Revised Standard CTS.01.01.01

The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

Note 1: For opioid treatment programs: If an individual eligible for treatment applies for admission to a comprehensive maintenance treatment program but cannot be placed within 14 days in a program that is within a reasonable geographic area, an opioid treatment program’s program sponsor may place the individual in interim maintenance treatment.

Note 2: For opioid treatment programs: There may be individuals in special populations who have a history of opioid use but are not currently physiologically dependent. Federal regulations waive the one-year history of addiction for these special populations, because these individuals are susceptible to relapse to opioid addiction, leading to high-risk behaviors with potentially life-threatening consequences. These populations include the following:

- Persons recently released from a penal institution
- Persons recently discharged from a chronic care facility
- Pregnant women
- Previously treated patients

Revised Elements of Performance for CTS.01.01.01

1. The organization has a written process for determining eligibility of individuals that includes the following:
   - The criteria to determine eligibility for care, treatment, or services
   - The information to be collected to determine eligibility for care, treatment, or services
   - The populations of individuals accepted or not accepted by the organization (for example, programs designed to treat adults that do not treat young children)
   - The procedures for accepting referrals

2. The organization screens individuals for eligibility at the point of first contact with the organization, whether by phone, in person, or other.

3. After screening, the organization matches accepted individuals with the care, treatment, or services most appropriate to their needs.

4. The organization accepts individuals for care, treatment, or services according to established processes.

5. The organization provides information about the locations and hours during which care, treatment, or services are available.

6. When warranted, the organization provides information about resources available to the individual for the care of his or her dependents.

7. For opioid treatment programs: Patients may have access to the program after the program physician documents a diagnosis of addiction or dependence and determines that maintenance or withdrawal treatment is medically necessary.

8. For opioid treatment programs: The treatment program gives priority for admission to pregnant women who seek treatment and documents the reasons for denying admission to any pregnant applicant on an intake log or other accessible program records.

9. For opioid treatment programs: Services are provided during hours that meet the needs of the majority of patients, including before and/or after the traditional 8:00 A.M. to 5:00 P.M. working day, when possible.
10. For opioid treatment programs: Admission procedures use accepted medical criteria, such as those listed in the current Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) to determine that the person is currently addicted to or dependent on an opioid drug, and that the person became addicted or dependent at least one year before admission for treatment. Note: In order to determine the one-year history of addiction or dependence, the program may accept arrest records, medical records, information from significant others and relatives, and other information.

11. For opioid treatment programs: Admission procedures use criteria for determining a diagnosis of addiction or dependence based on behavior. Note: Behavior indicative of opioid addiction includes the following:
   - Continuing use of the opiate despite known adverse consequences to self, family, or society
   - Obtaining illicit opiates
   - Using prescribed opiates inappropriately
   - Previous attempts at tapering methadone or other drugs

12. For opioid treatment programs: An individual younger than 18 years is not eligible for maintenance treatment unless he or she has two documented, unsuccessful short-term withdrawal or drug-free treatment attempts within a 12-month period.

13. For opioid treatment programs: The program physician waives the admission criteria requiring a one-year history of addiction or dependence only in the following circumstances:
   - The patient has been released from a penal institution in the last six months.
   - The patient is pregnant.
   - The patient was treated with an opioid agonist treatment medication within the last two years.

14. For opioid treatment programs: Admission procedures do not exclude patients that are not currently physiologically dependent.

15. For opioid treatment programs: Admission procedures include use of a central registry system (if applicable) or an alternative mechanism to prevent patients from enrolling in treatment provided by more than one clinic or individual practitioner. Note: In some cases, the program may, after obtaining the patient’s consent, contact other opioid treatment programs within a reasonable geographic distance (100 miles) to verify that the patient is not enrolled in another program.

16. For opioid treatment programs: Patients are limited to two withdrawal treatment episodes in one year.

17. For opioid treatment programs: When a physician makes a diagnosis and admits a patient after reviewing by telephone or fax the medical examination performed by another qualified health professional, the physician reviews and countersigns the patient record within 72 hours. Note: Standing orders for admitting patients are not acceptable.

18. For opioid treatment programs: Patients who are diagnosed with physical dependence and a pain disorder are eligible to receive medication-assisted treatment for maintenance or for medically supervised withdrawal in a program setting.

19. For opioid treatment programs: Patients in medication-assisted treatment are eligible to receive both medication-assisted treatment and adequate doses of opioid analgesics for pain.

20. For opioid treatment programs: If a patient is denied admission based on the results of the initial assessment, the program provides a full explanation to the patient and a referral to another program.
21. For opioid treatment programs: If the opioid treatment program provides interim maintenance treatment, it has written authorization to do so both by the Substance Abuse & Mental Health Services Administration (SAMHSA) and by the chief public health officer in the state in which the program operates. Note: SAMHSA may revoke its authorization if the program does not comply with the federal requirements for interim maintenance treatment. Additionally, SAMHSA will consider revoking the interim maintenance authorization of the program if the state in which the program operates is not in compliance with the requirements of 42 CFR 8.11(g).

22. For opioid treatment programs: Interim maintenance treatment, if provided by the program, does not exceed the 120-day maximum allowed by federal regulations for opioid treatment programs.

23. For opioid treatment programs: The program establishes and follows written criteria for prioritizing the transfer of patients from interim maintenance treatment to comprehensive maintenance treatment. These transfer criteria include a preference for admitting pregnant women to interim maintenance treatment and transferring them from interim maintenance to comprehensive maintenance treatment.

Revised Standard CTS.01.02.01
An organization that maintains waiting lists manages them in accordance with established organizational procedure and law and regulation.

Revised Elements of Performance for CTS.01.02.01

1. The organization has a written procedure for managing waiting lists for services.
2. The organization implements its procedure for managing waiting lists for services.

Revised Standard CTS.01.03.01
The organization develops a preliminary plan for care, treatment, or services, when needed.

Revised Elements of Performance for CTS.01.03.01

1. The organization develops a preliminary plan for care, treatment, or services when care, treatment, or services are initiated prior to completion of the screening and assessment process.
2. The preliminary plan for care, treatment, or services focuses on the individual’s safety.
3. The preliminary plan for care, treatment, or services addresses interventions in response to emergency needs, such as an immediate need for placement or danger to self or others.
Revised Standard CTS.01.04.01
For organizations that serve adults with serious mental illness: The organization supports the adult’s decisions (psychiatric advance directive) about how care, treatment, or services are to be delivered during times when he or she is unable to make such decisions.

Revised Elements of Performance for CTS.01.04.01

1. For organizations that serve adults with serious mental illness: The organization documents whether the adult has a psychiatric advance directive.
2. For organizations that serve adults with serious mental illness: Upon request, the organization shares with the adult sources of help in formulating psychiatric advance directives.
3. For organizations that serve adults with serious mental illness: If the adult has a psychiatric advance directive, clinical staff who are involved in the care, treatment, or services provided to that adult are aware that the psychiatric advance directive exists and know how to access it.

Revised Standard CTS.02.01.01
The organization has a screening procedure for the early detection of risk of imminent harm to self or others.

Revised Elements of Performance for CTS.02.01.01

1. The screening procedure determines the need for immediate intervention to protect the individual served or others.
2. The organization has a process for responding when an immediate risk of harm is identified.
   Note: The process may include referring the individual to another organization.
3. The organization responds when it determines the individual served poses an immediate risk of harm to self or others.
Revised Standard CTS.02.01.03
The organization performs screenings and assessments as defined by the organization's policy.

Revised Elements of Performance for CTS.02.01.03

1. The organization assesses each individual served in accordance with organization policy.
2. The organization conducts each individual's assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.
3. The organization collects information during screenings and/or assessments about the following: The individual's perceptions of his or her needs, preferences, and goals for care, treatment, or services.
4. The organization collects information during screenings and/or assessments about the following: When indicated and available, the family's perceptions and preferences for care, treatment, or services.
5. For acute 24-hour settings: A qualified, licensed independent practitioner is responsible for determining the degree of assessment and care for each individual treated in an emergency care area.
   Note: "Acute 24-hour settings" includes inpatient crisis stabilization or medical detoxification.
6. For opioid treatment programs: Patients receive a comprehensive evaluation that covers the following, based on the patient's condition and needs: medical, psychosocial, vocational, educational, behavioral, family, financial, legal, health, and self-care needs.
   Note: For patients receiving interim maintenance treatment, the program is not required to provide rehabilitative, education, and other counseling services to the patient.
7. For opioid treatment programs: The comprehensive evaluation is conducted by one or more disciplines within approximately 30 days of admission or earlier when necessary.
Revised Standard CTS.02.01.05
All non–24-hour care programs or services have and implement written procedures requiring a physical health screening to determine the need for a physical health assessment, including a medical history and physical examination.
Note: This standard does not apply to foster care and therapeutic foster care. (Refer to CTS.02.04.01, EP 1 for more information)

Revised Elements of Performance for CTS.02.01.05

1. Organizations providing non–24-hour care programs or services (such as partial hospitalization, day treatment, outpatient, intensive outpatient services, supportive living, case management, assertive community treatment, adult day care, or emergency shelters) have written procedures addressing physical health screening.

2. Organizations providing non–24-hour care programs or services have written procedures that specify the data to be collected, responsible staff, a time frame, and decision criteria for determining the need for a physical examination.

3. Organizations providing non–24-hour care programs or services implement their written procedures.

4. Organizations providing non–24-hour care programs or services have a qualified licensed independent practitioner who participates in developing the physical health screening procedure.

5. Organizations providing non–24-hour care programs or services collect the following physical health data:
   - Past medical procedures
   - Past and current physical diagnoses or problems
   - Currently and recently used medications
   - Allergies to food or medicine
Revised Standard CTS.02.01.07
For 24-hour settings: The organization completes a physical health assessment, including a medical history and physical examination.
Note: This standard does not apply to foster care and therapeutic foster care. (Refer to CTS.02.04.01, EP 1 for more information)

Revised Elements of Performance for CTS.02.01.07

1. For inpatient crisis stabilization: A physical health examination is performed by a licensed independent practitioner within 24 hours of admission.
   Note 1: Some physical health needs require completion of a physical health assessment within a shorter time frame.
   Note 2: If a medical history and physical examination has been completed by a licensed independent practitioner within 30 days before admission, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission.

2. For residential programs: A physical health examination is performed by a licensed independent practitioner within seven calendar days after admission (this time frame applies to weekend and holiday admissions as well as to weekdays).
   Note 1: Some physical health needs require completion of a physical health assessment within a shorter time frame.
   Note 2: If a medical history and physical examination has been completed by a licensed independent practitioner within 30 days before admission, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission.

3. For organizations that conduct outdoor/wilderness experiences: A physical health examination is performed by a licensed independent practitioner within 30 days prior to participating in an outdoor/wilderness experience.
   Note 1: Some physical health needs require completion of a physical health assessment within a shorter time frame.
   Note 2: If a medical history and physical examination has been completed by a licensed independent practitioner within 30 days before participating in an outdoor/wilderness experience, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission to the program.

4. For opioid treatment programs: The program completes a medical evaluation within 14 days after treatment is initiated.

5. For opioid treatment programs: The physical assessment includes an examination of the following:
   - Clinical signs of addiction, such as old and fresh needle marks, constricted or dilated pupils, and/or an eroded or perforated nasal septum
   - Observable and reported presence of withdrawal signs and symptoms, such as yawning, rhinorrhea, lacrimation, chills, restlessness, irritability, perspiration, piloerection, nausea, and diarrhea
   Note: On-site "point of collection" devices may be useful in screening a patient’s current physiological dependence.

6. For opioid treatment programs: The program documents the patient’s medical and family history to determine current chronic or acute medical conditions, such as diabetes; renal diseases; hepatitis A, B, C, and D; HIV exposure; tuberculosis; sexually transmitted diseases; other infectious diseases; sickle-cell trait or anemia; pregnancy (including past history of pregnancy and current involvement in prenatal care); and chronic cardiopulmonary disease.

7. For opioid treatment programs: Based on the patient’s history and physical examination, the program evaluates the possibility of various conditions (such as infectious disease, liver or pulmonary conditions, cardiac abnormalities, psychiatric problems, dermatologic sequelae of addiction, and concurrent surgical problems).
   Note: This may be accomplished within the program itself, or by referring the patient to a cooperating agency or a consultant clinician.
8. For opioid treatment programs: Patients who test positive for viral hepatitis receive a referral for further evaluation and treatment, if necessary.

9. For opioid treatment programs: The program immunizes the patient, or refers the patient for immunization, against hepatitis A and B if not already immune, and against other viral hepatitis strains as those vaccines become available.

### Revised Standard CTS.02.01.09

The organization screens all individuals served for physical pain.

#### Revised Elements of Performance for CTS.02.01.09

1. The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)

2. Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.

3. For opioid treatment programs: The program employs a multidisciplinary approach for treating patients with both chronic pain disorder and addiction, including both addiction medicine specialists and pain medicine specialists.

   Note: The site of such treatment may be either a medical clinic or an opioid treatment program, depending on the patient’s needs and the best utilization of available resources.

### Revised Standard CTS.02.01.11

The organization screens all individuals served for their nutritional status.

Note: Triggers for a nutritional assessment may include a 10-pound or more weight loss or gain in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies. (Refer to CTS.02.03.09, EP 1 for more information)

#### Revised Elements of Performance for CTS.02.01.11

1. The organization screens all individuals served to identify those for whom a nutritional assessment is indicated.

2. Individuals for whom a nutritional assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.

3. For organizations that assess nutritional status, the assessment identifies those individuals who may be at moderate or high nutritional risk.
Revised Standard CTS.02.01.13
As relevant to the needs, preferences, interests, and goals of the individual served, the organization screens for the educational status of the individual served.

Revised Elements of Performance for CTS.02.01.13

1. A screening identifies individuals for whom an educational assessment is indicated.
2. Individuals for whom an educational assessment is indicated are either assessed by the organization or referred for assessment.
3. For organizations that assess the educational status of individuals served, the information to be collected includes at least the following:
   - Educational background
   - Academic performance and preferred areas of study
   - Attitude toward academic achievement
   - Possibilities for future education

Revised Standard CTS.02.01.15
As relevant to care, treatment, or services, the organization screens for the legal issues of the individual served.

Revised Elements of Performance for CTS.02.01.15

1. A screening identifies individuals for whom a legal assessment is indicated.
2. Individuals for whom a legal assessment is indicated are either assessed by the organization or referred for assessment.
3. For organizations that assess the legal status of the individual, the information to be collected includes at least the following:
   - A legal history
   - A preliminary discussion to determine how much the individual's legal situation will influence his or her progress in care, treatment, or services, and the urgency of the legal situation
   - The relationship between the presenting conditions and legal involvement

Revised Standard CTS.02.01.17
As relevant to the needs, preferences, interests, and goals of the individual served, the organization screens for the vocational status of the individual served.

Revised Elements of Performance for CTS.02.01.17

1. The organization screens individuals for whom a vocational assessment is indicated, based on their needs, preferences, interests, and goals.
2. Individuals for whom a vocational assessment is indicated are either assessed by the organization or referred for assessment.
Revised Standard CTS.02.02.01

The organization collects assessment data on each individual served.

Revised Elements of Performance for CTS.02.02.01

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
   - Environment and living situation(s)
   - Leisure and recreation interests
   - Religion or spiritual orientation
   - Cultural preferences
   - Childhood history
   - Military service history, if applicable
   - Financial issues
   - Usual social, peer-group, and environmental setting(s)
   - Language preference and language(s) spoken
   - Ability to self-care
   - Family circumstances, including bereavement
   - Current and past trauma
   - Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization's scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities, and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking or retail stores, and so on). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

2. As relevant to care, treatment, or services, the assessment data collected about the individual's emotional and behavioral functioning include at least the following:
   - History of emotional functioning
   - History of behavioral functioning
   - Addictive behaviors as a primary or a co-occurring condition(s), including the use of alcohol, other drugs, gambling, or other addictive behaviors by the individual served and family members
   - Current emotional functioning
   - Current behavioral functioning

3. The assessment data collected include the individual’s short- and long-term personal goal(s).
When indicated, the following evaluations are conducted:
- Mental status
- Psychological
- Psychiatric
- Intellectual and cognitive functioning

Family members are invited to participate in the assessment process as relevant to the care, treatment, or services provided, and the age and preference of the individual served.

Revised Standard CTS.02.02.03
A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.

Revised Elements of Performance for CTS.02.02.03

1. The organization collects information about the individual's emotional and behavioral functioning and his or her needs, strengths, preferences, and goals.

2. The needs of the individual served are identified based on information from the assessment.

3. In collaboration with the individual served and, as appropriate, his or her family, the organization makes care, treatment, or service decisions that are based on information it has collected about the individual's needs, strengths, preferences, and goals.

4. The organization matches the individual with care, treatment, or services that will meet his or her needs, strengths, preferences, and goals.
Revised Standard CTS.02.02.05

The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.

Revised Elements of Performance for CTS.02.02.05

1. The organization educates staff about trauma, abuse, neglect, and exploitation and how to refer individuals, as needed.
   Note: Staff should be able to screen for trauma, abuse, neglect, and exploitation as indicated by the needs or conditions of the individual served. The organization may define who conducts the assessment for alleged or suspected trauma, abuse, neglect, and exploitation or when to refer to another organization.

2. The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation, during initial screening and assessment, and on an ongoing basis.

3. The organization assesses the individual who may have experienced trauma, abuse, neglect, or exploitation or refers the individual for such assessment.

4. For organizations that make referrals, the organization maintains a list of private and public community agencies that provide or arrange for assessment and care of individuals who may have experienced abuse, neglect, or exploitation.

5. All cases of alleged or suspected abuse, neglect, or exploitation are reported to appropriate authorities in accordance with organization policy and law and regulation.

6. Organization leaders are immediately made aware of reports made to external authorities regarding alleged or suspected cases of abuse, neglect, or exploitation involving staff.

Revised Standard CTS.02.02.07

The organization reassesses individuals served, as needed.

Note: The scope and intensity of any further assessments are based on the individual's functioning; the setting; the individual's preferences for care, treatment, or services; and the individual's response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following:
- To evaluate his or her response to care, treatment, or services
- To respond to a significant change in status and/or diagnosis or condition
- To satisfy legal or regulatory requirements
- To meet time intervals specified by the organization
- To meet time intervals determined by the course of the individual's care, treatment, or services

Revised Elements of Performance for CTS.02.02.07

1. The organization reassesses each individual served, as needed.

2. For opioid treatment programs: Assessments are updated quarterly during the patient's first year of continuous treatment and semiannually during subsequent years.
Revised Standard CTS.02.02.09

When necessary or relevant to the care, treatment, or services provided, the organization has a process to perform medical histories, physical examinations, and diagnostic and laboratory test results not directly provided by the organization.

Revised Elements of Performance for CTS.02.02.09

1. When necessary or relevant to the care, treatment, or services provided, organizations that do not provide physical health assessments or diagnostic and laboratory tests arrange for such services to be provided by an outside source that is a recognized health care organization, laboratory, or qualified and competent licensed independent practitioner.

2. For opioid treatment programs: The program conducts initial toxicology tests as part of the admission process.
   Note: The recommended medical laboratory analysis and diagnostic evaluation may include the following as medically appropriate for the patient:
   - Vital signs, including blood pressure, pulse, respirations, and temperature
   - TB skin test, and chest x-ray if the skin test is positive (including consideration for anergy)
   - Screening test for syphilis
   - Complete blood count (CBC) and lipid panel
   - Liver function tests and viral hepatitis marker tests
   - HIV testing and counseling
   - Tests appropriate for the screening or confirmation of illnesses or conditions based on concerns specific to the patient regarding renal function, electrolyte imbalance, metabolic syndromes, pain, and so forth
   - Pregnancy test
   - Neurological or psychological testing and assessment
   - Chest x-ray
   - Electrocardiogram (EKG)
   - Pap smear
   - Screening test for sickle-cell disease
   - Additional diagnostic testing based on the results of baseline screening tests, especially when those results have the potential to affect treatment decisions

3. For opioid treatment programs: The medical assessment addresses symptoms of and risk factors for torsades de pointes and includes any follow-up tests that are indicated, such as an EKG or comprehensive electrophysiological assessment.

4. For opioid treatment programs: On admission, the program tests the patient for opiates, methadone, amphetamines, cocaine, marijuana, and benzodiazepines. The need for testing for additional substances is determined by individual patient circumstances and local drug use patterns.

5. For opioid treatment programs: The program collects toxicological specimens in a manner that demonstrates trust and respect while taking reasonable steps to prevent falsification of samples.
   Note: Direct observation, although necessary for some patients, is neither necessary nor appropriate for all patients.

6. For opioid treatment programs: The program uses drug and alcohol screening as aids to monitor and evaluate a patient's progress in treatment.

7. For opioid treatment programs: The program performs drug tests for each patient on an ongoing basis as frequently as required by law and regulation.
8. For opioid treatment programs: For patients in interim maintenance treatment, the program performs a urine screen upon admission and performs at least two additional urine screens if the patient is present for the maximum of 120 days permitted for interim treatment.

9. For opioid treatment programs: The program’s clinicians determine the ongoing drug-testing regime by analyzing individual circumstances and community drug use patterns.
   Note: Testing might include, but is not limited to, opiates, benzodiazepines, barbiturates, cocaine, marijuana, methadone and its metabolites, amphetamines, and alcohol.

10. For opioid treatment programs: Program staff discusses results of toxicology testing promptly with patients. The program documents both the results of toxicology tests and the follow-up therapeutic interventions in the patient record.

11. For opioid treatment programs: The program establishes and implements procedures for addressing potentially false positive and false negative toxicology test results. *
    Footnote *: TIP 43 outlines principles for handling potentially false positive and negative test results. See TIP 43,"Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" (CSAT 2005, chapter 9).

12. For opioid treatment programs: Clinicians determine the frequency of ongoing toxicological testing by evaluating the need for testing in relation to the patient’s stage in treatment.

13. For opioid treatment programs: Clinicians intervene when the patient discloses illicit drug use, has a positive drug test, or is suspected of diversion of opioid medication as evidenced by a lack of opioids or related metabolites in drug toxicology tests.

Revised Standard CTS.02.03.01
For organizations providing care, treatment, or services to a child or youth: The organization facilitates and coordinates family or guardian involvement throughout the assessment process.

Revised Elements of Performance for CTS.02.03.01

1. For organizations providing care, treatment, or services to a child or youth: The organization assesses the family's or legal guardian's expectations for and involvement in the assessment and initial and continuing care, treatment, or services.

2. For organizations providing care, treatment, or services to a child or youth: The organization clearly explains the family’s or legal guardian's role in achieving care, treatment, or service goals.

3. For organizations providing care, treatment, or services to a child or youth: The organization establishes procedures that facilitate ongoing communication with the family or legal guardian about their perceptions of the child’s or youth’s needs and other issues.

4. For organizations providing care, treatment, or services to a child or youth: In conducting the assessment, the organization distinguishes between data provided by the family or legal guardian or referral sources and data based on the organization's interaction with the child or youth.
Revised Standard CTS.02.03.03
For organizations providing care, treatment, or services to a child or youth: The organization assesses the needs of children or youth.

Revised Elements of Performance for CTS.02.03.03

1. For organizations providing care, treatment, or services to a child or youth: As relevant to the care, treatment, or services, assessment information defined by the organization to be collected during the initial assessment of a child or youth includes the following:
   - Legal custody status, including the clear identification of the legal guardian(s)
   - The use of a developmental perspective in evaluating all aspects of functioning, including the child’s or youth’s physical, emotional, cognitive, educational, nutritional, and social development
   - Assessment of normative development as related to chronological age
   - The child’s or youth’s leisure and recreation interests
   - The family history and current living situation
   - The family dynamics and their impact on the child’s or youth’s current needs
   - Family factors that should be considered in discharge planning

2. For organizations providing care, treatment, or services to a child or youth: When a physical health examination is done for a child or youth, it addresses the following:
   - Motor development and functioning
   - Sensorimotor functioning
   - Speech, hearing, and language functioning
   - Visual functioning
   - Immunization status
   - Oral health and oral hygiene
   (For more information about the physical health assessment, refer to Standard CTS.02.01.07.)
Revised Standard CTS.02.03.05

For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization assesses the needs of the individual.

Revised Elements of Performance for CTS.02.03.05

1. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization bases the individual's care, treatment, or services on his or her assessed needs and functioning.

2. For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities: The individual served receives at least an annual physical examination.

3. For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities: The physical examination includes the following:
   - Motor development and functioning
   - Sensorimotor functioning
   - Speech, hearing, and language functioning
   - Visual functioning
   - Immunization status
   - Oral health and oral hygiene
   (Refer to Standard CTS.02.01.07 for more information)
   Note: The physical examination can be performed by the organization or another provider.

4. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The assessment includes the following:
   - Social history
   - Cognitive functioning
   - Family support
   - Support to family
   - Presenting conditions
   - Other disabilities
   - When possible, the causes of the individual's disabilities
   - Additional needs related to age such as senior services or early childhood intervention services
   (Refer to Standard CTS.02.02.01 for more information)

5. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The emotional and behavioral functioning assessment also includes the following:
   - Adaptive behavior
   - Social functioning
   - Independent living skills
   - Talents, aptitudes, and interests
   - Need for assistive functioning
   (Refer to Standard CTS.02.02.01 for more information)
6. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The vocational functioning assessment of older youth and adults also includes the following:
   - Vocational training history
   - Work history
   - Work interests
   - Work skills
   - Work-related behaviors
   (Refer to Standard CTS.02.01.17 for more information)
   Note: The assessments can be provided by the organization or another provider.

7. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The educational assessment also includes the following:
   - Reading and math levels
   - Educational status/history
   - Intelligence testing
   - The current level of concrete and abstract reasoning
   (Refer to Standard CTS.02.01.13 for more information)
   Note: The assessments can be provided by the organization or another provider.

8. For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities: Individuals are reassessed when there are changes in their functioning or living situation. The reassessment includes those elements of the assessment that are relevant to the changes identified.
Revised Standard CTS.02.03.07

For organizations providing care, treatment, or services to individuals with addictions: The assessment includes the individual's history of addictive behaviors.

Revised Elements of Performance for CTS.02.03.07

1. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual's history of alcohol use, drug use, nicotine use, and other addictive behaviors. The history includes the following information:
   - Age of onset
   - Duration
   - Patterns of use (for example, continuous, episodic, binge)

2. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual's history of mental, emotional, behavioral, legal, and social consequences of dependence or addiction.

3. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains information related to the consequences of dependence or addiction (for example, legal problems, divorce, loss of family members or friends, job-related incidents, financial difficulties, blackouts, memory impairment).

4. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual's history of physical problems associated with substance abuse, dependence, and other addictive behaviors.

5. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the history of the use of alcohol and other drugs, and other addictive behaviors by the individual's family.

6. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual's perception of the role of spirituality or religion in his or her life.

7. For organizations providing care, treatment, or services to individuals with addictions: Assessments of the individual served contain information about previous care, treatment, or services.

8. For organizations providing care, treatment, or services to individuals with addictions: Assessments of the individual served contain information about the individual's response to previous care, treatment, or services.

9. For organizations providing care, treatment, or services to individuals with addictions: Assessments of the individual served contain information about the individual's relapse history.
Revised Standard CTS.02.03.09

For organizations providing care, treatment, or services to individuals with eating disorders: The organization assesses the individual’s food-related behaviors. (Refer to Standard CTS.04.02.17 for more information)

Note: This standard applies to all individuals with eating disorders regardless of setting.

Revised Elements of Performance for CTS.02.03.09

1. For organizations providing care, treatment, or services to individuals with eating disorders: The organization assesses the individual’s beliefs, perceptions, attitudes, and behavior regarding food. (Refer to Standard CTS.02.01.11 for more information)

2. For organizations providing care, treatment, or services to individuals with eating disorders: The organization includes family observations regarding the individual’s food-related behavior in the assessment, when available.
Revised Standard CTS.02.04.01
For foster care: The agency screens and assesses each individual to determine needed services and placement.

Revised Elements of Performance for CTS.02.04.01

1. For foster care: Each individual in foster care receives a physical status screening.
2. For foster care: Each individual in foster care receives a developmental status screening.
3. For foster care: Each individual in foster care receives an educational status screening.
4. For foster care: Each individual in foster care receives an emotional status screening.
5. For foster care: Each individual in foster care receives a behavioral status screening.
6. For foster care: Each individual in foster care receives a social status screening.
7. For foster care: Each individual in foster care receives a legal status screening.
8. For foster care: Each individual in foster care receives a spiritual status screening.
9. For foster care: Each individual in foster care receives a cultural and linguistic status screening.
10. For foster care: To the extent possible, the agency collects information about the individual served from the individual in foster care, the foster parents, the child’s or youth’s family of origin, and the guardian.
11. For foster care: The agency provides for a process for rapid assessment (triage) of the child's or youth's family resources to determine the appropriateness of foster or kinship care and to develop a preliminary plan.
   Note: Family resources can include the family of origin and the extended family.
12. For foster care: The agency develops a preliminary plan based on the triage assessment to meet the needs of the individual in foster care and match the foster home to the individual.
13. For foster care: The agency conducts an assessment to secure stable placement of the individual.
14. For foster care: The agency conducts an assessment within the time frame specified by the needs of the individual in foster care, agency policy, and law and regulation.
15. For foster care: Based on the assessment, the agency determines appropriateness of the match of the individual in foster care to a foster home.
16. For foster care: The agency arranges for the history and physical examination, any laboratory or diagnostic tests, dental examinations, and immunization status confirmation to be performed in a time frame that is in compliance with law and regulation and accommodates the best interest and welfare of the individual in foster care.
17. For foster care: If the state or county agency has done an initial assessment, the foster care agency receives and evaluates this information.
Revised Standard CTS.02.04.03
For foster and/or respite care: The agency develops criteria to match a foster or respite home to an individual.

Revised Elements of Performance for CTS.02.04.03

1. For foster and/or respite care: The agency develops criteria to match a foster or respite home to an individual that is based on an assessment to identify the needs of the individual and an assessment of the qualities of the foster or respite family.

2. For foster and/or respite care: The agency uses the criteria to match a foster or respite home to an individual.

3. For foster and/or respite care: The agency develops criteria to address emergency placements of individuals.

4. For foster and/or respite care: The agency uses the criteria to address emergency placements of individuals.

5. For foster and/or respite care: The assessment for emergency placement in foster or respite care contains basic information essential to the safety of the individual and the family.
Revised Standard CTS.02.04.05
For foster and/or respite care: The agency assesses each prospective foster parent or respite caregiver to determine whether he or she is eligible to be a foster parent or respite caregiver.

Revised Elements of Performance for CTS.02.04.05

1. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Physical health.

2. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Emotional capacity.

3. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Interpersonal relationships.

4. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Knowledge of developmental needs.

5. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Financial stability.

6. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Cultural and linguistic evaluations.

7. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: A willingness to be educated.

8. For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Criminal background checks, including background checks on any adult living in the home.

9. For foster and/or respite care: The assessment of a prospective foster parent or respite caregiver establishes the following:
   - That the prospective foster parent or respite caregiver is free from any diseases or physical conditions that have been determined to be a detriment to the welfare of the individual in foster or respite care
   - That the prospective foster parent or respite caregiver has the ability to nurture and provide care and supervision to the individual in foster or respite care
   - That the prospective foster parent or respite caregiver demonstrates mental and emotional stability

10. For foster and/or respite care: The agency assesses a foster parent or respite caregiver on an ongoing basis, but no less than annually.
    Note: This assessment may occur at various times throughout service as a foster parent or respite caregiver, such as at license renewal, when a new individual is placed in the home, when physical arrangements change in the home, or when background checks are necessary for any new adult who moves into the home.
Revised Standard CTS.02.04.07
For foster care of children and youth: The agency assesses the needs of the family of origin.

Revised Elements of Performance for CTS.02.04.07

1. For foster care of children and youth: The agency assesses the family of origin and determines the interventions necessary to keep the children or youth with their families or to reunify children and youth in foster care with their families. Note: Some of the necessary interventions may include help with communication and problem-solving, parenting skills, behavioral contingencies techniques and skills, daily living skills, housing, child care, health care, mental health care, substance abuse care, family therapy, and employment.

2. For foster care of children and youth: Based on the results of the assessment, the family of origin is provided access or referral to care, treatment, or services that would alleviate or mitigate the causes of foster placement.

3. For foster care of children and youth: The family-of-origin assessment occurs at intake and regularly thereafter or as directed by the case plan of the placing agency authority.

4. For foster care of children and youth: The agency obtains relevant information from the family-of-origin assessment when that assessment is performed by another provider.

5. For foster care of children and youth: The family-of-origin assessment is made a part of the child’s or youth’s clinical/case record, and services are coordinated with the agency referring the child or youth.

Revised Standard CTS.02.04.09
For foster care: The agency uses a defined process to determine out-of-home placement decisions.

Revised Elements of Performance for CTS.02.04.09

1. For foster care: The agency clearly delineates the process for making out-of-home placement decisions that may involve protective services, voluntary placement, or court orders.

2. For foster care: The agency defines how it plans to carry out the voluntary placement agreement or judicial determination.
Revised Standard CTS.02.04.11
For foster and/or respite care: The agency defines and uses criteria to determine the need for foster and/or respite care services.

Revised Elements of Performance for CTS.02.04.11

1. For foster and/or respite care: The agency defines written criteria to determine the appropriateness of foster and/or respite care for an individual served.

2. For foster and/or respite care: The agency uses its criteria to determine the appropriateness of foster and/or respite care for an individual served.

3. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: Safety.

4. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The need for care for adults and care and protection for children and youth.

5. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: Any need for intensive out-of-home care beyond foster and/or respite care.

6. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The inability of family or friends to care for the individual.

7. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The benefits to the individual of family-based care.

8. For foster and/or respite care: Agencies accepting referrals receive and review information from the public or custodial agency as part of intake.

9. For foster and/or respite care: Agencies accepting referrals determine if they can meet the needs of the individual.

Revised Standard CTS.02.04.13
For foster and/or respite care: The agency defines and uses criteria to identify prospective foster parents and/or respite caregivers.

Revised Elements of Performance for CTS.02.04.13

1. For foster and/or respite care: The agency defines written criteria to identify prospective foster parents and/or respite caregivers.

2. For foster and/or respite care: The agency uses its written criteria to identify and select prospective foster parents and/or respite caregivers.

3. For foster and/or respite care: The agency determines a recruitment plan that includes targeting and marketing to attract prospective foster parents or respite caregivers.
Revised Standard CTS.02.04.15

For foster and/or respite care: The agency develops and uses criteria to determine the number of individuals that can be placed in each foster and/or respite care home.

Revised Elements of Performance for CTS.02.04.15

1. For foster and/or respite care: The agency develops written criteria to determine the number of individuals in foster care that can be placed in each foster and/or respite care home.
   Note: Criteria may include the following:
   - The individual’s needs (emotional, developmental, psychological, behavioral, age-related, history of legal involvement, history of mental health needs, special restrictions, special physical care needs)
   - Resources available to the foster parent and/or respite caregiver (education, respite)
   - Support services (for example, extended family support, church support, community support)
   - Anticipated length of placement
   - Special-needs training for foster parents and/or respite caregivers
   - Prior experience as a foster care and/or respite caregiver
   - For children and youth, the number of biological children and number of siblings

2. For foster and/or respite care: The agency uses its criteria to determine the number of individuals in foster and/or respite care that can be placed in each home.

3. For foster and/or respite care: The maximum number of individuals living in each home complies with state and federal law and regulation.

Revised Standard CTS.02.04.17

For foster care: The agency uses guidelines in making placement decisions.

Revised Elements of Performance for CTS.02.04.17

1. For foster care: The agency uses guidelines in making placement decisions.
   Note: Guidelines can either be developed and written by the agency or adopted in accordance with law and regulation.

2. For foster care: Guidelines for making placement decisions include the following:
   - Consideration for placing the child or youth with kinship care providers (if an appropriate kinship house can be located) before placing in a non-relative foster care provider
   - Consideration for community, schools, visitation, placing siblings together, and the proximity of the child or youth to the family of origin
   - Being culturally responsive to the characteristics of both the individual in foster care and the families, to the best of the agency's ability
   - Consideration for any respiratory risks to an individual from passive smoke due to existing health issues, such as asthma
   - The utmost consideration for the safety and well-being of the individual in foster care
   Note: The individual’s best interest and special needs are paramount when considering placement in close proximity to the parent's home.

3. For individuals in foster care who are receiving educational services: To meet educational needs and prevent exacerbation of educational problems, the individual is placed, if possible, in his or her own community and school district for continuity of educational services.
Revised Standard CTS.02.04.19
For foster and/or respite care: The agency determines the competence of and how to select foster parents and/or respite caregivers.

Revised Elements of Performance for CTS.02.04.19

1. For foster and/or respite care: The agency develops a process to determine the competence and selection of foster parents and/or respite caregivers.

2. For foster and/or respite care: The agency follows its process to determine the competence and selection of foster parents and/or respite caregivers.

3. For foster and/or respite care: When determining competence and selection of foster parents and/or respite caregivers, the agency uses the following:
   - The application
   - The applicant’s references
   - Criminal background checks for all adults in the household
   - Child abuse registry checks for children and youth
   - Physical examinations
   - Home inspection reports
   - Language of the family
   - Interviews with foster parents and/or respite caregivers

4. For foster and/or respite care: When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on the applicant’s ability to care for individuals with special needs, such as physical or intellectual and developmental disabilities or emotional disturbances.

5. For foster and/or respite care: When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on competencies that match the level or type of foster and/or respite care.

6. For foster and/or respite care: The agency has a written policy for circumstances under which unlicensed alternative care providers must have a safety check. The policy takes into consideration the level of risk involved with the situation.

Revised Standard CTS.02.04.21
For foster care for children and youth: Individuals providing therapeutic foster care services receive ongoing training and supervision to maintain competence.

Revised Elements of Performance for CTS.02.04.21

1. For foster care for children and youth: Individuals providing therapeutic foster care services receive ongoing training to maintain competence.

2. For foster care for children and youth: Individuals providing therapeutic foster care services receive ongoing supervision to maintain competence.
The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.

Note: For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

Revised Standard CTS.03.01.01

The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and used in the plan for care, treatment, or services.

Revised Elements of Performance for CTS.03.01.01

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and used in the plan for care, treatment, or services.

2. Care, treatment, or service decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.

3. Planning for care, treatment, or services includes identifying objectives for the identified goals. (See also CTS.03.01.03, EP 3)

4. Planning for care, treatment, or services includes interventions and services necessary to meet the identified goals.

5. For opioid treatment programs: Concurrent abuse of other drugs is managed.

6. For opioid treatment programs: The program manages concurrent abuse of other drugs * within the context of the medication-assisted treatment. (See also CTS.03.01.03, EP 3)

Footnote *: Principles for managing concurrent abuse of other drugs are described in TIP 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs” (CSAT 2005).

7. For opioid treatment programs: For patients with two or more unsuccessful withdrawal episodes within a 12-month period, the program physician assesses the patient to determine what other forms of treatment should be considered.

8. For opioid treatment programs: The program includes smoking and tobacco cessation as an integral part of the treatment of patients who use tobacco.

9. For opioid treatment programs: Patients diagnosed with diseases that must be reported to the public health department (such as tuberculosis or sexually transmitted diseases) are either treated by the program or are referred for further evaluation and treatment elsewhere.

10. For opioid treatment programs: The program provides patients with free or low cost access to the immunizations recommended by the Centers for Disease Control and Prevention (CDC) either on site or through referral.

11. For opioid treatment programs: The program establishes linkages with community HIV/AIDS treatment programs, prevention programs, and social support services to continue opioid medication when AIDS becomes the patient’s primary health concern.
Revised Standard CTS.03.01.03

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Revised Elements of Performance for CTS.03.01.03

1. The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

2. The plan for care, treatment, or services includes the following:
   - Goals that are expressed in a manner that captures the individual’s words or ideas
   - Goals that build on the individual’s strengths
   - Factors that support the transition to community integration when identified as a need during assessment

   Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.

   Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

3. The objectives of the plan for care, treatment, or services meet the following criteria:
   - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)
   - They are sufficiently specific to assess the progress of the individual served
   - They are expressed in terms that provide indices of progress

4. The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual’s needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.

5. Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.

6. The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.

7. For opioid treatment programs: Treatment plans are updated when there are changes in the patient’s problems, needs or response to treatment or, if no changes occur, at least quarterly during the patient’s first year of continuous treatment and semiannually during subsequent years.

8. For opioid treatment programs: The program offers people living with HIV/AIDS medication-assisted treatment that addresses medication side effects and toxicity.

9. For opioid treatment programs: The program supports a patient’s decision to breast-feed during methadone treatment, unless medically contraindicated, such as by the presence of HIV or HTLV1 or II infection in the mother.

10. For opioid treatment programs: Voluntary withdrawal from medication-assisted treatment is medically supervised and occurs at a rate well tolerated by the patient and in accordance with sound clinical judgment.

   Note: Voluntary withdrawal can occur when the physician and patient agree to the process or when the patient requests withdrawal against medical advice. Voluntary supervised withdrawal is distinct from involuntary tapering or administrative withdrawal (refer to Standard CTS.06.02.01).
11. For opioid treatment programs: The program offers a variety of options to promote successful medically supervised withdrawal, including increased counseling prior to discharge and encouraging attendance at a 12-step or other mutual help program that accepts individuals receiving medication-assisted treatment.

12. For opioid treatment programs: For medically supervised withdrawal against medical advice: The program explains the risks of leaving treatment and provides information about or referral to alternate treatment options.

13. For opioid treatment programs: For medically supervised withdrawal against medical advice: When a patient leaves the program abruptly, the program allows the patient to be readmitted without repeating the initial assessment procedures if the readmission is within 30 days.

14. For opioid treatment programs: For medically supervised withdrawal against medical advice: The program documents the reasons given by the patient for seeking medically supervised withdrawal against medical advice and documents all steps taken to avoid discharging the patient.

15. For opioid treatment programs: For medically supervised withdrawal against medical advice: If medically supervised withdrawal fails, the physician evaluates the appropriateness of resuming maintenance treatment.

16. For opioid treatment programs: For medically supervised withdrawal against medical advice: For a pregnant patient, the program informs the physician or agency providing prenatal care that the patient is undergoing medically supervised withdrawal, consistent with federal privacy standards.

**Revised Standard CTS.03.01.05**

The plan for care, treatment, or services addresses the family's involvement.

**Revised Elements of Performance for CTS.03.01.05**

1. The family of the individual served is involved in developing the plan for care, treatment, or services upon consent from the individual (if an adult) or in accordance with law and regulation (if a minor).

2. The plan for care, treatment, or services reflects family participation in care, treatment, or services unless such participation is contraindicated.

3. The organization documents family participation (if any) in the individual's record of care, treatment, or services.
Revised Standard CTS.03.01.07
When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record.

Revised Elements of Performance for CTS.03.01.07

1. The organization refers individuals served to an outside source when care, treatment, or services needed are not directly provided by the organization.

2. Concurrent care, treatment, or services provided by an outside source that are integral to meeting goals and objectives are addressed in the plan for care, treatment, or services.

3. The organization documents referrals of individuals served to outside sources in the clinical/case record.

4. For opioid treatment programs: The program helps female patients with infants that may be susceptible to neonatal abstinence syndrome to obtain a comprehensive evaluation and treatment for the infant.

5. For opioid treatment programs: The program offers referrals to parenting support groups or other services to patients in medication-assisted treatment who have children.
   
   Note: Children of patients in medication-assisted treatment may also need a referral for services because they may have special mental health and cognitive needs, especially if abuse or neglect has occurred.

6. For opioid treatment programs: The program offers or provides referrals for child care services to patients in medication-assisted treatment who have children.

7. For opioid treatment programs: If the program refers the patient elsewhere for prenatal care, it seeks reciprocity in the exchange of pertinent clinical information about compliance with the recommended course of medical care, in accordance with federal privacy regulations.

8. For opioid treatment programs: If a pregnant woman refuses direct prenatal services or appropriate referral for such care, the program’s treating physician or designee has the patient formally acknowledge in writing that the program offered these services but the patient refused them.

9. For opioid treatment programs: The program refers the patient for appropriate treatment if the assessment identifies mental health needs.

Revised Standard CTS.03.01.09
The organization assesses the outcomes of care, treatment, or services provided to the individual served.

Revised Elements of Performance for CTS.03.01.09

1. The organization monitors the individual’s progress in achieving his or her care, treatment, or service goals.

2. The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves.
Revised Standard CTS.03.02.01

For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization addresses the needs, strengths, preferences, and goals of individuals.

Revised Elements of Performance for CTS.03.02.01

1. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: Individuals served and, as appropriate, their families or advocates have the opportunity to participate in the planning process by expressing their needs and preferences, in regard to care, treatment, or services.

2. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization reviews the individualized plan of care, treatment, or services when the following occurs:
   - Change(s) in functioning
   - Change(s) in living situation
   - Change(s) in employment status and situations
   - Bereavement for a significant other
   - Introduction of assistive technology
   - Other major change(s), or at least at intervals in accordance with organization policy

3. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization accommodates the preferences of the individual served and his or her family, or, if it cannot, it finds the best options available.

4. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: When the individual’s identified needs, strengths, and preferences include developing skills for activities of daily living, the plan of care, treatment, or services includes the following:
   - Goals sufficiently specific to evaluate the progress made toward developing skills for activities of daily living
   - The interventions to be used
   - The frequency of the use of the interventions
Revised Standard CTS.03.02.03
For foster care: The agency develops and periodically reviews its case plans.

Revised Elements of Performance for CTS.03.02.03

1. For foster care: The agency develops a case plan.
2. For foster care: The agency evaluates the case plan in a time frame that is in accordance with organization policy and law and regulation.
3. For foster care: The agency involves relevant persons in evaluating the case plan.
   Note: These persons may include agency staff, the individual served, the foster parent(s), the family of origin (for children and youth only), and the representative of the state authority.
4. For foster care: The case plan is individualized based on an assessment of the emotional, behavioral, developmental, educational, spiritual, social, physical, cultural, linguistic, and legal status of the individual in foster care as well as that of the family of origin.
5. For foster care: The case plan identifies the permanency goal if the individual in foster care is a child or youth.
6. For foster care: The agency reviews and revises the case plan as needed to determine the continuing necessity for placement.
7. For foster care: The case planning process includes an assessment of preparation for transitional living when older youth or adults are discharged from foster care. (For more information on young adults preparing for transitional living, see Standard CTS.06.03.01)
   Note: Services for older youth or adults that help them develop skills necessary for independence include the following:
   - Employment career planning assessments
   - Financial management
   - Daily living skills (for example, cooking, transportation)
   - Completing high school or general educational development (GED)
   - Job search training
   - Vocational training
   Other possible services that prepare older youth or adults for independence include developing support systems and exploring educational needs such as GED programs/college, social/relationship skills, and parenting skills, when applicable.
8. For foster care: When the agency has custody of the individual in foster care, the agency is responsible for case planning.
9. For foster care: If the county or state agency retains custody and is responsible for the case plan, the foster care agency participates in developing and evaluating the plan.
The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization's scope of care, treatment, or services.

**Revised Standard CTS.04.01.01**

The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization's scope of care, treatment, or services.

**Revised Elements of Performance for CTS.04.01.01**

1. The organization coordinates the care, treatment, or services provided through internal resources to an individual served.

2. For acute 24-hour settings, a registered nurse plans, assigns, supervises, provides, and evaluates nursing care to individuals served.
   - Note: "Acute 24-hour settings" includes inpatient crisis stabilization or medical detoxification.

3. The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of information regarding the individual served.
   - Note: Such information may include the condition, care, treatment, medications, and services of the individual served, as well as any recent or anticipated changes to any of these.

4. When external resources are needed, the organization participates in coordinating care, treatment, or services with these resources.

5. The organization has a process to receive or share relevant information on the individual served to facilitate coordination and continuity when individuals are referred to other care, treatment, or service providers.

6. The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the behavioral health needs of the individual served.

7. When needs are identified for which the organization does not directly provide care, treatment, or services, the organization refers individuals served to an outside source.

8. Before taking action on a verbal order or verbal report of a test result, staff uses a record and "read back" process to verify the information.

9. For opioid treatment programs: The program works with the criminal justice system to provide continuous treatment to patients who are incarcerated, on probation, or on parole.

10. For opioid treatment programs: The program develops referral and consultative relationships with other agencies and providers that can provide services to treat patients for any psychiatric co-morbid conditions, medical complications, and communicable diseases.

11. For opioid treatment programs: When a patient is being treated for mental health issues, the program and the mental health provider jointly review the prescribed medications.

12. For opioid treatment programs: When a patient has hepatitis C, the program coordinates its treatment with the agency responsible for medical treatment. Attention is paid to the patient’s adherence to the medication regimen and adverse events.

13. For opioid treatment programs: The program notifies the state health officer both when a patient begins and leaves interim maintenance treatment and notifies the state health officer in advance when the patient is transferred to a comprehensive maintenance treatment program. All such notifications are documented.
Revised Standard CTS.04.01.03
The individual served receives education and training specific to the individual's needs and abilities consistent with the care, treatment, or services provided.
Note: This Standard does not apply to academic education.

Revised Elements of Performance for CTS.04.01.03

1. Education provided is based on the needs and abilities of the individual served.
2. The assessment of learning needs addresses the individual's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.
3. Education provided to the individual served is coordinated among the disciplines providing care, treatment, or services.
4. Based on the assessed needs and abilities of the individual served and the organization's scope of care, treatment, or services, the individual is educated about the following:
   - The plan for care, treatment, or services
   - Basic health practices and safety
   - The safe and effective use of medications
   - Nutrition interventions, modified diets, and oral health, as needed
   - Habilitation or rehabilitation techniques to help him or her reach the maximum level of independence possible
5. The content of the education provided to the individual served is presented in an understandable manner.
6. Teaching methods accommodate various learning styles.
7. The individual's comprehension of the education provided is evaluated.
8. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The nature of addictive disorders.
9. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The benefits of treatment and nature of the recovery process, including the phases of treatment.
10. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Clinic guidelines, rules, and regulations, including the requirement to sign a formal agreement of consent, and fees and billing procedures.
11. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Noncompliance and discharge procedures, including administrative withdrawal from medication.
12. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Toxicology testing procedures.
13. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Dispensing medication.
14. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Potential drug interactions.
15. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Any agreements needed in order to exchange appropriate information within the network of consultants and referral agencies (in accordance with HIPAA regulations).

16. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The availability of any 12-step or other mutual help group that is accepting of medication-assisted treatment and of the benefits of peer support.

17. For opioid treatment programs: The program documents that it informed and counseled the pregnant patient about the latest patient information sheets and product inserts for methadone.

18. For opioid treatment programs: If prenatal care is not available on site or by referral, or if the pregnant patient refuses prenatal care, the treatment program offers basic prenatal instruction on maternal, physical, and dietary care. Provision of the education is documented in the clinical record.

19. For opioid treatment programs: The program offers or refers the patient education and training for all patients who are parents or refers patients to parenting skills.

20. For opioid treatment programs: The program offers reproductive health education and referrals for contraceptive services.

21. For opioid treatment programs: The program educates patients about HIV/AIDS, including testing procedures, confidentiality, reporting, follow-up care, counseling, safer sex, social responsibilities, universal precautions, and sharing of intravenous injection equipment.

22. For opioid treatment programs: The program provides education to patients about viral hepatitis and its effects on physical and mental health, including prevention, treatment, and the effects of treatment on dosage levels of opioid medications.

23. For opioid treatment programs: The program provides education to patients about preventing HIV infection and other prevalent infectious diseases, such as hepatitis, sexually transmitted infections, and tuberculosis.
Revised Standard CTS.04.02.01
For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization recognizes and addresses the personal preferences of the individual served.
Note: The personal preferences of the individual served are addressed by the organization to the extent feasible.

Revised Elements of Performance for CTS.04.02.01
1. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization's philosophy is to recognize and support the preferences of each individual served.
2. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: To the extent feasible for each individual served, the organization fosters a quality of life comparable to that experienced by most people.
3. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The setting of care, treatment, or services supports the personal experiences, appearance, and behavior of each individual served.
4. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The social and living environment offers the individual a variety of social and community experiences that facilitate the development of self-awareness, independence, and use of personal strengths and skills.
5. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The individual served participates in formulating policies that affect his or her living and social environment.
Revised Standard CTS.04.02.03
For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization provides
for the health maintenance of all individuals with intellectual and developmental disabilities, including early detection and remediation of health
needs.

Revised Elements of Performance for CTS.04.02.03

1. For organizations providing 24-hour care to individuals with intellectual and developmental disabilities: Height is monitored at least quarterly
   for children and youth until cessation of growth.
2. For organizations providing 24-hour care to individuals with intellectual and developmental disabilities: Weight is monitored at least quarterly,
   or more frequently if needed, as determined by the individual’s physical health care practitioner.
3. For organizations providing 24-hour care to individuals with intellectual and developmental disabilities: The organization provides needed
   assistive technology directly, through contractual arrangement, or by referral to an outside source.
4. For organizations prescribing anticonvulsant drugs to individuals with intellectual and developmental disabilities and seizure activity:
   Physicians define the frequency and method of monitoring anticonvulsant drug levels. (See also MM.07.01.01)
5. For organizations prescribing anticonvulsant drugs to individuals with intellectual and developmental disabilities and seizure activity:
   Anticonvulsant drug levels are monitored regularly as part of the individual's physical health maintenance program, and the findings are
   documented in the clinical/case record. (See also MM.07.01.01)
6. For organizations providing physical therapy to individuals with intellectual and developmental disabilities: A qualified individual supervises
   and coordinates the physical therapy services.

Revised Standard CTS.04.02.05
For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization records
the use of assistive technology in the clinical/case record.

Revised Elements of Performance for CTS.04.02.05

1. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization
   includes the following in the clinical/case record of individuals who use assistive technology:
   - The condition that requires the assistive technology
   - The schedule or conditions for using the assistive technology
   - The intended results of using the assistive technology
Revised Standard CTS.04.02.07
For foster care: The foster parent(s) receives information and education to meet the needs of the individuals placed in his or her care.

Revised Elements of Performance for CTS.04.02.07

1. For foster care: Each foster parent receives preservice orientation, in-service training, and ongoing education.
2. For foster care: Orientation of each foster parent includes information on the following: Philosophy and practices of the agency.
3. For foster care: Orientation of each foster parent includes information on the following: The foster parent’s role.
4. For foster care: Orientation of each foster parent includes information on the following: The agency’s policies and procedures regarding discipline.
5. For foster care: Orientation of each foster parent includes information on the following: The agency’s role in helping the foster parent serve individuals placed in his or her care.
6. For foster care: Education is provided to each foster parent about the following: The individual's specific behavioral problems and health conditions.
7. For foster care: Education is provided to each foster parent about the following: Community resources.
8. For foster care: Education is provided to each foster parent about the following: First aid.
9. For foster care: Education is provided to each foster parent about the following: Safety.
10. For foster care: Education is provided to each foster parent about the following: The individual's medications.
11. For foster care: Education is provided to each foster parent about the following: Infection prevention and control.
12. For foster care: Education is provided to each foster parent about the following: The health risks of passive smoking.
13. For foster care: Education is provided to each foster parent about the following: Provision of emergency medical and mental health services, as needed.
14. For foster care: Education is provided to each foster parent about the following: The agency's visitation policies and scheduling of the visits.
15. For foster care: Education is provided to each foster parent about the following: Sitter policies.
16. For foster care: Each foster parent also participates in agency-approved education as required.
Revised Standard CTS.04.02.09
For respite care: The respite caregiver receives information needed to meet the needs of the individual placed in his or her care.

Revised Elements of Performance for CTS.04.02.09

1. For respite care: The information provided by the organization to each respite caregiver includes the following:
   - Needs, strengths, and preferences of the individual served
   - Medication(s) for the individual served
   - First aid
   - Safety
   - Provision of emergency medical care
   - Specific health conditions of the individual served

Revised Standard CTS.04.02.11
For organizations providing care, treatment, or services to children or youth: The plan for care, treatment, or services reflects needed educational services for every child or youth whose care, treatment, or services cause a significant absence from school.

Revised Elements of Performance for CTS.04.02.11

1. For organizations providing care, treatment, or services to children or youth: An individual education plan is developed for each child or youth whose care, treatment, or services cause a significant absence from school.

2. For organizations providing care, treatment, or services to children or youth: Qualified individuals provide educational services to children and youth whose care, treatment, or services cause a significant absence from school.

Revised Standard CTS.04.02.13
For organizations providing care, treatment, or services to children or youth: The organization provides academic education to children and youth as needed.

Revised Elements of Performance for CTS.04.02.13

1. For organizations providing care, treatment, or services to children or youth: The organization defines the length of stay and absence from school that would require providing educational services in accordance with applicable law and regulation.

2. For organizations providing care, treatment, or services to children or youth: The organization has a written policy that addresses the role of education as a therapeutic activity and protects children and youth from losing ground academically while receiving care, treatment, or services.
Revised Standard CTS.04.02.15
For organizations providing care, treatment, or services to children or youth: The organization facilitates educational continuity for children and youth.

Revised Elements of Performance for CTS.04.02.15

1. For organizations providing care, treatment, or services to children or youth: The organization facilitates communication with the child’s or youth’s school about past academic functioning and achievement.

2. For organizations providing care, treatment, or services to children or youth: The organization promotes regular communication among teachers, clinical and child-care staff, and parent or guardian.

3. For organizations providing care, treatment, or services to children or youth: The organization provides consistent intervention between teachers and clinical and child-care staff, as defined in the plan for care, treatment, or services.

Revised Standard CTS.04.02.17
For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s weight and food-related behaviors. (Refer to CTS.02.03.09 for more information)
Note: This standard applies to all individuals with eating disorders regardless of setting.

Revised Elements of Performance for CTS.04.02.17

1. For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s weight in accordance with organizational policy.

2. For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s food-related behaviors.
Revised Standard CTS.04.03.01
For organizations providing employment assistance: The organization assists the individual served in preparing for, gaining, maintaining, and/or improving employment, in accordance with the plan for care, treatment, or services.

Revised Elements of Performance for CTS.04.03.01

1. For organizations providing employment assistance: The organization assists the individual served in determining his or her desire to work.
2. For organizations providing employment assistance: The organization assists the individual served in identifying his or her personal interests, values, and vocational preferences.
3. For organizations providing employment assistance: The organization assists the individual served in identifying his or her employment needs.
4. For organizations providing employment assistance: The organization assists the individual served in identifying or refining his or her employment goals.
5. For organizations providing employment assistance: The organization assists the individual served in identifying employment opportunities (for example, reviewing employment ads, browsing the Internet) and in preparations to secure employment (for example, preparing resumes, completing applications).
6. For organizations providing employment assistance: The organization assists the individual served in developing the skills and supports needed to maintain employment.

Revised Standard CTS.04.03.03
For organizations that provide vocational rehabilitation services: The organization monitors changes in the local job market to facilitate employment of the individual served.

Revised Elements of Performance for CTS.04.03.03

1. For organizations that provide vocational rehabilitation services: The organization establishes and maintains relationships with other agencies providing employment services, vocational rehabilitation, and state vocational rehabilitation departments. Note: Vocational rehabilitation is defined as a service or program designed to attain, retain, or restore vocational skills of persons experiencing limited functioning. Vocational rehabilitation services may include vocational evaluation services, employment skills training, work activities, and supportive employment.
2. For organizations that provide vocational rehabilitation services: The organization establishes and maintains relationships with the business community.
3. For organizations that provide vocational rehabilitation services: The organization makes staff available to employers upon request to address stigma issues and concerns (for example, speakers, educators, referrals).
4. For organizations that provide vocational rehabilitation services: The organization monitors employment and unemployment trends in the community.
5. For organizations that provide vocational rehabilitation services: The organization makes improvements to service design and offerings in response to employers’ changing personnel and skill needs.
Revised Standard CTS.04.03.05
For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her desire for training and assessing needs, strengths, preferences, and goals related to training.

Revised Elements of Performance for CTS.04.03.05

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her desire for training.

2. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Pre-employment education/training.

3. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Training and education at the work site.

4. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Skill building, both pre-employment and at the work site.

5. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Assistance coaching.

6. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Long-term training and support needs.

7. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following: Peer and family support in these endeavors.
Revised Standard CTS.04.03.07

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her needs related to securing and maintaining employment.

Revised Elements of Performance for CTS.04.03.07

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Personal grooming and appearance.

2. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Assistive technologies or accommodations.

3. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Transportation.

4. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Clothing.

5. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Benefits counseling and management of wages.

6. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Social/cultural concerns.

7. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Safety risks.

8. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Flexibility in terms of scheduling and transportation.

9. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Assessment and support planning coordination with other service providers.

10. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following: Family or community support.
Revised Standard CTS.04.03.09
For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports related to securing and maintaining employment.

Revised Elements of Performance for CTS.04.03.09

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Previous work history including volunteer activities.

2. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Skills and experiences in seeking employment (for example, completing applications, interviewing).

3. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Current work skills and the potential for improving skills or developing new ones.

4. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Educational background.

5. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Cognitive skills and abilities.

6. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Physical abilities.

7. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following: Work habits related to tardiness, absenteeism, dependability, honesty, and relations with coworkers and supervisors.

Revised Standard CTS.04.03.11
For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her interests related to securing and maintaining employment.

Revised Elements of Performance for CTS.04.03.11

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own expectations for the personal, financial, and social benefits of working.

2. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own aptitudes, interests, and motivations toward involvement in various job-related activities.

3. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own desire for career planning assistance.
Revised Standard CTS.04.03.13
For organizations that provide vocational rehabilitation services: The organization assists the individual served to gain employment if such a goal is part of his or her plan for care, treatment, or services.

Revised Elements of Performance for CTS.04.03.13

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in developing a plan for employment that focuses on the individual's employment goals and objectives.

2. For organizations that provide vocational rehabilitation services: The organization develops a written employment plan that is specific to the individual served.

3. For organizations that provide vocational rehabilitation services: The written employment plan includes the following:
   - The types of employment, school, and/or training for which the individual served is qualified or interested
   - The goals of the individual served
   - Barriers to employment (for example, transportation, written or verbal communication skills, child care needs)
   - Resources available to address barriers
   - Assessment of employment opportunities available to the individual served based on preferences, barriers, and available positions within the local job market
   - A description of how wages may impact existing benefits
   - Alternatives to any lost benefits

4. For organizations that provide vocational rehabilitation services: The organization documents decisions that the individual served has made regarding accepting or declining employment opportunities.

5. For organizations that provide vocational rehabilitation services: The organization reviews opportunities and procedures for requesting changes to the employment plan with the individual served.

6. For organizations that provide vocational rehabilitation services: Once employment has occurred, the organization assesses the individual's satisfaction with his or her employment on a timetable established by the organization.

7. For organizations that provide vocational rehabilitation services: The organization monitors employer satisfaction with an individual that they employ, according to a schedule determined by the organization.
Revised Standard CTS.04.03.15
For 24-hour settings: In accordance with the needs of the individual served, good standards of personal hygiene and grooming are taught and maintained, particularly bathing, brushing teeth, caring for hair and nails, and using the toilet, with due regard for privacy.

Revised Elements of Performance for CTS.04.03.15

1. For 24-hour settings: Articles for grooming and personal hygiene based on the age, developmental level, and needs of the individual served are available and accessible.

2. For 24-hour settings: The individual served is encouraged to take responsibility for maintaining his or her own living quarters and for day-to-day housekeeping activities of the program, according to the individual’s ability.

3. For 24-hour settings: An oral care program is implemented as indicated by the needs of the individual served and includes the following components:
   - The method(s) of providing or referring individuals for regular dental care
   - The method(s) for providing emergency dental care
   - The proper storage and labeling of oral hygiene supplies
   - As needed, labeling, cleaning, and storing of oral prostheses and appliances

4. For 24-hour settings: The organization offers education on grooming activities based on the needs of the individual served.

5. For 24-hour settings: The individual served has access to the services of a barber or beautician, either in the organization or community.

6. For 24-hour settings: Individuals served get the help needed to perform self care activities and, when indicated, assume responsibility for self-care.

7. For 24-hour settings: Incontinent individuals are cleaned or bathed immediately after voiding or soiling, with due regard for privacy.

Revised Standard CTS.04.03.17
For organizations that use activity therapies: Activity therapies that are used to support achievement of a specific goal(s) are incorporated into the plan for care, treatment, or services.

Revised Elements of Performance for CTS.04.03.17

1. For organizations that use activity therapies: The individual’s plan for care, treatment, or services identifies activity therapies provided to support achievement of a specific goal(s).

2. For organizations that use activity therapies: Activity therapies provided to support achievement of a specific goal(s) reflect the individual’s interests and preferences.
Revised Standard CTS.04.03.19
For 24-hour settings: The organization provides recreational and diversional activities.

Revised Elements of Performance for CTS.04.03.19

1. For 24-hour settings: The organization selects diversional or recreational activities based on the age(s) and population(s) served.
2. For 24-hour settings: The organization’s diversional or recreational activities include, whenever possible, each individual served.
3. For 24-hour settings: The organization arranges for safe access to the outdoors as appropriate to the population(s) served and when individuals served experience long lengths of stay.

Revised Standard CTS.04.03.21
For organizations that use animal-assisted therapy: The therapy is provided safely and in accordance with the individual’s plan of care, treatment, or services.
Note: Animal-assisted therapy is distinct from having pets in the organization. This standard does not apply to pets kept in the organization.

Revised Elements of Performance for CTS.04.03.21

1. For organizations that use animal-assisted therapy: Each individual is assessed to determine whether he or she is a candidate for animal-assisted therapy and whether the individual has any contraindications to animal-assisted therapy.
2. For organizations that use animal-assisted therapy: The organization establishes procedures for the safety of the individuals served. (See also IC.02.01.01, EP 13)
3. For organizations that use animal-assisted therapy: Training of the staff includes the following:
   - Safe handling of animals
   - Therapeutic goals of the animal-assisted therapy
   - Safety of individuals served
   - Supervision of the individuals served during animal-assisted therapy
   (Refer to Standard HR.01.05.03 for more information on staff training)
4. For organizations that use animal-assisted therapy: The organization establishes guidelines for selecting animals that include the following:
   - Population(s) of individuals served
   - Health of animals
   - Vaccination status (See also EC.02.01.05, EP 4)
   - Temperament of the animals
Revised Standard CTS.04.03.23

For organizations that conduct outdoor/wilderness experiences: The organization safely conducts outdoor/wilderness experiences.

Note: This standard refers to an activity conducted for therapeutic reasons in remote areas away from the organization’s premises (for example, a wilderness experience). It does not refer to daily activities that may be conducted outside, such as going to community parks, participating in park district activities, and visiting the zoo.

Revised Elements of Performance for CTS.04.03.23

1. For organizations that conduct outdoor/wilderness experiences: Prior to the individual served engaging in an outdoor/wilderness experience, the organization communicates to its staff any special precautions related to the individual of which staff should be aware.

2. For organizations that conduct outdoor/wilderness experiences: The organization has a written plan to manage emergency situations that could occur during an outdoor/wilderness experience that includes the following:
   - How the organization will contact staff during the experience
   - How staff will contact the organization during the experience
   - How to handle a natural emergency (for example, weather, fire, landslide)
   - How to conduct an evacuation
   - How to remove an individual served from the experience

3. For organizations that conduct outdoor/wilderness experiences: The organization establishes a mechanism by which it will maintain a means of contact with all staff participating in the outdoor/wilderness experience.

4. For organizations that conduct outdoor/wilderness experiences: The organization determines what identifying information is to be carried by each individual served during an outdoor/wilderness experience.

5. For organizations that conduct outdoor/wilderness experiences: The organization develops and communicates to staff the guidelines for permissible activities based on the level of risk involved in each activity.

6. For organizations that conduct outdoor/wilderness experiences: The organization communicates the level of acceptable risk for the outdoor/wilderness activity to the outdoor/wilderness experience’s direct care staff.

7. For organizations that conduct outdoor/wilderness experiences: Prior to the individual’s enrollment in the outdoor/wilderness experience, the organization provides the individual and his or her guardian with a complete and accurate description of all planned off-site activities.

8. For organizations that conduct outdoor/wilderness experiences: The organization provides individuals served with the instruction needed to minimize the risk of physical or psychological harm associated with each outdoor/wilderness activity.
Revised Standard CTS.04.03.25
For organizations that conduct outdoor/wilderness experiences: Organizations determine that staff who engage in an outdoor/wilderness experience are qualified and competent.
Note 1: This standard refers to an activity conducted for therapeutic reasons in remote areas away from the organization's premises (for example, a wilderness experience). It does not refer to daily activities that may be conducted outside, such as going to community parks, participating in park district activities, and visiting the zoo.
Note 2: Requirements for assessing competence appear in the “Human Resources” (HR) chapter.

Revised Elements of Performance for CTS.04.03.25

1. For organizations that conduct outdoor/wilderness experiences: The outdoor/wilderness experience staff are qualified and physically able to lead the experience.
2. For organizations that conduct outdoor/wilderness experiences: The outdoor/wilderness experience staff are qualified to provide first aid and basic life support (CPR).
3. For organizations that conduct outdoor/wilderness experiences: The organization assigns staff to an outdoor/wilderness experience based on the sex of the individuals served.
4. For organizations that conduct outdoor/wilderness experiences: Staff are trained in using the outdoor/wilderness experience as a therapeutic intervention.

Revised Standard CTS.04.03.27
For organizations providing family support services: The plan for care, treatment, or services identifies the role of families.
Note: Family support is distinct from family therapy and family counseling.

Revised Elements of Performance for CTS.04.03.27

1. For organizations providing family support services: The individual served determines the role of family members and their access to information in accordance with his or her age, and law and regulation.
2. For organizations providing family support services: Family members providing support are involved in developing the plan for care, treatment, or services when indicated by the individual served.
3. For organizations providing family support services: The plan for care, treatment, or services reflects the roles and participation of family members designated by the individual served to provide support.
Revised Standard CTS.04.03.29
For organizations providing family support services: Family members are offered information, assistance, and education as needed to facilitate their roles and participation in meeting the needs of the individual served.
Note: Family support is distinct from family therapy and family counseling.

Revised Elements of Performance for CTS.04.03.29

1. For organizations providing family support services: Family members providing support are offered information, assistance, and education as needed from the organization on at least the following: Their roles and responsibilities.
2. For organizations providing family support services: Family members providing support are offered information, assistance, and education as needed from the organization on at least the following: Crisis recognition.
3. For organizations providing family support services: Family members providing support are offered information, assistance, and education as needed from the organization on at least the following: Available community resources to respond to a crisis.

Revised Standard CTS.04.03.31
For organizations providing peer support: The plan for care, treatment, or services addresses the involvement of peer support when provided.

Revised Elements of Performance for CTS.04.03.31

1. For organizations providing peer support: The individual served determines the amount of information that can be accessed by, and the involvement of, peers providing support.
2. For organizations providing peer support: Peers providing support assist in developing the plan for care, treatment, or services, when indicated by the individual served.
3. For organizations providing peer support: The plan for care, treatment, or services reflects the inclusion of peer support, as determined by the individual served.
Revised Standard CTS.04.03.33
For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.

Revised Elements of Performance for CTS.04.03.33

1. For organizations providing food services: Food and nutrition products are provided to the individual served as appropriate to the care, treatment, or services being provided.
2. For organizations providing food services: Food and nutrition products are prepared under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
3. For organizations providing food services: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
4. For organizations providing food services: Cultural, religious, and ethnic food preferences of the individual served are honored when possible, unless contraindicated.
5. For organizations providing food services: Staff assist the individual served who requires help eating.
6. For organizations providing food services: Special diets and altered diet schedules are accommodated.
7. For organizations providing food services: Meals and snacks are served at times that are normal and appropriate for the age of the individual served.
8. For organizations providing food services: The organization assigns responsibility for preparing, storing, distributing, and administering food and nutrition therapy products.
9. For organizations providing food services: The dining areas used by individuals served are adequately supervised.
Revised Standard CTS.04.03.35
The organization responds to medical emergencies according to organization policy and procedures.

Revised Elements of Performance for CTS.04.03.35

1. The organization develops a written policy and procedures for responding to medical emergencies such as respiratory arrest and cardiac arrest.

2. Policy and procedures that address medical emergencies include the following:
   - Availability of first aid and basic life support services
   - Emergency transfer to another organization
   - Placement of a phone call to 911

3. The organization responds to medical emergencies according to organization policy and procedures.

4. For opioid treatment programs: The program’s offices and waiting areas display the names and telephone numbers of whom to contact in case of emergency or 911 or similar local emergency resources.

5. For opioid treatment programs: The program has staff on duty who are trained and proficient in the following:
   - Cardiopulmonary resuscitation (CPR) through an evidence-based training program
   - Management of opiate overdose
   - Management of medical emergencies
   - Other appropriate techniques

Revised Standard CTS.05.01.01
The organization prohibits the use of any procedure that physically harms or is a psychological risk to the individual served.

Revised Elements of Performance for CTS.05.01.01

1. At a minimum, the following are prohibited: Procedures that deny any basic needs, such as nutritious food, water, shelter, and essential and safe clothing.

2. At a minimum, the following is prohibited: Corporal punishment.

3. At a minimum, the following are prohibited: Fear-eliciting procedures.

4. At a minimum, the following is prohibited: The use of intimidation, force, or threat.
Revised Standard CTS.05.02.01
For organizations that use exclusionary time-out: Time-out for behavioral reasons is provided safely and based on the needs of the individual served.

Revised Elements of Performance for CTS.05.02.01

1. For organizations that use exclusionary time-out: Written policies and procedures limit the use of time-out for behavioral reasons to no more than 30 minutes.
2. For organizations that use exclusionary time-out: The organization implements its written policies and procedures limiting the use of time-out for behavioral reasons.
3. For organizations that use exclusionary time-out: The time-out for behavioral reasons is consistent with the individual’s plan for care, treatment, or services.
4. For organizations that use exclusionary time-out: The time-out for behavioral reasons occurs only in an unlocked room.
5. For organizations that use exclusionary time-out: The individual served is educated about the conditions under which time-outs for behavioral reasons are used.
6. For organizations that use exclusionary time-out: Age and cognitive functioning of the individual served are considered in time-out conditions.

Revised Standard CTS.05.03.01
For organizations that use level systems: Level systems that apply to a group are individualized.

Note: This standard applies to any service or program that groups individuals served by their needs and behaviors and then uses methodologies such as level systems, group contingencies, and group consequences that are associated with privileges and restrictions. Organizations inform staff, individuals served, and families of the use of these methodologies.

Revised Elements of Performance for CTS.05.03.01

1. For organizations that use level systems: At admission, the individual served and, as appropriate, his or her family are educated about and agree to the organization’s use of level systems.
2. For organizations that use level systems: Requirements for moving through level systems are known and achievable, and such requirements are equitably and fairly applied to all individuals served.
3. For organizations that use level systems: Behavior of the individual served is separately monitored for compliance.
4. For organizations that use level systems: Group consequences are based on collective group outcomes and not based on the behavior of a single individual.
5. For organizations that use level systems: Group consequences respect the rights of each individual served.
Revised Standard CTS.05.04.01
For organizations that use individualized behavioral contingencies: Individualized behavioral contingencies are used in accordance with a process established by care, treatment, or services leaders.

Revised Elements of Performance for CTS.05.04.01

1. For organizations that use individualized behavioral contingencies: Written policies and procedures that govern the use of individualized behavioral contingencies are developed by care, treatment, or services leaders.
2. For organizations that use individualized behavioral contingencies: The organization implements written policies and procedures that govern the use of individualized behavioral contingencies.
3. For organizations that use individualized behavioral contingencies: Policies and procedures support the use of individualized behavioral contingencies as therapeutic interventions that foster adaptive behaviors and are not used exclusively for behavior control.
4. For organizations that use individualized behavioral contingencies: Policies and procedures require that the selection of individualized behavioral contingencies considers both the appropriateness of the contingencies and minimizing the restrictiveness of the interventions.
5. For organizations that use individualized behavioral contingencies: The organization's leaders approve the individualized behavioral contingencies to be used in the organization.

Revised Standard CTS.05.04.03
For organizations that use individualized behavioral contingencies: Individuals served and, as appropriate, their families participate in selecting the individualized behavioral contingencies used for the individual.

Revised Elements of Performance for CTS.05.04.03

1. For organizations that use individualized behavioral contingencies: Before implementing individualized behavioral contingencies, the individual served and, as appropriate, his or her family are educated about and agree to the organization's use of the contingencies.
2. For organizations that use individualized behavioral contingencies: Before implementing individualized behavioral contingencies, the individual served and, as appropriate, his or her family collaborate with the organization to determine and agree to the target behaviors for which the contingencies may be used.
3. For organizations that use individualized behavioral contingencies: The individual served and, as appropriate, his or her family collaborate with the organization on and agree to the selection of a specific individualized behavioral contingency or contingencies for the individual served.
4. For organizations that use individualized behavioral contingencies: The individual served and, as appropriate, his or her family participate in identifying antecedents to and consequences of the target behavior.
5. For organizations that use individualized behavioral contingencies: When the individualized behavioral contingency for an individual served includes an aversive procedure(s), written informed consent for the contingency is obtained.
Revised Standard CTS.05.04.05
For organizations that use individualized behavioral contingencies: Individualized behavioral contingencies are based on an assessment of the individual served and the target behavior.

Revised Elements of Performance for CTS.05.04.05

1. For organizations that use individualized behavioral contingencies: Individualized behavioral contingencies are based on an assessment of the individual served.
2. For organizations that use individualized behavioral contingencies: Assessment of the individual served addresses environmental and contextual factors associated with the target behavior.
3. For organizations that use individualized behavioral contingencies: Assessment of the individual served addresses skill deficits associated with the target behavior.
4. For organizations that use individualized behavioral contingencies: Assessment of the individual served addresses performance deficits associated with the target behavior.
5. For organizations that use individualized behavioral contingencies: Assessment of the individual served addresses the identification of strengths associated with the target behavior.
6. For organizations that use individualized behavioral contingencies: Assessment of the individual served addresses frequency, duration, and intensity of the target behavior.
7. For organizations that use individualized behavioral contingencies: The assessment of the effectiveness of the target behavior is ongoing.

Revised Standard CTS.05.04.07
For organizations that use individualized behavioral contingencies: Individualized behavioral contingencies support the acquisition and reinforcement of adaptive/replacement behaviors.

Revised Elements of Performance for CTS.05.04.07

1. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies identify and teach adaptive/replacement behaviors.
2. For organizations that use individualized behavioral contingencies: Adaptive/replacement behaviors are assessed to determine whether appropriate behavior is exhibited.
Revised Standard CTS.05.04.09
For organizations that use individualized behavioral contingencies: An individualized behavioral contingencies plan is aligned with the needs of the individual served and assessment results and is documented in the clinical/case record in accordance with the organization's policy.

Revised Elements of Performance for CTS.05.04.09

1. For organizations that use individualized behavioral contingencies: The organization develops a written, detailed, and individualized behavioral contingencies plan.
   Note: The plan may be a separate document or incorporated into the overall plan for care, treatment, or services.

2. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following: Target behavior.

3. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following: Adaptive/replacement behavior.

4. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following:
   - Method of implementation-strategy
   - Support
   - Teaching methods
   - Motivation and reward, if used
   - Frequency
   - Circumstances under which the plan will be implemented

5. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following: Condition for discontinuation.

6. For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following: All interventions attempted and the results.
Revised Standard CTS.05.04.11
For organizations that use individualized behavioral contingencies: Each individualized behavioral contingencies plan that includes the use of aversive contingencies is reviewed and approved by both a clinical leader(s) and a person(s) external to the organization.

Revised Elements of Performance for CTS.05.04.11

1. For organizations that use individualized behavioral contingencies: The use of aversive behavioral contingencies is subject to internal and external review before a plan for care, treatment, or services that includes aversive contingencies is implemented.

2. For organizations that use individualized behavioral contingencies: The use of aversive behavioral contingencies is reviewed and approved by both a clinical leader(s) and a person(s) external to the organization (for example, an outside expert, an advocate, a human rights committee).

3. For organizations that use individualized behavioral contingencies: The review of the use of aversive behavioral contingencies includes the following: Consideration of less restrictive alternatives, nonaversive procedures, and less aversive contingencies.

4. For organizations that use individualized behavioral contingencies: The review of the use of aversive behavioral contingencies includes the following: Consideration of any rights issues.

5. For organizations that use individualized behavioral contingencies: The review of the use of aversive behavioral contingencies includes the following: A time frame for implementing the plan and discontinuing the plan.

6. For organizations that use individualized behavioral contingencies: The review of the use of aversive behavioral contingencies includes the following: Other criteria established by the organization.

7. For organizations that use individualized behavioral contingencies: The organization prohibits individuals served from implementing an individualized behavioral contingency or special procedure.

Revised Standard CTS.05.04.13
For organizations that use individualized behavioral contingencies: Qualified and competent staff design and review the individualized behavioral contingencies plans.

Note: Requirements for assessing competence appear in the “Human Resources” (HR) chapter.

Revised Elements of Performance for CTS.05.04.13

1. For organizations that use individualized behavioral contingencies: Staff designing individualized behavioral contingencies plans have qualifications, training, experience, and knowledge related to designing behavioral contingencies plans.

2. For organizations that use individualized behavioral contingencies: Staff supervising and monitoring individualized behavioral contingencies plans have qualifications, training, experience, and knowledge related to supervising and monitoring behavioral contingencies procedures and plans.

3. For organizations that use individualized behavioral contingencies: Staff determining changes to or discontinuation of behavioral contingencies have qualifications, training, experience, and knowledge related to determining the need for changes or discontinuation of behavioral contingencies.
Revised Standard CTS.05.04.15
For organizations that use individualized behavioral contingencies: Staff involved in implementing the individualized behavioral contingencies plan are trained, competent, and supervised.
Note: Requirements for assessing competence appear in the "Human Resources" (HR) chapter.

Revised Elements of Performance for CTS.05.04.15
1. For organizations that use individualized behavioral contingencies: The organization educates and assesses staff on the skills and knowledge needed to implement the individualized behavioral contingencies plan.
2. For organizations that use individualized behavioral contingencies: Staff demonstrate competence in a specific individualized behavioral contingency before implementing the contingency.
3. For organizations that use individualized behavioral contingencies: Staff are supervised.

Revised Standard CTS.05.04.17
For organizations that use behavioral contingencies: The organization collects and analyzes data about the individual’s responses to his or her behavioral contingencies in order to monitor and improve the use of behavioral contingencies.

Revised Elements of Performance for CTS.05.04.17
1. For organizations that use individualized behavioral contingencies: Outcomes of interventions for the individual are measured for frequency of occurrence of replacement behavior(s).
2. For organizations that use individualized behavioral contingencies: Outcomes of interventions for the individual are measured for frequency of occurrence of problem behavior(s).
Revised Standard CTS.05.05.01

For organizations that use physical holding on a child or youth: The leaders establish and communicate the organization’s philosophy on physical holding of children or youth.

Revised Elements of Performance for CTS.05.05.01

1. For organizations that use physical holding on a child or youth: At a minimum, the organization’s philosophy addresses the following:
   - Its commitment to minimize the use of physical holding of children or youth
   - Prevention of emergencies that have the potential to lead to the use of physical holding of children or youth
   - Non-physical interventions as preferred interventions with input from the child or youth and parent or guardian
   - Limitation of the use of physical holding of children and youth to emergencies in which there is an imminent risk of a child or youth physically harming himself or herself, staff, or others
   - Responsibility to facilitate the discontinuation of physical holding of children or youth as soon as possible
   - Raising awareness among staff about how physical holding of children or youth may be experienced by the child or youth
   - Preserving the safety and dignity of the child or youth when physical holding is used

2. For organizations that use physical holding on a child or youth: The organization’s philosophy on the use of physical holding of children and youth is communicated to the child or youth served, the parent(s) or guardian, and staff.

Revised Standard CTS.05.05.03

For organizations that use physical holding on a child or youth: Staffing is set to minimize circumstances that give rise to physical holding of children or youth and to maximize safety when physical holding is used.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources” (HR) chapter.

Revised Elements of Performance for CTS.05.05.03

1. For organizations that use physical holding on a child or youth: The organization bases its staffing on a variety of factors, including the following: Staff qualifications.

2. For organizations that use physical holding on a child or youth: The organization bases its staffing on a variety of factors, including the following: The physical design of the environment.

3. For organizations that use physical holding on a child or youth: The organization bases its staffing on a variety of factors, including the following: Emotional and behavioral functioning of the children and youth served.

4. For organizations that use physical holding on a child or youth: The organization bases its staffing on a variety of factors, including the following: Age and developmental functioning of the children and youth served.
Revised Standard CTS.05.05.05
For organizations that use physical holding on a child or youth: Staff are trained and competent to minimize the use of physical holding of children and youth and, when use is indicated, to use physical holding safely.
Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the "Human Resources" (HR) chapter.

Revised Elements of Performance for CTS.05.05.05

1. For organizations that use physical holding on a child or youth: The organization educates staff about minimizing the use of physical holding of children and youth and, before staff participate in any use of physical holding of children or youth, assesses the competence of staff to use this procedure safely.
2. For organizations that use physical holding on a child or youth: To minimize the use of physical holding of children and youth, staff involved in the use of physical holding receive ongoing training in and demonstrate an understanding of the following:
   - The underlying causes of threatening behaviors exhibited by children and youth
   - That sometimes a child or youth may exhibit an aggressive behavior that is related to his or her medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers)
   - How staff behaviors can affect the behaviors of the child or youth
   - De-escalation, mediation, self-protection, and other techniques such as time-out
   - Helping the child or youth regain self-control
   - Recognizing readiness for discontinuing physical holding of a child or youth
   - How to recognize signs of physical distress in the child or youth who is being physically held
   - Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a child or youth reacts to physical contact
3. For organizations that use physical holding on a child or youth: Staff involved in physical holding of children and youth receive ongoing training and demonstrate competence in the safe use of physical holding techniques.
4. For organizations that use physical holding on a child or youth: The staff assigned to monitor the physical well-being of the child or youth being physically held demonstrate competence in the following:
   - Recognizing signs and symptoms of breathing difficulties
   - Providing hydration as needed
   - Checking circulation
   - Recognizing signs of any incorrect application of physical holding
   - Recognizing when to contact a medically trained practitioner or emergency medical services to evaluate and/or treat the physical status of the child or youth (See also CTS.05.05.09, EP 4)
5. For organizations that use physical holding on a child or youth: There are always staff available who are competent to initiate first aid and CPR.
Revised Standard CTS.05.05.07
For organizations that use physical holding on a child or youth: The initial assessment and reassessments of each child or youth assists the organization in obtaining information about the child or youth that could help minimize the use and impact of physical holding.

Revised Elements of Performance for CTS.05.05.07

1. For organizations that use physical holding on a child or youth: The initial assessment and reassessments of a child or youth identify techniques that would help the child or youth control his or her behavior.

2. For organizations that use physical holding on a child or youth: The initial assessment and reassessments of a child or youth identify pre-existing medical conditions or any physical disabilities and limitations that would place the child or youth at greater risk during a physical hold.

3. For organizations that use physical holding on a child or youth: The initial assessment and reassessments of a child or youth identify any history of sexual or physical abuse or other traumas that would place the child or youth at greater psychological risk during physical holding.

4. For organizations that use physical holding on a child or youth: When indicated, the child or youth served and/or his or her family helps in identifying techniques that would help minimize the use of physical holding.

5. For organizations that use physical holding on a child or youth: The parent(s) or guardian of the child or youth is notified of a physical hold episode. (See also CTS.05.05.21, EP 6)

Revised Standard CTS.05.05.09
For organizations that use physical holding on a child or youth: Physical holding of children and youth is used in a safe manner.

Revised Elements of Performance for CTS.05.05.09

1. For organizations that use physical holding on a child or youth: The authorization to initiate physical holding is in accordance with law and regulation and organization policy.

2. For organizations that use physical holding on a child or youth: The organization prohibits the use of physical holding techniques that restrict the flow of air to the child’s or youth’s lungs.

3. For organizations that use physical holding on a child or youth: The organization has a written process on physical holding of children and youth that identifies the techniques approved for use.

4. For organizations that use physical holding on a child or youth: A staff member not physically holding the child or youth is assigned to observe the child's or youth's physical well-being. (See also CTS.05.05.05, EP 4)

6. For organizations that use physical holding on a child or youth: The physical holding of the child or youth is documented in the clinical/case record.
Revised Standard CTS.05.05.11
For organizations that use physical holding on a child or youth: Nonphysical techniques are the preferred intervention in managing behaviors of children and youth.

Revised Elements of Performance for CTS.05.05.11

1. For organizations that use physical holding on a child or youth: Whenever possible, the organization uses nonphysical techniques in managing behaviors of children and youth.
   Note: Such interventions may include a crisis response plan, redirecting the focus of the child or youth, or employing verbal de-escalation and positive behavioral support.

Revised Standard CTS.05.05.13
For organizations that use physical holding on a child or youth: Physical holding is limited to emergencies in which there is an imminent risk of a child or youth physically harming himself or herself, staff, or others, and when nonphysical interventions would not be effective.

Revised Elements of Performance for CTS.05.05.13

1. For organizations that use physical holding on a child or youth: Physical holding is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of a child or youth physically harming himself or herself, staff, or others.
2. For organizations that use physical holding on a child or youth: When a physical hold is used, information learned from the initial assessment of the child or youth is considered.
3. For organizations that use physical holding on a child or youth: The organization does not permit physical holding for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
4. For organizations that use physical holding on a child or youth: The use of physical holding is not based on the history of past physical holding of the child or youth or solely on a history of dangerous behavior.

Revised Standard CTS.05.05.15
For organizations that use physical holding on a child or youth: The physical hold is discontinued when the child or youth regains control of his or her behavior.

Revised Elements of Performance for CTS.05.05.15

1. For organizations that use physical holding on a child or youth: As early as feasible in the physical holding process, the child or youth is made aware of the reason(s) for physical holding and reassured that the physical hold will be discontinued as soon as the child or youth regains control of his or her behavior.
   Note: Examples of regaining control include the ability of the child or youth to contract for safety, whether the child or youth is oriented to the environment, and/or cessation of verbal threats.
2. For organizations that use physical holding on a child or youth: The physical hold is discontinued as soon as the child or youth regains control of his or her behavior.
Revised Standard CTS.05.05.17
For organizations that use physical holding on a child or youth: The child or youth and staff participate in a debriefing about the physical holding episode.

Revised Elements of Performance for CTS.05.05.17

1. For organizations that use physical holding on a child or youth: The child or youth and involved staff participate in a debriefing following each episode of physical holding.

2. For organizations that use physical holding on a child or youth: The debriefing about each episode of physical holding occurs as soon as possible.

3. For organizations that use physical holding on a child or youth: The debriefing about each episode of physical holding is used to do the following:
   - Identify what led to the incident and what could have been handled differently.
   - Ascertain that the physical well-being, psychological comfort, and right to privacy of the child or youth were addressed.
   - Assess the impact of the holding on the child's or youth's emotional functioning.
   - When indicated, modify the child’s or youth's plan for care, treatment, or services.

4. For organizations that use physical holding on a child or youth: Information obtained and documented from debriefings is used in performance improvement activities.
Revised Standard CTS.05.05.19
For organizations that use physical holding on a child or youth: The organization collects data on the use of physical holding.

Revised Elements of Performance for CTS.05.05.19

1. For organizations that use physical holding on a child or youth: The leaders determine the frequency with which data on the use of physical holding are aggregated and reported to leadership.

2. For organizations that use physical holding on a child or youth: Individual identifiers are included in data collected on the use of physical holding.

3. For organizations that use physical holding on a child or youth: Data on all physical holding episodes are collected and classified for all settings/locations and include the following:
   - Setting or location
   - Shift
   - Staff who initiated the process
   - The number of minutes of each physical hold
   - Date and time each physical hold was initiated
   - Day of the week each physical hold occurred
   - Whether injuries were sustained by the child or youth or staff
   - Age of the child or youth
   - Sex of the child or youth
   - Debriefing data
   - Multiple instances of physical holding of the child or youth within a 12-hour time frame
   - The number of physical holds per child or youth
   - Use of psychoactive medications to enable discontinuation of a physical hold

4. For organizations that use physical holding on a child or youth: The administrative and clinical leader(s) are made aware when a child or youth experiences a physical hold longer than 30 minutes and when a child or youth experiences multiple episodes of holding within a 12-hour period.

5. For organizations that use physical holding on a child or youth: The organization evaluates the number of physical holding episodes per child or youth served.
Revised Standard CTS.05.05.21
For organizations that use physical holding on a child or youth: The organization’s policies and procedures address the prevention of the use of physical holding and, when employed, guide its use.

Revised Elements of Performance for CTS.05.05.21

1. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Staffing.

2. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Staff competence and training.

3. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Initial assessment of the child or youth.

4. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: The role of nonphysical techniques.

5. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Limiting physical holding to emergencies.

6. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Notification of the parent(s) or guardian of the child or youth. (See also CTS.05.05.07, EP 5)

7. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Monitoring of the child or youth.

8. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Discontinuation of the physical hold.

9. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Debriefing.

10. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Reporting injuries and deaths to the organization’s leadership and appropriate external agencies consistent with applicable law and regulation.

11. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Documentation of physical holding.

12. For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following: Data collection and the integration of physical holding into performance improvement activities.
Revised Standard CTS.05.06.01
For organizations that use restraint or seclusion: The leaders establish and communicate the organization's philosophy on restraint and seclusion to all staff with direct care responsibility.

Revised Elements of Performance for CTS.05.06.01

1. For organizations that use restraint or seclusion: At a minimum, the organization's philosophy addresses the following:
   - Its commitment to prevent, reduce, and strive to eliminate restraint and seclusion
   - Prevention of emergencies that have the potential to lead to the use of restraint or seclusion
   - Nonphysical interventions as preferred interventions
   - Limitation of the use of restraint and seclusion to emergencies in which there is an imminent risk of an individual physically harming himself or herself, staff, or others
   - Its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible
   - Raising awareness among staff about how restraint or seclusion may be experienced by the individual served
   - Preserving the safety and dignity of the individual served when restraint or seclusion is used

2. For organizations that use restraint or seclusion: The organization's philosophy on restraint or seclusion is communicated to all members of the organization who have direct care responsibility.

3. For organizations that use restraint or seclusion: The organization's philosophy on restraint or seclusion is communicated to the individual served.
Revised Standard CTS.05.06.03
For organizations that use restraint or seclusion: Staffing and assignments are set to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint or seclusion is used.
Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the "Human Resources" (HR) chapter.

Revised Elements of Performance for CTS.05.06.03

1. For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following: Staff qualifications.
2. For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following: The physical design of the environment.
3. For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following: Diagnoses.
4. For organizations that use restraint or seclusion: The organization bases its staffing and assignments on a variety of factors, including the following: Co-occurring conditions.
5. For organizations that use restraint or seclusion: The organization bases its staffing and assignments on a variety of factors, including the following: Acuity levels.
6. For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following: Age and developmental functioning of individuals served.
Revised Standard CTS.05.06.05

For organizations that use restraint or seclusion: Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint or seclusion safely.

Revised Elements of Performance for CTS.05.06.05

1. For organizations that use restraint or seclusion: The organization educates staff about minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, assesses the competence of staff to use them safely.

2. For organizations that use restraint or seclusion: To minimize the use of restraint and seclusion, all direct care staff and any other staff involved in the use of restraint and seclusion receive ongoing training in and demonstrate an understanding of the following:
   - The underlying causes of threatening behaviors exhibited by individuals served
   - That sometimes an individual served may exhibit an aggressive behavior that is related to an individual’s medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers)
   - How staff behaviors can affect the behaviors of individuals served
   - Escalation, mediation, self-protection, and other techniques such as time-out
   - How to recognize signs of physical distress in individuals who are being held, restrained, or secluded

3. For organizations that use restraint or seclusion: Staff who are authorized to apply restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.

4. For organizations that use restraint or seclusion: Direct care staff members receive ongoing training in and demonstrate competence in the safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.

5. For organizations that use restraint or seclusion: Staff who are authorized to perform 15-minute assessments of individuals in restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.

6. For organizations that use restraint or seclusion: Staff authorized to perform 15-minute assessments receive ongoing training and demonstrate competence in the following:
   - Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion
   - Recognizing nutritional and hydration needs
   - Checking circulation and range of motion in the extremities
   - Addressing hygiene and elimination
   - Addressing physical and psychological status and comfort
   - Helping individuals meet behavior criteria for discontinuing restraint or seclusion
   - Recognizing readiness for discontinuing restraint or seclusion
   - Recognizing signs of any incorrect application of restraints
   - Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the physical status of the individual

7. For organizations that use restraint or seclusion: Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/re-evaluations of individuals in restraint or seclusion to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence as required in Standard CTS.05.06.05, EPs 1-6.
8. For organizations that use restraint or seclusion: Staff are educated about and demonstrate competence in the following:
   - Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual served reacts to physical contact
   - Using behavior criteria for discontinuing restraint or seclusion and how to help individuals in meeting these criteria

9. For organizations that use restraint or seclusion: A sufficient number of staff with direct care responsibility receive additional training so that staff who are competent to initiate first aid and CPR are available at all times.

10. For organizations that use restraint or seclusion: The organization has a plan for providing emergency medical services.

11. For organizations that use restraint or seclusion: The viewpoints of individuals who have experienced restraint or seclusion are incorporated into staff training and education to help staff better understand all aspects of restraint and seclusion.

12. For organizations that use restraint or seclusion: Whenever possible, individuals who have experienced restraint or seclusion contribute to the training and education curricula and/or participate in staff training and education.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources” (HR) chapter.

Revised Standard CTS.05.06.07
For organizations that use restraint or seclusion: The initial assessment of each individual at admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.07

1. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies techniques that would help the individual control his or her behavior.

2. For organizations that use restraint or seclusion: When indicated, the initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies the individual's need for methods or tools to manage his or her aggressive behavior.

3. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies preexisting medical conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion.

4. For organizations that use restraint or seclusion: The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during restraint or seclusion.

5. For organizations that use restraint or seclusion: As appropriate, the individual served and/or his or her family helps in identifying techniques that would help minimize the use of restraint or seclusion.

6. For organizations that use restraint or seclusion: The individual served and his or her family are educated about the organization's philosophy on restraint and seclusion to the extent that such information is not clinically contraindicated.

7. For organizations that use restraint or seclusion: The family's role, including their notification of a restraint or seclusion episode, is discussed with the individual served and, as appropriate, his or her family, and in conjunction with the right to confidentiality of the individual served.
Revised Standard CTS.05.06.09
For organizations that use restraint or seclusion: Nonphysical techniques are the preferred intervention in managing behaviors of individuals served.

Revised Elements of Performance for CTS.05.06.09
1. For organizations that use restraint or seclusion: Whenever possible, the organization uses nonphysical techniques in managing behaviors of individuals served.
   Note: Such interventions may include redirecting the focus of the individual served or employing verbal de-escalation.

Revised Standard CTS.05.06.11
For organizations that use restraint or seclusion: Restraint or seclusion is limited to emergencies in which there is an imminent risk of an individual served physically harming himself or herself, staff, or others, and when nonphysical interventions would not be effective.

Revised Elements of Performance for CTS.05.06.11
1. For organizations that use restraint or seclusion: Restraint or seclusion is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of an individual served physically harming himself or herself, staff, or others.
2. For organizations that use restraint or seclusion: The type of physical intervention (restraint or seclusion) selected considers information learned from the initial assessment of the individual served.
3. For organizations that use restraint or seclusion: The organization does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.
4. For organizations that use restraint or seclusion: The use of restraint or seclusion is not based on the restraint or seclusion history of an individual served or solely on a history of dangerous behavior.
Revised Standard CTS.05.06.13
For organizations that use restraint or seclusion: A licensed independent practitioner orders the use of restraint or seclusion.
Note: This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state’s regulatory mechanism and allowed by the organization.

Revised Elements of Performance for CTS.05.06.13

1. For organizations that use restraint or seclusion: All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.
   Note: Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified, trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the licensed independent practitioner. In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.

2. For organizations that use restraint or seclusion: As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following:
   - Notifies and obtains an order (verbal or written) from the licensed independent practitioner
   - Consults with the licensed independent practitioner about the physical and psychological condition of the individual served

3. For organizations that use restraint or seclusion: The licensed independent practitioner does the following:
   - Reviews with staff the physical and psychological status of the individual served
   - Determines whether restraint or seclusion should be continued
   - Supplies staff with guidance in identifying ways to help the individual regain control so that restraint or seclusion can be discontinued
   - Supplies an order for restraint or seclusion

Revised Standard CTS.05.06.15
For organizations that use restraint or seclusion: The family of the individual served is notified promptly of the use of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.15

1. For organizations that use restraint or seclusion: The organization asks the individual served whether his or her family is to be informed about the individual's care, treatment, or services.

2. For organizations that use restraint or seclusion: The organization asks the individual's family whether they want to be informed about the individual's care, treatment, or services.

3. For organizations that use restraint or seclusion: In cases in which the individual served has consented to have the family kept informed about his or her care, treatment, or services and the family has agreed to be notified, staff attempts to contact the family as soon as possible to notify them of the use of restraint or seclusion.
Revised Standard CTS.05.06.17
For organizations that use restraint or seclusion: A licensed independent practitioner sees and evaluates the individual in restraint or seclusion in person.

Revised Elements of Performance for CTS.05.06.17

1. For organizations that use restraint or seclusion: The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.

2. For organizations that use restraint or seclusion: At the time of the in-person evaluation of the individual in restraint or seclusion, the licensed independent practitioner does the following:
   - Works with the individual and staff to identify ways to help the individual regain control
   - Revises the individual's plan for care, treatment, or services as needed
   - If necessary, provides a new written order

3. For organizations that use restraint or seclusion: The licensed independent practitioner evaluates the individual in restraint or seclusion in person within 24 hours of the initiation of restraint or seclusion if the individual is no longer in restraint or seclusion when an original verbal order expires.

Revised Standard CTS.05.06.19
For organizations that use restraint or seclusion: Written and verbal orders for initial and continuing use of restraint and seclusion are time limited.

Revised Elements of Performance for CTS.05.06.19

1. For organizations that use restraint or seclusion: Written and verbal orders for restraint and seclusion are limited to the following:
   - Four hours for adults ages 18 and older
   - Two hours for children and youth ages 9 to 17
   - One hour for children under age 9

2. For organizations that use restraint or seclusion: Orders for restraint or seclusion are not written as a standing order or for use on an as-needed basis (that is, PRN).

3. For organizations that use restraint or seclusion: If restraint or seclusion use needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the licensed independent practitioner primarily responsible for ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.
Revised Standard CTS.05.06.21
For organizations that use restraint or seclusion: Individuals in restraint or seclusion are regularly re-evaluated.

Revised Elements of Performance for CTS.05.06.21

1. For organizations that use restraint or seclusion: By the time the order for restraint or seclusion expires, the individual served is evaluated in person by one of the following:
   - The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served
   - His or her licensed independent practitioner designee
   - Another licensed independent practitioner or qualified, trained individual authorized by the organization to perform this function

2. For organizations that use restraint or seclusion: In conjunction with reevaluation of the individual in restraint or seclusion, a new written or verbal order is given by the licensed independent practitioner primarily responsible for the individual's ongoing care, treatment, or services, or his or her licensed independent practitioner designee, or other licensed independent practitioner if the restraint or seclusion is to be continued.

3. For organizations that use restraint or seclusion: The licensed independent practitioner or other qualified, authorized staff member re-evaluates the efficacy of the treatment plan of the individual served and works with the individual to identify ways to help him or her regain control.

4. For organizations that use restraint or seclusion: If the licensed independent practitioner of the individual served, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gave the order, the licensed independent practitioner of the individual served is notified of the individual's status if the restraint or seclusion is continued.

5. For organizations that use restraint or seclusion: The individual in restraint or seclusion is re-evaluated as follows:
   - Every four hours for adults ages 18 and older
   - Every two hours for children and youth ages 9 to 17
   - Every hour for children under age 9

6. For organizations that use restraint or seclusion: The licensed independent practitioner conducts an in-person re-evaluation of the individual in restraint or seclusion at least every eight hours for adults ages 18 and older and every four hours for children and youth ages 17 and younger.

Revised Standard CTS.05.06.23
For organizations that use restraint or seclusion: Clinical leaders are told of individuals who experience extended or multiple episodes of restraint or seclusion.

Revised Elements of Performance for CTS.05.06.23

1. For organizations that use restraint or seclusion: Clinical leaders are immediately notified when an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.

2. For organizations that use restraint or seclusion: Clinical leaders are notified every 24 hours if an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.
Revised Standard CTS.05.06.25
For organizations that use restraint or seclusion: Individuals in restraint or seclusion are assessed and assisted.

Revised Elements of Performance for CTS.05.06.25

1. For organizations that use restraint or seclusion: The organization prohibits the use of restraint techniques that restrict the flow of air to the individual's lungs.

2. For organizations that use restraint or seclusion: A staff member who is trained and competent in accordance with Standard CTS.05.06.05 assesses the individual at the initiation of restraint or seclusion and every 15 minutes thereafter.

3. For organizations that use restraint or seclusion: Staff assessment of the individual at initiation of restraint or seclusion and every 15 minutes thereafter includes, as relevant to the type of restraint or seclusion, the following:
   - Signs of any injury associated with applying restraint or seclusion
   - Nutrition and hydration status
   - Circulation and range of motion in the extremities
   - Vital signs
   - Hygiene and elimination
   - Physical and psychological status and comfort
   - Readiness for discontinuation of restraint or seclusion

4. For organizations that use restraint or seclusion: Staff help individuals in restraint or seclusion to meet behavior criteria for discontinuing restraint or seclusion.

Revised Standard CTS.05.06.27
For organizations that use restraint or seclusion: Individuals in restraint or seclusion are monitored.

Revised Elements of Performance for CTS.05.06.27

1. For organizations that use restraint or seclusion: Monitoring of individuals in restraint or seclusion is done through continuous in-person observation by an assigned staff member who is competent and trained in accordance with Standard CTS.05.06.05.

2. For organizations that use restraint or seclusion: After the first hour, an individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the individual's condition or wishes.
Revised Standard CTS.05.06.29
For organizations that use restraint or seclusion: Restraint and seclusion use are discontinued when the individual served meets the behavior criteria for their discontinuation.

Revised Elements of Performance for CTS.05.06.29

1. For organizations that use restraint or seclusion: As early as feasible in the restraint or seclusion process, the individual served is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation.
   Note: Examples of behavior criteria include the ability of an individual served to contract for safety, whether the individual is oriented to the environment, and/or cessation of verbal threats.

2. For organizations that use restraint or seclusion: Restraint or seclusion is discontinued as soon as the individual served meets his or her behavior criteria.

Revised Standard CTS.05.06.31
For organizations that use restraint or seclusion: The individual served and staff participate in a debriefing about the restraint or seclusion episode.

Revised Elements of Performance for CTS.05.06.31

1. For organizations that use restraint or seclusion: The individual served and, if appropriate, the individual's family participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion.

2. For organizations that use restraint or seclusion: The debriefing about each episode of restraint or seclusion occurs as soon as possible, but no longer than 24 hours after the episode.

3. For organizations that use restraint or seclusion: The debriefing about each episode of restraint or seclusion is used to do the following:
   - Identify what led to the incident and what could have been handled differently
   - Ascertain that the physical well-being, psychological comfort, and right to privacy of the individual served were addressed
   - Counsel the individual served for any trauma that may have resulted from the incident
   - When indicated, modify the individual's plan for care, treatment, or services

4. For organizations that use restraint or seclusion: Information obtained and documented from debriefings is used in performance improvement activities.
Revised Standard CTS.05.06.33

For organizations that use restraint or seclusion: The organization collects data on the use of restraint and seclusion.

Revised Elements of Performance for CTS.05.06.33

1. For organizations that use restraint or seclusion: The leaders determine the frequency with which data on the use of restraint and seclusion are aggregated.

2. For organizations that use restraint or seclusion: Individual identifiers are included in data collected on the use of restraint or seclusion.

3. For organizations that use restraint or seclusion: Data on all restraint and seclusion episodes are collected from and classified for all settings/locations by the following:
   - Shift
   - Staff who initiated the process
   - The length of each episode
   - Date and time each episode was initiated
   - Day of the week each episode was initiated
   - The type of restraint used
   - Whether injuries were sustained by the individual or staff
   - Age of the individual
   - Sex of the individual
   - Debriefing data

4. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Multiple instances of restraint or seclusion experienced by an individual within a 12-hour time frame.

5. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: The number of episodes per individual served.

6. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Instances of restraint or seclusion that extend beyond 12 consecutive hours.

7. For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data: Use of psychotropic medications as an alternative to, or to enable discontinuation of, restraint or seclusion.

8. For organizations that use restraint or seclusion: Licensed independent practitioners participate in measuring and assessing use of restraint and seclusion for all individuals served.
Revised Standard CTS.05.06.35
For organizations that use restraint or seclusion: Organization policies and procedures address prevention of restraint and seclusion and, when employed, guide their use.

**Revised Elements of Performance for CTS.05.06.35**

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15. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Reporting injuries and deaths to the organization's leadership and external agencies in accordance with law and regulation.

16. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Documentation of restraint or seclusion.

17. For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Data collection and the integration of restraint or seclusion data into performance improvement activities.
Revised Standard CTS.06.01.01

For organizations providing case management/care coordination services: Case management/care coordination services are based on the individual's needs, preferences, goals, and community resources available to the individual.

Revised Elements of Performance for CTS.06.01.01

1. For organizations providing case management/care coordination services: The individual served and, as appropriate, his or her family are partners with organization staff in service planning.

2. For organizations providing case management/care coordination services: With the assistance of staff, the individual served and, as appropriate, his or her family, identify needs, preferences, and goals for the following:
   - Housing
   - Employment
   - Education
   - Transportation
   - Crisis support
   - Health care and behavioral health services (for example, medication, therapy)
   - Financial services and benefits
   - Assistance with housekeeping
   - Assistance with personal hygiene
   - Assistance with the retention and improvement of other skills related to activities of daily living
   - Social support and adaptive skills
   - Support of spirituality
   - Schools
   - Leisure and recreation activities for children, youth, and adults
   - Parental support for children and youth
   - Interaction with the criminal or juvenile justice system, if applicable

3. For organizations providing case management/care coordination services: Staff coordinating case management/care coordination services assist the individual served in identifying, using, and accessing family, neighborhood, and community supports and services.

4. For organizations providing case management/care coordination services: Staff coordinating case management/care coordination services support informed choice by individuals served.

5. For organizations providing case management/care coordination services: Staff coordinating case management/care coordination services assist the individual served in achieving the individual's personal goals of independent living.

6. For organizations providing case management/care coordination services: The individual served and staff coordinating case management/care coordination services evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.
Revised Standard CTS.06.01.03

For organizations providing community integration services: The individual served, with assistance from the organization, determines his or her needs and wants for education, training, and support to help him or her progress toward independent living and community integration.

Revised Elements of Performance for CTS.06.01.03

1. For organizations providing community integration services: Needs, preferences, and goals of the individual served guide the following:
   - The type of education, training, and support provided
   - The intensity of education, training, and support provided
   - The duration of education, training, and support provided

2. For organizations providing community integration services: Needs, preferences, and goals of the individual served, and the organization’s scope of services, guide the provision to the individual of educational opportunities about the following:
   - Personal grooming and hygiene
   - Housekeeping
   - Shopping for necessities
   - Meal preparation and healthy eating
   - Budgeting
   - Banking
   - Accessing public transportation
   - Use of community resources
   - Communication skills
   - Social skills
   - Leisure and recreation activities for children, youth, and adults
   - Volunteer activity
   - Illness self-management (for example, symptom management, medication management), including what to do in case of a crisis or health problem
Revised Standard CTS.06.02.01
When an individual served is transferred or discharged, the continuity of care, treatment, or services is maintained.

Revised Elements of Performance for CTS.06.02.01

1. The organization has a process for addressing the continuity of care, treatment, or services after discharge or transfer that includes the following:
   - The transfer of responsibility for care, treatment, or services for the individual served from one staff, organization, organizational program, or service to another
   - The reason(s) for transfer or discharge when moving from one staff, organization, organizational program, or service to another
   - Mechanisms for internal and external transfer
   - Identification of the person who has accountability and responsibility for the safety of the individual served during an external transfer

2. For opioid treatment programs: The discharge planning process addresses relapse prevention.

3. For opioid treatment programs: The discharge planning process addresses any physical and mental health problems following medically supervised withdrawal.
   Note: For example, the program might address the need for counseling or appropriate medication to help with sleep disorders, depression, and other problems.

4. For opioid treatment programs: The discharge planning process addresses referrals for continuing outpatient care after the last dose of medication and planning for re-entry to maintenance treatment if relapse occurs.

5. For opioid treatment programs: Psychosocial treatment is continued for patients electing to discontinue medication-assisted therapy.

6. For opioid treatment programs: The program has a process for tracking patients and reinstituting medication-assisted therapy at the first sign of relapse or impending relapse.
   Note: It may not be possible for the program to track each patient, especially patients that leave the program, but it is important for the program to have processes in place in order to reinstitute medication-assisted therapy when possible.

7. For opioid treatment programs: The program provides the opportunity for patients receiving only long-term medication-assisted therapy to receive psychosocial services again if the need emerges.

8. For opioid treatment programs: The program’s process for administrative withdrawal is implemented on an individual basis and follows the principles involved in medically supervised withdrawal from medication.
   Note: Administrative withdrawal is usually involuntary and might be initiated based on nonpayment of fees, disruptive behavior, or incarceration. The principles followed for any medically supervised withdrawal also apply for administrative withdrawal; namely, that sound clinical judgment is followed; the time frame is generally 30 days but is adjusted by the physician depending on clinical factors; and a variety of supportive options are available to the patient.

9. For opioid treatment programs: When a pregnant patient is discharged, the program refers her for prenatal care and documents the name, address, and telephone number of the physician who will be caring for the patient after discharge.

10. For opioid treatment programs: The program makes decisions about administrative withdrawal on a case-by-case basis.
11. For opioid treatment programs: When the program makes an administrative decision to discharge a patient from medication-assisted treatment, the program offers a schedule of medically supervised withdrawal that is well-tolerated by the patient and based on clinical judgment. The offer is documented.

12. For opioid treatment programs: During medically supervised administrative withdrawal, the program documents the patient’s condition in the clinical/case record.

13. For opioid treatment programs: Upon discharge following medically supervised administrative withdrawal, the program provides the patient with referrals to an alternate treatment program. These referrals are documented.

Revised Standard CTS.06.02.03
When an individual served is discharged or transferred, the organization bases the discharge or transfer on the assessed needs of the individual and the organization’s capabilities.

Revised Elements of Performance for CTS.06.02.03

1. The organization identifies the physical and psychosocial needs for continuing care of the individual served.

2. Individuals served are told in a timely manner of the need to plan for discharge or transfer to another organization or level of care, treatment, or services.

3. Planning for transfer or discharge involves the individual served, his or her family, if applicable, and staff. Note: Family includes legal guardian and surrogate decision-maker (refer to the Glossary).

4. When the individual served is transferred, information provided to the individual includes the following:
   - The reason he or she is being transferred
   - Alternatives to transfer, if any

5. The organization discusses discharge and transfer plans, or changes in these plans, with the individual served and, with the individual’s consent, his or her family. If the individual is a child or youth, the organization acts in accordance with law and regulation.

6. When the individual served is discharged, information provided to the individual and his or her family, if applicable, includes the following:
   - The reason he or she is being discharged
   - The anticipated need for continued care, treatment, or services after discharge
   Note: Continued care, treatment, or services includes, as needed, special education, adult day care, case management, home health services, hospice, long term care, outpatient care, support groups, rehabilitation services, and community mental health services.

7. When indicated, the individual served is educated about how to obtain further care, treatment, or services to meet his or her identified needs.

8. When indicated and before discharge, the organization arranges for or helps the family arrange for care, treatment, or services needed to meet the needs of the individual served after discharge.

9. The organization provides the individual served and his or her family, if applicable, discharge instructions in a form the individual can understand. (See also RI.01.01.03, EP 1)
Revised Standard CTS.06.02.05
When individuals served are transferred or discharged, pertinent information related to the care, treatment, or services provided is exchanged with other providers.

Revised Elements of Performance for CTS.06.02.05

1. The organization communicates pertinent information to any organization or provider to which the individual served is transferred or discharged.
2. The information shared includes the following:
   - The reason for transfer or discharge
   - Relevant biopsychosocial status at transfer or discharge
   - A summary of care, treatment, or services provided and progress made toward goals
   - Community resources or referrals provided to the individual served

Revised Standard CTS.06.03.01
For organizations that provide care, treatment, or services to young adults: The organization assists young adults with their life transitions in accordance with their needs.

Revised Elements of Performance for CTS.06.03.01

1. For organizations that provide care, treatment, or services to young adults: The organization addresses life transition needs of young adults. Note: An organization may address the needs for transition services through referral or discharge planning based on the organization’s scope of care, treatment, or services.
2. For organizations that provide care, treatment, or services to young adults: Organizations that provide young adult life transition services assess the young adult’s needs related to independent functioning in the following areas:
   - Handling finances
   - Finding employment
   - Receiving and completing education
   - Finding housing
   - Receiving health care
   - Engaging in social support
   - Any other needs as determined by the organization
3. For organizations that provide care, treatment, or services to young adults: Organizations that provide young adult life transition services provide assistance based on the individual’s assessed needs.