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SURVEY OUTCOME

Three-Year Accreditation

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

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Three-Year Accreditation

Organization

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

Organizational Leadership

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

Trina Parks, M.H.A., Associate Executive Director

Survey Dates

July 12-14, 2010

Survey Team

Emmett Ervin, M.P.A., CPHQ, Administrative Surveyor

James C. Willis Sr., LPC, LSATP, Program Surveyor

Debra A. Dickinson, Program Surveyor

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)
Prevention/Diversion: Mental Health (Adults)
Prevention/Diversion: Mental Health (Children and Adolescents)

Community Services: Supported Living

Governance Standards Applied

Previous Survey

September 17-19, 2007
Three-Year Accreditation

Survey Outcome

Three-Year Accreditation
Expiration: August 2013

SURVEY SUMMARY

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

- There is a strong sense of teamwork and integration between clinical and administrative staff members that results in more consistent experiences for the persons served. All stakeholders interviewed throughout the site visit complimented the staff members and their show of respect for all individuals the staff members work with.
- The persons served praised the organization for its commitment to quality care, treatment, and support. They report being very satisfied with the services provided.
- Mental Health Association of Essex County is known within the community for being responsive to stakeholders' needs.
- The organization is commended for maintaining a large fleet of company vehicles. These clean vehicles are complemented with consistent maintenance checks and are adequately stocked.
- Throughout the previous two years, the state has made several budgetary cuts. Mental Health Association of Essex County's funding was decreased $900,000. In response, the organization stepped up the search for grants and secured adequate funding to continue the strong provision of care to the persons served. The commitment of leadership to its job and to the consumers is remarkable. Leadership serves as a positive role model for funding sources, persons served, and other stakeholders.
- The organization is complimented for embracing the CARF process and sharing it with all stakeholders, including clients, personnel, board members, and vendors.
- The leadership of the organization is provided by a well-qualified board of directors. The board members freely offer their expertise to the organization and their free time to assist with growing the business, meeting the needs of the persons served, and assisting with other issues as identified.
- The organization has benefited from excellent retention of core personnel. A large percentage of the employees have been employed at the organization for many years. In interviewing staff members, they presented a very positive outlook on the company and seem to enjoy their positions after many years.

- The analysis of incidents is extremely thorough and detailed. This information is shared with personnel throughout the organization.
- The staff is committed, motivated, responsive, and enthusiastic in serving the persons served. Staff members take pride in their strong, well-organized programs and in the progress of persons served.
- Teamwork, mutual respect, cooperation, and open communication are demonstrated throughout the organization.
- The organization's Intensive Family Support Services' (IFSS) Project F.E.R.S.T. (Family Emergency Room Support Team) has developed on-site professional support to families in need of both hospital-based and community mental health services.
- The organization's core programs enhance the individualized care of persons served based on both the needs and responsiveness of persons served.
- Numerous employees have long-term employment with the organization. They know the persons served and have developed trusting relationships, which are vital to growth and learning of persons served.
- Mental Health Association of Essex County's staff has developed a positive collaborative relationship with the Essex County Correctional Facility director and staff through timely availability and cooperation in sharing mental health and substance abuse expertise.
- Mental Health Association of Essex County's center for low cost psychotherapy consistently provides an exceptional level of therapeutic services to persons served unable to access this level of treatment in the community.
- Mental Health Association of Essex County's staff recognizes the value of peer support and assists persons served in learning communication skills and provides opportunities for a variety of peer support groups.
- Mental Health Association of Essex County has supported many of the most diagnostically challenging individuals, many of whom were previously unable to access quality mental health services.
- Good community integration and overall goodwill is ever present throughout all aspects of this organization.
- The organization demonstrates a strong commitment to training, which enhances the commitment and confidence of staff to provide quality services to persons served and keep best practices at the heart of service delivery. Essential Learning provides an efficient and comprehensive online training resource for staff.
- The organization's staff and participants at Prospect House were faced with a traumatic experience during the first day of the survey; the staff is commended for handling the matter in a respectful, professional manner that brought comfort to the participants and staff.
- The supported living program was initiated when Mental Health Association of Essex County recognized the need for community-based housing options in Essex County. Earlier this year, the organization added a newly renovated apartment building to the existing program and through diligent advocacy efforts will soon expand into the Montclair area.
- Case coordination/case management services are providing individuals support to access services needed to ensure that they are stable in their recovery.

- The organization has produced attractive, meaningful, and informative brochures, as well as a website, which portray persons with dignity and respect while accurately describing the services and successes of Mental Health Association of Essex County's programs.

In the following area Mental Health Association of Essex County demonstrates exemplary conformance to the standards.

- Leadership is commended for continuing to offer exceptional care even after the state cut its budget by over $900,000 during the previous two years. The outcomes remained positive, and the satisfaction of the persons served remained high. Lastly, leadership kept the staff fully aware of what was happening (budget wise).

Mental Health Association of Essex County 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, Mental Health Association of Essex County has made a commitment to conform to the standards. The organization's efforts to achieve accreditation are clearly evident in comprehensive policies and procedures and systems in place. Staff members at all levels of the organization appear to understand and are committed to the standards in the provision of quality services. The organization obviously has an understanding of cultural competency as evidenced by the many culture-specific programs offered, and it has forged many community relationships as well as maintained the ability to provide services in the criminal justice environment. Mental Health Association of Essex County is encouraged to review and rectify the recommendations noted in this report and to continue to use the CARF standards to ensure that the services provided are optimal. The organization is clearly aware of the areas for improvement and appears to have the commitment and ability to address them.

Mental Health Association of Essex County, Inc., has earned a Three-Year Accreditation. The board, administration, and staff members are commended for their efforts to accomplish accreditation and are encouraged to remain current with the CARF standards for continuous improvement of the services offered.

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.

Exemplary Conformance

A.1.a.

Leadership is commended for continuing to offer exceptional care, even after the state cut its budget by over $900,000 during the previous two years. The outcomes remained positive, and the satisfaction of the persons served remained high. Lastly, leadership kept the staff fully aware of what was happening (budget wise).

Consultation

- It is suggested that the current policy be amended to encompass all types of contracts. The current contract primarily speaks to independent contractors, but does not include vendor services.
- It is suggested that the organization continue to follow through consistently with all actions for improvement noted in pertinent minutes.
- It is suggested that all documents (plans and policies) contain a date developed or revised and the name of the individual submitting the document.

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 Integrated 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.

Consultation

- It is suggested that the organization review the satisfaction survey, as it is a bit lengthy. In addition, a few clients are illiterate. The amended tool should be available in a format easily understood by the persons served.

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.

Consultation

- Although the organization meets the intent of the CARF standards for medication storage, leadership may want to specify those staff members who have access.

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.13.a.

The organization was under the impression that the testing of emergency procedures must be conducted by the end of each fiscal year. Because of that, the drills were not conducted annually. For that reason, those tests conducted early in the fiscal year, followed up with testing later in the calendar year, would not meet the intent of the standard. It is recommended that all emergency procedures be conducted annually.

Consultation

- It may be helpful to document that assigned tasks noted in minutes are carried over to the following meeting, if not completed. Through staff interviews, it was determined that all tasks were completed; however, this was not evidenced in the minutes.
- Conclusions and recommendations/actions columns are routinely blank. It is suggested that all portions of forms be completed.
- The organization is encouraged to note those staff absent in all meetings. Some program meeting minutes do not document those staff not in attendance.
- It is suggested that the organization be clear about the difference between conclusions and recommendations/actions. There are several areas where action items are noted in the conclusion section.

- The organization might consider incorporating a due date into the meeting minutes.
- Regarding follow-up in the minutes, the organization is encouraged to be clear as to who's responsible. If it is the director, note the director of which program.
- As noted in other areas in this report, the organization is encouraged to ensure that there is one individual responsible for an action item. Having one individual responsible may decrease the time needed to discern the current status of an item.
- The analysis of critical incidents has a category of "other" for just over half the total number of incidents during the year. It is suggested that the incidents in this classification be broken down.
- It is suggested that the self-inspection form be amended to allow additional information such as performance improvement related information. Currently a separate sheet is used to document this information. The current form is a checklist that does not allow for additional documentation.
- It is suggested that the forms for fire drills be amended to allow for performance improvement documentation and action planning. The current form has a section for problems identified and comments.
- Leadership could consider providing storage for clients to place their purses, backpacks, and other items when visiting the program. Currently these items remain with them throughout their stay at the program.
- It is suggested that the organization consistently reflect its policy on tobacco use in its various documents.

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.6.d.(4)(a)

I.6.d.(4)(b)

Leadership is urged to both assess performance related to objectives established in the last evaluation period and to establish measurable performance objectives for the next year. Personnel files revealed a theme of no documentation for either of these areas. It also suggested that the employee be encouraged to provide formal feedback in the performance evaluation process. There was no evidence of feedback noted in the evaluations reviewed. The employee should be prompted to document "no comment" if there is no feedback. This would note his or her active involvement in the performance evaluation process.

I.7.e.

Leadership is urged to enhance its policy on termination to include students or volunteers. As discussed with the organization, there is no need to develop a new policy as the same criteria apply to students or volunteers as the organization's personnel.

Consultation

- It is suggested that the Mental Health Association of Essex County orientation checklist form be amended to note infection control. Although this is being discussed, it is not clearly noted. This is done via the overview of the "Bloodborne Pathogens, Personal Protection Equipment, Standard and Exposure Control Plan."
- It is suggested that the employee new hire packet form be amended to address infection control.
- It is suggested that the job description review be documented. Although this is likely occurring, it is difficult to track because the documents are not routinely documented.
- It is suggested that employees begin noting their involvement. This is not consistently done.

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.

Consultation

- It is suggested that the work planning documents for the technology plan be referenced in the formal plan. This could decrease the search time for the reader, or the work documents could merely be attached to the plan.

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

There are no recommendations in this area.

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.

Consultation

- It is suggested that leadership meet to determine the format of the report.
- It is suggested that the organization clearly identify the time lines for the removal of barriers, in addition to the actions for the removal of identified barriers. Currently the organization is using verbiage such as *ongoing, pending,* and *immediately* to note the due dates.

M. Information 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.

Consultation

- It may be beneficial to create strengths, needs, abilities, and preferences (SNAP) prompts on transition plans rather than current SNAP narratives. This would provide clarity in documenting information.

B. Screening and Access to Services

Principle Statement

The process of screening and assessment is designed 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 strengths, needs, abilities, and preferences of each person served. Assessment data may be gathered through various means, including face-to-face contact, telepsychiatry, 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. Individual Plan

Principle Statement

Each person served is actively involved in and has a significant role in the individual planning process and has a major role in determining the direction of his or her individual plan. The individual plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and problems. Planning is consumer directed and person centered.

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

Consultation

- The current format for individual plans begins with diagnostic and medical information. To assist persons served with focusing on their recovery goals and progress made, it is suggested that the format be reviewed.

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 clinical document that includes information about the person's progress in recovery and describes the completion of goals and the efficacy of services provided. It is prepared to ensure a seamless transition to another level of care, another component of care, or an after care program.

A discharge summary, identifying reasons for discharge, is completed when the person leaves services for any reason (planned discharge, against medical advice, no show, infringement of program rules, etc.).

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 contact the persons served after formal transition or discharge to gather needed information related to their postdischarge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

The transition plan and/or discharge summary may be included in a combined document as long as it is clear whether the information relates to a transition or discharge planning.

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

There are no recommendations in this area.

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 include over-the-counter or alternative medications provided to the person served as part of the therapeutic treatment/service program. 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

There are no recommendations in this area.

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 members 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 physical environment, 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 to 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 or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary administration of medication, in immediate response to a dangerous behavior, to temporarily subdue a person or manage their 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 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

There are no recommendations in this area.

H. Quality Records Review

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 individual service 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.

R. 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.

T. Prevention/Diversion

Principle Statement

Prevention/diversion programs are proactive and evidence based, 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/diversion 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 disorders, physical illness, or violence and abuse; to inform the general public of problems

associated with those issues, thereby raising awareness; or to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Programs are 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 reduce the overall prevalence of problem behaviors, and include comprehensive, well-coordinated components for individuals, families, schools, communities, and organizations.
- *Selected* programs target groups that are exposed to factors that place them at a greater than average risk for the problem behavior. These programs are tailored to reduce identified risk factors and strengthen protective factors in the individual. Selected programs may include student assistance (SAP), peer counseling, or peer mentor groups.
- *Indicated* programs target groups that are exhibiting early signs of the problem behavior. These individuals are at risk for continued or increased problems. Indicated prevention may include programs traditionally thought of as intervention that focus on changing outcomes for individuals and targeting antecedents of problem behavior. Indicated programs may also include diversion programs such as DUI/OWI classes, report centers, home monitoring, after-school tracking, or supervised visitation.

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. A psychosocial clubhouse, a drop-in center, an activity center, and a day program are examples of community integration services.

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 individual service 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

A. Children and Adolescents

Prevention/Diversion: 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.

C. 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 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. The service environment reflects identified cultural needs, practices, and diversity. The person served is given information about the purposes of the organization.

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

Recommendations

There are no recommendations in this area.

E. Medication Monitoring and Management

Principle Statement

These standards apply only to programs that are responsible for monitoring and/or managing medications for the persons served.

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.

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 members 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 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 or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary administration of medication, in immediate response to a dangerous behavior, to temporarily subdue a person or manage their 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 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.

O. 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
- Persons have opportunities to access community activities

Recommendations

There are no recommendations in this area.

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)
Prevention/Diversion: Mental Health (Adults)
Prevention/Diversion: Mental Health (Children and Adolescents)

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

60 South Fullerton Avenue
Montclair, NJ 07083

Community Services: Supported Living

Essex County Correctional Facility

254 Doremus Avenue
Newark, NJ 07104

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