Service Standards

Psychiatric Rehabilitation Services

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

Definition

Psychiatric or Psychosocial Rehabilitation Services provide skill building, peer support, and other supports and services to help adults with serious and persistent mental illness reduce symptoms, achieve optimal levels of community membership, increase satisfaction with their living environment, and restore and/or enhance their personal, social, and vocational capabilities.

Assertive Community Outreach services use a multi-disciplinary team approach to provide a full array of acute, active, and ongoing community-based psychiatric treatment, outreach, rehabilitation, and support services to adults with serious and persistent mental illness.

Note: *Often organizations that provide Psychiatric Rehabilitation Services combine that work with additional service sections, such as: Housing Stabilization and Community Living, Day Treatment Services, Group Living Services, or Vocational Rehabilitation Services. In those instances one or more service sections may be completed.*

Note: *Please see PSR 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 PSR Crosswalk.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Psychiatric Rehabilitation Services

PSR 1: Person-Centered Logic Model

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

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

PSR 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 persons served); and
f. expected long-term impact on the organization, community, and/or system.

Examples: P*lease 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. *needs assessments and periodic reassessments;*
2. *risks assessments conducted for specific interventions; and*
3. *the best available evidence of service effectiveness.*

PSR 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.*

Psychiatric Rehabilitation Services

PSR 2: Personnel

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

Program personnel have the competency and support needed to provide services and meet the needs of persons served.
Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Rating Indicators:

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

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

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

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

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

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

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	

Site Visit Evidence

* • Sample job descriptions from across relevant job categories • Documentation tracking staff completion of required trainings and/or competencies • Training curricula • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker

On-Site Activities

* • Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

PSR 2.01

Direct service personnel are qualified by:

a. a bachelor's degree in a health-related field;
b. an associate's degree in a health-related field and minimum one year of experience;
c. 30 hours, or their equivalent, of college credit toward a bachelor's degree in a health-related field and one year of experience; or
d. two years of work experience in a supervised mental health setting.

PSR 2.02

Supervisors are qualified by one or more of the following:

a. an advanced degree in social work;
b. an advanced degree from a program in psychosocial rehabilitation or rehabilitation counseling;
c. an advanced degree in a comparable human service field, with supervised post-graduate experience in providing case management and other services to persons with serious and persistent mental illness;
d. substantial experience in the psychosocial rehabilitation field which, based on the organization's decision, substitutes for specific educational requirements; and/or
e. national or state certification, licensing, or registration requirements in the psychosocial or psychiatric rehabilitation field.

PSR 2.03

Direct service personnel are trained on, or demonstrate competency in:

a. psychosocial rehabilitation;
b. substance use conditions;
c. special populations, including individuals who identify as lesbian, gay, bisexual, transgender, or gender non-conforming;
d. vocational issues;
e. crisis intervention;
f. the characteristics and treatment of mental illness; and

g. recognizing the early signs of decompensation and risk factors that increase vulnerability to relapse.

Examples: *Training on psychosocial rehabilitation can include evidence based practices, recovery, the psychiatric rehabilitation process, the consumer movement, and cultural issues.*

PSR 2.04

The organization maintains service continuity for persons served by:

a. assigning a worker early in the contact, when appropriate; and
b. minimizing the number of workers assigned to an individual over the course of their contact with the organization.

PSR 2.05

Employee workloads support the achievement of client 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 assessed level of needs of persons served.*

Psychiatric Rehabilitation Services

PSR 3: Rehabilitation Team

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

A rehabilitation team consisting of medical, clinical, vocational, educational, and activity personnel coordinates services to meet each individual's specific needs.

Rating Indicators:

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

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

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

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

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

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

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

Table of Evidence

Self Study Evidence

*	• Care coordination procedures	
*	• Case assignment procedures	

Site Visit Evidence

*	• Documentation of employment or contracts with individuals on the rehabilitation team • Coverage schedules for 24 hour emergency treatment for the previous six months

On-Site Activities

*	• Interviews may include: 1. Program director

2. Relevant personnel
3. Persons served

- Review personnel files

PSR 3.01

The rehabilitation team coordinates services and includes:

a. a lead worker who serves as primary point of contact;
b. the service recipient and family members or a legal guardian; and
c. medical, clinical, vocational, educational, and activity personnel, as appropriate.

Examples: *A point of contact is the individual responsible for ensuring proper implementation of the service plan and for serving as a clear point of contact for the service recipient. This position may have a different title from organization to organization, such as care coordinator, case worker, etc.*

PSR 3.02

The assertive community outreach team is the primary provider of treatment, rehabilitation, and social services and works with the person to support recovery, reduce symptoms, and to encourage membership in the community through an individualized, coordinated service approach.
NA: The organization does not provide assertive community outreach services.

PSR 3.03 (FP)

The assertive community outreach rehabilitation team includes one full-time staff person for every ten individuals, a team leader or supervisor, a licensed psychiatrist, a nurse, a substance use treatment professional, and other qualified mental health professionals, based on the needs of the service population.
NA: The organization does not provide assertive community outreach services.

Examples: *Other team members may include vocational specialists, housing specialists, and peer providers.*

PSR 3.04 (FP)

The assertive community outreach team shares the caseload, meets frequently, and:

a. is available on-call 24 hours a day for emergency treatment;
b. provides services to the person as often as needed;
c. works closely with the person's support network; and
d. is involved in hospital admission and discharge decisions.

NA: The organization does not provide assertive community outreach services.

Interpretation: *Although one team member may be designated as a case manager for an individual, the team must still share the program caseload and the team members know and work with all persons receiving services.*

Psychiatric Rehabilitation Services

PSR 4: Intake and Assessment

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

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

Rating Indicators:

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

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

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

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

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

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

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

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. Persons served
- Review case records

PSR 4.01

The organization defines in writing:

a. eligibility criteria;
b. scope of services and supports, special areas of expertise and range of behavioral/emotional concerns addressed;
c. opportunities for active family participation and support; and
d. opportunities for active participation in community activities.

PSR 4.02

Individuals are screened and informed about:

a. how well the individual's request matches the organization's services; and
b. what services will be available and when.

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

PSR 4.03 (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. give priority to urgent needs and emergency situations;
c. support timely initiation of services; and
d. provide placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

Interpretation: *Vulnerable populations, such as individuals that are lesbian, gay, bisexual, transgender, and questioning (LGBTQ), are at high risk of violence and harassment. The organization should ensure these individuals are safe, welcomed by staff, and are treated with respect. For example, providing intake forms that allow individuals to self-identify their gender as well as their first name and preferred pronouns can support that effort.*

Examples: *Organizations can respond to identified suicide risk by connecting the individual to more intensive services; facilitating the development of a safety and/or crisis plan; or contacting emergency responders, 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization, or 24-hour crisis hotlines, as appropriate.*

PSR 4.04

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

a. completed within established timeframes;
b. updated as needed based on the needs of persons served; and
c. focused on information pertinent for meeting service requests and objectives.

PSR 4.05

Individuals are assessed:

a. for a history and presence of serious and persistent mental illness and substance use or other health conditions;
b. for life skills and available resources;
c. for traumatic experiences and trauma-related symptomatology;
d. for past or present connection to the criminal justice system;
e. for medical history, including past medications and community support; and
f. to determine if they can benefit from services that promote the ability to live and function in the environment of their choice.

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

Psychiatric Rehabilitation Services

PSR 5: Rehabilitation Planning and Monitoring

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

Each person participates in the development and ongoing review of a rehabilitation plan that is the basis for delivery of 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
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, client or staff signatures are missing and/or not dated; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active client participation occurs to a considerable extent.

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

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- In several instances, client or staff signatures are missing and/or not dated; or
- Quarterly reviews are not being done consistently; or
- Level of care for some clients is clearly inappropriate; or
- Service planning is often done without full client participation; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

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

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

Table of Evidence

Self Study Evidence

*	• Rehabilitation planning and monitoring procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

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

- Review case records

PSR 5.01

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

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. possibilities for maintaining and strengthening family relationships and other informal social networks;
d. procedures for expedited service planning when crisis or urgent need is identified; and
e. the individual's signature.

Interpretation: *Experiences with family rejection and capacity for increasing family acceptance and support should be part of the assessment for family relationships. It should also include culturally appropriate education and guidance to help individuals identifying as part of the LGBTQ community to decrease family rejection and increase family support.*

PSR 5.02

The rehabilitation plan addresses, as appropriate:

a. psychological and emotional needs;
b. vocational goals;
c. cultural interests;
d. development of life skills, including preparation to work or continuation of schooling; and
e. improvement in the person's quality of life and necessary skills to remain within the community.

PSR 5.03 (FP)

The organization determines whether a crisis plan is necessary and, when indicated, engages individuals and involved family members 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 individuals can implement during a suicidal crisis, as appropriate; and
d. specifies interventions that may or may not be implemented in order to help the individual de-escalate and promote stabilization.

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

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

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

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 service recipient's mental health crisis.

PSR 5.04

The worker and a supervisor, or a clinical, service, or peer team, review the rehabilitation plan quarterly, or more frequently depending on the needs of persons served as determined by the service provider and supervisor, to assess:

a. service plan implementation;
b. progress toward achieving service goals and desired outcomes; and
c. the continuing appropriateness of service goals and chosen interventions.

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

PSR 5.05

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

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

Psychiatric Rehabilitation Services

PSR 6: Service Elements

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

The program encourages individuals to achieve their highest level of functioning by helping enhance coping abilities and create a supportive community in which to learn and grow.

Rating Indicators:

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

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

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

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

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

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

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

Table of Evidence

Self Study Evidence

*

- Crisis/safety planning procedures

Site Visit Evidence

*

- Curriculum for all educational/training components of the program

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served
- Review case records
- Observe the program

PSR 6.01

The program offers at least three of the following services:

a. case management;
b. pre-vocational and vocational training;
c. housing/residential care;
d. peer support services;
e. individual supportive therapy;
f. social rehabilitation services; and/or
g. educational services.

PSR 6.02

Core service components focus on helping individuals improve and manage the quality of their lives through:

a. development of self care and independent living skills;
b. medication adherence and an understanding of how to manage their illness;
c. socialization and use of leisure time;
d. organizational skills;
e. anger management;
f. coping skills;
g. conflict skill training;
h. housing, education, and family support services; and
i. vocational development.

PSR 6.03

The program offers persons served a variety of opportunities to achieve service goals through individual, group, and/or milieu activities, focused on:

a. learning how to relate positively to others;
b. anticipating and controlling behaviors that interfere with inclusion in the community;
c. experiencing peer support and feedback;
d. developing personal awareness and boundaries;
e. engaging in positive problem solving methods;
f. building on strengths and enhancing self-reliance and productivity; and
g. celebrating competence and success.

PSR 6.04 (FP)

The organization directly provides, coordinates, or formally arranges for:

a. 24-hour crisis intervention;
b. crisis residential and other emergency services;
c. inpatient and outpatient psychiatric services;
d. medical and dental services;
e. medication management;
f. integrated mental health and substance use services;
g. substance use education and treatment;
h. public assistance and income maintenance;
i. work-related services and job placements;
j. financial services;
k. legal advocacy and representation; and
l. transportation.

PSR 6.05

The organization:

a. provides most of its services in the community;
b. helps persons served to identify and use natural resources and peer support to create a social support network;
c. identifies and develops opportunities for persons served to develop positive ties to the community based upon interests and abilities;

d. presents opportunities for persons served to participate in group activities where they can meet, support, and share experiences with peers; and
e. supports the development of life skills necessary to support social and community integration.

PSR 6.06

The families or significant others of persons served are offered services, including:

a. family psychoeducation;
b. emotional support and therapy;
c. linkage to community services;
d. self-help referrals; and
e. care coordination, as needed.

Psychiatric Rehabilitation Services

PSR 7: Case Closing and Aftercare

Purpose

Adults with serious and persistent mental illness who participate in Psychiatric Rehabilitation Services achieve their highest level of self-sufficiency and recovery through gains in personal empowerment, hopefulness, and competency.

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

Rating Indicators:

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

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

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

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

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

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

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

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. Persons served

- Review case records

PSR 7.01

Planning for case closing:

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

PSR 7.02

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

PSR 7.03

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

PSR 7.04

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

PSR 7.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of persons served.
NA: The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.

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