

2024 BEHAVIORAL HEALTH PROGRAM DESCRIPTIONS

Contents

Screening and Access to Services.....	4
Person-Centered Planning.....	4
Transition/Discharge.....	4
Medication Use.....	5
Promoting Nonviolent Practices.....	6
Records of the Persons Served.....	7
Quality Records Management.....	7
Service Delivery Using Information and Communication Technologies.....	7
Assertive Community Treatment (ACT).....	8
Case Management/Services Coordination (CM).....	9
Community Integration (COI).....	9
Court Treatment (CT).....	10
Crisis Programs (CP).....	10
Crisis Contact Center (CP:CCC).....	11
Crisis Intervention (CP:CI).....	11
Crisis Stabilization (CP:CS).....	11
Day Treatment (DT).....	11
Detoxification/Withdrawal Management (DTX).....	12
Health Home (HH).....	12
Inpatient Treatment (IT).....	13
Integrated Behavioral Health/Primary Care (IBHPC).....	14
Intensive Family-Based Services (IFB).....	14
Intensive Outpatient Treatment (IOP).....	14
Office-Based Opioid Treatment Program (OBOT).....	15
Outpatient Treatment (OT).....	15
Partial Hospitalization (PH).....	15
Residential Treatment (RT).....	16
Specialized or Treatment Foster Care (STFC).....	16
Student Counseling (SC).....	16
Therapeutic Communities (TC).....	17
Assessment and Referral (AR).....	17
Information Call Centers (ICC).....	17
Community Housing (CH).....	17
Comprehensive Suicide Prevention Program (CSPP).....	18
Diversion/Intervention (DVN).....	19
Employee Assistance (EA).....	19
Prevention (P).....	20
Supported Living (SL).....	20
Adults with Autism Spectrum Disorder (ASD:A).....	21
Children/Adolescents with Autism Spectrum Disorder (ASD:C).....	22
Children and Adolescents (CA).....	24
Consumer-Run (CR).....	24
Criminal Justice (CJ).....	24
Eating Disorders (ED).....	24
Juvenile Justice (JJ).....	25

Medically Complex (MC).....	26
Older Adults (OA)	27
Certified Community Behavioral Health Clinic (CCBHC).....	27

Screening and Access to Services

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 the person's 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, family or significant others, or from external resources.

Person-Centered Planning

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of the 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.

Transition/Discharge

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 the person served when transitioning 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 organization (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 organization 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 or part of the plan for the person served 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.

Medication Use

Medication use is the practice of controlling, administering, and/or prescribing medications to persons served in response to specific symptoms, behaviors, or conditions for which the use of medications is indicated and deemed efficacious. The use of medication is one component of treatment directed toward maximizing the functioning of the persons served while reducing their specific symptoms. Prior to the use of medications other therapeutic interventions should be considered, except in circumstances that call for a more urgent intervention.

Medication use includes all prescribed medications, whether or not the program is involved in prescribing, and may include over-the-counter or alternative medications. 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, storing, transporting, and disposing of medications, including those self-administered by the person served.

Medication administration is the preparing and giving of prescription and nonprescription medications by authorized and trained personnel to the person served. Self-administration is the application of a medication (whether by oral ingestion, injection, inhalation, or other means) by the person served to the individual's own body. This may include the program storing the medication for the person served, personnel handing the bottle or prepackaged medication dose 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/or closely observing the person served self-administering the medication.

Prescribing is the result of an evaluation that determines if there is a need for medication and what medication is to be used in the treatment of the person served. Prior to providing a prescription for medication, the prescriber obtains the informed consent of the individual authorized to consent to treatment and, if applicable, the assent of the person served.

Prescription orders may be verbal or written and detail what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Note: *CARF has determined that the use of Narcan/Naloxone should be handled as a first-aid supply and not a medication. Therefore, the Medication Use standards are not applicable when these medications are used as a life-saving measure. CARF expects that the medications are secured, but readily accessible when needed, and at least some program personnel are trained on their use and administration.*

Promoting Nonviolent Practices

CARF-accredited programs strive to create learning environments for the persons served and to support the development of skills that build and strengthen resiliency and well-being. The establishment of quality relationships between personnel and the persons served provides the foundation for a safe and nurturing environment. Providers are mindful of creating an environment that cultivates:

- Engagement.
- Partnership.
- Holistic approaches.
- Nurturance.
- Respect.
- Hope.
- Self-direction.

It is recognized that persons served may require support to fully benefit from their services. This may include, but is not limited to, praise and encouragement, verbal prompts, written expectations, clarity of rules and expectations, or environmental supports.

Even with support there are times when persons served may demonstrate signs of fear, anger, or pain that could lead to unsafe behaviors. Personnel are trained to recognize and respond to these behaviors through various interventions, such as changes to the physical environment, sensory-based calming strategies, engagement in meaningful activities, redirection, active listening, approaches that have been effective for the individual in the past, etc. When these interventions are not effective in de-escalating a situation and there is imminent risk to the person served or others, 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.

As the use of seclusion or restraint creates potential physical and psychological risks to the persons subject to the interventions, to the personnel who administer them, and to those who witness the practice, an organization that utilizes seclusion or restraint should have the elimination thereof as its goal.

Seclusion refers to restriction of the person served to a segregated room or space 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 only if freedom to leave the segregated room or space is denied.

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 as an immediate response to a dangerous behavior. The following are *not* considered restraints for the purposes of this section of standards:

- Assistive devices used for persons with physical or medical needs.

- Briefly holding a person served, without undue force, for the purpose of comforting the individual or to prevent self-injurious behavior or injury to others.
- Holding a person’s hand or arm to safely guide the individual from one area to another or away from another person.
- Security doors designed to prevent elopement or wandering.
- Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel. When permissible, consideration is given to removal of physical restraints while the person is receiving services in the behavioral healthcare setting.
- In a correctional setting, the use of seclusion or restraint for purposes of security. Seclusion or restraint by trained and competent personnel is used only when other, less restrictive measures have been ineffective to protect the person served or others from unsafe behavior. Peer restraint is not an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation or in lieu of adequate programming or staffing.

Records of the Persons Served

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.

Quality Records Management

The organization implements 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.

Service Delivery Using Information and Communication Technologies

Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, telemental health, telerehabilitation, telespeech, etc. Based on the individual plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served, family/support system members, and other providers in or from remote settings (i.e., the person served and provider are not in the same physical location).

The provision of services via information and communication technologies may:

- Include services such as assessment, individual planning, monitoring, prevention, intervention, team and family conferencing, transition planning, follow-up, supervision, education, consultation, and counseling.
- Involve a variety of providers such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical

therapists, physicians, nurses, dieticians, employment specialists, direct support professionals, peer support specialists, rehabilitation engineers, assistive technologists, teachers, and other personnel providing services and/or supports to persons served.

— Encompass settings such as:

- Hospitals, clinics, professional offices, and other organization-based settings.
- Schools, work sites, libraries, community centers, and other community settings.
- Congregate living, individual homes, and other residential settings.

— Be provided via fully virtual platforms.

The use of technology for strictly informational purposes, such as having a website that provides information about the programs and services available or the use of self-directed apps, is not considered providing services via the use of information and communication technologies.

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multidisciplinary team approach that assumes responsibility for directly providing acute, active, and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The program team provides assistance to individuals to maximize their recovery, ensure consumer-directed goal setting, assist the persons served to gain hope and a sense of empowerment, and provide assistance in helping the persons served become respected and valued members of their community. The program provides psychosocial services directed primarily to adults with severe and persistent mental illness who often have co-occurring problems, such as substance abuse, or are homeless or involved with the judicial system.

The team is the single point of clinical responsibility and is accountable for assisting the persons served to meet their needs and to achieve their goals for recovery. Multiple members of the team are familiar with each person served to ensure the timely and continuous provision of services. Services are provided on a long-term care basis with continuity of caregivers over time. The majority of services are provided directly by ACT team members, with minimal referral to outside providers, in the natural environment of the person served and are available 24 hours a day, 7 days per week. Services are comprehensive and highly individualized and are modified as needed through an ongoing assessment and treatment planning process. Services vary in intensity based on the needs of the persons served.

Assertive Community Treatment has been identified as an effective model for providing community-based services for persons whose needs and goals have not been met through traditional office-based treatment and rehabilitation services. Desired outcomes specific to ACT services may include positive change in the following areas: community tenure, independent living, quality of life, consumer satisfaction of the person served, functioning in work and social domains, community integration, psychological condition, subjective well-being, and the ability of the persons served to manage their own healthcare.

In certain geographic areas, Assertive Community Treatment programs may be called Community Support programs, Intensive Community Treatment programs, Mobile Community

Treatment Teams, or Assertive Outreach Teams.

Case Management/Services Coordination (CM)

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.

Community Integration (COI)

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.

Note: *The use of the term persons served in Community Integration may include members, attendees, or participants.*

Court Treatment (CT)

Court Treatment programs provide comprehensive, integrated behavioral health services that work in conjunction with the judicial system. The purpose of court treatment programs is to appropriately respond to the abuse of alcohol and/or other drugs, mental illness, post traumatic stress disorder, family problems, or other concerns and their related criminal and/or civil judicial actions, in order to reduce recidivism and further involvement in the criminal justice system. Court treatment includes services provided to persons referred through various types of problem-solving courts including drug, mental health, veterans, family dependency, tribal, re-entry, and others.

The treatment team works in collaboration with judges, prosecutors, defense counsel, probation authorities, law enforcement, pretrial services, treatment programs, evaluators, and an array of local service providers. Treatment is usually multi-phased and is typically divided into a stabilization phase, an intensive phase, and a transition phase. During each phase, the treatment team is responsible for assessing the behavioral health needs of the person served within the parameters of the legal sanctions imposed by the court. The treatment team either directly provides or arranges for the provision of screening and assessment, case management, detoxification/withdrawal support, intensive outpatient treatment, outpatient, residential treatment, medication use, self-help and advocacy, recovery, health and wellness, relapse prevention, and education regarding factors contributing to the person's court involvement. A court treatment program may be a judicial or law enforcement organization that provides or contracts for the identified services or may be a direct treatment provider working as part of the court treatment team.

Crisis Programs (CP)

Crisis programs include a continuum of services designed to rapidly respond to the needs of persons experiencing acute emotional, mental health, and/or substance use crises in order to keep them safe, seek to resolve the crisis, and maintain community tenure. Crisis response, depending on the immediate needs and preferences of the persons served, may be managed through a crisis contact center, a crisis intervention program that might include mobile crisis intervention services, or admission to a crisis stabilization program.

Crisis Contact Center (CP:CCC)

Crisis contact centers interact with persons served in the community through a variety of mechanisms including voice, chat, text, and video, and provide or arrange for the provision of services 24 hours a day, 7 days a week. Programs are designed to rapidly respond to and resolve crises in a manner that is sensitive to the needs, preferences, and cultural backgrounds of the persons served and that protects their safety and the safety of others. The program may work in coordination with other crisis resources such as crisis intervention and mobile crisis programs. Crisis contact centers may be staffed by a variety of individuals including full and part-time employees, volunteers, and peer support specialists. Programs may be referred to as a crisis line, suicide hotline, 988 contact center, or other similar description.

Crisis Intervention (CP:CI)

Crisis intervention is a face-to-face service (which may be delivered using information and communication technologies) that rapidly assesses the needs of and seeks to stabilize persons in crisis. In accordance with their needs, preferences, and cultural backgrounds, the program strives to engage and link persons served to appropriate services while maintaining their community tenure. Services are provided at times and in locations that meet the needs of the persons served. The program follows up with persons served subsequent to the crisis intervention to facilitate adequate coordination of care. Crisis intervention services may be delivered by a mobile crisis intervention team, in an urgent care setting, embedded in care settings such as an emergency department or psychiatric emergency center, or in other settings.

Crisis Stabilization (CP:CS)

Crisis stabilization programs are short-term programs organized to respond to the needs of persons experiencing acute emotional, mental health, and/or substance use crises that cannot be effectively managed in other less intensive programs. These programs operate 24 hours a day, 7 days a week and can quickly triage the needs of persons served to engage them safely into care. Utilizing a person-centered approach and a collaborative decision-making process, a crisis stabilization plan is developed for each person served with the goal of stabilizing the acute crisis and managing effective transition to appropriate programs/services following discharge. A variety of treatment services and structured therapeutic activities is available to meet the individual needs of persons served. Through various observation and monitoring activities the program ensures the safety of the environment for the persons served and personnel. Crisis stabilization programs offer a calm, welcoming environment that maintains the dignity of the persons served.

Day Treatment (DT)

Day treatment programs offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the persons served in achieving the goals identified in their person-centered plans. Day treatment programs are

offered four or more days per week, typically with support available in the evenings and on weekends. A day treatment program may prevent or minimize the need for a more intensive level of treatment. It may also function as a step-down from inpatient care or partial hospitalization or as transitional care following an inpatient or partial hospitalization stay to facilitate return to the community.

Detoxification/Withdrawal Management (DTX)

A detoxification/withdrawal management program is a time-limited program designed to assist the persons served with the physiological and psychological effects of acute withdrawal from alcohol and other drugs. Based on current best practices in the field, the program's purpose is to provide a medically safe, professional and supportive withdrawal experience for the persons served while preparing and motivating them to continue treatment after discharge from the program and progress toward a full and complete recovery. The program is staffed to ensure adequate biomedical and psychosocial assessment, observation and care, and referrals to meet the individual needs of the persons served. Additionally, the program develops and maintains a rich network of treatment providers for referrals after completion of the program to ensure the best possible match for the persons served to ongoing treatment services. A detoxification/withdrawal management program may be provided in the following settings:

- **Inpatient:** This setting is distinguished by services provided in a safe, secure facility-based setting with 24-hour nursing coverage and ready access to medical care. This is for persons served who need round-the-clock supervision in order to successfully manage withdrawal symptoms or when there are additional complications or risk factors that warrant medical supervision, such as co-occurring psychiatric or other medical conditions.
- **Residential:** This setting is distinguished by services provided in a safe facility with 24-hour coverage by qualified personnel. Persons served need the supervision and structure provided by a 24-hour program but do not have risk factors present that warrant an inpatient setting. It may also be appropriate for persons who lack motivation or whose living situation is not conducive to remaining sober.
- **Ambulatory:** This setting is distinguished by services provided in an outpatient environment with the persons served residing in their own homes, a sober living environment or other supportive community settings. Persons served in ambulatory settings typically have adequate social supports to remain sober, family involvement in care planning, the ability to maintain regular appointments for ongoing assessment and observation, and the ability to successfully self-manage prescription medications. Persons served in ambulatory settings are concurrently enrolled in or actively linked to a treatment program.

Health Home (HH)

A health home is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, and community

and social support services. A health home allows for individual choice and is capable of assessing the various physical and behavioral health needs of persons served. The program demonstrates the capacity to address, either directly or through linkage with or referral to external resources, behavioral health conditions, such as mental illness and substance use disorders, and physical health conditions. Programs may also serve persons who have intellectual or other developmental disabilities and physical health needs or those who are at risk for or exhibiting behavioral disorders. Care is coordinated over time across providers, functions, activities, and sites to maximize the value and effectiveness of services delivered to persons served.

A health home provides comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family/support services, and linkage and referral to community and social support services. Services are designed to support overall health and wellness and:

- Embody a recovery-focused model of care that respects and promotes independence and responsibility.
- Promote healthy lifestyles and provide prevention and education services that focus on wellness and self-care.
- Ensure access to and coordination of care across prevention, primary care (including ensuring that persons served have a primary care physician), and specialty healthcare services.
- Monitor critical health indicators.
- Support individuals in the self-management of chronic health conditions.
- Coordinate/monitor emergency room visits and hospitalizations, including participation in transition/discharge planning and follow up.

A health home collects, aggregates, and analyzes individual healthcare data across the population of persons served by the program and uses that data and analysis to manage and improve outcomes for the persons served. If the health home is not the actual provider of a particular healthcare service, it remains responsible for supporting and facilitating improved outcomes by providing disease management supports and care coordination with other providers.

Inpatient Treatment (IT)

Inpatient treatment programs provide interdisciplinary, coordinated, integrated, medically supervised services in freestanding or hospital settings. Inpatient treatment programs include a comprehensive, biopsychosocial approach to service delivery in a managed milieu that is recovery focused and trauma informed. There are daily therapeutic and other activities in which the persons served participate. Inpatient treatment is provided 24 hours a day, 7 days a week. The goal of inpatient treatment is to provide a protective environment that includes medical stabilization, support, treatment for psychiatric and/or addictive disorders, supervision, wellness, and transition to ongoing services. Such programs operate in designated space that

allows for appropriate medical treatment and engagement.

Integrated Behavioral Health/Primary Care (IBHPC)

Integrated Behavioral Health/Primary Care programs have an identified level of medical supervision and are supported by an “any door is a good door” philosophy. These programs allow for choice and are capable of assessing the various medical and behavioral needs of persons served in an integrated manner. Programs demonstrate competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders, and general medical or physical concerns in an integrated manner. Integration is the extent to which care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served. Programs may also serve persons who have intellectual or other developmental disabilities and medical needs, or those who are at risk for or exhibiting behavioral disorders.

Models may include, but are not limited to, the following: contractual, where two separate, legal entities enter into an agreement to staff and operate a single program either at a location specifically identified for the provision of integrated care or located within another institution (such as a school-based health center); a distinct, integrated program located within a larger entity such as a Veterans Health Administration campus; the collocating of complementary disciplines such as the placement of behavioral staff in a primary care setting (as in a federally qualified health center) or primary care staff in a community mental health center; or a single organization that incorporates both behavioral health and primary care services into an integrated model. Although most integrated models focus on primary care, the standards could also be applied to an integrated system located in specialty care settings such as OB/GYN and HIV.

Intensive Family-Based Services (IFB)

These intensive services are provided in a supportive and interactive manner and directed toward maintaining or restoring a positive family relationship. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multisystemic approach to treatment and have a goal of keeping families together. The services may include wraparound and family preservation programs. The program may also provide services directed toward family restoration when a child has been in an out-of-home placement.

Intensive Outpatient Treatment (IOP)

Intensive outpatient treatment programs are clearly identified as separate and distinct programs that provide culturally and linguistically appropriate services. The intensive outpatient program consists of a scheduled series of sessions appropriate to the person-centered plans of the persons served. These may include services provided during evenings and on weekends and/or interventions delivered by a variety of service providers in the community. The program may function as a step-down program from partial hospitalization, detoxification/withdrawal support, or residential services; may be used to prevent or minimize the need for a more

intensive level of treatment; and is considered to be more intensive than traditional outpatient services.

Office-Based Opioid Treatment Program (OBOT)

Office-based opioid treatment (OBOT) programs are medically managed programs that provide treatment services to persons with opioid use disorders. Central to treatment are medications, typically buprenorphine or naltrexone, which are provided in concert with other medical and psychosocial interventions designed to realize a person's highest achievable recovery. Based on the needs of the persons served, these programs provide or arrange for a comprehensive array of treatment services that includes counseling/therapy, medication supports, social supports, education and training, care coordination, and other recovery-enhancing services.

OBOT programs provide services under the supervision of a physician and are guided by written treatment procedures and protocols that address the routine needs of persons with opioid use disorders, including the needs of special populations. From induction to stabilization and into maintenance, OBOT programs provide ongoing care to persons served to support their recovery.

Note: *These services may also be known as medication-assisted treatment (MAT).*

Outpatient Treatment (OT)

Outpatient treatment programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. 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, and substance use disorders and other addictive behaviors.

Partial Hospitalization (PH)

Partial hospitalization programs are time limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Partial hospitalization programs are available at least five days per week but may also offer half-day, weekend, or evening hours. Partial hospitalization programs may be freestanding or part of a broader system but should be identifiable as a distinct program or service line.

A partial hospitalization program consists of a series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency. Partial hospitalization programs are typically designed for persons who are experiencing increased symptomatology, disturbances in behavior, or other conditions that negatively impact the mental or behavioral health of the person served. The program must be able to address the presenting problems in a setting that is not residential or inpatient. Given this, the persons served in partial hospitalization do not pose an immediate risk to themselves or others. Services are provided for the purpose of diagnostic evaluation; active treatment of a person's condition; or to prevent

relapse, hospitalization, or incarceration. Such a program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute level of care is tenuous.

Residential Treatment (RT)

Residential treatment programs are organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, 7 days a week for persons with behavioral health or co-occurring needs, including intellectual or developmental disabilities. Residential treatment programs provide environments in which the persons served reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems. These services are provided in a safe, trauma-informed, recovery-focused milieu designed to integrate the person served back into the community and living independently whenever possible. The program involves the family or other supports in services whenever possible.

Residential treatment programs may include domestic violence treatment homes, nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Specialized or Treatment Foster Care (STFC)

Specialized or treatment foster care programs use a community-based treatment approach for children/youth with emotional and/or behavioral issues. Children/youth who participate in the program may also have documented reports of maltreatment, involvement with juvenile justice, and/or co-occurring disorders. Intensive, clinically based treatment that is child/youth centered and family focused is delivered through an integrated team approach that individualizes services for each child/youth. Treatment foster parents are trained, supervised, and supported by program personnel and they fulfill a primary role in therapeutic interventions. Program personnel monitor the child's/youth's progress in treatment and provide adjunctive services in accordance with the individualized plan and program design. The program's goal is to provide clinically effective treatment to children/youth so they may return to their family or alternative community placement and avoid being removed from a community setting or placed in an inpatient or residential treatment setting.

The program may also be called intensive foster care, therapeutic family services, or therapeutic foster care.

Student Counseling (SC)

Student counseling programs serve as the primary behavioral health resource for higher education campus communities and their students. Services are designed to provide students with an opportunity to develop personal insight, identify and solve problems, and implement positive strategies to better manage their lives both academically and personally. Services include individual, family, and/or group counseling, prevention, education, and outreach. In addition to working directly with students, program goals are realized through outreach, partnerships, and consultation initiatives with faculty, staff, parents, students' internships sites,

or other educational entities or community partners.

Therapeutic Communities (TC)

Therapeutic communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of substance abuse or other behavioral health needs and the fostering of personal growth leading to personal accountability. The program addresses the broad range of needs identified by the person served. The therapeutic community employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The therapeutic community emphasizes the integration of an individual within the person's community, and progress is measured within the context of that therapeutic community's expectation.

Assessment and Referral (AR)

Assessment and referral programs provide a variety of activities, including prescreening, screening, psychosocial assessment, determination of need, and referral to appropriate level of care. The provision of information on available resources is not considered a full assessment and referral program. An adequate assessment must be conducted to provide more informed referrals.

Such programs may be separate, freestanding programs, an independent program within a larger organization, or a specifically identified activity within a system of care. Organizations performing assessment and referral as a routine function of entrance into other core programs, such as their outpatient treatment, case management, or residential programs, are not required to apply these standards unless they are specifically seeking accreditation for assessment and referral.

Information Call Centers (ICC)

Information call centers respond to a variety of immediate requests identified by the persons served such as information and referral or response to other identified human service needs.

Community Housing (CH)

Community housing addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the persons served, regardless of the home in which they live and/or the scope, duration, and intensity of the services they receive. The residences in which services are provided may be owned, rented, leased or operated directly by the organization, or a third party, such as a governmental entity. Providers exercise control over these sites.

Community housing is provided in partnership with individuals. These services are designed to assist the persons served to achieve success in and satisfaction with community living. They may be temporary or long term in nature. The services are focused on home and community integration and engagement in productive activities. Community housing enhances the

independence, dignity, personal choice, and privacy of the persons served. For persons in alcohol and other drug programs, these services are focused on providing sober living environments to increase the likelihood of sobriety and abstinence and to decrease the potential for relapse.

Community housing programs may be referred to as recovery homes, transitional housing, sober housing, domestic violence or homeless shelters, safe houses, group homes, or supervised independent living. These programs may be located in rural or urban settings and in houses, apartments, townhouses, or other residential settings owned, rented, leased, or operated by the organization. They may include congregate living facilities and clustered homes/apartments in multiple-unit settings. These residences are often physically integrated into the community, and every effort is made to ensure that they approximate other homes in their neighborhoods in terms of size and number of residents.

Community housing may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living can be offered in apartments or homes, or in congregate settings that may be larger than residences typically found in the community.
- Long-term housing that provides stable, supported community living or assists the persons served to obtain and maintain safe, affordable, accessible, and stable housing.

The residences at which community housing services are provided must be identified in the survey application. These sites will be visited during the survey process and identified in the survey report and accreditation outcome as a site at which the organization provides a Community Housing program.

Comprehensive Suicide Prevention Program (CSPP)

Comprehensive suicide prevention programs are designed to reduce the incidence and impact of suicide events and promote hope and healing in the population served. Suicide prevention programs work to reduce risk factors and increase protective factors through the implementation of universal, selected, and indicated strategies that address the needs and reflect the culture and environment of the population served. They take a strategic approach to the design and implementation of activities that will be accessible to and have the greatest impact on persons served and their families/support systems, personnel, and partners and other stakeholders in the community.

Personnel in a comprehensive suicide prevention program receive competency-based training on suicide prevention, intervention, and postvention. Suicide prevention activities must be integrated into numerous community and clinical environments to be successful. To that end, comprehensive suicide prevention programs engage with stakeholders, including persons with lived experience, regarding capacity building; communication and messaging; and outreach, education, and training to increase awareness and expertise related to evidence-informed suicide prevention practices.

The program collects and analyzes data to measure its performance, inform capacity building

to address gaps in resources and services, and further reduce risks and build resilience in the population served.

Diversion/Intervention (DVN)

Diversion/Intervention programs may include programs traditionally thought of as intervention that focus on changing outcomes for persons served and targeting antecedents of the problem. Diversion/Intervention programs utilize strategies designed to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Within the child welfare field, examples include alternative response, differential response, or multiple response systems.

Diversion/Intervention programs may serve persons on a voluntary and/or involuntary basis. Programs that serve persons on an involuntary basis are designed to implement special strategies for engaging this population.

Diversion programs may include programs such as juvenile justice/court diversion, substance abuse diversion, truancy diversion, DUI/OWI classes, report centers, home monitoring, after-school tracking, anger management, and building healthy relationships.

Intervention programs target persons who are exhibiting early signs of identified problems and are at risk for continued or increased problems.

Employee Assistance (EA)

Employee assistance programs are work site focused programs designed to assist:

- Work organizations in addressing productivity issues.
- Employee clients in identifying and resolving personal concerns (including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues) that may affect job performance.

Employee Assistance Program Services (EAP Services) may include, but are not limited to, the following:

- Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance and outreach to and education of employees and their family members about availability of EAP services.
- Confidential and timely problem identification and/or assessment services for clients with personal concerns that may affect job performance.
- Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.
- Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.
- Assistance to work organizations in managing provider contracts and in establishing and maintaining relations with service providers, managed care organizations, insurers, and other third-party payers.

- Assistance to work organizations in providing support for employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional behaviors.
- Identification of the effects of EAP services on the work organization and individual job performance.

Prevention (P)

Prevention programs are proactive and evidence-based/evidence-informed, striving to reduce individual, family, and environmental risk factors, increase resiliency, enhance protective factors, and achieve individual and comprehensive community wellness through a team or collaborative approach. Prevention programs utilize strategies designed to keep individuals, families, groups, and communities healthy and free from the problems related to alcohol or other drug use, mental health disorders, physical illness, parent/child conflict, abuse or neglect, exposure to or experience of violence in the home and community; to inform the general public of problems associated with those issues, thereby raising awareness; or to intervene with at-risk individuals to reduce or eliminate identified concerns. Programs may be provided in the community, school, home, workplace, or other settings.

Organizations may provide one or more of the following types of prevention programs, categorized according to the population for which they are designed:

- *Universal* programs target the general population and seek to increase overall wellbeing and reduce the overall prevalence of problem behaviors, and include comprehensive, well-coordinated components for individuals, families, schools, communities, and organizations. Universal prevention programs promote positive behavior and include social marketing and other public information efforts.
- *Selected* programs target groups that are exposed to factors that place them at a greater than average risk for the problem. These programs are tailored to reduce identified risk factors and strengthen protective factors.
Examples of prevention programs include pregnancy prevention, drop-out prevention, Strengthening Families, substance abuse prevention, violence prevention, HIV prevention, nicotine use prevention, child abuse prevention, and suicide prevention.
- *Training* programs provide curriculum-based instruction to active or future personnel in human service programs.
Examples of training programs include caseworker training, child welfare supervisory training, foster parent training, leadership training, guardian/guardian ad-litem training, and childcare assistant training.

Supported Living (SL)

Supported living addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of persons living in their own homes (apartments, townhouses, or other residential settings). Supported living services are generally long term in nature, but may change in scope,

duration, intensity, or location as the needs and preferences of individuals change over time. Supported living refers to the support services provided to the person served, not the residence in which these services are provided. A sample of these sites will be visited as part of the interview process of the person served. Although the residence will generally be owned, rented, or leased by the person who lives there, the organization may occasionally rent or lease an apartment when the person served is unable to do so. Typically, in this situation the organization would co-sign or in other ways guarantee the lease or rental agreement; however, the person served would be identified as the tenant. The home or individual apartment of the person served, even when the organization holds the lease or rental agreement on behalf of the person served, is not included in the survey application or identified as a site on the accreditation outcome.

Note: *The term home is used in the following standards to refer to the dwelling of the person served; however, CARF accreditation is based on the services provided. This is not intended to be certification, licensing, or inspection of a site.*

Adults with Autism Spectrum Disorder (ASD:A)

Supports for adults with autism spectrum disorder (ASD:A) enhance accessibility and community membership opportunities for adults with ASD. Education, employment, residential, social, and recreational opportunities; identification from research of successful techniques to apply to service provision including treatment and intervention research; and lifelong planning are means to achieve full inclusion and participation.

Standards for ASD services and supports present a roadmap for successful outcomes in the lives of persons with ASD by encouraging organizational values that focus on individualized, person-centered services for persons to achieve full inclusion and participation as desired in their communities. Services involve families, networks of resources, and education and support communities for older adolescents transitioning to adulthood and adult persons with ASD. The standards in this section focus on planning for transitions and development of supports as needed for persons with ASD, with the outcomes of employment, further education, community living, and life planning.

Some of the quality results (outcomes) desired by the different stakeholders of ASD services may include:

- Creating and supporting lifelong self-advocacy skills.
- Developing supports and community resources for persons and families.
- Enhancing quality of life by increasing social contacts and support communities.
- Encouraging service provider capacity building by networking with governmental, educational, business/employer, and other community resources.
- Recognizing and sharing reliable evidence-based knowledge, innovations, interventions, and therapies with proven, research-based, and peer-reviewed track records of getting results.

- Planning for transition from school to successful employment and community living supports.
- Individualized, comprehensive life planning that is transferred to other service providers to ensure continuity of service planning and supports.
- Persons served moving toward:
 - Optimal use of natural supports.
 - A social supports network.
 - Self-help.
 - Greater self-sufficiency.
 - Greater ability to make appropriate choices.
 - Greater control of their lives.
 - Increased participation in the community.
 - Employment and/or continued education.

Note: *The Specific Population Designation of Adults with Autism Spectrum Disorder (ASD:A) is typically applied if the population served is at the age of majority or older.*

If the population served is individuals from birth to the age of majority, the standards in Section 5.B. Children/Adolescents with Autism Spectrum Disorder (ASD:C) typically would be applied.

CARF allows that there may be services provided to adolescents and adult persons who are technically in transition range from one category to the other and does not require strict adherence to these age cutoffs. This would be identified in the program's scope of services.

Children/Adolescents with Autism Spectrum Disorder (ASD:C)

Early identification, intervention, treatment planning, and educational strategies for children with autism spectrum disorder (ASD) remain a challenge for families, their physicians, community supports, and educational systems. Early recognition of the condition allows families to receive advice and support to help them adjust to the child's learning and development challenges and to mobilize resources to provide the best early intervention services for the child.

Services for children and adolescents with ASD are designed to provide to the child/adolescent and family a variety of resources that reflect sound research. The family will have access to results-oriented therapies, education, advocacy, and supports for their child's optimal progress and to establish a lifetime of positive learning and behaviors. Services involve families, networks of resources, and education and support communities for adolescents transitioning to adulthood. Individuals served under this designation may range from birth to the age of majority, although sometimes services for adolescents transitioning to adulthood are provided by programs that also serve adults. Ages served would be identified in a program's scope of

services.

Organizations with accredited services/supports for children with ASD are a resource for families, community services, and education. With the focus on continuous learning about ASD, the organization can assist parents with:

- Obtaining early intervention screening.
- Obtaining early intervention services.
- Obtaining an evaluation by clinicians experienced in evaluating children with ASD to improve treatment and outcomes.
- Navigating the multiple and complex systems that families need to coordinate, including medical, educational, mental health, disability, and community services.
- Connecting to resources to identify and treat medical or other conditions associated with ASD, as they are needed, to improve independence, family well-being, and adaptive behavior.
- Gaining understanding of the core features of ASD and associated conditions.
- Adjusting and adapting to the challenges of raising a child with ASD.
- Understanding the future opportunities, services, and challenges that lay before them as they raise their child.
- Planning for transition to/from school and life planning.
- Building linkages within segments of school systems and across school systems to facilitate successful transitions between placements.
- Providing outcomes information to schools to enhance individualized education plans and employment transition planning.
- Connecting with mentors and parent-to-parent support groups or contacts.
- Connecting with community organizations and support groups dedicated to people with ASD.
- Becoming an advocate for policy changes, as desired.

Note: *The Specific Population Designation of Children/Adolescents with Autism Spectrum Disorder (ASD:C) is typically applied if the population served is individuals from birth to the age of majority.*

If the population served is individuals at the age of majority or older, the standards in Section 5.A. Adults with Autism Spectrum Disorder (ASD:A) typically would be applied.

CARF allows that there may be services provided to adolescents and adult persons who are technically in transition range from one category to the other and does not require strict adherence to these age cutoffs. This would be identified in the program's scope of services.

Children and Adolescents (CA)

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.

Consumer-Run (CR)

Improvement of the quality of an individual's situation requires a focus on the person served and the person's identified strengths, abilities, needs, and preferences. The program is designed around the identified needs and desires of the persons served, is responsive to their expectations, and is relevant to their maximum participation in the environments of their choice.

The person served participates in decision making and planning that affects the person's life. Efforts to include the person served in the direction of the program or delivery of applicable services are evident. The service environment reflects identified cultural needs and diversity. The person served is given information about the purposes of the program.

Criminal Justice (CJ)

Criminal justice programs serve special populations comprised of accused or adjudicated individuals referred from within the criminal justice system who are experiencing behavioral health needs, including alcohol or other drug abuse or addiction, or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, in community-based or institutional settings, or in sex offender programs. Institutional settings may include jails, prisons, and detention centers. The services are designed to maximize the person's ability to function effectively in the community. The criminal justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

Criminal justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/DWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Eating Disorders (ED)

Standards for eating disorder programs apply to residential, inpatient, and partial hospitalization programs that offer treatment to patients under the supervision of a licensed healthcare professional who has access to a licensed physician. Patients served in these programs have been diagnosed with eating disorders according to the current DSM, ICD-9 or ICD-10, including Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified. Symptom management and interruption requires an intensity of service delivery that

is beyond an outpatient a level of care.

The standards consider the individual's biopsychosocial needs and strengths as well as the needs and strengths of family members. Services maximize the person's ability to function effectively within the family, school, and community environment and to achieve and maintain an optimal state of health to enhance quality of life. Services provided also consider any culturally specific issues relevant to the individual and family/caregivers as appropriate. Services to persons with eating disorders can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. However, programs serving persons with eating disorders within larger general medical or psychiatric units, similar to exclusive programs, must demonstrate programming that is specialty- and evidence-based and demonstrate that staff are specialty-trained and competent to provide eating disorder treatment. Exclusive programs and programs within larger general psychiatric or medical units must also demonstrate that services are designed based on the needs and expectations of the persons served and their legal guardians/caregivers. For example, they can be informed by the World Wide Charter on Action for Eating Disorders (www.aedweb.org/get-involved/advocacy). The charter describes the following rights of persons with eating disorders and carers:

- Right to communication and partnership with healthcare professionals
- Right to comprehensive assessment and treatment planning
- Right to accessible, high-quality, fully funded specialized care
- Right to respectful, fully informed, age-appropriate, safe levels of care
- Right of carer(s) to be informed, valued, and respected as a treatment resource
- Right of carer(s) to accessible, appropriate support and education resources

Some examples of the quality results desired by different stakeholders of these services include:

- Replacing the person's connection with the eating disorder with satisfying, supportive and meaningful relationships and the use of healthy coping strategies.
- Effective transitions between levels of care or transition to community living.
- Development of an effective and efficient network of community support services including access to therapies, medical supports, and other school, work, and community-based resources.
- Achievement of goals in health, education, work, and activities of daily living.
- Personal and family development.
- Maintenance of recovery and improved functioning.

Juvenile Justice (JJ)

Juvenile justice programs serve special populations comprised of accused or adjudicated juveniles referred from within the juvenile justice system who are experiencing behavioral

health needs including alcohol or other drug abuse or addiction or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, or in community-based or institutional settings. Institutional settings may include juvenile detention centers, jails, prisons, or other delinquency-focused settings. The services are designed to maximize the person's ability to function effectively in the community. The juvenile justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

Juvenile justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/OWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Medically Complex (MC)

Medically complex standards are applied to programs that serve a specific population of persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to the person's health status.

These standards consider the individual's overall medical condition, including acuity, stability, impairments, activity limitations, participation restrictions, psychological status, behavioral status, placement, and long-term outcomes expectations. Appropriate medical consultation occurs specific to each person served in addition to medical consultation related to policies and procedures.

Services to persons with medically complex conditions can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. The services within the program are designed based on the needs, desires, and expectations of the persons served and their legal guardian/caregivers to maximize the ability to function effectively within their family (or placement), school, and/or community environments and to achieve and maintain an optimal state of health to enhance their quality of life. The services provided also consider any culturally specific issues relevant to the individual and family/caregivers as appropriate. The service plan supports all transitions in the person's life and is changed as necessary to meet the person's identified needs as well as the needs of the

family/caregivers.

Some examples of the quality results desired by the different stakeholders of these services include:

- Development of an effective and efficient network of community support services including access to therapies, medical supports, and guidance.
- Satisfying and meaningful relationships.
- Achievement of goals in health, education, and activities of daily living.
- Being able to choose and pursue meaningful activities in the least restrictive environment possible to achieve personal satisfaction in life activities.
- Maintenance of health and well-being.
- Restored or improved functioning.
- Enhanced quality of life.
- Personal and family development.
- Transitions between levels of care or transition to independence.
- End-of-life services and supports for the person, family/caregiver, legal guardian, and/or other significant persons in the individual's life to assist with meaningful closures.

Older Adults (OA)

Programs for older adults consist of an array of services designed specifically to address the behavioral health needs of this population. Such programs tailor their services to the particular needs and preferences of older adults and their families/support systems. Services are provided in environments appropriate to their needs. Personnel are trained to effectively address the complex needs of older adults.

Certified Community Behavioral Health Clinic (CCBHC)

A Certified Community Behavioral Health Clinic (CCBHC) is a form of provider within the U.S., established by the Excellence in Mental Health Act. CCBHCs are designed to provide whole-person care by integrating physical health with a comprehensive range of mental health and substance use disorder services to vulnerable individuals. Whole-person care means considering all aspects of a person's health, including their physical, mental, and behavioral health, as well as their socioeconomic status, housing situation, and other social determinants of health, which can exacerbate health issues.

CCBHCs offer nine types of services, including:

- Crisis mental health services
- Screening, assessment, and diagnosis
- Person-centered treatment planning

- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring
- Targeted case management
- Psychiatric rehabilitation services
- Peer support, counselor services, and family supports
- Intensive, community-based mental health care to persons served (includes members of the armed forces and Veterans)

Services must be person-centered and family-centered, trauma-informed, and recovery-oriented. In addition, CCBHCs are required to expand service hours, provide timely access for routine needs, provide daily 24-hour access to crisis management services, provide services beyond the walls of the clinic (for example, in clients' homes and elsewhere in the community), and maintain partnerships with a range of health and social service providers to facilitate referrals and care coordination. CCBHCs can partner with Designated Collaborating Organizations (DCOs) to provide some of the required services. DCOs are entities that are not directly supervised by a CCBHC but have a formal relationship with a CCBHC to provide specified services. CCBHCs that engage DCOs maintain clinical responsibility for services the DCO provides to CCBHC clients.