Service Standards

Mental Health and/or Substance Use Services

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 recovery-focused, comprehensive, community-based, and designed to help people across the lifespan 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 strengths, needs, and preferences of the individual or family, services promote long-term recovery and wellness by addressing mental health symptoms, diagnoses, and associated functional impairments; resolving issues resulting from the use of alcohol, drugs, or other substances; helping manage co-occurring mental health, substance use, and physical health conditions; and/or providing 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 and the achievement of whole-person wellness through the delivery of therapeutic, evidence-based or culturally relevant, evidence-supported interventions provided by appropriately trained, licensed, and/or credentialed personnel.

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

MHSU providers may offer outpatient withdrawal management that includes medication management and monitoring, clinical counseling, and other necessary support and referral services to help people safely withdraw from the substance(s) on which they are dependent. Services include but are not limited to individual assessment and treatment planning, medical and non-medical withdrawal management, counseling and education, therapeutic interventions, and linkages with ongoing substance use treatment including medication-assisted treatment when applicable. 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 is determined by the level of care provided (e.g., outpatient, intensive outpatient, and partial hospitalization) and whether or not extended onsite monitoring is performed. Withdrawal management without transitioning to ongoing medication-assisted treatment is not recommended for people with opioid use disorder.

MHSU providers may offer office-based opioid treatment (OBOT) under the Drug Addiction Treatment Act of 2000 as part of the organization's MHSU services or program(s). OBOT is different from more structured Opioid Treatment Programs (OTP), which require daily medication dosing and supervision. OBOT allows medical providers in community-based clinics or programs to administer injectable or oral forms of buprenorphine on-site or prescribe buprenorphine that the person can fill at a pharmacy and administer at home with ongoing monitoring provided by the prescriber at regularly scheduled office visits.

Certified Community Behavioral Health Clinics (CCBHC) provide low-barrier, comprehensive, and coordinated care for mental health and substance use conditions to individuals and families of all ages. CCBHCs provide person- or family-centered services that integrate behavioral health care, physical health care, and social services to promote whole-person wellness and recovery. Additional Service Standards may also be assigned based on which of the following CCBHC core services the organization is providing directly:

1. crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization;
2. screening, assessment, and diagnosis including risk assessment;
3. patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
4. outpatient mental health and substance use services;
5. outpatient clinic primary care screening and monitoring of key health indicators and health risks;
6. targeted case management;
7. psychiatric rehabilitation services;
8. peer support, counselor services, and family support services; and
9. intensive community-based mental health care for members of the armed forces and veterans.

Interpretation: *Throughout this section, family involvement has been emphasized due to the significant impact family engagement has on resilience and recovery. However, family should be defined by the person and their involvement will vary given the age and preferences of the person and as permitted by law.*

For example, due to the importance of family involvement in achieving positive outcomes for children and youth, 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.

Program models and structures can also impact family involvement. For example, due to the nature of withdrawal management programs, involving family members in the early stages of service delivery may not be possible or appropriate.

Interpretation: *Services can be offered in a variety of settings within the community including outpatient clinics, schools, and homes, and often will take advantage of electronic interventions such as videoconferencing, online chat platforms, texting, and mobile applications to promote accessibility, particularly for underserved populations or communities.*

Note: *Clinical Counseling programs will complete all applicable standards in MHSU 1, MHSU 2, MHSU 3, MHSU 4, MHSU 5, MHSU 6, MHSU 10, MHSU 12, and MHSU 13.*

Diagnosis, Assessment, and Referral programs will complete all applicable standards in MHSU 1, MHSU 2, MHSU 3, and MHSU 13.

MHSU 8 will be added for outpatient withdrawal management programs.

MHSU 9 will be added when office-based opioid treatment is provided.

MHSU 11 will be added when the organization operates as a Certified Community Behavioral Health Clinic.

Note: *Clinical counseling programs reviewed under MHSU are distinct from counseling programs reviewed under Coaching, 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.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Mental Health and/or Substance Use Services

MHSU 1: Person-Centered Logic Model

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.

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.
Note: *Please see the Logic Model Template for additional guidance on this standard.?*

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.,
- 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 outcome has been identified for all of its programs.

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

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.

Table of Evidence

Self Study Evidence

*

• Program logic model that includes a list of outcomes being measured	
• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel

MHSU 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in individuals and families served); and
f. expected long-term impact on the organization, community, and/or system.

CCBHC Interpretation: *The organization should maintain one integrated logic model, or equivalent framework, that covers all the CCBHC core services offered by the organization and its designated collaborating organizations (DCOs).*

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA Accreditation's PQI Guide 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. *characteristics of the service population;*
2. *needs assessments and periodic reassessments;*
3. *risks assessments conducted for specific interventions; and*
4. *the best available evidence of service effectiveness.*

MHSU 1.02

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

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

CCBHC Interpretation: *CCBHCs should identify and monitor both behavioral and physical health outcomes including outcomes for populations experiencing health disparities.*

Mental Health and/or Substance Use Services

MHSU 2: Personnel

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.

Personnel have the competency and support needed to provide services and meet the needs of individuals and families.
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, 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 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.

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	
*		

	• Procedures or other documentation relevant to continuity of care and case assignment	

*	• List of program personnel that includes:
	  • Title
	  • Name
	  • Employee, volunteer, or independent contractor
	  • Degree or other qualifications
	  • Time in current position
	• See organizational chart submitted during application	

*	• Policy addressing employee health and vaccinations	

Site Visit Evidence

*	• Sample job descriptions from across relevant job categories • Resume and job description of buprenorphine prescriber, when applicable • 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

On-Site Activities

*	• 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.*

Interpretation: *Qualifications for clinical personnel in substance use treatment programs should include training and/or experience in alcohol and other drug use, diagnosis, and treatment, and/or licensure or certification by the designated authority in their state as approved substance use treatment counselors or specialists.*

MHSU 2.02

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

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

Interpretation: *Regarding element (a), supervisors overseeing withdrawal management may have an advanced degree in a medical field.*

Interpretation: *Regarding element (b), supervisors of peer support staff should be trained on recognizing and responding to signs of trauma among peer support workers.*

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

MHSU 2.03

Clinical personnel are trained on, or demonstrate competence in:

a. evidence-based or culturally relevant, evidence-supported practices and other relevant emerging bodies of knowledge;
b. psychosocial and ecological or person-in-environment perspectives;
c. understanding human development and individual and family functioning;
d. physical health conditions or social factors commonly associated with mental health or substance use conditions;
e. methods of crisis prevention and intervention, including assessing for and responding to signs of suicide risk, overdose prevention and response, or other safety threats/risks; and
f. criteria to determine the need for more intensive services.

Interpretation: *Signature injuries and co-occurring conditions often found in military or veteran populations 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: *When people are receiving office-based opioid treatment, element (f) should include criteria for determining when a transition to a higher level of care, including a more structured opioid treatment program (OTP), may be necessary.*

MHSU 2.04

Clinical personnel are trained on, or demonstrate competence in:

a. responding to the diverse needs and characteristics of the service population including but not limited to those related to race, ethnicity, culture, religion, sexual orientation, gender identity, ability, and military service;
b. clarifying the values and preferences of individuals and families and working collaboratively to develop and implement person- or family-centered, recovery-oriented service plans;
c. identifying and building on strengths and protective factors;
d. recognizing and working with people with co-occurring physical health, mental health, and substance use conditions; and
e. working with difficult-to-reach or disengaged individuals and families.

Interpretation: *Regarding element (a), when the organization serves military or veteran populations, staff should 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. Providers who possess the requisite military competency support improved communication and more effective care.*

MHSU 2.05

Clinical personnel are trained on, or demonstrate competence in:

a. working as a member of an interdisciplinary team; and
b. effectively communicating and coordinating care across disciplines, systems, and services.

Examples: *Regarding element (b), when working with children and youth, relevant systems may include child welfare, behavioral health, healthcare, education, and justice systems.*

MHSU 2.06

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:

a. diagnostic criteria for substance use disorders and their severity;
b. the signs and symptoms of withdrawal;
c. addiction as a disease;
d. ASAM level of care assessments;
e. treatment needs of special populations including women, individuals and families experiencing homelessness, adolescents, and people with HIV/AIDS;
f. relapse prevention;
g. management of drug overdose;
h. the benefits and limitations of tests that screen for drug use, when applicable;
i. harm reduction interventions or practices; and

j. FDA-approved medications used to treat opioid use disorder, their benefits and limitations, and current federal policy regulating their use, when applicable.

NA: NA The organization provides mental health services only.

MHSU 2.07

When staff with lived experience provide peer support to individuals and families, the organization:

a. clearly defines their roles and responsibilities;
b. includes peer support staff as equal partners on the interdisciplinary team;
c. helps other program personnel understand the position and its purpose at the program;
d. establishes guidelines for recruitment and selection;
e. ensures peer support staff are trained to perform their roles and responsibilities;
f. provides ongoing support and supervision to address any issues that occur, including helping peer support staff manage personal triggers that may arise on the job;?and
g. facilitates opportunities for peer support staff to connect and consult with others performing similar roles.

NA: The program does not utilize peer support staff.

MHSU 2.08

Personnel involved in providing office-based opioid treatment are annually screened for potential exposure to tuberculosis, and providers recommend a hepatitis B vaccination if personnel are at risk for exposure to hepatitis.
NA: The organization does not provide office-based opioid treatment.

MHSU 2.09 (FP)

There is at least one person on duty at each service delivery location any time persons served are present who has received first aid and age-appropriate CPR training in the previous two years that included an in-person, hands-on CPR skills assessment conducted by a certified CPR instructor.
NA:

- The organization provides technology-based services only and staff never interact with individuals and families in any physical space.
- The organization only provides MHSU services in the homes of the individuals and families they serve and staff have been trained on how to respond to a medical emergency when away from the program's facilities.

Interpretation: *When services are provided in a school or other setting where medical staff are available to respond in an emergency, implementation of this standard can be met by demonstrating that staff have been trained on the emergency response plan for that service delivery location.*

MHSU 2.10 (FP)

Personnel who prescribe or dispense opioid treatment medication in office-based settings stay current with all applicable federal, state, and local laws and regulations applicable to the delivery of office-based opioid treatment.
NA: The organization does not provide office-based opioid treatment.

MHSU 2.11

The organization promotes stability and service continuity by:

a. assigning a worker at intake or early in the contact; and
b. minimizing the number of workers assigned to the individual or family during their contact with the organization.

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

CCBHC Interpretation: *The CCBHC must assign a Principal Behavioral Health Provider to every military veteran seen unless the Veterans Health Administration has already assigned one. The Principal Behavioral Health Provider should be communicated to the person and documented in the case record. The Principal Behavioral Health Provider is responsible for ensuring services are provided in accordance with the requirements of the CCBHC certification criteria.*

MHSU 2.12

Employee workloads support the achievement of positive outcomes and are regularly reviewed.
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 the assessed level of needs of individuals and families.*

MHSU 2.13

The organization counteracts the development of compassion fatigue by:

a. helping personnel understand how they can be impacted by stress, distress, and trauma;
b. helping personnel develop the skills and behaviors needed to manage and cope with work-related stressors;
c. encouraging respectful collaboration, coaching, and support among co-workers;
d. examining how the organization's culture and policies can prevent the development of compassion fatigue; and
e. informing personnel about treatment services, as needed.

Examples: *Regarding element (b), organizations can help personnel develop the skills and behaviors that will enable them to: (1) engage in positive thinking; (2) increase their self-awareness; (3) know their limits and needs; (4) practice self-compassion; (5) establish healthy boundaries; (6) effectively communicate about unrealistic and unspoken expectations; (7) identify and manage emotional triggers; (8) have difficult conversations with co-workers and supervisors; (9) practice brain-aware activities to stay regulated; and (10) take time for self-care.*

Regarding element (d), areas to consider include, but are not limited to: (1) supervision; (2) caseload assignment; (3) scheduling; (4) training; (5) crisis response; (6) psychological safety; and (7) healthy and realistic staff expectations and boundaries.

Mental Health and/or Substance Use Services

MHSU 3: Intake and Assessment

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.

The organization ensures that individuals and families receive prompt and responsive access to appropriate services and supports.

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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment procedures	
*	• Copy of assessment tool(s)	

Site Visit Evidence

*

- Community resource and referral list

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families
- Review case records

MHSU 3.01

The organization has taken steps to improve access to its services for individuals and families.
CCBHC Interpretation: *CCBHCs must facilitate accessibility by providing services:*

1. *during times that meet the needs of the population served by the CCBHC, including some evening and weekend hours;*
2. *at locations that meet the needs of the population served by the CCBHC;*
3. *via telehealth and/or other technologies where appropriate;*
4. *on a sliding fee discount schedule and waiving or reducing costs for services when needed; and*
5. *regardless of place of residence, homelessness, or lack of permanent address.*

Examples: *Organizations can improve accessibility by offering some evening and weekend appointments; providing services out in the community in locations individuals and families are likely to frequent such as schools, community centers, primary care clinics, or homes; offering walk-in appointments; and taking advantage of telehealth or other virtual service delivery methods when appropriate.*

MHSU 3.02

Individuals and families served are screened and informed about:

a. how well their request matches the organization's services;
b. what services will be available and when; and
c. rules and expectations of the program.

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

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.*

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.*

MHSU 3.03 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. identify emergency situations and facilitate immediate access to stabilization and harm reduction activities;
c. give priority to urgent needs including access to expedited assessment and service planning;
d. support timely initiation of services for routine needs; and
e. provide for placement on a waiting list or timely referral to appropriate resources when people cannot be served or cannot be served promptly.

Interpretation: *People 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 people 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.*

CCBHC Interpretation: *Regarding element (c), if the initial screening identifies an urgent need, clinical services and the initial evaluation are to be provided within one business day. Regarding element (d), if screening identifies routine needs the initial evaluation must be completed, and services provided, within 10 business days.*

Examples: *Regarding element (b), emergency situations can include drug overdose, impairment, or severe withdrawal; and people at risk of suicide. Referral providers for crisis situations may include 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization, or 24-hour crisis hotline. Regarding element (c), urgent situations can include pregnancy in women with opioid use disorder and cases where a parent has a child in the child welfare system.*

MHSU 3.04

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

a. completed within established timeframes;
b. appropriately tailored to meet the age, developmental level, and preferences of persons served;
c. conducted through a combination of standardized and validated tools, interviews, discussion, and observation;
d. inclusive of information, screenings, and assessments provided by partnering or referring providers, when appropriate; and
e. focused on information pertinent for meeting the individual's or family's 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 individual or family rather than deficits and weaknesses. Adopting this assumption at all levels of treatment ensures that the organization actively prevents instances that could potentially lead to re-traumatization.*

CCBHC Interpretation: *Regarding element (a), the comprehensive assessment must be completed within a timeframe that is responsive to the needs of the individual or family and no later than 60 days following the initial request for services.*

Examples: *Organizations can review information, screenings, and assessments completed by partnering or referring providers to identify, for example:*

1. *gaps in information;*
2. *out-of-date information; and*
3. *information that can be used to minimize duplication of effort.*

MHSU 3.05 (FP)

The comprehensive assessment includes:

a. a behavioral health evaluation of mental health and substance use symptoms or disorders, their severity, treatment history, and whether or not treatments were helpful;
b. a medical history including identification of urgent or critical medical conditions;
c. 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;
d. individual and family values, preferences, strengths, risks, and protective factors;
e. social factors that may influence overall health and achievement of treatment goals including housing instability, food insecurity, unemployment, financial insecurity, social supports, intimate partner violence, systems involvement, and any other factors known to be impacting individuals and families;
f. the impact of the individual's health care needs on the family unit;
g. barriers to change;
h. a risk evaluation to assess the risk of suicide, self-injury, withdrawal or overdose, neglect, exploitation, and violence towards others; and
i. 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 Accreditation's Service Sections. The assessment elements of the Matrix can be tailored according to the needs or preferences of specific individuals or families, or service design.*

Interpretation: *When working with children and youth, the assessment of individual and family values, preferences, strengths, risks, and protective factors should include the following areas:*

1. *the child's developmental history;*
2. *a history of involvement in other systems, including education, child welfare, and juvenile justice;*
3. *individual family members' experiences and perspectives;*
4. *family relationships, dynamics, and functioning, including any presence or history of child abuse or neglect or domestic violence; and*
5. *the specific challenges, factors, and patterns that lead to problems in the family's daily life, focusing on the issues that precipitated the need for service.*

Interpretation: *Due to the nature of withdrawal management programs, people seeking treatment may not have the opportunity to address trauma history and/or recent incidents of trauma during the assessment process.*

Interpretation: *Personnel that conducts 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 an employer or many people in a confined area; unclear family relationships; a heightened sense of fear or distrust of authority; the presence of an older significant other or pimp; loyalty or positive feelings towards an abuser; an inability or fear of making eye contact; chronic running away or homelessness; possession of excess amounts of cash or hotel keys; and an inability to provide a local address or information about parents.*

Interpretation: *Completion of the comprehensive assessment should not delay the initiation of medication-assisted treatment for opioid use disorder. The assessment can be completed over a series of visits following the initiation of office-based opioid treatment, as delaying treatment increases the risk of overdose and mortality.*

Examples: *Substance use assessments may examine a variety of factors in the person's substance use history including age at first use, routes of ingestion and history of tolerance, withdrawal, drug mixing, and overdose as well as information on current patterns of use such as which drugs the person uses, comorbid alcohol and tobacco use, and the frequency, recency, and intensity of use.*

MHSU 3.06

The organization completes a comprehensive safety assessment when an individual expresses suicidal ideation using an assessment tool, the worker's professional judgment, and the person's input and active involvement, paying specific attention to their:

a. suicidal desire;
b. intent to die and any identified method and plan;
c. suicidal capability, including history of attempts and available means; and
d. buffers/protective factors.

Interpretation: *The safety assessment should be an engaging, collaborative process between personnel and the person that retains the individual's autonomy and choice to the greatest extent possible. Over-reliance on a single, standardized suicide assessment tool to predict future suicidal behavior and risk level may not provide an accurate assessment of a person's suicide risk. People do not always accurately report suicidal ideation when asked, and suicidal desire and intent may vary widely at any given moment.*

MHSU 3.07 (FP)

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

a. screening and ongoing monitoring for chronic medical conditions;
b. medication monitoring and management;
c. physical examinations or other physical health services;
d. medical management of withdrawal symptoms;
e. laboratory testing and toxicology screens;
f. specialized screenings, assessments, or tests; or
g. other diagnostic procedures.

CCBHC Interpretation: *The outpatient primary care screening and monitoring responsibilities of the CCBHC include monitoring key health indicators and health risks, and coordinating care in a timely fashion; screening for common physical health conditions experienced by the CCBHC population across the lifespan including ongoing periodic lab testing when indicated; and having the ability to collect and analyze biologic samples either directly or through formal arrangement with a provider outside the CCBHC.*

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 any results of medical screens, tests, and services should be documented in the case record 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.

Interpretation: *People with both chronic pain and substance use disorder should receive integrated treatment from appropriate medical specialists.*

MHSU 3.08

Reassessments are conducted as needed according to the needs and preferences of the individual or family and inform revisions to the service plan when indicated.
NA: The organization provides Diagnosis, Assessment, and Referral Services only.

Interpretation: *Certain events may heighten or trigger suicide risk, as could a new physical or mental health diagnosis, and should prompt a new safety 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.*

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;*
7. *when significant environmental changes or external stressors occur; or*
8. *following discharge from an inpatient acute care hospital, residential psychiatric treatment facility, or emergency department.*

Mental Health and/or Substance Use Services

MHSU 4: Service Planning and Monitoring

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.

Individuals and families participate in the development and ongoing review of a service plan that is the basis for the delivery of appropriate services and support.
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.

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
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation of persons served 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
- Case reviews are not being done consistently; or
- Level of care for some people is clearly inappropriate; or
- Service planning is often done without the full participation of persons served; 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.

Table of Evidence

Self Study Evidence

• Service planning and monitoring procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Review case records

MHSU 4.01

An assessment-based service plan is developed promptly with the full participation of individuals and families and includes:

a. agreed-upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. procedures for expedited service planning when a crisis or urgent need is identified; and
d. documentation of the individual's or family's participation in service planning.

CCHBC Interpretation: *Service planning should involve consultation with specialty providers when needed to address the unique needs and preferences of the person or family.*

Interpretation: *Although personnel should help identify available services and their potential risks and benefits and participate in evaluating options, individuals and families should be the primary planners of their goals and objectives and have the right to make their own decisions regarding what services and supports will be provided and by whom.*

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 preferences of the person. Research has shown that this population is often unsure of which services they are entitled to and how to navigate military care systems. The clinician should take an active role in navigating these care systems when possible.*

Interpretation: *Generally, children aged six and over should be included in service planning, unless there are clinical justifications for not doing so. The organization should have a developmentally appropriate discussion with children about the reason for accessing services and what they can expect to happen during service delivery.*

MHSU 4.02 (FP)

The organization determines whether a crisis plan is necessary and, when indicated, engages individuals and families in crisis and/or safety planning that:

a. is individualized and centered around strengths;
b. identifies individualized warning signs of a crisis;
c. identifies coping strategies and sources of support that can be implemented during a suicidal crisis, as appropriate;
d. specifies interventions that may or may not be implemented to help the individual or family de-escalate and promote stabilization; and
e. does not include "no-suicide" or "no-harm" contracts.

Interpretation: *For people who have been deemed to be at high risk of suicide, a safety plan includes a prioritized written list of coping strategies and sources of support that people can use before or during a suicidal crisis. A personalized safety plan and appropriate follow-up can help suicidal people cope with suicidal thoughts 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: *For organizations serving children and youth, when safety issues are identified, the organization:*

1. *involves supervisory personnel in reviewing safety concerns and plans; and*
2. *reports safety concerns in accordance with mandated reporting requirements.*

CCBHC Interpretation: *CCBHCs must develop crisis plans with all people receiving services and crisis planning should include*

the creation of a psychiatric advanced directive when desired by the person. If the individual does not wish to participate in advanced crisis planning, that decision must be documented in the case record.

Examples: *Depending on the needs and preferences of the person, crisis plans may reference advanced mental health directives, also known as psychiatric advanced 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 people 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 individual or family. For example, safety plans for survivors of domestic violence may focus on helping people prepare for immediate escape, while safety plans for people 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 organization partners with the individual or family to review their case at least quarterly, or more frequently when indicated, to:

a. assess service plan implementation;
b. evaluate the person's continued engagement in their treatment;
c. review progress toward achieving service goals and desired outcomes; and
d. determine the continuing effectiveness of therapeutic interventions and the appropriateness of agreed-upon service goals.

NA: The organization provides withdrawal management only.

Examples: *Individuals and families with higher level of care needs require frequent review. For example, weekly review is recommended for people with suicidal ideation, recent relapse, or those with a recent mental health- or substance use-related emergency room visit or hospitalization. People with acute or complex needs (e.g., people receiving medications for diagnosed symptoms and conditions) or those in a higher level of care such as intensive outpatient may require that their service plan be reviewed and updated every 30 days. Additionally, plans may be reviewed and updated during specific milestones in the treatment process or following changes in the person's or family's status.*

Examples: *In office-based opioid treatment, indicators that revisions to the treatment plan may be needed include:*

1. *signs or symptoms of withdrawal;*
2. *evidence of continued illicit opioid use;*
3. *the absence of opioid treatment medication in toxicology samples;*
4. *potential complications from concurrent disorders; and*
5. *inability to safely store buprenorphine in the person's living environment.*

Adjustments to the treatment plan can include increasing buprenorphine dosing, increasing the level of care (e.g. outpatient to intensive outpatient/partial hospitalization), or referring people to an opioid treatment program when indicated and available.

Mental Health and/or Substance Use Services

MHSU 5: Clinical Counseling

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.

The organization provides person- or family-centered, trauma-informed clinical counseling services that:

a. provide an appropriate level and intensity of support and treatment;
b. emphasize personal growth, development, and situational change; and
c. promote recovery, resilience, and wellness.

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

Interpretation: *Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies) provided to people on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person, their preferences, and their treatment progress.*

Examples: *Organizational self-assessments can help evaluate the extent to which an organization's policies and practices are trauma-informed, as well as identify strengths and barriers regarding 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 in trauma-informed care practices.*

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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Procedures for evaluating level/intensity of care and follow-up	

• Procedures for accommodating the schedules and unique needs of individuals and families	

Site Visit Evidence

• Educational/informational materials

On-Site Activities

• Interviews may include: 1. Program director 2. Relevant personnel 3. Individuals and families • Review case records

MHSU 5.01

Clinical counseling services are person- or family-driven and:

a. recognize individual and family preferences, beliefs, values, and goals; and
b. utilize evidence-based or culturally-relevant, evidence-supported approaches, tailored for adults, children, and families.

MHSU 5.02

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

a. manage mental health and/or substance use disorders;
b. cultivate and sustain positive, meaningful relationships with peers, family members, and the community; and
c. develop self-sufficiency and self-efficacy.

MHSU 5.03

Personnel assist individuals and families to:

a. explore and clarify the concern or issue;
b. voice the goals they wish to achieve;
c. identify successful coping or problem-solving strategies based on their strengths, formal and informal supports, and preferred solutions; and
d. realize ways of maintaining and generalizing gains.

MHSU 5.04

Clinical personnel:

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

Interpretation: *Element (c) does not apply to withdrawal management programs.*

MHSU 5.05

When working with children and youth, services are designed to:

a. focus on the family as a whole;
b. involve all family members to the extent possible; and
c. be provided at times and locations that accommodate family members' schedules and needs.

NA: The organization does not provide services to children and youth.

Examples: *Times that accommodate family members' schedules may include, for example, evenings and weekends. Times that accommodate family members' needs may include other days and times that family members identify as challenging to navigate (e.g., meal time, nap time, vacation days).*

Locations that accommodate family members' needs may include places where families are likely to frequent such as community centers, schools, primary care clinics, other community-based social service providers, or the family home.

MHSU 5.06

When providing family therapy, personnel help family members develop and hone new competencies through:

a. instruction and discussion about the topics and practices being targeted, why they are important, and their relevance to the family;
b. modeling of the practices and skills being targeted;
c. within-session practice that enables family members to use new skills and strategies with the worker present to intervene in the moment with coaching, positive reinforcement, or corrective feedback, as needed;
d. follow-up tasks that call for practice outside of the session; and
e. support in planning how to use skills and strategies in different situations, how to manage setbacks, and how to avoid future crises.

NA: The organization does not provide family therapy.

Mental Health and/or Substance Use Services

MHSU 6: Therapeutic Services

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.

Individuals and families receive therapeutic services that are:

a. based on their preferences, needs, and goals;
b. evidence-based or culturally-relevant, evidence-supported; and
c. trauma-informed.

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

Interpretation: *Outpatient withdrawal management programs include a range of therapies (e.g., cognitive, behavioral, medical, and mental health therapies) provided to people on an individual or group basis. Services aim to enhance the person's understanding of addiction, manage their withdrawal symptoms, and connect them with an appropriate level of care for ongoing substance use treatment. The delivery of services will vary and depends on the assessed needs of the person, their preferences, and their 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
- Active participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Referral procedures	

Site Visit Evidence

*
- Copies of agreements with cooperating service providers and/or community resource and referral list, as applicable
- Information on crisis services made available to individuals and families

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Review case records

MHSU 6.01

Individuals and families receive psychosocial, therapeutic, and educational interventions that are:

a. matched with their assessed needs, preferences, readiness for change, age, developmental level, and personal goals;
b. discontinued immediately if they produce adverse side effects or are deemed unacceptable according to prevailing professional standards; and
c. provided in individual, family, and/or group format.

Interpretation: *For withdrawal management programs, therapeutic and educational interventions may be limited given the length of treatment and the person's treatment progress.*

MHSU 6.02

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

a. psychotherapy;
b. illness management and psychoeducation interventions;
c. coping skills training;
d. social skills training;
e. alternative therapies;
f. traditional practices and/or therapies;
g. relapse prevention;
h. acute care;
i. support groups and self-help referrals;
j. withdrawal management;
k. medication-assisted treatment;
l. inpatient care;
m. intensive outpatient care;
n. medical care;
o. psychiatric services including medication management; and
p. case management and other supportive services.

CCBHC Interpretation: *Targeted case management should be made available to (1) people served by the CCBHC who are at high risk of suicide or overdose, particularly during times of transitions; (2) people with complex or serious mental health or substance use conditions; and (3) people who have a short-term need for support in a critical period.*

Examples: *Traditional practices and/or therapies are interventions based on the beliefs or customs of different cultural groups. Providing access to traditional approaches to care can be part of providing person- or family-centered services and contribute to removing barriers to care for underserved populations.*

MHSU 6.03

Individuals and families are actively connected with peer support services appropriate to their request or need for service, either directly or by referral.
Interpretation: *Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting. Organizations can support acclimation to a new group by, for example, discussing meeting protocols and what to expect before attending, accompanying individuals and families to their first meeting, and encouraging them to make connections with peers while at the meeting.*

MHSU 6.04

The organization ensures access to crisis services 24 hours a day, 7 days a week, either directly or through publicly available systems, and educates individuals and families on how to access them.

Interpretation: *Organizations may take advantage of existing community crisis systems or resources such as 988 when available as long as individuals and families have been educated on how to access crisis services when needed.*

CCBHC Interpretation: *CCBHCs must provide access to crisis services either directly or through one of their Designated Collaborative Organizations (DCO).*

Mental Health and/or Substance Use Services

MHSU 7: Medical Care and Clinical Support Team

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.

Treatment decisions are guided by a qualified clinical team and are made in collaboration with individuals and families.
NA:

- The organization provides Diagnosis, Assessment, and Referral Services only.
- The organization provides Clinical Counseling services only.

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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

No Self Study Evidence

Site Visit Evidence

*

- Job description and resume of qualified health professional and/or formal agreement with a professional or community-based provider
- Documentation tracking staff completion of required trainings and/or competencies related to opioid overdose, when applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Review case records
- Review personnel record, when applicable
- Observe facility

MHSU 7.01 (FP)

A licensed physician, or another qualified health professional, with experience, training, and competence in engaging, assessing, diagnosing, and treating people 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 a contract or formal agreement.*

Interpretation: *Medical aspects should include the following, when applicable:*

1. *prescribing medication and medication management, including appropriate management of pharmacotherapy for people with co-occurring conditions or those receiving office-based opioid treatment;*
2. *providing or reviewing diagnostic, toxicological, and other health-related examinations of people not currently under medical care and supervision or those receiving office-based opioid treatment;*
3. *reviewing complicated cases where co-occurring substance use, health, and mental health conditions intersect and guiding the coordination and/or integration of care; and*
4. *other medical and psychiatric-related issues, such as seizure disorders, psychosomatic disorders, or traumatic brain injury.*

Interpretation: *Health professionals should be knowledgeable of appropriate prescribing practices for people with substance use disorders.*

Examples: *The qualifications and training of the physician may vary as appropriate to the program. For example, organizations that provide substance use services may have a board-eligible psychiatrist who has experience in treating substance use disorders including intoxication, withdrawal, and withdrawal management; outpatient addiction treatment; toxicology testing; and the effects of various substances on the body.*

Qualified health professionals may include psychiatric or mental health nurse practitioners, physician assistants, or health professionals who are permitted by law in their state to provide medical care and services (e.g., prescribe and monitor medications) without direction or supervision.

MHSU 7.02 (FP)

A clinical team makes decisions about the level of care, treatment, and aftercare or discharge planning and includes:

a. a licensed physician, or other qualified health professional;
b. a licensed provider serving as the clinical team lead;
c. the individual or family; and
d. other providers or supports according to the needs and preferences of the individual or family.

MHSU 7.03

The organization maintains a supply of naloxone on-site, and appropriately trained staff are available to administer this medication in the event of an overdose.

NA: The organization provides mental health services only.

MHSU 7.04

Individuals at risk of opioid overdose, and their families when appropriate, are provided with a naloxone kit or prescription.

NA: NA The organization provides mental health services only.

Interpretation: *Individuals at risk of opioid overdose who should receive a naloxone kit or prescription include individuals withdrawing from opioids who refuse MAT, individuals withdrawing from MAT for opioid use disorder, or individuals who are currently using opioids.*

Mental Health and/or Substance Use Services

MHSU 8: Outpatient Withdrawal Management

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.

Withdrawal management is provided based on the needs and preferences of the person.
NA: The organization does not provide withdrawal management.

Interpretation: *For people with opioid use disorder, withdrawal management without transitioning to ongoing medication-assisted treatment is not recommended. According to the American Society of Addiction Medicine, medication-assisted treatment in combination with individualized psychosocial supports and services is the standard of care for treatment of opioid use disorder. Detoxification from opioids is not required to initiate maintenance medication. See MHSU 8.04 for more information on providing withdrawal management to this population and MHSU 9 for more information on Office-Based Opioid Treatment.*

Note: *Withdrawal management 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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Criteria for determining the level of care	

Site Visit Evidence

*	• Sample job descriptions from across relevant job categories • Educational materials or other documentation of information provided to individuals and families • MOU(s) with MAT providers, when applicable

On-Site Activities

*

- Interviews may include:
    1. Clinical/Medical director
    2. Relevant personnel
    3. Individuals and families

- Review case records

MHSU 8.01

Qualified personnel determine the appropriate level of withdrawal management for the person using diagnostic criteria outlined in clinical decision support tools and clinical practice guidelines.
Examples: *Organizations can utilize the American Society of Addiction Medicine (ASAM) criteria to determine the appropriate level of care.*

MHSU 8.02

Withdrawal management services include:

a. assessment and evaluation;
b. monitoring and stabilization; and
c. engagement with substance use treatment to assist with relapse prevention following the discontinuation of substance use.

MHSU 8.03 (FP)

Withdrawal management is provided by a qualified team of trained and licensed professionals appropriate to the intensity of services offered.
Examples: *Organizations providing medically-monitored withdrawal management 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.*

MHSU 8.04

Prior to discharge, all people receive:

a. education about relapse, overdose, and mortality risk and prevention; and
b. information on relevant harm reduction activities.

MHSU 8.05 (FP)

Organizations providing withdrawal management to people withdrawing from opioids:

a. counsel them on the importance of medication-assisted treatment (MAT) and the risks of relapse, overdose, and death following detoxification without transitioning to maintenance medication;
b. offer MAT following withdrawal management either directly or through linkages with MAT providers; and
c. clearly document when people refuse MAT.

Interpretation: *Organizations that do not offer medication-assisted treatment should have MOUs with MAT providers to ensure timely initiation of treatment. Studies have shown the risk of relapse increases dramatically following withdrawal without ongoing treatment, with 25% of readmissions occurring within the first 7 days post discharge.*

Mental Health and/or Substance Use Services

MHSU 9: Office-Based Opioid Treatment

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.

The organization provides buprenorphine-assisted treatment for opioid use disorder that is responsive to individual strengths, needs, preferences, and goals.
NA: The organization does not provide office-based opioid 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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Access procedures, including operating hours and 24/7 emergency coverage	
*	• Office-based opioid treatment screening and assessment procedures	
*	• Procedures for administration of opioid treatment medication	
*	• Procedures for referring people for services	
*	• Policies related to toxicology testing	

* • Procedures for toxicology testing	
* • Diversion control plan	
* • Procedures for withdrawal from medication assisted treatment	
* • PDMP procedures	

Site Visit Evidence

* • Office-based opioid treatment provider coverage schedule for the previous month • Educational materials or other documentation of information provided to individuals and families • Evidence of collaboration with obstetricians

On-Site Activities

* • Interviews may include: 1. Clinical/Medical director 2. Relevant personnel 3. Individuals and families • Observe facility • Review case records

MHSU 9.01

The organization provides a welcoming environment for people to receive office-based opioid treatment that is conducive to rehabilitation, and services are available:

a. during hours that are based on the needs of the service population; and
b. 24 hours a day, seven days a week for emergencies including the availability of alternate prescribers when the primary provider is out of the office.

MHSU 9.02

The provider and the person work together to explore available treatment options and determine the appropriateness of office-based opioid treatment based on:

a. the person's preference and goals for treatment;
b. results of the comprehensive assessment including confirmation of opioid use disorder (OUD), OUD severity, and potential contraindications to opioid treatment medications;
c. co-occurring disorders;
d. risk of diversion;
e. ASAM placement criteria; and
f. legal requirements and/or national guidelines for accessing treatment.

Examples: *Information that can assist people in choosing their preferred treatment option can include: the indications, risks, and benefits of medication-assisted treatment and its alternatives; the types of settings that offer medication-assisted treatment; geographic location of treatment providers and the availability of public transportation; cost of treatment; and requirements for participating in various treatment options (e.g. frequency of visits.)*

MHSU 9.03

The organization queries the state prescription drug monitoring program (PDMP):

a. prior to initiating medication-assisted treatment; and
b. once per quarter or more frequently when required by state law.

NA: There is no PDMP available in the state.

MHSU 9.04 (FP)

Office-based opioid treatment is administered as follows:

a. an approved prescriber makes all dosage decisions within the medically accepted dosage range for effective treatment and in accordance with approved product labeling; and
b. medication-assisted treatment is used in conjunction with individualized psychosocial treatment.

Examples: *Guidelines published by the American Society of Addiction Medicine include dosage recommendations.*

MHSU 9.05

Early in treatment, each person receives a physical exam and laboratory testing in accordance with national practice guidelines that includes, but is not limited to:

a. screening for commonly co-occurring medical conditions, pregnancy and methods of contraception, acute trauma, and history of narcotic dependence and IV drug use;
b. evidence of current physical dependence; and
c. laboratory testing to identify existing medical conditions and current substance use.

Interpretation*: Completion of the physical exam and/or lab work should never delay the initiation of medication-assisted treatment. This standard requires that all people receiving office-based opioid treatment have an up-to-date physical exam that meets the requirements of the standard. If a current physical exam that satisfies these requirements is not present in the person's record, the prescriber should conduct the exam as part of the comprehensive assessment process or facilitate completion of the exam in partnership with the person and applicable providers.*

Examples: *Guidelines published by the American Society of Addiction Medicine and by the Substance Abuse and Mental Health Services Administration include practice recommendations for conducting physical exams and laboratory testing.*

MHSU 9.06 (FP)

Persons served, and the adults with whom they live, are educated about the dangers of continued alcohol, tobacco, or drug use including:

a. cross-tolerance and other risks of continued use during medication-assisted treatment;
b. signs and symptoms of overdose, administering opioid antagonist medications, and when to seek emergency assistance; and
c. clinical support and other treatment options including recommended FDA-approved medications for cessation when available.

MHSU 9.07

Persons served, and adults with whom they live, are educated about:

a. the nature of addictive disorders;
b. dependency substitution and self-medication;
c. therapeutic effects of opioid treatment medication;
d. common myths about opioid treatment medication;
e. the benefits of treatment and the recovery process; and
f. toxicology testing expectations and procedures.

MHSU 9.08

Persons served receive:

a. infectious disease prevention and risk reduction information and education;

b. counseling on HIV infection and other infectious diseases and referral for testing;
c. counseling on the importance of treatment adherence and honest communication with the provider; and
d. noncompliance procedures.

MHSU 9.09

Ongoing, random drug testing is conducted using CLIA-waived tests at a frequency that supports the achievement of the person's treatment goals, and testing procedures include:

a. maintaining a therapeutic atmosphere that respects individual privacy during testing;
b. minimizing falsification during drug testing sample collection;
c. discussing positive results with the person and investigating the possibility of false positive results when people deny drug use;
d. reviewing false-positive and false-negative results;
e. conducting confirmation testing when indicated; and
f. documenting results in the case record along with the person's response.

Interpretation: *Evidence of ongoing drug use on its own should not be considered grounds for discharge.*

MHSU 9.10

Following the receipt of drug test results, the organization:

a. immediately investigates possible diversion of opioid medication when test results indicate lack of buprenorphine and related metabolites;
b. reviews dosage when positive results for drugs are received; and
c. uses the results to determine the need for additional interventions or changes to the treatment plan.

MHSU 9.11

The organization implements a plan to reduce the risk of diversion of controlled substances from legitimate treatment use that includes a process for corrective action when systemic problems are identified.
Examples: *Diversion control strategies may include, but are not limited to:*

1. *frequent office visits, including weekly visits at the beginning of treatment;*
2. *observed urine drug testing;*
3. *validity testing of urine samples;*
4. *use of combination buprenorphine products;*
5. *use of injectable buprenorphine when clinically indicated;*
6. *recall visits for pill counts; and*
7. *providing people with guidance on how to safely secure their medication at home.*

MHSU 9.12

Treatment of pregnant woman with opioid use disorder:

a. is in accordance with national treatment guidelines for treatment during pregnancy; and
b. is coordinated with an obstetrician.

MHSU 9.13 (FP)

People are maintained on opioid treatment medication as long as they desire and derive benefit from treatment, but when withdrawal from opioid treatment medication is needed or desired, the organization:

a. documents the reason for discontinuation;
b. educates the person about the process including risk of relapse, overdose, and mortality;
c. assesses for pregnancy, when applicable;
d. conducts dose reduction at a rate well tolerated by the person and in accordance with accepted medical practices;
e. conducts periodic assessments of mental status;
f. discontinues withdrawal and resumes treatment in the event of impending relapse;
g. offers the person relapse prevention services including counseling, support, and education;
h. encourages the person to participate in continued monitoring and support beyond the point of discontinuation;
i. invites the person to re-enter treatment at any time if they fear or have experienced a return to opioid use; and

j. provides the person with information about, and referral or transfer to a suitable, alternative treatment program, whenever possible.

Mental Health and/or Substance Use Services

MHSU 10: Care Coordination

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.

The organization collaborates with individuals and families to coordinate services in order to promote continuity of care and whole-person wellness.
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.

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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*
- Procedures for care coordination

Site Visit Evidence

*
- Copies of agreements with cooperating service providers and/or community resource and referral list, as appropriate

On-Site Activities

*
- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Review case records

MHSU 10.01

The organization works in active partnership with individuals and families to:

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

CCBHC Interpretation: *When the organization is operating as a CCBHC, the implementation of this standard will overlap with the implementation of MHSU 11.04.*

MHSU 10.02 (FP)

People 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 applies 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 disorders, and organizations that only treat mental health disorders are expected to have the core capability to address co-occurring substance use disorders.*

MHSU 10.03 (FP)

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

a. providing referrals to identified primary care providers;
b. communicating with the primary care doctor about treatment planning; and
c. linking individuals and families to providers that can help them navigate the health care system.

CCBHC Interpretation: *When the organization operates as a CCBHC, the implementation of this standard will overlap with the implementation of MHSU 11.04.*

MHSU 10.04

In collaboration with individuals and families, the organization coordinates with, as needed:

a. the child welfare system;
b. the justice system including specialty courts; and
c. the school system.

Interpretation: *The organization should coordinate with the justice system to advocate for continuous medication-assisted treatment with buprenorphine for people receiving office-based opioid treatment who are incarcerated or on probation or parole.*

Interpretation: *The implementation of MSHU 10.04 should include collaboration with the referral source when families are referred and mandated to receive services by an agency with statutory responsibility.*

CCBHC Interpretation: *CCBHCs must seek to develop formal partnerships with organizations from these systems that operate within their service area.*

MHSU 10.05

Care coordination activities include:

a. linkages to community providers, as well as completed follow-up when possible;
b. communication with partnering providers both internally and externally; and
c. communication with individuals and families.

Mental Health and/or Substance Use Services

MHSU 11: Certified Community Behavioral Health Clinics (CCBHC)

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.

The CCBHC works with individuals and families to ensure the effective delivery of comprehensive and coordinated care.
NA: The organization is not a Certified Community Behavioral Health Clinic (CCBHC).

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.,

1. Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
2. Procedures need strengthening; or
3. With few exceptions, procedures are understood by staff and are being used; or
4. For the most part, established timeframes are met; or
5. Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
6. Active participation of persons served 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.,

1. Procedures and/or case record documentation need significant strengthening; or
2. Procedures are not well-understood or used appropriately; or
3. Timeframes are often missed; or
4. Several case records are missing important information; or
5. Participation of persons served 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.,

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

Table of Evidence

Self Study Evidence

*	• Procedures that outline appropriate terminology and concepts to use for documentation	
*	• Care transition procedures	
*	• Procedures for conducting or tracking medication reconciliation and adherence	

Site Visit Evidence

*	• See care coordination procedures submitted in MHSU 10 • Copies of informational materials provided to individuals and families and other stakeholders • Copies of agreements with community providers, as applicable

- Community resource and referral list
- Health promotion educational materials, training curricula, and other information made available to individuals and families

On-Site Activities

*

- Interviews may include:

1. Program director
2. Relevant personnel
3. Individuals and families

- Review case records
- Observe health information technologies

MHSU 11.01

Documentation techniques utilize common terms and concepts to facilitate clear and effective communication across disciplines, systems, and services.

MHSU 11.02 (FP)

The CCBHC clearly defines for its stakeholders:

a. the scope of services offered directly by the organization;
b. how information will be shared both internally and externally among designated collaborating organizations (DCOs); and
c. the nature of the relationship that exists between DCOs when CCBHC core services are provided through contracts or other agreements between separate legal entities.

MHSU 11.03

The CCBHC uses health information technologies to:

a. capture physical health, behavioral health, and social service information;
b. link services including shared access to the person's health information and effective communication across disciplines, systems, and services;
c. organize, track, and analyze critical program information or data including referrals and needed follow-up, engagement or participation in services, and progress in treatment;
d. satisfy applicable reporting requirements; and
e. support billing and other administrative functions.

MHSU 11.04

The CCBHC facilitates access to needed behavioral health care, physical health care, and social services by:

a. establishing partnerships and/or coordination procedures with direct service providers in the CCBHC service area;
b. establishing communication procedures with individuals and families and across disciplines, both internally and externally;
c. maintaining a comprehensive, up-to-date referral list;
d. removing barriers to the initiation of needed services including taking advantage of telehealth services to increase access to needed specialists;
e. providing a warm handoff whenever possible when linking the individual to needed services; and
f. assisting the person with system navigation.

Interpretation: *CCBHCs should seek to develop formal, signed agreements or unsigned, written procedures for partnering with the following direct service providers in the CCBHC service area:*

1. *primary care providers that are not affiliated with the CCBHC, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and other primary care providers;*
2. *988 Suicide & Crisis Lifeline call centers;*
3. *acute care hospitals and their affiliated facilities or departments, including emergency departments;*

4. *inpatient/residential treatment facilities, including crisis stabilization units, inpatient psychiatric facilities, residential substance use treatment, withdrawal management, and Indian Health Service youth regional treatment centers;*
5. *Veterans Affairs medical centers and other veterans' health care providers; and*
6. *specialty mental health and substance use providers, including providers of medication-assisted treatment.*

Interpretation: *Implementation of this standard will overlap with implementation of MHSU 10.01 and MHSU 10.03*

MHSU 11.05

Individuals and families are assisted in making appointments for needed or requested services, and the CCBHC follows up to:

a. ensure the service was received;
b. identify any needed follow-up; and
c. make needed changes to the care plan in partnership with the individual or family.

MHSU 11.06

The CCBHC supports smooth transitions between care settings by:

a. maintaining systems for tracking when people served by the CCBHC are admitted to or discharged from partnering facilities;
b. documenting reasonable attempts to contact anyone who is discharged from inpatient acute-care hospital services/facilities (e.g., emergency departments, residential crisis settings, urgent care clinics) within 24 hours of discharge;
c. coordinating information sharing and service provision with providers and the individual or family;
d. developing, or supporting the development of, a comprehensive discharge or transition plan with steps for follow-up;
e. providing expedited discharge planning and follow-up when suicide or overdose risks are present; and
f. facilitating face-to-face interactions between providers, whenever possible.

Examples: *Supported transitions can include, but are not limited to, transitioning from inpatient hospitalization, residential treatment, therapeutic group care, the juvenile justice system, foster care, and from pediatric to adult settings.*

Examples: *Admission-Discharge Transfer (ADT) systems embedded in electronic health records are an effective way to manage movement between healthcare facilities and ensure continuity of care and the efficient transfer of relevant health information between care providers.*

MHSU 11.07 (FP)

The CCBHC:

a. conducts medication reconciliation and adherence; or
b. tracks that it is being done by another provider as part of their care coordination activities.

MHSU 11.08

The CCBHC offers individuals and families, either directly or by referral, health education on topics relevant to their preferences and needs that will empower them to manage their chronic conditions, make informed decisions regarding their health, and promote wellness.

Examples: *Education topics can include, but are not limited to, smoking cessation, nutrition, physical fitness, obesity education, the connection between mental and physical health, chronic disease management, medication use, and resilience and recovery.*

Mental Health and/or Substance Use Services

MHSU 12: Support Services

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.

Individuals and families receive support services that increase the likelihood of treatment progress, improved functioning, and sustained positive change.

NA:

- The organization provides Diagnosis, Assessment, and Referral Services only.
- The organization provides withdrawal management 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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Referral procedures	

Site Visit Evidence

*	• Copies of agreements with cooperating service providers and/or community resource and referral list, as appropriate

On-Site Activities

*	• Interviews may include: 1. Program director

2. Relevant personnel
3. Individuals and families

- Review case records

MHSU 12.01

The organization provides, either directly or by referral, support services directed at addressing social factors that influence overall health and recovery which may include, as appropriate to the needs and preferences of the person or family:

a. basic needs, such as food, clothing, and housing;
b. work-related services and job placement including supported employment, when indicated;
c. transportation;
d. legal services;
e. financial counseling;
f. public benefits;
g. educational services; and
h. respite care.

Interpretation: *Service members and veterans should be linked to any services or benefits for which they may be eligible, including enrollment in the Veterans Health Administration.*

MHSU 12.02

The organization collaborates with individuals and families to identify natural supports and social networks to cultivate and sustain a supportive community.
Examples: *Social networking opportunities can include: social, recreational, education, or vocational activities; religious or spiritual gatherings; or neighborhood and community events that provide individuals and families with an opportunity to meet, support, and share experiences with peers.*

MHSU 12.03

People who have primary responsibility for children are offered assistance with accessing:

a. child care arrangements;
b. educational and recreational services for children; and
c. parenting workshops.

NA: The organization does not serve people who have primary responsibility for children.

Examples: *Regarding element (a), the organization may offer child care while treatment or support groups meet or provide referrals to community child care resources.*

Mental Health and/or Substance Use Services

MHSU 13: Case Closing and Aftercare

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.

The organization collaborates with individuals and families 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.

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 participation of persons served 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 case records are missing important information; or
- Participation of persons served 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.

Table of Evidence

Self Study Evidence

*	• Case closing procedures	
*	• Aftercare planning and follow-up procedures	

Site Visit Evidence

*	• Relevant portions of contract with public authority, as applicable

On-Site Activities

*

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Individuals and families

- Review case records

MHSU 13.01

Planning for case closing:

a. is a clearly defined process that includes the assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, persons served, and others, as appropriate to the needs and preferences of the individual or family.

MHSU 13.02

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

MHSU 13.03

If an individual or family has to leave the program unexpectedly or they voluntarily discontinue services, the organization makes every effort to identify other service options and link them with appropriate services.
Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to people whose third-party benefits are denied or have ended and who are in critical situations.*

Interpretation: *See MHSU 9.13 for more information on withdrawal from office-based opioid treatment.*

MHSU 13.04

When appropriate, the organization works with individuals and families to:

a. 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
b. 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 13.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of individuals and families.
NA:

- The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.
- The organization provides Diagnosis, Assessment, and Referral Services only.

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 person such as in cases of domestic violence.*