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Three-Year Accreditation

CARF Survey Report for Arab-American and Chaldean Council

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Organization

Arab-American and Chaldean Council (ACC)
28551 Southfield Road
Lathrup Village, MI 48076

Organizational Leadership

Radwan Khoury, Ph.D., Executive Director/COO

Survey Dates

July 22-24, 2013

Survey Team

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Anita Robinson, LCSW, Program Surveyor

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Programs/Services Surveyed

Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Community Integration: Psychosocial Rehabilitation (Adults)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Previous Survey

August 2-4, 2010
Three-Year Accreditation

Survey Outcome

Three-Year Accreditation
Expiration: August 2016

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SURVEY SUMMARY

Arab-American and Chaldean Council (ACC) has strengths in many areas.

- The commitment of the community is demonstrated through the board of directors. The board of directors is composed of dedicated, conscientious individuals from diverse backgrounds with diverse expertise who demonstrate their commitment by donating their time and talent to operations assistance as needed.
- The president/chief executive officer is the cornerstone for the organization and is a strong advocate with local, state, regional, national, and international entities that promote the betterment of the organization's operations and community at large. Her vision, passion, and dedication has positively impacted the lives of countless refugees and enabled them to start new lives with hope and dignity. She continues to be recognized and receive prestigious awards and recognition for "making a difference."
- The behavioral health division is led by a highly capable executive director/chief operating officer who is visionary; competent; responsive to community needs; and committed to the success of programs, services, personnel, and the persons served. His continued leadership with managed care and other funding streams plays a critical role in advocating for and securing diminishing funding for persons in need.
- The leadership team is well integrated, with an effective team process that is mutually supportive and person centered. The leadership team members appear competent and compassionate as they effectively manage their many functions and responsibilities in an open and positive manner.
- There is evidence of sound administrative and financial management of the organization.
- ACC is highly regarded and respected within several communities for providing quality services to the persons served and families. ACC has developed extensive community partnerships and has been a leading force in community improvement, involvement, and collaboration. ACC has successfully partnered in community projects with many community groups. Forgotten Harvest is a bi-monthly food pantry event that provides fresh groceries to an average of 800 individuals on any given day.
- The organization is excellent at maximizing limited resources, both internally and in the community.
- The oversight and process to protect the rights of the persons served are efficient and sensitive to individual needs and preferences and ensures the dignity and respect of the persons served.
- The persons served speak with a great deal of passion when describing the high quality of services received and their experience with all staff members as welcoming, supportive, and genuinely dedicated.
- The Wayne County Network Clubhouse demonstrates strong fidelity to the clubhouse model, clearly demonstrating consumer-run services.

- The organization's facilities are clean and attractive. Many organization facilities are gems in otherwise blighted neighborhoods, revitalizing the areas in which they reside. The facilities are warm and welcoming. The facilities are nicely furnished with culturally competent décor.
- The staff members are qualified, enthusiastic, and dedicated to the persons served. They take pride in the programs and in the progress and recovery of the persons served.
- The persons served described reception support staff members as welcoming, helpful, and supportive. One stated, "They greet us with a smile and know our names."
- ACC is applauded for offering its staff members a wide array of rich benefits to assist in the retention of qualified, skilled personnel.
- ACC is fortunate to have a forward-thinking and experienced information technology team that manages and maintains a complex information management system with three electronic medical record software programs. Its use of leading-edge technology supports operations and provides highly effective service delivery while maximizing efficiency.

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

- In its efforts to best meet the needs of the highly ethnically diverse communities served, the leadership has historically and continues to focus its efforts on cultural competency and the ability of the staff members to meet the mental health needs of the persons served in an environment that understands and welcomes culturally diverse persons. This is an organization that embraces unpredictable masses of refugees from war-torn countries and areas of chronic instability, many of whom have been tortured and experienced trauma. The organization exhibits sensitivity to the cultural needs of the persons served, and the majority of the staff members speak two or three foreign languages, thus maximizing the comfort, adjustment, and individualized care provided to all persons served. When possible, ACC literature, signage, and even the organization's logo are written in the language of the persons served.

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

On balance, ACC is a unique, proactive, and accountable nonprofit organization that has a rich history of providing comprehensive social and human services that include mental health outpatient treatment, psychiatric services, and community support to children, youth, adults, and their families focusing on person-first recovery and resilience. Services are provided in the multicultural, multiethnic communities of metropolitan Detroit, and Wayne, Oakland, and Macomb counties in southeast Michigan. The board, leadership, and staff members are recognized for their continued dedication to the mission and values of the organization and to maintaining quality and affordable community-based treatment and support services. Target population groups continue to expand to serve persons in its community. It is evident that the leadership pays close attention to financial planning and management, keeping abreast of the current fiscal climate in the local counties and state. Community service partners are highly valued, and ACC staff members work diligently to maintain and broaden these and other stakeholder relationships. Staff members continue to serve on numerous task groups, coalitions, networks, and community initiatives. The organization worked hard work preparing for this survey. The team has embraced the CARF standards with enthusiasm and dedicated efforts to achieve international accreditation. The organization demonstrates substantial conformance to the CARF standards, and the persons served benefit greatly from the

programming provided. The leadership and staff members have a clear commitment to providing quality services and to improving the quality of life of the persons served. The organization is aware of the areas for improvement and has the resources and commitment to address them.

Arab-American and Chaldean Council has earned a Three-Year Accreditation. The organization has made the commitment to continue to embrace the CARF standards to further improve the quality of services. The board, leadership, and staff members are committed to the pursuit of accreditation. They are encouraged to build on the organization's strengths and use the organization's resources to address opportunities for improvement noted in this report in the pursuit of service excellence.

SECTION 1. ASPIRE TO EXCELLENCE®

A. Leadership

Principle Statement

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

Exemplary Conformance

A.5.a.(1)

In its efforts to best meet the needs of the highly ethnically diverse communities served, the leadership has historically and continues to focus its efforts on cultural competency and the ability of the staff members to meet the mental health needs of the persons served in an environment that understands and welcomes culturally diverse persons. This is an organization that embraces unpredictable masses of refugees from war-torn countries and areas of chronic instability, many of whom have been tortured and experienced trauma. The organization exhibits sensitivity to the cultural needs of the persons served, and the majority of staff members speak two or three foreign

languages, thus maximizing the comfort, adjustment, and individualized care provided to all persons served. When possible, ACC literature, signage, and even the organization's logo are written in the language of the persons served.

C. Strategic Planning

Principle Statement

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

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

D. Input from Persons Served and Other Stakeholders

Principle Statement

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

E. Legal Requirements

Principle Statement

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

Key Areas Addressed

- Compliance with all legal/regulatory requirements

Recommendations

There are no recommendations in this area.

F. Financial Planning and Management

Principle Statement

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and annual performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budget(s) prepared, shared, and reflective of strategic planning
- Financial results reported/compared to budgeted performance
- Organization review
- Fiscal policies and procedures
- Review of service billing records and fee structure
- Financial review/audit
- Safeguarding funds of persons served

Recommendations

There are no recommendations in this area.

G. Risk Management

Principle Statement

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

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

Recommendations

G.1.a.(4) through G.1.a.(7)

Although the risk management plan identifies some areas of loss exposure, it is recommended that the plan be expanded to specifically include implementation and monitoring of actions to reduce risks, reporting results of actions taken to reduce risks, and inclusion of risk reduction activities in performance improvement activities.

H. Health and Safety

Principle Statement

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Inspections
- Emergency procedures
- Access to emergency first aid
- Competency of personnel in safety procedures
- Reporting/reviewing critical incidents
- Infection control

Recommendations

H.4.a.(1)

H.4.a.(2)

H.4.b.(7)

It is recommended that personnel consistently receive documented initial and annual competency-based training in the area of medication management.

H.6.a.(1) through H.6.e.

Tests of all emergency procedures were conducted at some locations but not others. The leadership is urged to ensure that unannounced tests of all emergency procedures are consistently conducted at least annually on all shifts at all locations. The tests should include complete actual or simulated physical evacuation drills. All tests should be analyzed in writing for performance improvement that addresses areas for improvement, actions to be taken, results of performance improvement plans, and necessary education and training of personnel.

H.12.b.(3)

It is noted that it continues to be difficult to obtain comprehensive health and safety inspection reports from an external authority. Written reports of the results of the external comprehensive health and safety inspections should identify actions taken to respond to the recommendations.

H.13.b.(2)

H.13.b.(3)

It is recommended that written reports of the comprehensive health and safety self-inspections identify recommendations for improvement and actions taken to respond to the recommendations.

Consultation

- It is suggested that the organization indicate the location of safety equipment, such as first aid kits, fire extinguishers, and automated external defibrillator (AED) devices.

I. Human Resources

Principle Statement

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

Key Areas Addressed

- Adequate staffing
- Verification of background/credentials
- Recruitment/retention efforts

- Personnel skills/characteristics
- Annual review of job descriptions/performance
- Policies regarding students/volunteers, if applicable

Recommendations

There are no recommendations in this area.

Consultation

- Although the organization provides informal recognition and reward activities, leadership is encouraged to develop formal strategies to further acknowledge achievements and identify proven practices.
- To increase efficiency, the human resource department could obtain and utilize a human resource information system.
- ACC might consider developing posttests for internal training to demonstrate competency based on the training provided. In addition, it is suggested that training documentation include the training curricula and sign-in sheets.

J. Technology

Principle Statement

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

Key Areas Addressed

- Written technology and system plan

Recommendations

There are no recommendations in this area.

K. Rights of Persons Served

Principle Statement

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

L. Accessibility

Principle Statement

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

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

M. Performance Measurement and Management

Principle Statement

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

Key Areas Addressed

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

Recommendations

M.3.a.(9)

The data collected by the organization should consistently include health and safety reports.

N. Performance Improvement

Principle Statement

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

Key Areas Addressed

- Proactive performance improvement
- Performance information shared with all stakeholders

Recommendations

There are no recommendations in this area.

Consultation

- The organization is encouraged to further involve all levels of staff in the development and monitoring of performance improvement activities.

SECTION 2. GENERAL PROGRAM STANDARDS

Principle Statement

For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. A commitment to quality and the involvement of the persons served span the entire time that the persons served are involved with the organization. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. The persons served have the opportunity to transition easily through a system of care.

A. Program/Service Structure

Principle Statement

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

Key Areas Addressed

- Written program plan
- Crisis intervention provided
- Medical consultation
- Services relevant to diversity
- Assistance with advocacy and support groups
- Team composition/duties
- Relevant education
- Clinical supervision
- Family participation encouraged

Recommendations

There are no recommendations in this area.

B. Screening and Access to Services

Principle Statement

The process of screening and assessment is designed to determine a person's eligibility for services and the organization's ability to provide those services. A person-centered assessment process helps to maximize opportunities for the persons served to gain access to the organization's programs and services. Each person served is actively involved in, and has a significant role in, the assessment process. Assessments are conducted in a manner that identifies the historical and current information of the person served as well as his or her strengths, needs, abilities, and preferences. Assessment data may be gathered through various means including face-to-face contact, telehealth, or written material; and from various sources including the person served, his or her family or significant others, or from external resources.

Key Areas Addressed

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

Recommendations

B.14.k.

It is recommended that the assessment process consistently include information about the person's co-occurring disabilities, disorders, and medical conditions.

B.15.b.

The organization should ensure that the assessment process consistently includes the preparation of a written interpretative summary that identifies any co-occurring disabilities, co-morbidities, and/or disorders.

C. Person-Centered Plan

Principle Statement

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of his or her plan. The person-centered plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and potential solutions. The planning process is person-directed and person-centered. The person-centered plan may also be referred to as an individual service plan, treatment plan, or plan of care. In a family-centered program, the plan may be for the family and identified as a family-centered plan.

Key Areas Addressed

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

Recommendations

C.6.a.

It is recommended that, when the person served has concurrent disorders, disabilities, and/or co-morbidities, the person-centered plan consistently address these conditions in an integrated manner.

D. Transition/Discharge

Principle Statement

Transition, continuing care, or discharge planning assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization. The transition process is planned with the active participation of each person served. Transition may include planned discharge, placement on inactive status, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.

The transition plan is a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation. It is prepared with the active participation of person served when he or she moves to another level of care, after-care program, or community-based services. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served receives a copy of the transition plan.

A discharge summary is a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the program (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the program provided and the response by the person served.

Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual's ongoing recovery or well-being. The organization proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary may be a combined document as long as it is clear whether the information relates to transition or pre-discharge planning or identifies the person's discharge or departure from the program.

Key Areas Addressed

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

Recommendations

D.2.

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

D.3.a.(1) through D.3.f.

It is recommended that written transition plans be consistently prepared or updated to ensure a seamless transition when a person served is transferred to another level of care, an aftercare program, or prepares for a planned discharge. The transition plan should consistently identify the person's current progress in his or her own recovery or move to well-being; gains achieved during program participation; need for support systems or other types of services that will assist in continuing his or her recovery, well-being, or community integration; information on the continuity of medications, when applicable; referral information, such as a contact name, telephone number, locations, hours, and days of services, when applicable; and information on options and resources available if symptoms recur or additional services are needed, when applicable.

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

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

D.7.a. through D.7.d.

It is recommended that when a transition plan or discharge summary is provided to external programs or services to support a person's transition or discharge, it include the person's identified strengths, needs, abilities, and preferences.

E. Medication Use

Principle Statement

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

Medication use includes prescribed or sample medications, and may, when required as part of the treatment regimen, include over-the-counter or alternative medications provided to the person served. Alternative medications can include herbal or mineral supplements, vitamins, homeopathic remedies, hormone therapy, or culturally specific treatments.

Medication control is identified as the process of physically controlling, transporting, storing, and disposing of medications, including those self administered by the person served.

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

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

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

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

Key Areas Addressed

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

Recommendations

E.2.a.(1) through E.2.b.(16)

It is recommended that the organization provide documented ongoing training and education regarding medications to the persons served, family members when applicable, and personnel providing direct services to the persons served. The training and education should include how the medication works; the risks associated with each medicine; the intended benefits as related to the behavior or symptom targeted by the medication; side effects; contraindications; potential implications between medication and diet and/or exercise; risks associated with pregnancy; the importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence; the need for laboratory monitoring; the rationale for each medication; early signs of relapse related to medication efficacy; signs of nonadherence to medication prescriptions; potential reactions when combining prescription and nonprescription medications, including alcohol, tobacco, caffeine, illegal drugs, and alternative medications; instructions on self-administration, when applicable; wellness management and recovery planning; and the availability of financial supports and resources to assist the persons served with handling the costs associated with medications.

E.5.h. through E.5.j.

It is recommended that ACC have written medication procedures that include the use of medications by women of childbearing age, the use of medications during pregnancy, and special dietary needs and restrictions associated with medication use.

E.8.a. through E.8.e.(2)

It is recommended that the organization conduct a documented peer review at least annually on a representative sample of records of persons for whom prescriptions were provided to assess the appropriateness of each medication, as determined by the needs and preferences of each person served, and the efficacy of the medication; to determine if the presence of side effects, unusual effects, and contraindications were identified and addressed and necessary tests were conducted; and to identify the use of multiple simultaneous medications and medication interactions.

E.9.a. through E.9.c.

It is recommended that information collected from the peer review process be reported to applicable staff members, used to improve the quality of services provided, and incorporated into the organization's performance improvement system.

F. Nonviolent Practices

Principle Statement

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

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

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

Even with supports, there are times when individuals may show signs of fear, anger, or pain, which may lead to aggression or agitation. Staff members are trained to recognize and respond to these signs through de-escalation, changes to the physical environmental, implementation of meaningful and engaging activities, redirection, active listening, etc. On the rare occasions when these interventions are not successful and there is imminent danger of serious harm, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort. The use of seclusion and restraint must always be followed by a full review, as part of the process to eliminate the use of these in the future.

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

Restraint is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication, in immediate response to a dangerous behavior. Restraints used as an assistive device for persons with physical or medical needs are not considered restraints for purposes of this section. Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to self, or holding a person's hand or arm to safely guide him or her from one area to another, is not a restraint. Separating individuals threatening to harm one another, without implementing restraints, is not considered restraint.

Seclusion refers to restriction of the person served to a segregated room with the person's freedom to leave physically restricted. Voluntary time out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the person served is considered in seclusion if freedom to leave the segregated room is denied.

Seclusion or restraint by trained and competent personnel is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm. Peer restraint is not considered an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation.

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

Key Areas Addressed

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

Recommendations

F.1.c.(2)

The ACC has as part of its medication policies a process for using chemical restraint as an option for managing aggressive or dangerous behaviors. However, the medical director and staff members interviewed report that chemical restraint is not used in practice. The ACC also has as part of its nonviolent practices policy that it does not use restraint. It is recommended that the organization review its policy regarding the use of chemical restraint and clearly identify its policy on whether, and under what circumstances, restraints are used in the programs it provides.

G. Records of the Persons Served

Principle Statement

A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

Key Areas Addressed

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

Recommendations

G.4.h.(7)

It is recommended that the individual records consistently include a transition plan, when applicable.

H. Quality Records Management

Principle Statement

The organization has systems and procedures that provide for the ongoing monitoring of the quality, appropriateness, and utilization of the services provided. This is largely accomplished through a systematic review of the records of the persons served. The review assists the organization in improving the quality of services provided to each person served.

Key Areas Addressed

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

Recommendations

H.4.h.(1)

It is recommended that the quality records reviews address whether the transition plan has been completed, when applicable.

MENTAL HEALTH

Core programs in this field category are designed to provide services for persons with or who are at risk for psychiatric disabilities/disorders or have other mental health needs. These programs encompass a wide variety of therapeutic settings and intervention modalities. Core programs in this field category may also provide services to persons with co-occurring disabilities/disorders, such as mental illness and a developmental disability.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

C. Case Management/Services Coordination

Principle Statement

Case management/services coordination programs provide goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Successful service coordination results in community opportunities and increased independence for the persons served. Programs may provide occasional supportive counseling and crisis intervention services, when allowed by regulatory or funding authorities.

Case management/services coordination may be provided by an organization as part of its person-centered planning and delivery, by a department or division within the organization that works with individuals who are internal and/or external to the organization, or by an organization with the sole purpose of providing case management/services coordination. Such programs are typically provided by qualified case managers/coordinators or by case management teams.

Organizations performing case management/services coordination as a routine function of other services or programs are not required to apply these standards unless they are specifically seeking accreditation for this program.

Recommendations

There are no recommendations in this area.

T. Outpatient Treatment

Principle Statement

Outpatient treatment programs provide services that include, but are not limited to, individual, group, and family counseling and education on recovery and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, addictions (such as alcohol or other drugs, gambling, and internet), eating or sexual disorders, and the needs of victims of abuse, domestic violence, or other trauma.

Recommendations

There are no recommendations in this area.

PSYCHOSOCIAL REHABILITATION

Core programs in this field category demonstrate a strong collaborative partnership with the persons served, the development of opportunities for personal growth, a commitment to community integration, goal-oriented and individualized supports, and the promotion of satisfaction and success in community living. Programs in this category may serve persons with a variety of concerns, including persons with developmental or physical disabilities.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to

improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

E. Community Integration

Principle Statement

Community integration is designed to help persons to optimize their personal, social, and vocational competency in order to live successfully in the community. Activities are determined by the needs of the persons served. The persons served are active partners in all aspects of these programs. Therefore, the settings can be informal in order to reduce barriers between staff members and program participants. In addition to services provided in the home or community, this program may include a psychosocial clubhouse, a drop-in center, an activity center, or a day program.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services based on the identified needs and desires of the persons served. A person may participate in a variety of community life experiences that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

Recommendations

There are no recommendations in this area.

SECTION 4. BEHAVIORAL HEALTH SPECIFIC POPULATION DESIGNATION STANDARDS

B. Children and Adolescents

Case Management/Services Coordination: Mental Health
Outpatient Treatment: Mental Health

Principle Statement

Programs for children and adolescents consist of an array of behavioral health services designed specifically to address the treatment needs of children and adolescents. Such programs tailor their services to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

Recommendations

There are no recommendations in this area.

PROGRAMS/SERVICES BY LOCATION

Arab-American and Chaldean Council

28551 Southfield Road
Lathrup Village, MI 48076

Administrative Location Only

Arab-American and Chaldean Council

62 West Seven Mile Road
Detroit, MI 48203

Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Arab-American and Chaldean Council

26400 Lahser Road, Suite 220
Southfield, MI 48033

Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Arab-American and Chaldean Council

16921 West Warren Avenue
Detroit, MI 48228

Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Arab-American and Chaldean Council

34628 Dequindre, Suite 2
Sterling Heights, MI 48310

Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)

Arab-American and Chaldean Council

201 West Seven Mile Road
Detroit, MI 48203

Community Integration: Psychosocial Rehabilitation (Adults)