirements 94
service delivery, requirements 94–95
training for persons served 94
written procedures 93
Therapeutic communities
cultural and spiritual activities 251
description 247
hours of operation 248
in correctional settings 250–251
personnel, qualifications 252
review of rule infractions 252
transition planning 252
in non-correctional residential settings 250
in residential settings 248
meals and snacks 250
mutual-help principle, use of 248
peer mentors, use of 248
personnel, core competencies 249
reviews of service plans, goals, objectives, and progress 250
scheduled activities 250
services provided 249
sleeping areas 250
therapeutic activities 250
therapeutic duty assignments 251
therapeutic learning interventions 251
treatment environment 248
visits 251
written plan 247
Training and educational events sponsored by CARF 11
Training of personnel
emergency and evacuation procedures 66
safety procedures 66
medication management 66
Transfers
procedures for 145
Transition plan
procedures
documentation of 143
requirements 144–145
Transition planning, requirements 144
Transition/discharge
description 143
process to ensure coordination 146
unplanned transition or discharge 146
Transportation of persons served
health and safety 76
Treatment team
See Team

U
Universal precautions, procedures 75
Utility failures

emergency procedures 68
V
Values of CARF 1
Vehicles
first aid supplies 76
insurance requirements 76
owned by organization, safety requirements 76
staff use of personal vehicles 76
Vision of CARF 1
W
Workforce development and management
adequate staffing, requirements 86
description 80
documentation of workforce composition, requirements 80
job descriptions 81
onboarding and engagement activities 83
orientation for personnel, requirements 83
performance appraisals, written procedures for 86
policies and written procedures for workforce engagement 84
practices, requirements 80
promoting workforce engagement 84
requirements for personnel 87
succession planning 87
workforce development activities, requirements 85
workforce planning, requirements 81
written procedures for verifications of backgrounds, credentials, and fitness for duty 81
Written program description, requirements 120
How well did the CARF 2019 Behavioral Health Standards Manual meet your needs?

Your comments will help us evaluate and improve the quality of this publication. Please email any comments to us at documents@carf.org.