2020 Edition

Mental Health and/or Substance Use Services Definition

Purpose

Individuals and families who receive Mental Health and/or Substance Use Services improve social, emotional, psychological, cognitive, and family functioning to attain recovery and wellness.

Definition

Mental Health and/or Substance Use Services (MHSU) are comprehensive, community-based, and designed to help individuals with diagnosable conditions, including: mental health disorders; disorders relating to the use of alcohol, drugs, or other substances; and co-occurring mental health and substance use disorders.

Based on the needs of the individual, services may address mental health symptoms, diagnoses, and associated functional impairments; resolve issues resulting from the use of alcohol, drugs, or other substances; help manage co-occurring mental health, substance use, and/or health conditions; or provide clinical support for psychosocial adjustments related to life cycle issues.

Clinical counseling programs reviewed under Mental Health and/or Substance Use Services provide counseling, support, and education to address a range of issues related to behavioral health disorders. Services focus on the treatment of diagnosable conditions where therapeutic, evidence-based interventions are provided by appropriately trained, licensed, and/or credentialed personnel.

Diagnosis, Assessment, and Referral programs provide individuals with evaluation, diagnosis, and referral to appropriate services.

Ambulatory Detoxification programs provide medication management and monitoring, clinical counseling, and other necessary support and referral services to help individuals safely withdraw from the substance(s) on which they are dependent. Services include, but are not limited to: individual assessment and treatment planning, withdrawal management (medical and non-

medical), counseling and education, and referrals for ongoing substance use treatment. Programs are available 24 hours a day, seven days per week and are staffed by an interdisciplinary team of qualified professionals. The intensity of the services are determined by the level of care provided (e.g., outpatient, intensive outpatient, and partial hospitalization) and whether or not extended onsite monitoring is performed.

Interpretation

Services can be offered in a variety of settings within the community including outpatient clinics, schools, and individuals' homes. As communication technology continues to evolve, organizations are increasingly utilizing electronic interventions to deliver services. Technologies include videoconferencing, online chat platforms, texting, and mobile applications.

Notes

Note:

1. *Clinical Counseling programs will complete all applicable standards in: MHSU 1, MHSU 2, MHSU 3, MHSU 4, MHSU 5, MHSU 6, MHSU 9, MHSU 10, and MHSU 11*
2. *Diagnosis, Assessment, and Referral programs will complete all applicable standards in: MHSU 1 , MHSU 2, MHSU 3, and MHSU 11*
3. *Ambulatory Detoxification programs will complete all applicable standards in the section including MHSU 8.*

Note: *Clinical counseling programs reviewed under MHSU are distinct from counseling programs reviewed under Counseling, Support, and Education Services (CSE), which provide non-clinical types of counseling that offer guidance, coaching, community support, and skills building to individuals, families, and groups. Services reviewed under CSE are provided by non-clinical staff, and while there is a screening and intake process, assessments and service plans are not required.*

Note: *Please see the MHSU Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see the MHSU Crosswalk.*

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 1: Client-Centered Logic Model

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Rating Indicators

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one client outcome has been identified for all of its programs; or
- All but a few staff have been trained on use of therapeutic interventions and training is scheduled for the rest; or
- With few exceptions the policy on prohibited interventions is understood by staff, or the written policy needs minor clarification.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs; or
- Several staff have not been trained on the use of therapeutic interventions; or
- There are gaps in monitoring of therapeutic interventions, as required; or
- There is no process for identifying risks associated with use of therapeutic interventions; or
- Policy on prohibited interventions does not include at least one of the required elements.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs; or
- There is no written policy or procedures for the use of therapeutic interventions; or
- Procedures are clearly inadequate or not being used; or
- Documentation on therapeutic interventions is routinely incomplete and/or missing; or
- There is evidence that clients have been harmed by inappropriate or unmonitored use of therapeutic interventions.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• See program description • Program logic model that includes a list of outcomes being measured • Procedures for the use of therapeutic interventions • Policy for prohibited interventions	• Training curricula that addresses therapeutic interventions • Documentation tracking staff completion of training and/or certification related to therapeutic interventions	• Interviews may include: 1. Program director 2. Relevant personnel

MHSU 1.01

A program logic model, or equivalent framework, identifies:

1. needs the program will address;
2. available human, financial, organizational, and community resources (i.e. inputs);
3. program activities intended to bring about desired results;
4. program outputs (i.e. the size and scope of services delivered);
5. desired outcomes (i.e. the changes you expect to see in persons served); and
6. expected long-term impact on the organization, community, and/or system.

Examples

Examples: Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA's PQI Tool Kit for more information on developing and using program logic models.

Examples: Information that may be used to inform the development of the program logic model includes, but is not limited to:

1. needs assessments and periodic reassessments;
2. risks assessments conducted for specific interventions; and
3. the best available evidence of service effectiveness.

MHSU 1.02

The logic model identifies client outcomes in at least two of the following areas:

1. change in clinical status;
2. change in functional status;
3. health, welfare, and safety;
4. permanency of life situation;
5. quality of life;
6. achievement of individual service goals; and
7. other outcomes as appropriate to the program or service population.

Fundamental Practice

MHSU 1.03

The organization:

1. ensures staff are trained on therapeutic interventions prior to coming in contact with the service population;
2. monitors the use and effectiveness of therapeutic interventions;
3. identifies potential risks associated with therapeutic interventions and takes appropriate steps to minimize risk, when necessary; and
4. discontinues an intervention immediately if it produces adverse side effects or is deemed unacceptable according to prevailing professional standards.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Fundamental Practice

MHSU 1.04

Organization policy prohibits:

1. corporal punishment;
2. the use of aversive stimuli;
3. interventions that involve withholding nutrition or hydration or that inflict physical or psychological pain;
4. the use of demeaning, shaming, or degrading language or activities;
5. forced physical exercise to eliminate behaviors;
6. unwarranted use of invasive procedures or activities as a disciplinary action;
7. punitive work assignments;
8. punishment by peers; and
9. group punishment or discipline for individual behavior.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 2: Personnel

Program personnel have the competency and support needed to provide services and meet the needs of the target population.

Interpretation

Competency can be demonstrated through education, training, experience, or licensure. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or

- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• See organizational chart and program staffing information • Table of contents of training curricula • Procedures or other documentation relevant to continuity of care and case assignment	• Sample job descriptions from across relevant job categories • Documentation tracking staff completion of required trainings and/or competencies • Training curricula • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker	• Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

MHSU 2.01

Clinical personnel are qualified by education, training, supervised experience, and licensure or the equivalent as appropriate to the services provided and program design.

Interpretation

Clinical personnel may also include individuals who are license-eligible and supervised by experienced, licensed staff.

MHSU 2.02

Supervisor qualifications are tailored to the services provided and program design, and include:

1. an advanced degree in a human services field and a minimum of two years professional experience;
2. specialized training in supervision; and
3. certification and/or licensure by the designated authority in their state, as appropriate.

Interpretation

Regarding element (a), supervisors in detoxification treatment programs may have an advanced degree in a medical field.

Examples

Examples: Qualifications for supervisors in substance use treatment programs may include training and experience in alcohol and other drug use, diagnosis, and treatment, and/or certification by the designated authority in their state as approved alcohol and/or drug counseling supervisors.

MHSU 2.03

Clinical personnel are trained on, or demonstrate competence in:

1. evidence-based practices and other relevant emerging bodies of knowledge;
2. psychosocial and ecological or person-in-environment perspectives;
3. criteria to determine the need for more intensive services;
4. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk;
5. understanding child development and individual and family functioning;
6. working with difficult to reach or disengaged individuals and families;
7. recognizing and working with individuals with co-occurring physical health, mental health, and substance use conditions; and
8. collaborating with other disciplines and services.

Interpretation

When the organization serves military or veteran populations, it is essential that staff have the competencies needed to effectively support and assist service members, veterans, and their families, including sufficient knowledge regarding: military culture, values, policies, structure, terminology, unique barriers to service, traumas and signature injuries, applicable regulations, benefits, and other relevant issues. When providers possess the requisite military competency, they are capable of supporting improved communication and more effective care.

Signature injuries and co-occurring conditions often found in this population include post-traumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), substance use, and intimate partner violence, which could subsequently increase the risk for suicide. Personnel serving military and veteran populations should have the competencies to identify, assess, and develop a treatment plan for these injuries and conditions.

Interpretation

Element (e) is not applicable to detoxification treatment programs.

Examples

Examples: Ecological or person-in-environment perspectives view social, economic, and environmental factors as critical in the development and resolution of personal and family

problems. Factors may include:

1. poverty and lack of employment opportunities;
2. local mores;
3. language and cultural differences; and
4. alternative medicine and traditional healing processes.

MHSU 2.04

Clinical personnel are trained on, or demonstrate competence in the latest information, theories, and proven practices related to the treatment of alcohol and other drug use disorders, including:

1. the signs and symptoms of withdrawal;
2. addiction as a disease;
3. relapse prevention; and
4. interventions that demonstrate respect for sociocultural values, personal goals, life style choices, and complex family interactions.

NA *The organization provides mental health services only.*

MHSU 2.05

Individuals who provide peer support:

1. obtain certification, as defined by their state;
2. are willing to share their personal recovery stories;
3. have a job description and clearly understand the role of a peer support worker; and
4. have adequate support and appropriate supervision.

NA *The organization does not utilize peer support workers.*

MHSU 2.06

Individuals who provide peer support receive pre- and in-service training on:

1. how to recognize the need for more intensive services and how to make an appropriate referral;
2. established ethical guidelines, including setting appropriate boundaries and understanding confidentiality;
3. wellness support methods, trauma-informed care practices, and recovery resources; and
4. skills, concepts, and philosophies related to recovery and peer support.

NA *The organization does not utilize peer support workers.*

MHSU 2.07

The organization minimizes the number of workers assigned to persons served over the course of their contact with the organization by:

1. assigning a worker at intake or early in the contact; and
2. avoiding the arbitrary or indiscriminate reassignment of direct service personnel.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

MHSU 2.08

Employee workloads support the achievement of client outcomes and are regularly reviewed.

Examples

Examples: Factors that may be considered when determining employee workloads include, but are not limited to:

1. the qualifications, competencies, and experience of the worker, including the level of supervision needed;
2. the work and time required to accomplish assigned tasks and job responsibilities; and
3. service volume, accounting for assessed level of needs of clients.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 3: Intake and Assessment

The organization's intake and assessment practices ensure that persons served receive prompt and responsive access to appropriate services.

Interpretation

For detoxification treatment programs, due to the physical and mental state of the service recipient, family involvement in the intake and assessment process may not be appropriate. Therefore, the process will focus on the individual and his or her care needs.

Rating Indicators

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice

Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Screening and intake procedures • Assessment procedures • Copy of assessment tool(s)	• Community resource and referral list	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 3.01

Persons served are screened and informed about:

1. how well their request matches the organization’s services;
2. what services will be available and when; and
3. rules and expectations of the program.

Interpretation

For organizations providing services for substance use disorders, rules and expectations of the program should include any consequences that can result from the verified use of alcohol, drugs, or other substances while participating in the program.

NA *Another organization is responsible for screening, as defined in a contract.*

Examples

Examples: Screenings will vary based on the program’s target population and services offered and may include information to identify any of the following: trauma history, substance use disorders, mental illness, developmental delays, suicide and self-harm history and current level of risk, and/or risk of harm to others.

Fundamental Practice

MHSU 3.02

Prompt, responsive intake practices:

1. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
2. give priority to urgent needs and emergency situations including access to expedited service planning;
3. facilitate the identification of individuals and families with co-occurring conditions and multiple needs;
4. support timely initiation of services; and
5. provide for placement on a waiting list or timely referral to appropriate resources when individuals cannot be served or cannot be served promptly.

Interpretation

Individuals discharged from emergency rooms or psychiatric inpatient facilities after a suicide attempt remain a high-risk group post discharge. To reduce the risk of suicide re-attempt, these individuals should be contacted within 24 hours, receive access to services within three to seven calendar days, and active outreach should be initiated in cases of a missed appointment until contact is made.

Examples

Examples: Referral providers for crisis situations may include 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization, or 24-hour crisis hotline. Urgent situations can also include those in which an individual has a child in the child welfare system.

MHSU 3.03

Persons served participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is:

1. completed within established timeframes;
2. appropriately tailored to meet the age and developmental level of persons served;
3. updated as needed based on the needs of persons served; and
4. focused on information pertinent for meeting service requests and objectives.

Interpretation

For an assessment to be trauma-informed, the organization understands and recognizes the role of traumatic life events in the development of mental health and/or substance use disorders. Personnel should focus on the experiences and strengths of the service recipient rather than personal deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially re-traumatize persons served.

Examples

Examples: When working with children, assessments may include an evaluation of factors that impact the child’s social and emotional well-being (e.g., family characteristics), an observation of the child’s behavior, a thorough health and developmental history, and/or involvement in other systems including education, child welfare, and juvenile justice.

Fundamental Practice

MHSU 3.04

The comprehensive assessment includes:

1. the service recipient’s behavioral health, physical health, and community and social support service needs and goals;
2. a brief screen for trauma history and recent incidents of trauma followed by a comprehensive, evidence-based trauma assessment conducted by an appropriately qualified individual when indicated;
3. individual and family strengths, risks, and protective factors;
4. natural supports, resources and helping networks that can increase service participation and achievement of agreed-upon goals;
5. a risk evaluation to assess risk of suicide, self-injury, neglect, exploitation, and violence towards others; and
6. a summary of symptoms and diagnoses based on a standardized diagnostic tool.

Interpretation

The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA’s Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.

Interpretation

Due to the short-term nature and focus of detoxification treatment programs, individuals seeking treatment may not have the opportunity to address trauma history and/or recent incidents of trauma during the assessment process.

Interpretation

Personnel that conduct evaluations should be aware of the indicators of a potential trafficking victim, including, but not limited to, evidence of mental, physical, or sexual abuse; physical exhaustion; working long hours; living with employer or many people in confined area; unclear family relationships; heightened sense of fear or distrust of authority; presence of older significant other or pimp; loyalty or positive feelings towards an abuser; inability or fear of making eye contact; chronic running away or homelessness; possession of excess amounts of cash or hotel keys; and inability to provide a local address or information about parents.

Examples

Examples: Assessment of behavioral health can include an evaluation of mental health and/or substance use disorders, a psychiatric history, a complete alcohol and drug use history, medical history, and evaluation of social support and community support networks.

MHSU 3.05

The organization uses a comprehensive, evidence-based suicide risk assessment tool to assess the following when suicide risk is identified:

1. suicidal desire;
2. capability;
3. intent; and
4. buffers/protective factors.

Fundamental Practice

MHSU 3.06

Unmet medical needs identified in the assessment are addressed directly, or through an established referral relationship, and can include:

1. medication monitoring and management;
2. physical examinations or other physical health services;
3. medical detoxification;
4. laboratory testing and toxicology screens; or
5. other diagnostic procedures.

Interpretation

The nature of problems resulting from mental health and/or substance use disorders may require medical services to be available. The organization is not required to provide services directly, but the results of medical screens, tests, and services should be documented in the case record when available and incorporated into service planning and monitoring.

Interpretation

Organizations providing treatment services for mental health and/or substance use disorders are expected to have a licensed physician or other qualified health professional with appropriate training and experience on staff or available through a contract or formal arrangement. See MHSU 7.01 for more information.

All other services must have, at minimum, an established referral relationship with a licensed physician or other qualified health professional.

MHSU 3.07

Reassessments are conducted as necessary, according to the needs of the service recipient.

Interpretation

Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new suicide risk assessment as part of the reassessment. Once any potential suicide risk is identified, it may be important to conduct reassessments regularly even if these trigger events are not observed.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Examples

Examples: Timeframes for reassessment depend on the service population and length of treatment, or may be delineated by regulatory requirements. The organization may conduct a reassessment during specific milestones in the treatment process, for example:

1. after significant treatment progress;
2. after a lack of significant treatment progress;
3. after new symptoms are identified;
4. after changes in treatment strategy and/or medication;
5. when significant behavioral changes are observed;
6. when there are changes to a family situation; or
7. when significant environmental changes or external stressors occur.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 4: Service Planning and Monitoring

Individuals and their families, as appropriate to the program model and the age and expressed wishes of the person, participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support.

Interpretation

Due to the importance of family involvement in achieving positive outcomes for children, all aspects of service delivery should be family-driven when working with this population, accounting for the dynamics of the family as well as the needs of the child. Family should be defined in partnership with the child.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Examples

Examples: Family involvement has been emphasized due to the significant impact family engagement can have on resilience and recovery. However, the level of family involvement can vary given the age and expressed wishes of the person and as permitted by law.

Program model and structure can also impact family involvement. For example, detoxification treatment programs are short-term and primarily focused on withdrawal management; therefore, persons served have limited opportunities to involve family members in the service planning and monitoring process. Furthermore, it may not be appropriate to engage family members due to the service recipient's physical and mental state and treatment progress.

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2	Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g., • Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or • Procedures need strengthening; or • With few exceptions, procedures are understood by staff and are being used; or • For the most part, established timeframes are met; or • Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or • In a few instances, client or staff signatures are missing and/or not dated; or • With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or • Active client participation occurs to a considerable extent.
3	Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g., • Procedures and/or case record documentation need significant strengthening; or • Procedures are not well-understood or used appropriately; or • Timeframes are often missed; or • In several instances, client or staff signatures are missing and/or not dated; or • Quarterly reviews are not being done consistently; or • Level of care for some clients is clearly inappropriate; or • Service planning is often done without full client participation; or • Appropriate family involvement is not documented; or • Documentation is routinely incomplete and/or missing; or • Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.
4	Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g., • No written procedures, or procedures are clearly inadequate or not being used; or • Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Service planning and monitoring procedures	*No On-Site Evidence*	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 4.01

An assessment-based service plan is developed in a timely manner with the full participation of persons served, and their family when appropriate, and includes:

1. agreed upon goals, desired outcomes, and timeframes for achieving them;
2. services and supports to be provided, and by whom;
3. possibilities for maintaining and strengthening family relationships and other informal social networks;
4. procedures for expedited service planning when crisis or urgent need is identified; and
5. the individual's or legal guardian's signature.

Interpretation

For service members, veterans, and their families, the service plan should also clearly outline which services will be provided on the installation or Veterans Affairs facility, when appropriate to the needs and wishes of the service recipient. Research has shown that this population is often unsure of the services to which they are entitled and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible.

Examples

Examples: Treatment outcomes for adults may include the ability to live independently or obtain employment, while outcomes for children and youth may focus on school performance and social and emotional well-being.

Fundamental Practice

MHSU 4.02

The organization determines whether a crisis plan is necessary and, when indicated, engages persons served and involved family members in crisis and/or safety planning that:

1. is individualized and centered around strengths;
2. identifies individualized warning signs of a crisis;
3. identifies coping strategies and sources of support that individuals can implement during a suicidal crisis, as appropriate; and
4. specifies interventions that may or may not be implemented in order to help the individual de-escalate and promote stabilization.

Interpretation

A safety plan includes a prioritized written list of coping strategies and sources of support that individuals who have been deemed to be at high risk for suicide can use. Individuals can implement these strategies before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal individuals cope with suicidal feelings in order to prevent a suicide attempt or possibly death. The safety plan should be developed once it has been determined that no immediate emergency intervention is required.

Interpretation

“No-suicide contracts,” also known as “no-harm contracts” and other similar terms, should never be used. No-suicide contracts are based on a verbal or written agreement by the service recipient to not engage in self-harm or suicidal acts during a specific timeframe. Research does not support this practice or show that these agreements are effective at preventing suicides, nor have they been found to provide protection against malpractice lawsuits.

Examples

Examples: Depending on the needs of the individual, crisis plans may reference advanced mental health directives, also known as advanced psychiatric directives.

Examples: Components of a safety plan can also include: internal coping strategies, socialization strategies for distraction and support, family and social contacts for assistance,

professional and agency contacts, and lethal means restriction.

Examples: Warning signs for individuals assessed as being at high risk for suicide can include a missed appointment, or significant change in status, and personnel may conduct active outreach and service engagement strategies such as phone calls, text messages, or home visits until contact is made.

Examples: Safety plans may look different depending on the specific needs of the service recipient. For example, safety plans for survivors of domestic violence may focus on helping individuals prepare for immediate escape, while safety plans for individuals at risk for suicide may address coping strategies and sources of support, such as socialization strategies for distraction and support, family and social contacts for assistance, professional and agency contacts, and lethal means restriction. Organizations may also provide family members with information on crisis prevention. For example, Mental Health First Aid is a one-day training that can prepare someone to recognize, understand, and respond to a person's mental health crisis.

MHSU 4.03

The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of persons served, to assess:

1. service plan implementation;
2. progress toward achieving service goals and desired outcomes; and
3. the continuing appropriateness of the agreed upon service goals.

Interpretation

When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.

NA *The organization provides detoxification treatment only.*

Examples

Examples: Individuals with higher level of care needs require frequent review. For example, weekly review is recommended for individuals with substance use disorders at high risk for relapse. Individuals with acute or complex needs (e.g., individuals receiving medications for diagnosed symptoms and conditions) may require that their service plan be reviewed and updated every 30 days.

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MHSU 4.04

The worker and individual, and his or her family when appropriate:

1. review progress toward achievement of agreed upon service goals; and
2. sign revisions to service goals and plans.

NA *The organization provides detoxification treatment only.*

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 5: Clinical Counseling

The organization provides trauma-informed clinical counseling services that:

1. provide an appropriate level and intensity of support and treatment;
2. recognize individual and family values and goals;
3. accommodate variations in lifestyle;
4. emphasize personal growth, development, and situational change; and
5. promote recovery, resilience, and wellness.

Interpretation

Ambulatory detoxification treatment programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies), provided to persons served on an individual or group basis. Services aim to enhance the service recipient's understanding of addiction, completion of withdrawal management, and referral to an appropriate level of care for substance use treatment. The delivery of services will vary and depends on the assessed needs of the service recipient and his or her treatment progress.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Examples

Examples: Organizational self-assessments can help evaluate the extent to which organizations’ policies and practices are trauma-informed, as well as identify strengths and barriers in regards to trauma-informed service delivery and provision. For example, organizations can evaluate staff training and professional development opportunities and review supervision ratios to assess whether personnel are trained and supported on trauma-informed care practices.

Notes

Note: *Recovery is a holistic process of change where individuals learn to overcome or manage their diagnosed symptoms and conditions in order to improve overall well-being and achieve optimal health.*

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4 Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Procedures for evaluating level/intensity of care and follow-up	*No On-Site Evidence*	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 5.01

Clinical counseling services promote whole-person wellness and help the individual to develop the knowledge, skills, and supports necessary to:

1. manage mental health and/or substance use disorders;
2. cultivate and sustain positive, meaningful relationships with peers, family members, and the community; and
3. develop self-efficacy.

MHSU 5.02

Personnel assist persons served to:

1. explore and clarify the concern or issue;
2. voice the goals she or he wishes to achieve;
3. identify successful coping or problem-solving strategies based on the individual's strengths, formal and informal supports, and preferred solutions; and
4. realize ways of maintaining and generalizing the individual's gains.

Examples

Examples: Personnel can help to engage and motivate persons served in this process by demonstrating, for example:

1. sensitivity to the needs and personal goals of the service recipient;
2. a non-threatening manner;
3. respect for the person's autonomy, confidentiality, sociocultural values, personal goals, lifestyle choices, and complex family interactions;
4. flexibility; and
5. appropriate boundaries.

MHSU 5.03

Clinical personnel:

1. determine the optimal level and intensity of care, including clinical and community support services;
2. follow up when an evaluation for psychotropic medications and medication-assisted treatment is recommended; and
3. use written criteria to determine when the involvement of a psychiatrist is indicated.

Interpretation

Element (c) does not apply to detoxification treatment programs.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 6: Therapeutic Services

Persons served receive ongoing, coordinated, trauma-informed therapeutic services based on their assessed needs and goals.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Notes

Note: *For detoxification treatment programs, please refer to the interpretation at MHSU 5.*

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Referral procedures	• Copies of agreements with cooperating service providers and/or community resource and referral list, as applicable	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 6.01

Persons served receive psychosocial, therapeutic and educational interventions that are:

1. matched with the assessed needs, age, developmental level, and personal goals of the service recipient; and
2. provided in individual, family, and/or group format.

Interpretation

For detoxification treatment programs, therapeutic and educational interventions may be limited given the length of treatment and the service recipient's treatment progress.

MHSU 6.02

The organization directly provides or makes referrals for a comprehensive range of prevention and treatment services, including:

1. psychotherapy;
2. illness management and psychoeducation interventions;
3. coping skills training;
4. relapse prevention;
5. acute care;
6. support groups and self-help referrals;
7. detoxification;
8. inpatient care;
9. intensive outpatient care;
10. medical care;
11. psychiatric rehabilitation; and
12. targeted case management services.

MHSU 6.03

Individuals and their families, when appropriate, are connected with peer support services, either directly or by referral, appropriate to their request or need for service.

Notes

Note: *Peer support refers to services provided by individuals who have shared, lived experience. Services promote resiliency and recovery and can include peer recovery groups, peer-to-peer counseling, peer mentoring or coaching, family and youth peer support or other consumer-run services.*

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 7: Medical Care and Clinical Support Team

Treatment decisions are guided by a qualified clinical team and are made in collaboration with persons served.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

NA *The organization provides Clinical Counseling services only.*

Notes

Note: *Medical care includes psychiatric care and treatment.*

Rating Indicators

1	All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2	Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g., • Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or • Procedures need strengthening; or • With few exceptions, procedures are understood by staff and are being used; or • For the most part, established timeframes are met; or • Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or • Active client participation occurs to a considerable extent.
3	Practice requires significant improvement, as noted in the ratings for the Practice

Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
No Self-Study Evidence	• Job description and resume of qualified health professional and/or formal agreement with a professional or community-based provider	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records • Review personnel record, when applicable

Fundamental Practice

MHSU 7.01

A licensed physician, or another qualified health professional, with experience, training, and competence in engaging, diagnosing, and treating persons with mental health and/or substance use disorders is responsible for the medical aspects of treatment.

Interpretation

When an appropriately qualified health professional is not employed by the organization, their participation on the treatment team should be secured through contract or formal agreement.

Examples

Examples: Medical aspects can include:

1. prescribing medication and medication management, including appropriate management of pharmacotherapy for individuals with co-occurring conditions;
2. providing or reviewing diagnostic, toxicological, and other health related examinations of persons not currently under medical care and supervision;
3. review of complicated cases where co-occurring substance use, health, and mental health conditions intersect; and
4. other medical and psychiatric related issues, such as seizure disorders, psychosomatic disorders, or traumatic brain injury.

Examples: The qualifications and training of the physician may vary as appropriate to the program. For example, organizations that provide mental health services may have a board-eligible psychiatrist who is responsible for the medical aspects of treatment. Qualified health professionals may include: psychiatric or mental health nurse practitioners, physician assistants, or health professionals that are permitted by law in their state to provide medical care and services (e.g., prescribe and monitor medications) without direction or supervision.

Fundamental Practice

MHSU 7.02

In collaboration with the service recipient, a clinical team and a licensed physician, or other qualified health professional, make decisions about level of care, treatment, and aftercare or discharge planning.

MHSU 7.03

Organizations that employ or have formal agreements with telemedicine practitioners, or individuals that provide telehealth services, monitor and share information in a way that ensures privacy and security of confidential information.

NA *The organization does not employ or have formal agreements with telemedicine practitioners.*

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 8: Ambulatory Detoxification Treatment

Detoxification treatment is provided based on the needs of the service recipient.

NA *The organization does not provide detoxification treatment.*

Notes

Note: *Detoxification can occur at varying levels of intensity.*

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or

- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Criteria for determining the level of care	• Sample job descriptions from across relevant job categories	• Interviews may include: 1. Clinical/Medicaldirector 2. Relevant personnel 3. Persons served • Review case records

MHSU 8.01

Qualified personnel determine the appropriate level of detoxification care and treatment for the individual using diagnostic criteria outlined in clinical decision support tools and clinical practice guidelines.

Examples

Examples: Organizations can utilize the American Society of Addiction Medicine (ASAM) criteria to determine the appropriate level of care.

MHSU 8.02

Detoxification services include:

1. assessment and evaluation;
2. monitoring and stabilization; and
3. preparation for entry into substance use treatment.

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Fundamental Practice

MHSU 8.03

Detoxification treatment is provided by a qualified team of trained and licensed professionals appropriate to the intensity of services offered.

Examples

Examples: Organizations providing medically-monitored detoxification may employ an interdisciplinary staff of nurses, counselors, social workers, addiction specialists and/or other health and technical personnel, whom all work under the supervision of a licensed physician.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 9: Care Coordination

The organization coordinates services in order to promote continuity of care and whole-person wellness.

Interpretation

The standards in MHSU 9 address the efforts an organization makes to promote information sharing and collaboration with the various systems touching a particular individual. Organizations are not required to provide integrated care to implement the standards in this section. Organizations that offer integrated behavioral health and primary care services (e.g., health homes) will complete the Integrated Care; Health Home (ICHH) standards.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

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2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3	Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g., • Procedures and/or case record documentation need significant strengthening; or • Procedures are not well-understood or used appropriately; or • Timeframes are often missed; or • Several client records are missing important information; or • Client participation is inconsistent.
4	Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g., • No written procedures, or procedures are clearly inadequate or not being used; or • Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Procedures for care coordination	• Copies of agreements with cooperating service providers and/or community resource and referral list, as appropriate	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 9.01

The organization works in active partnership with persons served to:

1. ensure that they receive appropriate advocacy support;
2. assist with access to the full array of services to which they are eligible; and
3. mediate barriers to receiving coordinated services.

Fundamental Practice

MHSU 9.02

Individuals with co-occurring mental health and substance use disorders receive coordinated treatment either directly or through active involvement with a cooperating service provider.

Interpretation

This standard is applicable to all programs regardless of the services offered. Organizations that only treat substance use disorders are expected to have the core capability to address co-occurring mental health conditions, and organizations that only treat mental health disorders are expected to have the core capability to address co-occurring substance use disorders.

Fundamental Practice

MHSU 9.03

The organization supports the coordination of behavioral and physical health care to increase service recipients' access to needed services by:

1. providing referrals to identified primary care providers;
2. communicating with the primary care doctor about treatment planning; and
3. linking individuals to providers that can help them navigate the health care system.

MHSU 9.04

In collaboration with the service recipient, the organization coordinates with, as needed:

1. the child welfare system;
2. the juvenile justice system;
3. courts; and
4. the school system.

MHSU 9.05

Care coordination activities include:

1. linkages to community providers, as well as completed follow-up when possible;
2. communication with partnering providers both internally and externally; and
3. communication with the service recipient.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 10: Support Services

Persons served receive support services that increase the likelihood of progress in treatment and positive change.

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

NA *The organization provides Detoxification Treatment only.*

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or

- Client participation is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Referral procedures	• Copies of agreements with cooperating service providers and/or community resource and referral list, as appropriate	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 10.01

The organization provides, either directly or by referral, necessary support services which may include, as appropriate:

1. work-related services and job placement;
2. supported housing;
3. transportation;
4. social skills training;
5. public benefits;
6. educational services; and
7. respite care.

Interpretation

Service members and veterans should be linked to any services or benefits for which they may be eligible, including Veterans Affairs health services.

MHSU 10.02

The organization works with the service recipient to identify natural supports and social networks to cultivate and sustain a supportive community.

Examples

Examples: Social networking opportunities can include: social, recreational, education, or vocational activities; religious or spiritual gatherings; or neighborhood and community events that provide individuals with an opportunity to meet, support, and share experiences with peers.

MHSU 10.03

Individuals who have primary responsibility for children receive accommodations for, or assistance with, child care arrangements.

NA *The organization does not serve persons who have primary responsibility for children.*

Examples

Examples: The organization may offer child care while treatment or support groups meet or provide referrals to community child care resources.

2020 Edition

Mental Health and/or Substance Use Services (MHSU) 11: Case Closing and Aftercare

The organization works with persons served and family members, when appropriate, to plan for case closing and, when possible, to develop aftercare plans.

Rating Indicators

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

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2 Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active client participation occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

---

3 Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or

- Several client records are missing important information; or
- Client participation is inconsistent.

4

Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- No written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

Self-Study Evidence	On-Site Evidence	On-Site Activities
• Case closing procedures • Aftercare planning and follow-up procedures	• Relevant portions of contract with public authority, as applicable	• Interviews may include: 1. Program director 2. Relevant personnel 3. Persons served • Review case records

MHSU 11.01

Planning for case closing:

1. is a clearly defined process that includes assignment of staff responsibility;
2. begins at intake; and
3. involves the worker, persons served, family members, and others, as appropriate to the needs and wishes of the person served.

MHSU 11.02

Upon case closing, the organization notifies any collaborating service providers, including the courts, as appropriate.

MHSU 11.03

If an individual has to leave the program unexpectedly or the individual voluntarily discontinues services, the organization makes every effort to identify other service options and link the person with appropriate services.

Interpretation

The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.

MHSU 11.04

When appropriate, the organization works with persons served and their family to:

1. develop an aftercare plan, sufficiently in advance of case closing, that identifies short- and long-term needs and goals and facilitates the initiation or continuation of needed supports and services; or
2. conduct a formal case closing evaluation, including an assessment of unmet need, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

NA The organization provides Diagnosis, Assessment, and Referral Services only.

MHSU 11.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of persons served.

NA *The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.*

NA *The organization provides Diagnosis, Assessment, and Referral Services only.*

Examples

Examples: Reasons why follow-up may not be appropriate, include, but are not limited to, cases where the person’s participation is involuntary, or where there may be a risk to the individual such as in cases of domestic violence.

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