CARF Survey Report for
Institute for Community Living, Inc.
Organization
Institute for Community Living, Inc. (ICL)
40 Rector Street, Eighth Floor
New York, NY 10006

Organizational Leadership
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Survey Dates
July 17-19, 2013

Survey Team
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Programs/Services Surveyed
Community Housing: Integrated: AOD/MH (Adults)
Community Housing: Mental Health (Adults)
Community Housing: Mental Health (Children and Adolescents)
Outpatient Treatment: Family Services (Adults)
Outpatient Treatment: Family Services (Children and Adolescents)

Governance Standards Applied

Previous Survey
June 7-9, 2010
Three-Year Accreditation

Survey Outcome
Three-Year Accreditation
Expiration: May 2016
SURVEY SUMMARY

Institute for Community Living, Inc. (ICL), has strengths in many areas.

■ ICL has a clear and unwavering commitment to doing the right things for the persons served and enjoys a reputation as an organization that is truly committed to operational excellence. The organization has established high expectations regarding the administrative and clinical systems. It is apparent that significant groundwork and resources were put into the ongoing implementation, review, and revision of policies and procedures. They were comprehensive and well written.

■ The leadership team is experienced, dedicated, committed to the needs of the persons served, and supportive of growth and works well as a cohesive, mission-focused team. The longevity of many staff members is particularly impressive. They bring stability, history, and continuity to service delivery.

■ The staff is competent, caring, and genuinely dedicated to the success and long-term viability of the organization and the accomplishment of its mission.

■ The board of directors offers leadership and dedication to the organization. It meets its fiduciary responsibilities, meets its obligations to be representative of community needs, and is highly supportive of the organization.

■ The leadership is committed to the implementation of best practices and evidence-based research practices to position the organization for growth and/or changes in the behavioral health marketplace.

■ The organization appears to be financially stable and has benefited from strong leadership and sound financial management and decision making.

■ The chief executive officer is well respected in the health management field and is recognized for his expertise and vision. He has a long and distinguished legacy of leadership, and, although early in his current tenure, brings longstanding knowledge and rapport with care management and other third party payers that will result in further stability to the organization.

■ ICL engages in a thorough process in developing the organizational strategic plan. Many stakeholders are involved, and input is obtained from a variety of sources and methodologies. The environmental scan is comprehensive. The strengths, weaknesses, opportunities, and threats (SWOT) analysis shows that much thought is invested in the process. The resulting plan is a useful and relevant tool to guide the organization’s future growth and/or changes in the behavioral health marketplace.

■ The process of performance improvement is of high priority. There is ample evidence that data are used effectively in refining services, programs, and overall operations.

■ The organization has an interactive state-of-the-art training facility and can be linked to other providers within the community mental health system. The training system allows accessing mandatory clinical training in areas required for state licensure and competency-based trainings for personnel.
■ The organization demonstrates the use of multiple languages that afford accessibility to persons who are non-English speaking. This is evidenced by the organization having staff that provides services in primary languages of the persons served including English, Spanish, Creole, and Russian.

■ Throughout the organization’s apartments, it is evident that countless accommodations have been made to ensure that the decor of each individual’s room and the special collection displays honor the individual’s taste while maintaining a safe and healthy environment.

■ It is evident that the clients hold the staff in high regard.

■ Key workers have been assigned to each person served in community housing. They are responsible for coordinating the team in the development, implementation, and monitoring of the individual plan. In addition, the staff members of the community homes develop community activities on a regular basis.

■ The staff is acknowledged for a commitment to providing positive behavior supports for the persons served who demonstrate challenging behaviors in their supportive living environments.

■ The staff is passionate about providing quality care that truly makes a difference in the lives of the persons served.

■ The organization and staff members are committed to delivering services in an atmosphere characterized by a high level of regard for removing stigma and affording dignity and respect to the persons served.

■ The staff members at all levels of the organization demonstrate true compassion and are proud of the programs delivered and the progress of the persons served.

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

■ The organization has developed comprehensive training protocols in trauma-informed care/management. This process enables clinicians to practice an empirically based intervention to effectively address trauma. The organization also engages in trauma sensitivity training that enables leadership and direct treatment staff to enhance a supportive environment in the treatment of the persons served who have witnessed or experienced trauma.

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

On balance, ICL is highly regarded in the community for providing needed and quality services. ICL has competent leadership and is dedicated to the development, implementation, and evaluation of the services provided. The persons served and referral sources report a high level of satisfaction with the effectiveness of the services. The management staff members continually explore new ways to improve the quality of services and the financial stability of the organization. ICL demonstrates substantial conformance to the CARF standards. The organization is aware of the areas for improvement that include educating personnel on the written ethical code of conduct, consistently reviewing and updating job descriptions, developing performance objectives for personnel, and assessing their attainment in the coming year. As the organization moves toward a paperless process, coupled with new leadership, there is no doubt that ICL is dedicated to the ongoing development, implementation, and evaluation of the services provided.
Institute for Community Living, Inc., has earned a Three-Year Accreditation. The leadership and staff members are congratulated on this accomplishment. They are encouraged to continue to use the CARF standards to continuously improve the quality of the programs and the services provided.

**SECTION 1. ASPIRE TO EXCELLENCE®**

**A. Leadership**

**Principle Statement**

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

**Key Areas Addressed**

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

**Recommendations**

A.5.c.
A.5.d.

It is recommended that the organization review its cultural plan annually and update it as needed.

A.6.a.(4)(f)
A.6.b.(2)(a) through A.6.c.(1)

It is recommended that the written ethical codes of conduct include the witnessing of documents and time frames that are adequate for prompt consideration and result in timely decisions. Further, it is recommended that the organization consistently educate personnel on ethical codes of conduct.
B. Governance

Principle Statement

The governing board should provide effective and ethical governance leadership on behalf of its owners’/stakeholders’ interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization’s long-term success and stability. The board is responsible for ensuring that the organization is managed effectively, efficiently, and ethically by the organization’s executive leadership through defined governance accountability mechanisms. These mechanisms include, but are not limited to, an adopted governance framework defined by written governance policies and demonstrated practices; active and timely review of organizational performance and that of the executive leadership; and the demarcation of duties between the board and executive leadership to ensure that organizational strategies, plans, decisions, and actions are delegated to the resource that would best advance the interests and performance of the organization over the long term and manage the organization’s inherent risks. The board has additional responsibilities under the domain of public trust, and as such, it understands its corporate responsibility to the organization’s employees, providers, suppliers, and the communities it serves.

Key Areas Addressed

- Ethical, active, and accountable governance
- Board composition, selection, orientation, development, assessment, and succession
- Board leadership, organizational structure, meeting planning, and management
- Linkage between governance and executive leadership
- Corporate and executive leadership performance review and development
- Executive compensation

Recommendations

There are no recommendations in this area.

C. Strategic Planning

Principle Statement

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.
Key Areas Addressed
■ Strategic planning considers stakeholder expectations and environmental impacts
■ Written strategic plan sets goals
■ Plan is implemented, shared, and kept relevant

Recommendations
C.2.c.(2)
The organization has a comprehensive strategic plan. It is recommended that the plan’s goals be prioritized in the event that these may require repositioning or eliminating altogether, given the ever changing shifts in the behavioral health marketplace.

D. Input from Persons Served and Other Stakeholders

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

Key Areas Addressed
■ Ongoing collection of information from a variety of sources
■ Analysis and integration into business practices
■ Leadership response to information collected

Recommendations
There are no recommendations in this area.

E. Legal Requirements

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

Key Areas Addressed
■ Compliance with all legal/regulatory requirements
F. Financial Planning and Management

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

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

Recommendations
There are no recommendations in this area.

G. Risk Management

Principle Statement
CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.
Key Areas Addressed
■ Identification of loss exposures
■ Development of risk management plan
■ Adequate insurance coverage

Recommendations
There are no recommendations in this area.

H. Health and Safety

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

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

Recommendations
There are no recommendations in this area.

I. Human Resources

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

- Adequate staffing
- Verification of background/credentials
- Recruitment/retention efforts
- Personnel skills/characteristics
- Annual review of job descriptions/performance
- Policies regarding students/volunteers, if applicable

Recommendations

I.4.b.
It is recommended that ICL demonstrate that it assesses the current competencies of personnel at least annually.

I.6.a.(1)
I.6.a.(2)
I.6.d.(4)(a) through I.6.d.(5)
Performance management should include job descriptions that are reviewed and/or updated annually, as needed. ICL has processes in place for assessing performance based on job functions and necessary competencies. It is recommended that performance evaluations establish measurable performance objectives for the next year and be used to assess objectives established in the last evaluation period. Performance evaluations should be performed annually.

J. Technology

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

Key Areas Addressed

- Written technology and system plan

Recommendations
There are no recommendations in this area.
K. Rights of Persons Served

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

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

**Recommendations**
There are no recommendations in this area.

L. Accessibility

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

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

**Recommendations**
There are no recommendations in this area.

M. Performance Measurement and Management

**Principle Statement**
CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and information is used to manage and improve service delivery.
Key Areas Addressed
- Information collection, use, and management
- Setting and measuring performance indicators

Recommendations
There are no recommendations in this area.

N. Performance Improvement

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

Key Areas Addressed
- Proactive performance improvement
- Performance information shared with all stakeholders

Recommendations
There are no recommendations in this area.

SECTION 2. GENERAL PROGRAM STANDARDS

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

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

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

Recommendations
A.22.a. through A.22.g.
Documented ongoing clinical supervision of clinical or direct service personnel should address the accuracy of assessment and referral skills; the appropriateness of the treatment or service intervention selected relative to the specific needs of the person served; treatment/service effectiveness as reflected by the person served meeting his or her individualized goals; the provision of feedback that enhances the clinical skills of direct service personnel; issues of ethics, legal aspects of clinical practice, and professional standards including boundaries; clinical documentation issues as identified through ongoing compliance reviews; and cultural competency issues.

Exemplary Conformance
A.6.
The organization has developed comprehensive training protocols in trauma-informed care/management. This process enables clinicians to practice an empirically based intervention to effectively address trauma. The organization also engages in trauma sensitivity training that enables leadership and direct treatment staff to enhance a supportive environment in the treatment of the persons served who have witnessed or experienced trauma.
B. Screening and Access to Services

Principle Statement

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

Key Areas Addressed

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

Recommendations

B.14.e.
B.14.f.
B.14.h.

It is recommended that the assessment process gather and record information about the abilities and/or interests and preferences of the persons served, information on the person’s mental status, and risk-taking behaviors.

C. Person-Centered Plan

Principle Statement

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

Key Areas Addressed

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

Recommendations

C.1.c.(3)
C.1.c.(4)
It is recommended that the person-centered plan be based on the person’s abilities and preferences.

C.2.a.(1)
It is recommended that the person-centered plan consistently include goals expressed in the words of persons served.

Consultation

- The organization is currently identifying the strengths, needs, abilities, and preferences (SNAP) components in various areas of documentation and not specifically identifying them as SNAP. Identifying SNAP as a specific section on all assessment, planning, transition, and discharge documents could make SNAP easier to identify and to use.
- It is suggested that the organization provide additional training on writing specific, measurable, achievable, relevant, and targeted (SMART) objectives.

D. Transition/Discharge

Principle Statement

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

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

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

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

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

**Key Areas Addressed**

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

**Recommendations**

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

A written transition plan should be prepared or updated with each person when the person is transferred to another level of care or an aftercare program or prepares for a planned discharge to ensure a seamless transition. The written transition plan should identify the person’s current progress in his or her recovery or move toward well-being; gains the person has achieved during participation in the program; 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; include information on the person’s medication, when applicable; include referral information, such as the contact name, telephone number, locations, hours, and days of services, when applicable; and communication of information on options and resources available if symptoms recur or if additional services are needed, when applicable.
D.4.a.(1) through D.4.b.
The written transition plan should be developed with the input and participation of the person served; the family or legal guardian, when applicable and permitted; a legally authorized representative, when appropriate; team members; the referral source, when appropriate and permitted; and other community services, when appropriate and permitted. The transition plan should be given to individuals who participate in its development, when permitted.

D.7.a. through D.7.d.
The organization is urged to ensure that, when a transition plan and/or a discharge summary is provided to external programs/services to support a person’s transition, it includes the person’s strengths, needs, abilities, and preferences.

E. Medication Use

Principle Statement

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

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

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

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

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

Dispensing is considered the practice of pharmacy; the process of preparing and delivering a prescribed medication (including samples) that has been packaged or re-packaged and labeled by a physician or pharmacist or other qualified professional licensed to dispense (for later oral ingestion, injection, inhalation, or other means of administration).
Prescribing is evaluating, determining what agent is to be used by and giving direction to a person served (or family/legal guardian), in the preparation and administration of a remedy to be used in the treatment of disease. It includes a verbal or written order, by a qualified professional licensed to prescribe, that details what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

**Key Areas Addressed**

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

**Recommendations**

There are no recommendations in this area.

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**F. Nonviolent Practices**

**Principle Statement**

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

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

Programs need to recognize that individuals may require supports to fully benefit from their services. Staff are expected to access or provide those supports wanted and needed by the individual. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement.
Even with supports, there are times when individuals may show signs of fear, anger, or pain, which may lead to aggression or agitation. Staff members are trained to recognize and respond to these signs through de-escalation, changes to the physical environment, implementation of meaningful and engaging activities, redirection, active listening, etc. On the rare occasions when these interventions are not successful and there is imminent danger of serious harm, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort. The use of seclusion and restraint must always be followed by a full review, as part of the process to eliminate the use of these in the future.

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

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

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

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

In a correctional setting, the use of seclusion or restraint for purposes of security is not considered seclusion or restraint under these standards. Security doors designed to prevent elopement or wandering are not considered seclusion or restraint. Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel, are not subject to these standards. When permissible, consideration is made to removal of physical restraints while the person is receiving services in the behavioral health care setting.
Key Areas Addressed
- Training and procedures supporting nonviolent practices
- Policies and procedures for use of seclusion and restraint
- Patterns of use reviewed
- Persons trained in use
- Plans for reduction/elimination of use

Recommendations
There are no recommendations in this area.

G. Records of the Persons Served

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

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

Recommendations
G.2.c.
ICL is urged to consistently ensure that the records of the persons served are complete.

G.4.f. through G.4.l.
It is recommended that the individual record of the person served include information about the individual’s primary care physician including name, address, and telephone number, when available; healthcare reimbursement information, if applicable; the person’s health history, current medications, and preadmission screening, when conducted; documentation of orientation and assessments; a transition plan, when applicable; a discharge summary; correspondence pertinent to the persons served; and documentation of internal or external referrals.
H. Quality Records Management

**Principle Statement**

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

**Key Areas Addressed**

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

**Recommendations**

There are no recommendations in this area.

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**MENTAL HEALTH**

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

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**SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS**

**Principle Statement**

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

Principle Statement

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 is typically provided for 6 to 12 months and can be offered 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 Intent to Survey. 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.

Recommendations

There are no recommendations in this area.
FAMILY SERVICES

Core programs in this field category are designed to maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals. Core programs in this field category are directed at the reduction of symptoms and/or the improvement of functioning for the person served or family unit.

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

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

S. Outpatient Treatment

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

Recommendations
There are no recommendations in this area.
INTEGRATED AOD/MENTAL HEALTH

Core programs in this field category are designed to provide a combination of alcohol and other drugs/addictions and mental health services. This may include services provided in a psychosocial format. Services may be provided through a seamless system of care for individuals with needs in one or both areas or for persons with the identified co-occurring disorders.

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D. Community Housing

Principle Statement

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 is typically provided for 6 to 12 months and can be offered 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 Intent to Survey. 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.

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**Recommendations**

There are no recommendations in this area.

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**SECTION 4. BEHAVIORAL HEALTH SPECIFIC POPULATION DESIGNATION STANDARDS**

**B. Children and Adolescents**

*Community Housing: Mental Health*  
*Outpatient Treatment: Family Services*

**Principle Statement**

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

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**Recommendations**

There are no recommendations in this area.
PROGRAMS/SERVICES BY LOCATION

Institute for Community Living, Inc.
40 Rector Street, Eighth Floor
New York, NY 10006
Administrative Location Only

Governance Standards Applied

Eastern Parkway Residence
948 Eastern Parkway
Brooklyn, NY 11213
Community Housing: Integrated: AOD/MH (Adults)

Halsey House
1225 Halsey Street
Brooklyn, NY 11237
Community Housing: Integrated: AOD/MH (Adults)

Prospect House
516 Flatbush Avenue
Brooklyn, NY 11225
Community Housing: Integrated: AOD/MH (Adults)

Walit House
415-417 State Street
Brooklyn, NY 11217
Community Housing: Integrated: AOD/MH (Adults)

Broadway Residence
2643 Broadway
New York, NY 10025
Community Housing: Mental Health (Adults)

Lawton Street Residence
25-29 Lawton Street
Brooklyn, NY 11221
Community Housing: Mental Health (Adults)
St. Marks Congregate Treatment I and II
839 Saint Marks Avenue
Brooklyn, NY   11213
Community Housing: Mental Health (Adults)

Stepping Stone Residence Congregate Treatment/Support/Apartment Program
50 Nevins Street
Brooklyn, NY   11217
Community Housing: Mental Health (Adults)

Highland Park Clinic
2581 Atlantic Avenue
Brooklyn, NY   11207
Outpatient Treatment: Family Services (Adults)
Outpatient Treatment: Family Services (Children and Adolescents)

Rockaway Parkway Center
2128 Rockaway Parkway
Brooklyn, NY   11236
Outpatient Treatment: Family Services (Adults)
Outpatient Treatment: Family Services (Children and Adolescents)

Lewis Avenue
44-52 Lewis Avenue
Brooklyn, NY   11206
Community Housing: Mental Health (Adults)

Pennsylvania ICL, Inc.
230 Fitzwatertown Road
Willow Grove, PA   19090
Community Housing: Integrated: AOD/MH (Adults)

Pratt House
518 Flatbush Avenue
Brooklyn, NY   11225
Community Housing: Mental Health (Adults)

Guidance Center of Brooklyn, Inc. - IS 220 Satellite Clinic
4812 Ninth Avenue
Brooklyn, NY   11220
Outpatient Treatment: Family Services (Children and Adolescents)
**Emerson - Davis Family Center**
161 Emerson Place  
Brooklyn, NY  11205  
Community Housing: Mental Health (Adults)

**Linden House Child Community Residence**
198 Linden Boulevard  
Brooklyn, NY  11226  
Community Housing: Mental Health (Children and Adolescents)

**Queens Treatment Apartment Program**
102-105 63rd Road  
Queens, NY  11374  
Community Housing: Mental Health (Adults)

**Guidance Center of Brooklyn Heights**
25 Chapel Street, Suite 903  
Brooklyn, NY  11201  
Outpatient Treatment: Family Services (Adults)  
Outpatient Treatment: Family Services (Children and Adolescents)

**Coney Island Children’s CR**
2855 West 37th Street  
Brooklyn, NY  11224  
Community Housing: Mental Health (Children and Adolescents)

**Livonia Community Residence**
684 Livonia  
Brooklyn, NY  11207  
Community Housing: Mental Health (Adults)