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Three-Year Accreditation

CARF Survey Report for Mental Health Association of Essex County, Inc.

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Organization

Mental Health Association of Essex County, Inc. (MHAEC)
33 South Fullerton Avenue
Montclair, NJ 07042

Organizational Leadership

Robert N. Davison, M.A., LPC, Executive Director

Three-Year Accreditation

Survey Dates

October 2-4, 2013

Survey Team

Karen Friedman, M.S.W., Administrative Surveyor

Wanda J. Campbell, M.S., CAP, ICADC, CMHP,CE, Program Surveyor

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Programs/Services Surveyed

Case Management/Services Coordination: Integrated: AOD/MH (Adults)
Case Management/Services Coordination: Integrated: AOD/MH (Criminal Justice)
Case Management/Services Coordination: Mental Health (Adults)
Community Integration: Psychosocial Rehabilitation (Adults)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)
Prevention: Mental Health (Adults)

Supported Living

Governance Standards Applied

Previous Survey

July 12-14, 2010
Three-Year Accreditation

Survey Outcome

Three-Year Accreditation
Expiration: August 2016

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SURVEY SUMMARY

Mental Health Association of Essex County, Inc. (MHAEC), has strengths in many areas.

- The organization demonstrates efforts to accurately reflect the expectations of the persons served. To ensure active participation by the persons served, MHAEC facilitates focus groups with the persons served designed to solicit information regarding their needs, preferences, and meaningful input. The organization additionally invites the persons served and their families to review, reflect, and make recommendations to the strategic plan. The success of these efforts is clearly demonstrated by positive satisfaction surveys solicited from the persons served and their families, high retention rates, and effective outcomes.
- MHAEC has worked diligently to create an attractive, user-friendly website that was developed with input from the employees and the persons served. The organization demonstrates efforts to operate transparently by including its comprehensive strategic plan and management report on the website for public view.
- The organization is well known for its advocacy efforts and responsiveness to community and stakeholder needs. Recent successes in this area include establishing a social worker in Pennsylvania Station in partnership with New Jersey Transit to work with the homeless population and a partnership with the local hospital to provide services to the families of the persons served who are experiencing psychotic episodes. Through this affiliation and targeted community education and outreach, MHAEC staff members are consistently and immediately contacted by the hospital to provide these services.
- The commitment of the board of directors and the dedication, enthusiasm, and skills of the staff members are strengths. This level of professional commitment is found throughout the organization, from upper management to direct care staff members.
- The organization demonstrates a strong commitment to improving the well-being of consistently underserved populations. Toward this end, the CEO went undercover in March of 2013 to bring attention to poorly run residential facilities by posing as a homeless man for three days. His experience was documented in written media and on NPR®, and resulted in increased awareness by the public and state officials.
- The organization crafted and implemented a mixed media campaign to educate the community about available services through radio and television advertisements, sporting event public services announcements, sponsorship of community music events, and ads on buses.
- MHAEC demonstrates efforts to continue providing services to the persons served in the midst of numerous system-related changes and challenges.
- MHAEC offers quality services free of charge to those who would otherwise not be able to receive much needed care and support.
- The persons served express a high degree of respect and appreciation for the staff and commend the staff at all levels of care for the role that they play in their recovery.
- MHAEC has an extensive and well-designed prevention program that meets the needs of the persons served.

- The inclusion of peer support persons as staff members has given these persons additional insight into their illnesses and hope for their recovery.
- The leadership fosters positive lines of communication among management and line staff members, facilitating an effective transfer of innovative ideas, the resolution of issues, and the development of a healthy environment.
- The leadership is focused on a sound vision and competently copes with issues as they arise.
- MHAEC displays an effective outreach approach that provides a strong presence within the community and is highly appreciated by the persons served.
- MHAEC has an effective case management program with competent, caring, and resourceful leadership and staff.
- The Essex County Correctional Facility staff is knowledgeable regarding corrections and is strongly supported and respected by the criminal justice staff.
- MHAEC has a dedicated and enthusiastic staff that is responsive to the needs of the persons served. The personnel serve the persons with commitment, respect, compassion, and dignity. This is clearly visible in the staff members' noticeable commitment to improving the quality of life for each person served and empowering him or her to be active participants in his or her communities.
- MHAEC has strong clinical programs based in large part on the number of evidence-based and research-based practices, including illness management and recovery, motivational interviewing, and the use of wellness recovery action planning to meet the diverse and complex needs of the persons served.
- The persons served voiced gratitude for and high levels of satisfaction with the services received. They indicate that the treatment they are receiving has been instrumental in changing their lives. One person stated, "I was broken and MHAEC saved my life. I don't know where I would be without them."
- Collaboration and coordination between the programs are strong. The persons served can be quickly and efficiently linked with internal resources, ensuring a seamless continuity of care.
- Empowerment of the persons served is a focus in all programs surveyed. The persons served are educated on the principles of self-advocacy, offered personal choice regarding services and treatment options, and encouraged to take an active role in the quality improvement activities of the organization.
- The directors are creative and innovative when it comes to program design and development. For example, a business based on the concept of social enterprise is being explored as a supplement to the supported employment services program. A social enterprise is an organization that applies commercial strategies to maximize improvements in human and environmental well-being, rather than maximizing profits for external shareholders. In the case of MHAEC, the social enterprise would provide individuals diagnosed with mental illness an opportunity to gain valuable skills that could transfer to future employment.
- MHAEC is responsive to accommodating individuals who are challenging to serve and whom other providers are reluctant to serve. For example, over the past year, the Assisted Outpatient Treatment Services (AOTS) program has made great strides in working with the court-ordered

outpatient population. The program has provided court-ordered intensive case management services to over 30 persons served with mental health issues who historically have been resistant and have difficulty engaging in treatment.

- MHAEC continues to remain on the cutting edge of service delivery. At Prospect House Partial Care, renovations are taking place to add a fitness room and primary care office. These additions will further allow the persons served to be provided holistic and integrated care with a focus on the health and well-being of the whole person.

In the following area MHAEC demonstrates exemplary conformance to the standards.

- MHAEC demonstrates a commitment to securing and maintaining housing that is safe, affordable, and accessible. The organization mounted a unique initiative to provide supportive housing for individuals with mental illness, but was halted by the Montclair Board of Adjustment that contended that the development would constitute a substantial detriment to the zoning plan and the community. Despite ongoing opposition, the organization tirelessly fought for two years to provide needed housing and services to this population. This commitment to the mission has resulted in great success with the stunning facilities that consists of two six-unit buildings (twelve apartments) that were developed and built specifically for the chronically homeless, mentally ill population served by the MHAEC's supported living program. The buildings include six ground floor units that are accessible and one building that includes an elevator, which accesses a finished exercise room. In addition, outdoor space was developed that includes a walking loop, space for a garden, and a basketball court. The buildings and units themselves are fully furnished with modern appliances and high quality furnishings.

MHAEC should seek improvement in the areas identified by the recommendations in the report. Consultation given does not indicate nonconformance to standards but is offered as a suggestion for further quality improvement.

On balance, it is apparent that MHAEC has worked diligently to create and foster an environment conducive to the provision of quality services. The leadership and staff members are compassionate, mission-focused people who demonstrate a warm and caring approach to service provision. The organization has successfully identified and prioritized the needs of the persons served. The commitment to the person served, the needs of the staff, and continuous performance improvement was clearly demonstrated by the organization. MHAEC has the ability, resources, and passion to provide quality services. The leadership and staff members are urged to use its resources to address the improvements noted in the recommendations in this report.

Mental Health Association of Essex County, Inc., has earned a Three-Year Accreditation. The organization is congratulated for this accomplishment and recognized for its efforts to provide quality services. The leadership and staff members are encouraged to continue to use the CARF standards as guidelines for continuous quality improvement in operations and service delivery.

SECTION 1. ASPIRE TO EXCELLENCE®

A. Leadership

Principle Statement

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.

Key Areas Addressed

- Leadership structure
- Leadership guidance
- Commitment to diversity
- Corporate responsibility
- Corporate compliance

Recommendations

There are no recommendations in this area.

B. Governance

Principle Statement

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.

Key Areas Addressed

- Ethical, active, and accountable governance
- Board composition, selection, orientation, development, assessment, and succession
- Board leadership, organizational structure, meeting planning, and management
- Linkage between governance and executive leadership
- Corporate and executive leadership performance review and development
- Executive compensation

Recommendations

There are no recommendations in this area.

C. Strategic Planning

Principle Statement

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

Key Areas Addressed

- Strategic planning considers stakeholder expectations and environmental impacts
- Written strategic plan sets goals
- Plan is implemented, shared, and kept relevant

Recommendations

There are no recommendations in this area.

D. Input from Persons Served and Other Stakeholders

Principle Statement

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.

Key Areas Addressed

- Ongoing collection of information from a variety of sources
- Analysis and integration into business practices
- Leadership response to information collected

Recommendations

There are no recommendations in this area.

E. Legal Requirements

Principle Statement

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

Key Areas Addressed

- Compliance with all legal/regulatory requirements

Recommendations

There are no recommendations in this area.

F. Financial Planning and Management

Principle Statement

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and annual 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.

Key Areas Addressed

- Budget(s) prepared, shared, and reflective of strategic planning
- Financial results reported/compared to budgeted performance
- Organization review
- Fiscal policies and procedures

- Review of service billing records and fee structure
- Financial review/audit
- Safeguarding funds of persons served

Recommendations

There are no recommendations in this area.

G. Risk Management

Principle Statement

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.

Key Areas Addressed

- Identification of loss exposures
- Development of risk management plan
- Adequate insurance coverage

Recommendations

There are no recommendations in this area.

H. Health and Safety

Principle Statement

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.

Key Areas Addressed

- Inspections
- Emergency procedures
- Access to emergency first aid

- Competency of personnel in safety procedures
- Reporting/reviewing critical incidents
- Infection control

Recommendations

H.5.a.(1) through H.5.b.(2)

Although the organization does maintain and implement written emergency procedures that are practical and meaningful for its sites and the population served, they are not specific with regard to fires, bomb threats, natural disasters, and utility failures. It is recommended that MHAEC develop written emergency procedures that address fires, bomb threats, natural disasters, and utility failures. The written procedures should satisfy the requirements of applicable authorities and have practices appropriate for the locale.

H.8.f.(14) through H.8.f.(16)

The organization's written procedures regarding critical incidents should specifically address abuse, neglect, and suicide or attempted suicide.

I. Human Resources

Principle Statement

CARF-accredited organizations demonstrate that they value their human resources. It should be evident that personnel are involved and engaged in the success of the organization and the persons they serve.

Key Areas Addressed

- Adequate staffing
- Verification of background/credentials
- Recruitment/retention efforts
- Personnel skills/characteristics
- Annual review of job descriptions/performance
- Policies regarding students/volunteers, if applicable

Recommendations

I.7.b.(1)

I.7.b.(2)

The organization utilizes interns from local colleges and universities and maintains a personnel file for each. It is recommended that a written identification of duties and scope of responsibility be developed.

J. Technology

Principle Statement

CARF-accredited organizations plan for the use of technology to support and advance effective and efficient service and business practices.

Key Areas Addressed

- Written technology and system plan

Recommendations

There are no recommendations in this area.

K. Rights of Persons Served

Principle Statement

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.

Key Areas Addressed

- Communication of rights
- Policies that promote rights
- Complaint, grievance, and appeals policy
- Annual review of complaints

Recommendations

K.5.a. through K.5.b.(3)

It is recommended that the organization complete an annual written analysis of all formal complaints that determines trends, areas needing performance improvement, and actions to be taken. It is suggested that this analysis be included in the annual management report.

L. Accessibility

Principle Statement

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Written accessibility plan(s)
- Status report regarding removal of identified barriers
- Requests for reasonable accommodations

Recommendations

There are no recommendations in this area.

M. Performance Measurement and Management

Principle Statement

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and information is used to manage and improve service delivery.

Key Areas Addressed

- Information collection, use, and management
- Setting and measuring performance indicators

Recommendations

There are no recommendations in this area.

N. Performance Improvement

Principle Statement

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.

Key Areas Addressed

- Proactive performance improvement
- Performance information shared with all stakeholders

Recommendations

There are no recommendations in this area.

SECTION 2. GENERAL PROGRAM STANDARDS

Principle Statement

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.

A. Program/Service Structure

Principle Statement

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.

Key Areas Addressed

- Written program plan
- Crisis intervention provided
- Medical consultation

- Services relevant to diversity
- Assistance with advocacy and support groups
- Team composition/duties
- Relevant education
- Clinical supervision
- Family participation encouraged

Recommendations

There are no recommendations in this area.

B. Screening and Access to Services

Principle Statement

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.

Key Areas Addressed

- Screening process described in policies and procedures
- Ineligibility for services
- Admission criteria
- Orientation information provided regarding rights, grievances, services, fees, etc.
- Waiting list
- Primary and ongoing assessments
- Reassessments

Recommendations

There are no recommendations in this area.

C. Person-Centered Plan

Principle Statement

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.

Key Areas Addressed

- Development of person-centered plan
- Co-occurring disabilities/disorders
- Person-centered plan goals and objectives
- Designated person coordinates services

Recommendations

There are no recommendations in this area.

D. Transition/Discharge

Principle Statement

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 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 program (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 program 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 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.

Key Areas Addressed

- Referral or transition to other services
- Active participation of persons served
- Transition planning at earliest point
- Unplanned discharge referrals
- Plan addresses strengths, needs, abilities, preferences
- Follow-up for persons discharged for aggressiveness

Recommendations

D.2.

It is recommended that transition planning be initiated with the persons served as early as possible in the person-centered planning and service delivery process.

D.4.a.(1) through D.4.b.

It is recommended that the written transition plan be developed with the input and participation of the person served; family/legal guardian, when applicable or permitted; a legally authorized representative, when appropriate; team members; the referral source when appropriate and permitted; and other community services, when appropriate and permitted. The plan should be given to individuals who participate in the development of the transition plan, when appropriate and permitted.

E. Medication Use

Principle Statement

Medication use is the practice of handling, prescribing, dispensing, and/or administering medications to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious. Medication use may include self administration, or be provided by personnel of the organization or under contract with a licensed individual. Medication use is directed toward maximizing the functioning of the persons served while reducing their specific symptoms and minimizing the impact of side effects.

Medication use includes prescribed or sample medications, and may, when required as part of the treatment regimen, include over-the-counter or alternative medications provided to the person served. 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, transporting, storing, and disposing of medications, including those self administered by the person served.

Self administration for adults is the application of a medication (whether by injection, inhalation, oral ingestion, or any other means) by the person served, to his/her body; and may include the organization storing the medication for the person served, or may include staff handing the bottle or blister-pak 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 closely observing the person served self-administering the medication.

Self administration by children or adolescents in a residential setting must be directly supervised by personnel, and standards related to medication use applied.

Dispensing is considered the practice of pharmacy; the process of preparing and delivering a prescribed medication (including samples) that has been packaged or re-packaged and labeled by a physician or pharmacist or other qualified professional licensed to dispense (for later oral ingestion, injection, inhalation, or other means of administration).

Prescribing is evaluating, determining what agent is to be used by and giving direction to a person served (or family/legal guardian), in the preparation and administration of a remedy to be used in the treatment of disease. It includes a verbal or written order, by a qualified professional licensed to prescribe, that details what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Key Areas Addressed

- Individual records of medication
- Physician review
- Policies and procedures for prescribing, dispensing, and administering medications
- Training regarding medications
- Policies and procedures for safe handling of medication

Recommendations

E.3.k.

It is recommended that the organization develop and implement written procedures for the off-site use of medications.

F. Nonviolent Practices

Principle Statement

Programs strive to be learning environments and to support persons served in the development of recovery, resiliency, and wellness. Relationships are central to supporting individuals in recovery and wellness. Programs are challenged to establish quality relationships as a foundation to supporting recovery and wellness. Providers need to be mindful of developing cultures that create healing, healthy and safe environments, and include the following:

- Engagement
- Partnership—power with, not over
- Holistic approaches
- Respect
- Hope
- Self-direction

Programs need to recognize that individuals may require supports to fully benefit from their services. Staff are expected to access or provide those supports wanted and needed by the individual. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement.

Even with supports, there are times when individuals may show signs of fear, anger, or pain, which may lead to aggression or agitation. Staff members are trained to recognize and respond to these signs through de-escalation, changes to the physical environmental, implementation of meaningful and engaging activities, redirection, active listening, etc. On the rare occasions when

these interventions are not successful and there is imminent danger of serious harm, 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. The use of seclusion and restraint must always be followed by a full review, as part of the process to eliminate the use of these in the future.

The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use of seclusion or restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice. Each organization still utilizing seclusion or restraint should have the elimination thereof as an eventual goal.

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, in immediate response to a dangerous behavior. Restraints used as an assistive device for persons with physical or medical needs are not considered restraints for purposes of this section. 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 self, or holding a person's hand or arm to safely guide him or her from one area to another, is not a restraint. Separating individuals threatening to harm one another, without implementing restraints, is not considered restraint.

Seclusion refers to restriction of the person served to a segregated room 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 if freedom to leave the segregated room is denied.

Seclusion or restraint by trained and competent personnel 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. Peer restraint is not considered an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation.

In a correctional setting, the use of seclusion or restraint for purposes of security is not considered seclusion or restraint under these standards. Security doors designed to prevent elopement or wandering are not considered seclusion or restraint. Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel, are not subject to these standards. When permissible, consideration is made to removal of physical restraints while the person is receiving services in the behavioral health care setting.

Key Areas Addressed

- Training and procedures supporting nonviolent practices
- Policies and procedures for use of seclusion and restraint
- Patterns of use reviewed
- Persons trained in use
- Plans for reduction/elimination of use

Recommendations

There are no recommendations in this area.

G. Records of the Persons Served

Principle Statement

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.

Key Areas Addressed

- Confidentiality
- Time frames for entries to records
- Individual record requirements
- Duplicate records

Recommendations

G.2.c.

It is recommended that the individual record consistently communicate information in a manner that is complete.

H. Quality Records Management

Principle Statement

The organization has 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.

Key Areas Addressed

- Quarterly professional review
- Review current and closed records
- Items addressed in quarterly review
- Use of information to improve quality of services

Recommendations

There are no recommendations in this area.

MENTAL HEALTH

Core programs in this field category are designed to provide services for persons 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. Core programs in this field category may also provide services to persons with co-occurring disabilities/disorders, such as mental illness and a developmental disability.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

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.

C. Case Management/Services Coordination

Principle Statement

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.

Recommendations

There are no recommendations in this area.

T. Outpatient Treatment

Principle Statement

Outpatient treatment programs provide services that include, but are not limited to, individual, group, and family counseling and education on recovery and wellness. 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, addictions (such as alcohol or other drugs, gambling, and internet), eating or sexual disorders, and the needs of victims of abuse, domestic violence, or other trauma.

Recommendations

There are no recommendations in this area.

V. Prevention

Principle Statement

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 three types of prevention programs, categorized according to the audience 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.

  Examples of prevention programs include pregnancy prevention, drop-out prevention, Strengthening Families, substance abuse prevention, violence prevention, HIV prevention, smoking prevention, child abuse prevention, and suicide prevention.

- *Training* programs provide curriculum-based instruction to active or future personnel in child and youth 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.

Key Areas Addressed

- Personnel qualifications
- Public awareness
- Appropriate program activities
- Program strategies

Recommendations

There are no recommendations in this area.

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.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

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.

E. Community Integration

Principle Statement

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.

Recommendations

There are no recommendations in this area.

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 the identified co-occurring disorders.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

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.

C. Case Management/Services Coordination

Principle Statement

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.

Recommendations

There are no recommendations in this area.

SECTION 4. BEHAVIORAL HEALTH SPECIFIC POPULATION DESIGNATION STANDARDS

B. Children and Adolescents

Outpatient Treatment: Mental Health

Principle Statement

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.

Recommendations

There are no recommendations in this area.

D. Criminal Justice

Case Management/Services Coordination: Integrated: AOD/MH

Principle Statement

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.

Recommendations

There are no recommendations in this area.

SECTION 5. COMMUNITY AND EMPLOYMENT SERVICES

A. Program/Service Structure

Principle Statement

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.

Key Areas Addressed

- Services are person centered and individualized
- Persons are given information about the organization's purposes and ability to address desired outcomes
- Documented scope of services shared with stakeholders
- Service delivery based on accepted field practices
- Communication for effective service delivery
- Entrance/exit/transition criteria

Recommendations

There are no recommendations in this area.

B. Individual-Centered Service Planning, Design, and Delivery

Principle Statement

Improvement of the quality of an individual's services/supports requires a focus on the person and/or family served and their identified strengths, abilities, needs, and preferences. The organization's services are designed around the identified needs and desires of the persons served, are responsive to their expectations and desired outcomes from services, and are relevant to their maximum participation in the environments of their choice.

The person served participates in decision making, directing, and planning that affects his or her life. Efforts to include the person served in the direction or delivery of those services/supports are evident.

Key Areas Addressed

- Services are person centered and individualized
- Persons are given information about the organization's purposes and ability to address desired outcomes

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Recommendations

There are no recommendations in this area.

C. Community Services Principle Standards

Key Areas Addressed

- Access to community resources and services
- Enhanced quality of life
- Community inclusion
- Community participation

Recommendations

There are no recommendations in this area.

E. Medication Monitoring and Management

Key Areas Addressed

- Current, complete records of medications used by persons served
- Written procedures for storage and safe handling of medications
- Educational resources and advocacy for persons served in decision making
- Physician review of medication use
- Training and education for persons served regarding medications

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Recommendations

There are no recommendations in this area.

M. Supported Living

Principle Statement

Supported living addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of persons usually 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 sampling of people receiving services/supports in these sites will be visited as part of the interview process. 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.

Supported living programs may be referred to as supported living services, independent living, supportive living, semi-independent living, and apartment living; and services/supports may include home health aide and personal care attendant services. Typically there would not be more than two or three persons served living in a residence, no house rules or structure would be applied to the living situation by the organization, and persons served can come and go as they please. Service planning often identifies the number of hours and types of support services provided.

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 intent to survey or identified as a site on the accreditation outcome.

Key Areas of Addressed

- Safe, affordable, accessible housing chosen by the individual
- In-home safety needs
- Support personnel available based on needs
- Supports available based on needs and desires
- Living as desired in the community
- Persons have opportunities to access community activities

Recommendations

There are no recommendations in this area.

Exemplary Conformance

M.1.a. through M.1.c.

MHAEC demonstrates a commitment to securing and maintaining housing that is safe, affordable, and accessible. The organization mounted a unique initiative to provide supportive housing for individuals with mental illness, but was halted by the Montclair Board of Adjustment that contended that the development would constitute a substantial detriment to the zoning plan and the community. Despite ongoing opposition, the organization tirelessly fought for two years to provide needed housing and services to this population. This commitment to the mission has resulted in great success with the stunning facilities that consists of two six-unit buildings (twelve apartments) that were developed and built specifically for the chronically homeless, mentally ill population served by the MHAEC's supported living program. The buildings include six ground floor units that are accessible and one building that includes an elevator, which accesses a finished exercise room. In addition, outdoor space was developed that includes a walking loop, space for a garden, and a basketball court. The buildings and units themselves are fully furnished with modern appliances and high quality furnishings.

PROGRAMS/SERVICES BY LOCATION

Mental Health Association of Essex County, Inc.

33 South Fullerton Avenue
Montclair, NJ 07042

Case Management/Services Coordination: Integrated: AOD/MH (Criminal Justice)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)
Prevention: Mental Health (Adults)

Governance Standards Applied

Integrated Case Management Services/Supported Employment

60 Evergreen Place, Suites 401 and 402
East Orange, NJ 07018

Case Management/Services Coordination: Integrated: AOD/MH (Adults)
Case Management/Services Coordination: Mental Health (Adults)

Prospect House Partial Care

424 Main Street
East Orange, NJ 07018

Community Integration: Psychosocial Rehabilitation (Adults)

Supportive Living/Assisted Outpatient Treatment Services

60 South Fullerton Avenue, Suites 102 and 206
Montclair, NJ 07083

Case Management/Services Coordination: Integrated: AOD/MH (Adults)

Supported Living

Essex County Correctional Facility

254 Doremus Avenue
Newark, NJ 07104

Case Management/Services Coordination: Integrated: AOD/MH (Criminal Justice)