

Quality Practice Notice—September 2016

Suicide Prevention in CARF-Accredited Organizations: Advancing Clinical and Service Workforce Preparedness

Suicide is the tenth leading cause of death in the United States and the ninth leading cause of death in Canada. The Centers for Disease Control (CDC) recently reported that suicide rates have increased 24 percent over the last 15 years. The average annual percent increase in the age-adjusted suicide rate was about 1 percent per year from 1999 through 2006 but increased to 2 percent per year from 2006 through 2014. The percentage increase was greater for females than males, signifying a narrowing of the gender gap in suicide rates.⁽¹⁾ According to a report released by the Substance Abuse and Mental Health Services Administration (SAMHSA), about 1 in 13 young adults in the United States had serious thoughts of suicide in 2013–2014, or 2.6 million Americans between the ages of 18 and 25, an alarmingly high number.⁽²⁾ However, it's not just youth who face a risk of suicide, the suicide rate has increased for all age groups under 75.⁽¹⁾ Statistics are similar in other countries.

According to the National Action Alliance for Suicide Prevention (Action Alliance): "Suicide is a major public health issue, taking life without regard to age, income, education, social standing, race, or gender. The legacy of suicide continues long after the death, impacting bereaved loved ones and communities."⁽³⁾ The Action Alliance also notes that, "While more is being done now than ever before to prevent suicides in the United States, greater efforts must occur to reverse this disturbing trend in a preventable cause of death."⁽³⁾

CARF International actively participates in the Action Alliance, the public-private partnership advancing the National Strategy for Suicide Prevention, through its CEO, Brian J. Boon, Ph.D., who serves on the Executive Committee. While much of the data and background information presented in this notice are from U.S. sources, suicide is a global public health issue. As all organizations providing health and human services have the potential to encounter individuals at risk for suicide, CARF strongly supports all suicide prevention efforts. It is a fact that crisis intervention is a necessity within any of the areas in which CARF accredits. It is imperative that organizations and their staffs are vigilant and prepared to take the most reasonably prudent steps when presented with a person who is at risk for suicide. The following information provides background, direction, and resources for organizations in addressing this critical issue.

Suicide is often the result of multiple risk factors, but not everyone at risk indicates suicidal ideation.⁽¹⁾ The responsibility of professionals in health and human services to assess, intervene, and monitor suicidal behavior presents a significant opportunity to save a life. Such a situation,

however, can also present a heavy burden if the professional is ill-prepared for such a situation.⁽⁴⁾ It has been well-documented that, although a wide range of professionals will encounter individuals at risk for suicide,^(5, 6, 7, 8, 9) many do not have confidence in dealing with such challenges,^(10, 11) and a majority of professionals, in various settings, have minimal to no training to competently deal with a situation to prevent suicide.^(12, 13)

In order to reduce suicide rates in the United States, the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*⁽¹⁴⁾ recognizes that one of the key steps to preventing and intervening competently with persons who are at risk of suicide is to ensure a ready and able community and clinical workforce that is prepared to assess and intervene when necessary. This goal is challenging given the varied health and human service professions who need training, each with their respective scope of practice, the varied settings in which such services are delivered, and the ongoing requirements for maintaining practice currency.

The National Strategy specifically includes **Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.**⁽¹⁴⁾ Goal 7 states “All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide.” Two of the objectives under this goal are:

Objective 7.3: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

The intent of this objective is for education and training programs, including continuing education, for health and human service professionals, to adopt core education and training guidelines addressing the prevention of suicide and related behaviors.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

The intent of this objective is to ensure that health and human service professionals achieve competence in “addressing suicidal behaviors and remain competent over time.” This can be accomplished through state requirements for licensing examinations and certification programs “in order to maintain active licenses and/or professional certifications.” Several states (including Washington, Kentucky, Louisiana, Utah, New Hampshire, and Nevada) have passed legislation requiring suicide prevention training for some health and human service professionals, and efforts are currently underway in other states. In addition, accrediting and credentialing organizations can “promote evidence-based and best practice suicide prevention training for the organizations and practitioners they accredit or credential.”

CARF wishes to sustain and raise the bar for accredited organizations to ensure clinical and service workforce preparedness as it relates to addressing matters related to suicide prevention.

CARF's current requirements and future developments

Key elements in suicide prevention and care have been identified, including ensuring a safe environment, uniformly administered evidence-based screening and assessment tools, use of evidence-based treatments, continuity of care to ensure transition to the proper level of care and follow-up, and utilization of data-driven quality improvement.⁽¹⁵⁾ The CARF standards address all of these elements with numerous standards for having a well-trained and competent workforce prepared to intervene. Included in these are screening for suicide risk and the need for providers to have the competencies to be adequately prepared when encountering an individual at risk for suicide. With the complexity of assessing suicidality across the domains CARF accredits in the broad band of health and human services, CARF standards support an organizational vigilance to those at risk for suicide by ensuring a focus on the individual needs of the person served. Because CARF-accredited behavioral health programs routinely encounter individuals at risk for suicide, there is a higher degree of vigilance and practices in place in those organizations to address this risk, with standards to support this scope of practice matter. Risks of suicide are assessed at the assessment, treatment, and post-treatment phases of services, including targeted referrals to experts in intervention.

Even those organizations whose primary service focus is not behavioral health must be aware of this issue and provide or arrange for resources to address suicide risk. Further, the scope of many programs includes interaction with and service delivery to the families/support systems of persons receiving services, requiring accredited programs to intervene on their behalf. Although some personnel may require more extensive training based on their position, CARF supports and encourages organizations to ensure that suicide prevention is a component of training for all personnel, regardless of their role within the organization.

To further strengthen this position, CARF is advancing its efforts regarding suicide prevention through reviewing and revising its standards in the areas of training, assessment, and intervention, including expanded intent statements, examples, and resources, as appropriate. Organizations providing health and human services need to ensure this fundamental training for their personnel to provide them with the knowledge and framework to competently and confidently take action, including the timely transition of a person at risk into appropriate care.

The following is a high-level illustration of how CARF's standards address key elements in suicide prevention in all standards manuals. For more detail and information on additional standards that are specific to each area of accreditation, refer to the addendum: [How the CARF Standards Address Suicide Prevention](#).

Person-centered care

Person-centered care throughout the service delivery process is the primary focus of CARF's standards. The persons served are treated with dignity and respect at all times, and the rights of persons served are provided to them in an understandable format. Input from the person served is obtained on an ongoing basis, and a person-centered service plan is developed with the involvement of the person served.

Evidence-based practice

Evidence-based practices are required by standards in the Leadership and Program/Service Structure sections.

Health and safety

The standards in the Health and Safety section require organizations to maintain healthy, safe, and clean environments that support quality services and minimize risk to persons served, personnel, and other stakeholders. Specifically, organizations are required to have written procedures regarding suicide and attempted suicide. Additional standards in other areas of the manuals also address safety and security measures, including suicide risk.

Competent and trained staff

Standards in the Human Resources section address the provision of training and identification of required personnel competencies. There are additional standards that address training and competencies specific to the programs and services throughout the manuals. This includes training in screening and assessment tools, tests, and instruments as relevant to the respective disciplines and as determined by the organization's leadership.

Screening and assessment

Although the terminology used is different in the respective manuals, information is gathered on the person served in all of the areas CARF accredits as part of determining eligibility for services and developing individualized service plans. It is at this point where risk for suicide may be identified and immediate action taken. However, ongoing assessment and responding to the changing needs of the persons served is required throughout the service delivery process.

Continuity of care

Numerous standards require that, if an organization cannot provide the needed services, referrals to other providers or resources are provided. The organization should be knowledgeable about available community resources and able to assist the person served with information about how to access needed services. All manuals require coordinated care. Transition planning, as appropriate, is included in the service plan process, and follow-up is conducted as necessary.

Data-driven quality improvement

It goes without saying that suicide and attempted suicide are critical incidents in all organizations. CARF's Health and Safety standards include the requirement that a written analysis of all critical incidents is provided to or conducted by leadership at least annually and addresses causes, trends, actions for improvement, results of performance improvement plans, necessary education and training of personnel, prevention of recurrence, and internal and external reporting requirements. Further, standards in the Performance Measurement and Management section address the collection of data by the organization, including information on risk management and health and safety reports. Performance improvement standards ensure that the organization is focused on ongoing improvement and that quality improvement is driven by the data collected.

What should be included in suicide prevention training

Fortunately, there are many resources and tools available to community and clinical service providers to ensure access to appropriate training and examples of successful implementation. The guidelines for training contained in the report prepared by the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention provide guidance about what should be included in a training program.⁽¹⁶⁾ As detailed in the report, topics that should be covered in training include:

- Protecting the rights and dignity of the person served and recognizing individual preferences, needs, and activities (establishing a safe environment).
- Suicide concepts and facts, including suicide risk and protective factors, legal and regulatory requirements, documentation requirements, follow-up and transition, and cultural and local factors.
- Suicide first aid and risk assessment.
- Intervention, including determining risk level, issues related to imminent harm, and development of safety plans.
- Developing a continuity of care plan.

Although CARF does not endorse any specific training program, there are many training resources available to assist organizations in providing their personnel with proper and effective training. Programs are available for varying types of providers. Some of the information and resources currently available include the following:

- Connect Suicide Prevention/Intervention Training: www.theconnectprogram.org
- AMSR: www.sprc.org/training-institute/amr
- SAFETALK: www.livingworks.net/programs/safetalk/
- QPR Institute: www.qprinstitute.com/
- ASIST: www.livingworks.net/programs/asist/

- Zero Suicide Toolkit: <http://zerosuicide.sprc.org/toolkit>
- American Foundation for Suicide Prevention: www.afsp.org
- Suicide Awareness Voices of Education: www.save.org
- The Linehan Institute Behavioral Tech Research: <http://behavioraltech.org/index.cfm>
- Quantum Units Education: www.QuantumUnitsEd.com
- OnlineCE: www.chirocredit.com/
- State Laws: Training for Health Professionals in Suicide Assessment, Treatment, and Management: <http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf>

Resources Available for Organizations

Screening and assessment tools

Screening and assessment are critical in identifying individuals who are at risk for suicide. There are many screening tools that can be used. Although not all of the assessment or screening tools will be appropriate for all human service sectors, the following are provided as potential resources:

- PHQ-2 Patient Health Questionnaire: www.cqaimh.org/pdf/tool_phq2.pdf
- PHQ-9 Patient Health Questionnaire 9: www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
- C-SSRS: www.cssrs.columbia.edu/
- SAFE-T: <http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432>
- Suicide Behaviors Questionnaire-Revised SBQ-R: www.integration.samhsa.gov/images/res/SBQ.pdf
- GLAD-PC (adolescents): <http://www.glad-pc.org/>
- M3 Clinician: <https://m3clinician.com/WhyM3.aspx>
- Kessler 6: www.integration.samhsa.gov/images/res/K6%20Questions.pdf
- Kessler 10: www.integration.samhsa.gov/images/res/K10%20-%20Self%20Administered.pdf
- QPR Institute: www.qprinstitute.com
- SPRC: www.sprc.org/sites/sprc.org/files/EDGuide_quickversion.pdf
- VA/DoD clinical Practice Guidelines for Assessment: www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf

Safety plan development

- www.mentalhealth.va.gov/docs/va_safety_planning_manual.pdf
- www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf
- www.suicidesafetyplan.com/About_Safety_Planning.html

General resources for more information

- American Association of Suicidology: www.suicidology.org/
- American Foundation for Suicide Prevention: <https://afsp.org/>
- National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org
- Suicide Awareness and Voices of Education: www.save.org
- Suicide Prevention Resource Center: www.sprc.org
- Canadian Association for Suicide Prevention: <http://suicideprevention.ca/>
- centre for suicide prevention: www.suicideinfo.ca/
- centre for suicide prevention training workshops: www.suicideinfo.ca/workshops/
- ReachOutNow: www.reachoutnow.ca/resources_e.php
- Together to Live: www.togethertolive.ca/prevention-tools-and-resources

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Quality Practice Notice Addendum

How the CARF Standards Address Suicide Prevention

Established in 1966, CARF accredits health and human services across the lifespan and continuum of care. Accreditation opportunities are available in the fields of Aging Services, Behavioral Health, Opioid Treatment Programs, Child and Youth Services, Employment and Community Services, Vision Rehabilitation Services, and Medical Rehabilitation. The CARF standards address key elements of suicide prevention, including:

- Use of evidence-based practices.
- Ensuring a safe environment.
- Person-centered care.
- Screening and assessment of suicide risk.
- Well-trained and caring staff prepared to intervene.
- Ensuring continuity of care including during and after transition/discharge.
- Ongoing performance improvement.

This document provides an overview of how the CARF standards address each of these key elements. The standards in Section 1. ASPIRE to Excellence® are the same in all manuals and are applied to all CARF-accredited organizations. Section 2 in each manual includes a set of standards in Section 2.A. that address overall program/service structure and also are applied across all fields.

There are additional standards in each manual that are specific to the field and further address these topics. The depth and scope of such standards vary depending on the field and the specific programs and services for which the organization seeks accreditation, with those that serve higher-risk populations having more detailed and in-depth requirements.

This document provides an overview of some of the CARF standards that address each of these key elements related to suicide prevention; it does not identify all standards that are applied or that support suicide prevention efforts in CARF-accredited programs and services. Individualized, person-centered service planning and service delivery and a commitment to protecting the health and safety of the persons served are key requirements for all CARF-accredited organizations. These concepts are connected and reinforced throughout the standards in all areas.

For further information on the CARF standards and suicide prevention efforts within CARF-accredited organizations, please contact Lori Rogers at lrogers.carf.org.

Use of evidence-based practices

Section 1. ASPIRE to Excellence standards

To ensure that the use of evidence-based practices is supported throughout the organization, the Leadership standards include a requirement that the organization's leadership provide resources and education for personnel to stay current in the field in order to demonstrate program strategies and interventions that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Program/Services Structure—standards for all fields

Standards in this area include the requirement that service delivery models be based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Behavioral Health/Child and Youth Services/Employment and Community Services

Diversion/Intervention programs that provide suicide prevention services are required to have a written plan or logic model that details the specific theoretical approaches to be used in the program.

Medical Rehabilitation

The use of evidence-based practices and current research are emphasized throughout the standards in all areas in medical rehabilitation and specialty programs.

Ensuring a safe environment

Section 1. ASPIRE to Excellence standards

To reinforce the importance of health and safety in CARF-accredited organizations, the Leadership standards include a requirement that the organization's leadership guide health and safety.

The Health and Safety standards begin with a directive that the organizations maintain a healthy and safe environment—a key requirement to ensure that the organization is focused on protecting the safety of the persons served. Additional Health and Safety standards require written procedures for medical emergencies and for violent or other threatening situations, as well as written procedures regarding critical incidents, including suicide and attempted suicide, that address prevention, reporting, documentation, remedial action and timely debriefings.

This concept is further reinforced in the Human Resources standards, which include a requirement that the organization have an adequate number of personnel to ensure the safety of persons served.

Program/Services Structure—standards for all fields

Standards include a requirement that the organization provide the resources needed to support the overall scope of each program/service.

Aging Services

Standards include requirements for safety and security measures that are consistent with the behavioral, cognitive, and physical needs of the persons served and address multiple areas including mental health issues, self-injurious behaviors, and suicidal ideation. These measures are also addressed in annual personnel training.

Assisted Living program standards require a process for scheduled safety checks for persons served, as indicated by their individual person-centered plans.

Dementia Care Specialty program standards require that the environment addresses the unique needs of persons with dementia, including maintaining the safety of the persons served.

Behavioral Health/Opioid Treatment Programs/Child and Youth Services

Organizations are required to have written procedures that address provision of crisis intervention services. This may be done either through a crisis-response service within the organization or through arrangements with area providers that provide crisis intervention services.

Behavioral Health and Opioid Treatment Program standards on person-centered planning include the requirement to develop a personal safety plan for the persons served when assessment identifies a potential risk for dangerous behaviors.

Child and Youth Services standards require written procedures that address positive approaches to behavioral interventions, including development of a personal safety plan for each person served on an individual basis, when indicated.

In the Behavioral Health standards manual, standards for the Older Adults Specific Population Designation require provision of an organized education program that addresses risk of suicide, as appropriate to the needs of the persons served and their families/support systems.

Medical Rehabilitation

Standards require safety and security practices that are consistent with behavioral, cognitive, and physical needs of the persons served and address multiple areas, including self-injurious behaviors and suicidal ideation.

Standards for Interdisciplinary Pain Rehabilitation programs include requirements for initial and ongoing risk assessments for each person served that address suicide and actions to reduce identified risks.

Employment and Community Services/Vision Rehabilitation Services

Standards require that the persons served and/or their families or legal representatives, as applicable, are involved in risk assessments and identifying actions to be taken to minimize risks that are identified.

Comprehensive Blind Rehabilitation Services for Veterans and Active Duty Service Members conduct risk assessments for each person served and address risk factors that may affect the rehabilitation process. Inpatient medical care includes emergency and transfer procedures and mental health services.

Person-centered care

Section 1. ASPIRE to Excellence standards

Person-centered care is a core element of all CARF-accredited programs and services. Leadership standards specify that a person-centered philosophy guides service delivery and is demonstrated by leadership and personnel throughout the organization. Human Resources standards include the requirement that personnel receive documented training at orientation and regular intervals that addresses person-centered practice and the unique needs of the persons served.

Program/Services Structure—standards for all fields

All CARF standards manuals include standards that direct the organization to gather information about each person served and use this information to develop and implement individualized, person-centered planning and service delivery that addresses the person's needs. Although the specific standards and terminology used in each manual vary according to the field and types of programs and services provided, this concept is embedded throughout all CARF-accredited organizations.

Screening and assessment of suicide risk

Program/Services Structure—standards for all fields

Standards require the organization to document entry, exit, and transition criteria to determine which persons it is qualified to serve and to identify conditions for exit from the program and/or transition to other levels of care or services. Standards further require the organization to provide recommendations for alternative services when a person is found ineligible for any reason.

To address these requirements, all organizations conduct some form of screening and assessment, both upon admission/entry and on an ongoing basis. Although the specific terminology used and the scope and intensity of such screening and assessments vary widely based on the field and the specific programs and services offered, screening and assessment is an integral part of ensuring that persons served receive appropriate services, care, and referrals when needed to address identified needs.

Aging Services

Standards require written screenings/assessments to be conducted prior to the initiation of services, at a frequency that is consistent with the needs of the persons served, in response to changes in care needs, and in response to changes in preferences of the persons served.

Initial and ongoing written screenings/assessments address behavioral, psychological, and other areas as appropriate to the needs of the person served.

Person-centered plans are based on initial and ongoing screening/assessments and address identified needs, including necessary interventions and supports, and choices and behaviors that pose a risk to the person's health or safety.

The service delivery team is responsible for conducting initial and ongoing screening/assessments, establishing and implementing the person-centered plan, and transitioning or referring the person to other levels of care or other services or programs as needed.

Standards for Person-Centered Long-Term Care Communities require placement of each person to be addressed through initial and ongoing screening and assessments that gather detailed information about each person served.

Standards for Home and Community Services require risk assessments of each person served that address multiple areas including behavioral, emotional, environmental, and physical risks; the capacity of the person's family/support system; and other areas as appropriate to the person.

Behavioral Health/Opioid Treatment Program

Person-centered care is demonstrated throughout the screening and assessment process.

When screening is conducted, it is documented, includes a review of each person's eligibility for admission based on presenting problems and identification and documentation of any urgent or critical needs. Screening identifies whether the organization can provide the appropriate services needed and alternate resources when services cannot be provided. The organization ensures that screening tools used are uniformly administered and personnel are trained on use of tools prior to administration.

If the screening identifies an urgent and critical need, appropriate action is taken immediately.

If a crisis assessment is conducted, it is documented and addresses suicide risk, danger to self or others, urgent or critical medical conditions and immediate threat(s).

Assessments are conducted by qualified personnel who are knowledgeable to assess the specific needs of the persons served.

The assessment process focuses on the person's specific needs, identifies the person's goals and expectations, and is responsive to changing needs. The assessment includes provisions for communication of the results of the assessments to the person served/legal guardian, applicable personnel, and others as appropriate.

The assessment process gathers sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's presenting issues from the perspective of the person served and urgent needs including suicide risk, personal safety, and risk to others. When past suicide attempts are identified or a suicide risk is determined, assessment of the severity of the suicide intent is documented and suicide precautions initiated.

Residential and inpatient programs conduct risk assessments at the time of admission that identify suicide risk, risk of self-harm, risk of harm to others, and trauma. The assessment results in a personal safety plan when risks are identified.

For Behavioral Health crisis response programs, if the assessment identifies a need for an initial crisis intervention response, it includes, when applicable, the immediate need for response to suicide risk and/or threatened or actual abuse or violence. A written statement describing the crisis resolution is also required.

Child and Youth Services

When screening is conducted by the organization, it is documented, includes a review of each person's eligibility for admission based on presenting needs and legal eligibility criteria, when applicable, and assesses for the appropriateness of available services and whether the program can provide the services needed.

If screening identifies an urgent and critical need, appropriate action is taken immediately and is documented.

Programs continuously conduct assessments or obtain assessment information that identifies needs and issues of the persons served and is responsive to changing needs. There are provisions for communicating results of assessments to the persons served, relevant personnel, and appropriate others.

Assessments are conducted by qualified personnel who are knowledgeable to assess the specific needs of the persons served and are trained in the use of applicable tools, tests, or instruments.

Reassessments are conducted or obtained in accordance with established timeframes or when otherwise indicated.

Standards for Home and Community Services require risk assessments of each person served that address multiple areas including behavioral, emotional, environmental, and physical risks; the capacity of the person's family/support system; and other areas as appropriate to the person.

Assessment and referral programs implement policies and procedures that include linkage to emergency and crisis intervention services as needed.

For crisis response programs, if the assessment identifies a need for an initial crisis intervention response, it includes, when applicable, the immediate need for response to suicide risk and/or threatened or actual abuse or violence. A written statement describing the crisis resolution is also required.

Employment and Community Services/Vision Rehabilitation Services

Information gathered about persons served includes relevant medical history, psychological history, and social information; available information on previous services and supports; and other relevant assessments as available.

Individualized service plans are reviewed on a regular basis and revised as appropriate based on changing needs. When applicable to the person served, risk assessment results are documented in the individualized service plan.

Employment and Community Services standards for Children and Youth Specific Population Designation require information to be gathered about the child/youth served that includes medical, physical, mental, and social/emotional health history and status. If residential services are provided, the in-home safety needs of the child/youth served are addressed including environmental risks, abuse and/or neglect by self or others, self-protection skills, and medication management.

Employment and Community Services standards for Home and Community Services require risk assessments that address multiple areas including behavioral, emotional, environmental, and physical risks; the capacity of the person's family/support system; and other areas as appropriate to the person.

Outpatient Low Vision and Blind Rehabilitation Services for Veterans and Active Duty Service members ensure that necessary patient care is available in a timely manner, including psychological or psychiatric services and social work services, as appropriate. Low vision evaluations include assessment of quality of life and psychological functioning.

Medical Rehabilitation

Admission and ongoing assessments are relevant to the needs of the persons served and identify barriers to the achievement of predicted outcomes.

The service delivery team is determined by assessments and the individual planning process, and includes personnel with the competencies necessary to evaluate and address a variety of areas including behavior, pain management, and psychological needs.

Standards for most medical rehabilitation and specialty programs include requirements for initial and ongoing assessments that document information about the persons served and include a variety of areas as relevant to the person and to the program and scope of services provided. Information gathered includes status in areas such as behavioral, decision-making capacity, psychological, social, and vocational. While not every person will have needs in all areas, assessments are performed at points in time to ensure that all relevant needs are identified and addressed. The extensiveness of the assessment may vary according to the unique needs of each person served.

Standards in many program areas and for specific diagnostic populations include requirements for initial and ongoing risk assessments that address a variety of areas including behavioral, emotional, medical, physical, environmental, and other areas as appropriate to the person and the scope of services provided.

Comprehensive Integrated Inpatient Rehabilitation Programs conduct documented preadmission assessments that address a variety of areas including mental status, support system, and alternative resources to address identified needs. Additionally, the program addresses prevention through assessment of potential risks, including depression, and actions to reduce identified risks.

Standards for Home and Community Services require risk assessments of each person served that address multiple areas including behavioral, emotional, environmental, and physical risks; the capacity of the person's family/support system; and other areas as appropriate to the person.

Well-trained and caring staff prepared to intervene

Section 1. ASPIRE to Excellence standards

All CARF standards manuals have many standards related to training of personnel to ensure that safe, appropriate care and services are provided to the persons served by a qualified, trained staff. Some of the key standards in this area are summarized below.

All organizations are required to provide documented, competency-based training to personnel both upon hire and at least annually in a variety of areas, including health and safety practices;

identification of unsafe environmental factors; emergency procedure; identification and reporting of critical incidents; medication management, if appropriate; and reducing physical risks.

The organization identifies the competencies needed by personnel to assist the persons served in accomplishing their established outcomes and to support the organization in the accomplishment of its mission and goals. Personnel competencies are assessed at least annually, and the organization provides resources to personnel for professional development.

Documented personnel training is provided at orientation and regular intervals that addresses the identified competencies needed by personnel, promoting wellness of the persons served, person-centered practice, rights of persons served, and the unique needs of the persons served.

The organization has a process to address the provision of services by personnel that are consistent with relevant legislation governing practices; licensure, registration, and certification requirements; professional degrees; professional training to maintain established competency levels, on-the-job training requirements, and professional standards of practice.

Program/Services Structure—standards for all fields

All CARF manuals include additional standards on personnel training that are specific to the field and the types of programs and services provided in each area. These standards include requirements for training at orientation and at regular intervals that addresses a variety of specific topics, as relevant to the populations served and the individual staff member's roles and responsibilities. Personnel who work directly with persons served to provide clinical or direct support services must be qualified, demonstrate required competencies, and receive training to ensure that they are prepared to address the needs of the persons served.

Aging Services

Personnel are consistently assigned to each person served to meet his or her needs.

Personnel receive training at least annually that addresses safety and security measures consistent with the person's needs, including mental health and suicide ideation.

The service delivery team is determined by the screening/assessment and person-centered planning processes and includes personnel with the competencies necessary to address a variety of areas, including behavior, pain management, psychological, social, and other needs as appropriate to each person served.

Person-centered long-term care community standards require policies and written procedures that address medical and rehabilitation management; access to physician services and consulting physicians; and prevention of further disability, medical complications, and adverse events.

Person-centered long-term care community personnel receive documented, competency-based training at orientation and regular intervals that address multiple areas including behavior management, pain management, prevention related to potential risks, psychological issues, and wellness.

Independent senior living program personnel receive documented, competency-based training at orientation and regular intervals that addresses multiple areas including aging issues, communication of unusual occurrences regarding persons served, psychological and social/cultural issues of the persons served, and wellness.

Behavioral Health/Opioid Treatment Program

For personnel providing direct services, the organization assesses personnel competencies and provides competency-based training in areas that reflects specific needs of the persons served, clinical skills appropriate to the position, person-centered plan development, interviewing skills, and program-related research-based treatment approaches.

Supervision of clinical and direct service personnel addresses assessment and referral skills; appropriateness of treatment or service intervention selected; treatment/service appropriateness relative to specific needs of persons served; provision of feedback that enhances skills of direct service personnel; ethics; legal aspects of clinical practice; and professional standards, including boundaries. Supervision also addresses clinical documentation, and model fidelity when implementing evidence-based practices.

Assessments are conducted by qualified personnel who are trained in the use of applicable tools, tests, or instruments prior to administration. The assessment process gathers information about the person's presenting issues and urgent needs including suicide risk, personal safety, and risk to others.

Residential/inpatient programs provide documented, competency-based training to direct service personnel at orientation and at regular intervals that includes de-escalation techniques, risk assessment, and trauma informed approaches.

Behavioral Health crisis intervention program personnel demonstrate knowledge of appropriate use of community resources and crisis intervention techniques.

Crisis and information call center programs provide initial and ongoing training to personnel that is guided by a written training plan and detailed curriculum, includes mechanisms for modeling and evaluation, and is updated to reflect current community issues or trends and field trends and research.

Health Home programs provide documented cross-training to direct service personnel at orientation and regular intervals that addresses the most common conditions prevalent in the populations served, including physical and mental health conditions and substance abuse disorders.

Child and Youth Services

Personnel who provide direct services are assessed for competency and receive competency-based training in areas that reflect the specific needs of the persons served, clinical skills appropriate to the position, person-centered plan development and implementation, interviewing skills, and program-related research-based approaches.

Documented ongoing supervision of direct service personnel addresses accuracy of assessment skills, proficiency of referral skills, appropriateness of services selected relative to the needs of each person served, cultural competency, and model fidelity when implementing evidence-based practices.

Personnel are trained on the use of screening instruments prior to administration.

Assessments are conducted by qualified personnel who are knowledgeable to assess the specific needs of the person served and are trained in the use of applicable tools, tests, and instruments prior to administration.

Personnel in many program areas are required to receive competency-based training to meet the identified needs of the children/youth served that covers a variety of areas as relevant to the program and populations served, including trauma; behavior management skills; the effects of placement on children/youth; and specialized training, as needed, which may include substance abuse and mental health issues when relevant to identified needs of the children/youth served.

Crisis and information call center programs provide initial and ongoing training to personnel that is guided by a written training plan and detailed curriculum, includes mechanisms for modeling and evaluation, and is updated to reflect current community issues or trends and field trends and research.

Health Home programs provide documented cross-training to direct service personnel at orientation and regular intervals that addresses the most common conditions prevalent in the populations served, including physical and mental health conditions and substance abuse disorders.

Employment and Community Services/Vision Rehabilitation Services

Personnel providing services are trained initially and at least annually on the use of positive interventions.

If a person served needs services or supports that are not available through the organization, referrals to other providers or resources are suggested to the person served and/or referral source, as appropriate.

Policies and procedures address use of positive interventions, including building positive relationships with the persons served, evaluation of the environment and personal stressors,

appropriate interactions with staff to promote de-escalation, and empowering persons served to change their own behavior.

Employment and Community Services standards for Children and Youth Specific Population Designation require training for personnel that covers a variety of areas including social and emotional needs, the effects of separation and placement on children, crisis situations, family support practices, and other specific needs.

Rapid Rehousing and Homelessness Prevention programs are knowledgeable about community resources that are relevant to the lives of persons served, including nonhousing-related resources, and program personnel receive documented training at orientation and regular intervals that addresses housing issues, a housing first approach, and other topics as appropriate to the needs of the persons served.

Medical Rehabilitation

Organizations provide documented personnel training at orientation and regular intervals that includes information on psychological and social/cultural issues of the persons served and other training as related to the specific program.

The service delivery team for persons served is determined by the screening/assessment and person-centered planning processes and includes personnel with the competencies necessary to address a variety of areas, including behavior, pain management, psychological, social, and other needs as appropriate to each person served.

Leadership fosters a continuous learning environment that provides education opportunities that reflect the learning styles, needs, and strengths of personnel.

Programs promote a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs.

Program standards for medical rehabilitation and specialty programs include specific personnel training requirements that address areas specific to the program and populations served.

Ensuring continuity of care including during and after transition/discharge

Aging Services standards

As much notice as possible regarding transition or exit is provided to persons served; their families/support systems, in accordance with their choices; personnel; and other relevant stakeholders.

To facilitate the continuity of services, at the time of transition or exit, the program communicates to relevant stakeholders information related to the person's participation

in the program, including information on behavioral interventions, the person's family/support system, healthcare information, and personal preferences.

Residential programs provide, arrange for, or assist with arrangements for services, based on the needs of the persons served, that include social services, counseling for persons served and members of their family/support system, support services, and education on community resources.

Adult day services provide information, based on needs, regarding care management services, crisis intervention services, wellness and health promotion, and other services as needed or requested.

Case management programs ensure that persons served have the benefit of a consistently assigned case manager, and that the case manager for each person served is responsible for ensuring communication with external and internal sources, ensuring that discharge/transition arrangements are completed, and ensuring that discharge/transition recommendations are communicated to appropriate stakeholders.

Behavioral Health and Opioid Treatment Program

A designated individual assists in coordinating services for each person served. This involves a variety of responsibilities, including identifying and addressing gaps in service provision; sharing information with the person served on how to access community resources relevant to his or her needs; facilitating the transition process, including arrangements for follow-up services; coordinating services provided outside of the organization; communicating information regarding progress of the person served to the appropriate persons; and involving the family or legal guardian, when permitted.

The person-centered plan includes information on, or conditions for, any needs beyond the scope of the program, referrals for additional services, transition to other community services, and available aftercare options when needed.

The program implements written procedures for referrals; transfer to another level of care, when applicable; transfer to other services; discharge; follow-up; and identifying when transition planning will occur and where the transition plan and discharge summary are documented.

Transition planning is initiated with the person served as soon as clinically appropriate in the person-centered planning and service delivery process.

Written transition plans are prepared to ensure seamless transitions when a person served is transferred to another level of care or an aftercare program or prepares for a planned discharge. The transition plan identifies the person's need for support systems or other types of services that will assist in continuing his or her recovery, well-being, or community integration.

For all persons leaving services, a written discharge summary is prepared to ensure that the person served has documented treatment episodes and results of treatment.

When an unplanned discharge occurs, follow-up is conducted as soon as possible.

When a person is transferred or discharged, the program identifies a process to ensure coordination and the person responsible for coordinating the transfer or discharge.

Child and Youth Services

Programs implement written procedures for the provision of crisis intervention services.

A designated individual assists in coordinating services for each person served. This involves a variety of responsibilities, including identifying and addressing gaps in service provision; sharing information on how to access community resources relevant to the person's needs; facilitating the transition process, including arrangements for follow-up services; coordinating services provided outside of the organization; communicating information regarding progress of the person served to the appropriate persons; and involving the family/support system, when applicable and permitted.

The individual plan is developed with the active involvement of the child/youth served and addresses identified needs, including areas such as safety, emotional/behavioral, living situation, and other specific needs. The plan identifies any needs beyond the scope of the program and specifies referrals for additional services as needed.

Programs implement written procedures for referrals, transfers to other levels of care or to other services, discharge, follow-up, and identifying when transition planning will occur and where transition plans and discharge summaries are documented.

Transition planning is included in the service planning and delivery process and is initiated with the person served at the beginning of services or as soon as appropriate.

To support transition, youth who will be leaving the service system as independent adults are engaged in a structured planning process at least one year prior to discharge, when possible. This process is designed to ensure discharge to a safe, stable living situation and includes an identified follow-up period, during which aftercare services and supports are available directly or through referral.

The written transition plan identifies the person's well-being and need for support systems or other types of services that will assist in continuing his or her well-being or community integration. The plan includes information on the person's needs, including behavioral and medication needs, when applicable; referral source information; and communication of information on options available if additional services are needed.

When the transition plan indicates the need for additional services or supports, follow-up includes maintaining the continuity and coordination of needed services; offering or referring to needed services, when possible; and implementing formal protocols for transition from the child/youth service system to an adult service system according to all applicable governmental policies and statutory requirements.

For all persons leaving services, a written discharge summary is prepared that provides a variety of information, including the presenting condition, services provided, reason for discharge, the status of the person at last contact, and recommendations for services or supports.

Specific program standards include additional requirements that address care coordination, transition, and follow-up, as relevant to the services provided and populations served.

Employment and Community Services/Vision Rehabilitation Services

A coordinated, individualized service plan is developed with the active involvement of each person served, is reviewed on a regular basis, and is revised as appropriate based on changing needs and the satisfaction of the person served. The service plan reflects timely transition planning when a person moves from one level of services/supports or program to another, either within the organization or externally to another provider.

If a person served needs services/supports that are not available through the organization, referrals to other providers or resources are suggested to the person served and/or referral source, as appropriate.

An exit summary report is prepared on a timely basis for each person who leaves the organization's services and summarizes results of the services received.

Employment and Community Services standards for Older Adults Specific Population Designation provide for an array of services based on individual needs that include direct provision or referral for: coordination that provides the persons served with access to needed services; advocacy to meet medical and psychological needs; promoting continuity of care between different environments/programs that are involved with the person; and support for caregivers, including those who may themselves have special needs related to aging.

Medical Rehabilitation

To ensure the achievement of predicted outcomes, the person who coordinates the provision of care for each person served has the authority to coordinate the provision of care and is responsible for a variety of areas, including communication with external and internal sources; facilitating the involvement of the person served throughout the rehabilitation process; ensuring that discharge/transition arrangements are completed; and facilitating the implementation of discharge/transition recommendations.

Discharge/transition planning is done in collaboration with the persons served, families/support systems, providers in the continuum of services, and other relevant stakeholders.

In its discharge/transition planning, the program strives to achieve the most integrated setting appropriate to the person served.

Written discharge/transition recommendations are provided, as appropriate, to the persons served, providers in the continuum of services, primary care physicians, referral sources, the family/support system, personal care attendants, payers, case managers, caregivers, and other stakeholders.

The written discharge/transition recommendations address the needs of the persons served in a variety of areas, including but not limited to behavior, case management, substance misuse, family support, medical and psychological issues, ongoing treatment recommendations, pain management, psychosocial issues, risks, safety issues, supervision needs, and transition planning.

Ongoing performance improvement

Section 1. ASPIRE to Excellence standards

As noted earlier, suicide and attempted suicide are considered critical incidents.

Health and Safety standards require that a written analysis of all critical incidents be provided to or conducted by the organization's leadership at least annually that addresses causes, trends, actions for improvements, results of performance improvement plans, necessary education and training of personnel, prevention of recurrence, internal reporting requirements, and external reporting requirements.

Additionally, all CARF-accredited organizations are required to meet all of the standards in Sections 1.M. Performance Measurement and Management, and 1.N. Performance Improvement.

The Performance Measurement and Management standards require organizations to collect valid, reliable, complete, and accurate data in a variety of areas, including risk management; health and safety reports; field trends, including research findings, if applicable; and service delivery. These data are used to set relevant objectives, performance indicators, and performance targets related to both business function and service delivery.

Performance Improvement standards require a written analysis at least annually that identifies areas needing performance improvement, results in an action plan to address needed improvements, and outlines actions taken or changes made to improve performance.