carf INTERNATIONAL

Three-Year Accreditation

CARF Survey Report for Detroit Rescue Mission Ministries

carf INTERNATIONAL

Three-Year Accreditation

Organization

Detroit Rescue Mission Ministries (DRMM)
150 Stimson Street
Detroit, MI 48201

Organizational Leadership

Chad Audi, Ph.D., President/CEO

Aurine M. Moore, Vice President, Development

Barbara J. Willis, M.A., Chief Operating Officer

Japheth Agboka, B.S., Director of Quality Assurance

Survey Dates

June 8-10, 2015

Survey Team

David J. MacDonald, Administrative Surveyor

Linda L. Brown, Program Surveyor

Tana Michele Cox, Program Surveyor

Programs/Services Surveyed

Community Housing: Psychosocial Rehabilitation (Adults)
Detoxification: Alcohol and Other Drugs/Addictions (Adults)
Detoxification: Alcohol and Other Drugs/Addictions (Criminal Justice)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)

Previous Survey

June 11-13, 2012
Three-Year Accreditation

Survey Outcome

Three-Year Accreditation
Expiration: June 2018

SURVEY SUMMARY

Detroit Rescue Mission Ministries (DRMM) has strengths in many areas.

- DRMM has a long history of positive response from prior CARF surveys and continues to be committed to CARF's principles by working diligently and eagerly to maintain conformance to the CARF standards.
- DRMM is guided by an experienced and highly capable team that values its employees, clients, and community stakeholders. The board is responsible for ensuring that the organization is managed effectively, efficiently, and ethically by the executive leadership through defined governance accountability mechanisms.
- Administrative and clinical staff members are enthusiastic and dedicated. The organization is invested in recruiting and retaining qualified personnel and maintains strong program management.
- The president and senior managers are committed to carrying out the organization's mission by working with the staff members in a team approach that promotes quality of care in a culture that stimulates longevity, respect, professionalism, shared vision, and care.
- Community stakeholders express that the organization provides quality services. DRMM is seen as a credible expert in the fields of homelessness; addiction; substance abuse prevention for youth and adults; and innovative, sustainable economic development projects.
- Strategic planning is focused on taking advantage of strengths and opportunities and addressing weaknesses and threats. Risk management activities include a coordinated set of activities designed to control threats to the organization's personnel, property, income, goodwill, and ability to accomplish goals. Financial management appears to adhere to established accounting and business practices. The annual financial review by an independent CPA disclosed no material modifications or weaknesses.
- Input is solicited from clients, personnel, and other stakeholders. This input process engages all parties in a sense of shared future that promotes long-term organizational excellence and optimal outcomes. Input has resulted in the addition of a summer camp program for students in partnership with the Detroit Public Schools; additional correctional treatment programs, including The Duluth Model Domestic Abuse Intervention Programs; expansion of services to other counties; expansion of services to the Arab American community; and the Working Homes/Working Families program that refurbishes abandoned homes so needy working families can be given a decent clean place to live and one they must maintain while continuing employment.
- DRMM maintains a healthy, clean, and safe environment that supports the quality services and minimizes risk of harm to clients, personnel, and other stakeholders.
- DRMM constantly monitors and assesses its performance against a series of performance indicators and targets in the domains of effectiveness, efficiency, service access, and satisfaction, thereby staying on target at both strategic and tactical levels. The outcome is an annual analysis

and evaluation that drive the organization to engage in a dynamic, proactive process to review, renew, or revise its strategy and tactics while ensuring alignment of philosophy and purpose, clinical service, business practices, and resources.

- Persons served report that staff members are sensitive to different cultures and individualize services based on presenting needs.
- The culinary arts training program provides an opportunity for persons served to learn a marketable skill while in treatment.
- DRMM's renovation of a local restaurant is only one of many initiatives to strengthen the local community and provide workforce development opportunities.
- Persons served describe programs as safe, secure, and a place where miracles happen daily. Many have recommended this program to others who need assistance.
- The organization's teen program provides a safe and clean environment for both the mother and child. The teen program provides a good foundation for stabilized housing, education, and childcare assistance.

DRMM 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, DRMM demonstrates substantial conformance to the CARF standards. The organization's commitment to the CARF principles and diligence in addressing the standards are evidenced in its documentation, policies and procedures, performance improvement efforts, and provision of quality services. Teamwork and an atmosphere of cooperation are noted across the organization. DRMM benefits from the talented leadership's commitment and competence. The organization's services, setting, and environment communicate a sense of respect across its business operations and service delivery processes. Areas for improvement include documenting training, refining the employee performance evaluation process, and improving the medication peer review system. The receptivity of the leadership and staff members to the consultation and other feedback provided during the survey instills confidence that DRMM possesses the willingness and capacity to bring it into full conformance to the CARF standards.

Detroit Rescue Mission Ministries has earned a Three-Year Accreditation. The leadership and staff members are congratulated on this achievement and recognized for their efforts in pursuit of international accreditation. They are encouraged to use their resources to address the opportunities for improvement noted in this report and to continue to utilize the CARF standards on an ongoing basis as guidelines for the continuous quality improvement of the organization's business operations and service delivery processes.

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.6.a.(4)(f)

Although the organization has a written ethical code of conduct, it is recommended that the code of conduct be expanded to address the witnessing of documents.

C. Strategic Planning

Principle Statement

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

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

D. Input from Persons Served and Other Stakeholders

Principle Statement

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

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

E. Legal Requirements

Principle Statement

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

Key Areas Addressed

- Compliance with all legal/regulatory requirements

Recommendations

There are no recommendations in this area.

F. Financial Planning and Management

Principle Statement

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

Key Areas Addressed

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

Recommendations

There are no recommendations in this area.

G. Risk Management

Principle Statement

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to its 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

H.4.a.(1)

Documentation of competency-based safety training should consistently occur upon hire.

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.5.a.(1)

I.5.b.(4)

Diversity training during orientation should be documented.

I.6.b.(4)(b)

The annual personnel performance evaluations should establish measurable performance objectives for the next year.

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)
- 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 analyzed, 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

There are no recommendations in this area.

Consultation

- It is suggested that the current supervision document more accurately reflect the accuracy of assessment and referral skills; the appropriateness of the treatment or service intervention selected relative to the specific needs of each person served; treatment/service effectiveness as reflected by the person served meeting his or her individual goals; the provision of feedback that enhances the skills of direct service personnel; issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries; and cultural competency issues. This could be accomplished by adding these as fields on the current supervision form.

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.i.(2)

It is recommended that the assessment process gather and record sufficient information to develop a comprehensive person-centered plan for each person served, including information about the efficacy of current or previously used medication.

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

There are no recommendations in this area.

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 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.

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

There are no recommendations in this area.

E. Medication Use

Principle Statement

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

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

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

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

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

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

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

Key Areas Addressed

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

Recommendations

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

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

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

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

F. Nonviolent Practices

Principle Statement

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

- Engagement
- Partnership—power with, not over
- Holistic approaches

- Respect
- Hope
- Self-direction

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

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

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

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

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

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

In a correctional setting, the use of seclusion or restraint for purposes of security is not considered seclusion or restraint under these standards. Security doors designed to prevent elopement or wandering are not considered seclusion or restraint. Security measures for forensic purposes, such

as the use of handcuffs instituted by law enforcement personnel, are not subject to these standards. When permissible, consideration is made to removal of physical restraints while the person is receiving services in the behavioral health care setting.

Key Areas Addressed

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

Recommendations

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

There are no recommendations in this area.

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.

ALCOHOL AND OTHER DRUGS/ADDICTIONS

Core programs in this field category are designed to provide services for persons who have or are at risk of having harmful involvement with alcohol or other drugs/addictions. These programs use a team approach to minimize the effects and risks associated with alcohol, other drugs, or other addictions.

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.

I. Detoxification

Principle Statement

Detoxification programs provide support to the persons served during withdrawal from alcohol and/or other drugs. Services may be provided in a unit of a medical facility, in a freestanding residential or community-based setting, or in the home of the person served.

Recommendations

There are no recommendations in this area.

Q. Outpatient Programs

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, and addictions.

Recommendations

There are no recommendations in this area.

T. Residential Treatment

Principle Statement

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 disabilities or co-occurring disabilities, including intellectual or developmental disability. Residential treatment services are organized to provide environments in which the persons reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems. Residential treatment may be provided in freestanding, nonhospital-based facilities or in clearly identified units of larger entities, such as a wing of a hospital. Residential treatment programs may include domestic violence treatment homes, nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Recommendations

There are no recommendations in this area.

PSYCHOSOCIAL REHABILITATION

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

SECTION 3. BEHAVIORAL HEALTH CORE PROGRAM STANDARDS

Principle Statement

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

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 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 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.

SECTION 4. BEHAVIORAL HEALTH SPECIFIC POPULATION DESIGNATION STANDARDS

D. Criminal Justice

Principle Statement

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.

Recommendations

There are no recommendations in this area.

PROGRAMS/SERVICES BY LOCATION

Detroit Rescue Mission Ministries

150 Stimson Street
Detroit, MI 48201

Administrative Location Only

12900 West Chicago

12900 West Chicago
Detroit, MI 48227

Community Housing: Psychosocial Rehabilitation (Adults)

19211 Anglin

19211 Anglin
Detroit, MI 48234

Detoxification: Alcohol and Other Drugs/Addictions (Adults)
Detoxification: Alcohol and Other Drugs/Addictions (Criminal Justice)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)

2015 Webb

2015 Webb
Detroit, MI 48206

Community Housing: Psychosocial Rehabilitation (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
Outpatient Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)
Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)
Residential Treatment: Alcohol and Other Drugs/Addictions (Criminal Justice)

3840 Fairview

3840 Fairview
Detroit, MI 48214

Community Housing: Psychosocial Rehabilitation (Adults)

Brainard House

816 Brainard
Detroit, MI 48201

Community Housing: Psychosocial Rehabilitation (Adults)

My Own Place Community House

20535 Archdale
Detroit, MI 48235

Community Housing: Psychosocial Rehabilitation (Adults)

My Own Place Community Housing

1981 Webb Avenue
Detroit, MI 48206

Community Housing: Psychosocial Rehabilitation (Adults)

Third Street

3535 Third Street
Detroit, MI 48201

Community Housing: Psychosocial Rehabilitation (Adults)

13130 Woodward

13130 Woodward Avenue
Highland Park, MI 48203

Community Housing: Psychosocial Rehabilitation (Adults)

13220 Woodward

13220 Woodward Avenue
Highland Park, MI 48203

Community Housing: Psychosocial Rehabilitation (Adults)

211 Glendale

211 Glendale
Highland Park, MI 48203

Community Housing: Psychosocial Rehabilitation (Adults)