These standards are available only to participating organizations in CCA. They are intended only for the internal use of the organization to which they have been provided and beyond this are not to be shared.

For further information, contact:

Canadian Centre for Accreditation | Centre canadien de l’agrément
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Section 1. Introduction

The CCA Accreditation Program

The Canadian Centre for Accreditation (CCA) is a national non-profit bilingual accreditation body geared to a wide range of community-based health and social service organizations.

CCA believes that organizations benefit most by having their whole organization accredited. Organizations accredited through CCA are asked to meet a common set of Organizational Standards, as well as standards in the program-specific and sector-specific modules that are most relevant to them. While the CCA accreditation program is aimed at reviewing the whole organization, at a minimum, the relevant modules of at least one sector must be used.

About These Standards

The standards in this manual are geared to any organization that delivers child and youth mental health services.

CCA's program for organizations that offer child and youth mental health services was developed by CCA in collaboration with Children’s Mental Health Ontario (CMHO).

CMHO is one of the founding members of CCA. The standards in the CCA Child and Youth Mental Health Program and Service Standards Module and the CCA Child and Youth Mental Health Service-Specific and Setting-Specific Standards Module are owned by CMHO.

An organization that is a member of CMHO has access to CCA accreditation as part of its membership fee. An Ontario-based organization that delivers more than $250,000 per year of child and youth mental health services must be a member in good standing of CMHO in order to access CCA accreditation using these modules.

Notwithstanding this, any other organization that delivers child and youth mental health services can access CCA accreditation using the CCA Child and Youth Mental Health modules. An Ontario-based organization that delivers less than $250,000 per year in child and youth mental health services may access accreditation using these modules either by becoming a member of CMHO or by paying a licensing fee. An organization outside Ontario that provides children's mental health services is required to pay a licensing fee in order to use these modules.

How Do the Standards Apply?

For child and youth mental health organizations, the applicable standards in all three modules in this manual must be met for accreditation.

The CCA Organizational Standards Module applies to all of the human services (child, youth and adult) that are directly provided by the organization. The Organizational Standards look at the whole organization, and cover things like governance, management, planning and evaluation, quality improvement, and important risk management functions. The standards also look for person-centred services, a strength-based approach, accessibility of services, and engagement and responsiveness to the communities served.

The Child and Youth Mental Health Program and Service Standards Module applies only to the organization’s child and youth mental health programs/services. The module addresses areas such as service approach, collaboration and partnerships, knowledge and learning, and intervention/treatment planning, implementation and review.
The Child and Youth Mental Health Service-Specific and Setting-Specific Standards Module is used where particular services are offered including for prevention programs, groups, consultation to other community service providers, respite, treatment foster care, day treatment, youth engagement, and for child and youth mental health services in schools, homes and other community settings. To learn more about which service-specific and setting-specific standards apply, see the detailed description provided under each component.

How Are the Requirements Organized?

Accreditation expectations are organized under two types of standards. Each standard has a series of indicators by which its achievement is assessed.

Mandatory Standards address legislated requirements, significant safety or risk issues, and crucial elements of good practice. In order to achieve a Mandatory Standard, all of its indicators must be met.

Leading Practice Standards promote quality, learning, excellence and creativity. In order to achieve a Leading Practice Standard, a certain number of its indicators must be met. The label “Required” next to a Leading Practice indicator signifies that it must be one of the indicators among those that are met in order for the standard to be achieved.

Some standards may not apply to all organizations or may apply differently. Information on applicability is included in a note that appears with the standard.

In order to be accredited, an organization must meet all the Mandatory Standards that apply and a certain number of the Leading Practice Standards that apply—specifically, 50% of the Leading Practice Standards in each component, as well as a total of 80% of Leading Practice Standards across each module.
Where Can I Find More Information?

A glossary, tools and a manual on preparing for accreditation are available to participating organizations and CCA reviewers by logging in at [www.canadiancentreforaccreditation.ca](http://www.canadiancentreforaccreditation.ca).

About this Edition

There is a standards manual for each sector that includes general information along with the standards modules that typically apply to services in that sector. Each module has its own version number and release date. When a change is made, the general information and applicable modules are repackaged into a new edition of the sector’s manual.

This is the **Sixth Edition** of the Standards Manual for Child and Youth Mental Health Organizations.

<table>
<thead>
<tr>
<th>Section</th>
<th>Section Title</th>
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<tr>
<td>1</td>
<td>Introduction to the CCA Accreditation Program</td>
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<td>CCA Organizational Standards Module (ORG)</td>
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<td>May 1, 2016</td>
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<td>3</td>
<td>Child and Youth Mental Health Program and Service Standards (PSS)</td>
<td>Version 2.5</td>
<td>November 1, 2015</td>
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<td>4</td>
<td>Child and Youth Mental Health Service- Specific and Setting-Specific Standards (SSS)</td>
<td>Version 2.5</td>
<td>May 1, 2016</td>
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Consult a detailed version history by logging in to CCA’s Web site and going to GoCCA > Standards.
Component: Governance

Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure. Organizations that do not have a governing body should complete the ORG-OVR Component. Please inquire with CCA.

---

**MAN Standard**

**ORG-GOV-1**

Members of the governing body have clear guidelines addressing conduct and ethics. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 3 out of 3 indicators must be met.

---

**ORG-GOV-1.1**

Required

The governing body has adopted a written code of conduct that addresses:

- Confidentiality
- Diversity and inclusion
- Anti-discrimination
- Ethical conduct
- Conflict of interest

---

**ORG-GOV-1.2**

Required

Written governance policies and procedures address:

- What is a conflict of interest
- How to identify, declare and resolve a conflict of interest
- How to deal with breaches of the governance code of conduct

---

**ORG-GOV-1.3**

Required

Actual and perceived conflicts of interest and any breaches of conduct are managed according to policy and procedure.

---

**MAN Standard**

**ORG-GOV-2**

The organization has adopted an approach to

---

**ORG-GOV-2.1**

Required

Written policies and procedures outline the governing body's role, responsibilities and structure.
governance that clearly distinguishes the governing body’s role from the role of management. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 7 out of 7 indicators must be met.

---

**ORG-GOV-2.2**

Required

The mandate, authority and reporting requirements of any governing body committees are clearly outlined in bylaws, policy or terms of reference.

**Pre-Site Document(s)**
- by-laws
- governance - policies/procedures
terms of reference

---

**ORG-GOV-2.3**

Required

The chief executive’s role and responsibilities are detailed in writing.

Note: May be detailed in written policy and/or in executive limitations and/or in a job description.

**Pre-Site Document(s)**
- personnel - job/role
descriptions
- policies/procedures - other

---

**ORG-GOV-2.4**

Required

Written policies and procedures address the steps and circumstances under which staff can gain access to the governing body to express concerns.

**Pre-Site Document(s)**
- governance - policies/procedures
- Interview(s)
- Staff - Staff Group (Cross-section)

---

**ORG-GOV-2.5**

Required

The governing body documents its expectations regarding the nature and frequency of reporting on the organization's activities, operations and performance.

**Pre-Site Document(s)**
- governance - policies/procedures
<table>
<thead>
<tr>
<th>Standard</th>
<th>Requirement</th>
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<tbody>
<tr>
<td><strong>ORG-GOV-2.6</strong></td>
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<td>Pre-Site Document(s) governance - minutes governance - policies/procedures Interview(s) Governing Body</td>
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<td><strong>ORG-GOV-3.1</strong></td>
<td>Required</td>
<td>Pre-Site Document(s) by-laws governance - policies/procedures</td>
</tr>
<tr>
<td><strong>ORG-GOV-3.2</strong></td>
<td>Required</td>
<td>Pre-Site Document(s) lists of governing body and staff Interview(s) Governing Body</td>
</tr>
</tbody>
</table>

**LP Standard ORG-GOV-3**

The governing body uses mechanisms to ensure its own effectiveness, stability and renewal. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 3 out of 5 indicators must be met.

Written policies and procedures and/or bylaws address the composition of the governing body and at a minimum cover the following:

- Size
- Length of terms
- Limits on consecutive terms
- Staggering of terms
- Recruitment and selection of members

The composition of the governing body is consistent with written policies and procedures, bylaws and any legal requirements.
**ORG-GOV-3.3**

The governing body ensures its composition reflects the diversity of the communities it serves.

---

**ORG-GOV-3.4**

Recruitment takes into account the knowledge, skills and experience needed to govern effectively.

---

**ORG-GOV-3.5**

The governing body actively plans for succession of its officer positions.

---

**ORG-GOV-4.1**

Members of the governing body are familiarized with the organization and their responsibilities through orientation that covers at minimum:

- Mission, vision and values
- Approach to governance, including roles and responsibilities of members of the governing body and of the chief executive
- What is expected of members, including conduct, time commitment, liability, duties and responsibilities
- Bylaws, governance policies and procedures and committee terms of reference, if applicable
- Strategic directions
- Programs and services
- Funding, finances and the fiscal stewardship role

To achieve this standard, 4 out of 6 indicators must be met.

---

Survey(s)
Board
Interview(s)
Governing Body

Survey(s)
Board
Pre-Site Document(s)
suggested governance - orientation policies, procedures, tools
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ORG-GOV-4.2</strong></td>
<td>Required Members of the governing body sign a statement acknowledging their understanding of and commitment to abide by their responsibilities, code of conduct and other expectations.</td>
</tr>
<tr>
<td><strong>ORG-GOV-4.3</strong></td>
<td>The orientation of new members occurs no later than the second meeting after appointment or election.</td>
</tr>
<tr>
<td><strong>ORG-GOV-4.4</strong></td>
<td>The governing body evaluates its work and performance at least once a year.</td>
</tr>
<tr>
<td><strong>ORG-GOV-4.5</strong></td>
<td>Findings from evaluations are used to improve the work and performance of the governing body.</td>
</tr>
</tbody>
</table>
ORG-GOV-4.6

Members of the governing body participate in training and development activities based on the results of governing body evaluations and planning.

ORG-GOV-5.1

Procedures for meetings outline, at minimum:

- Meeting frequency - Meeting type (for example, in person, teleconference, video conference) - Decision-making processes

ORG-GOV-5.2

The governing body develops and follows an annual work plan or calendar of key activities, reports and milestones.

ORG-GOV-5.3

Required

The governing body meets at least quarterly.
ORG-GOV-5.4
Quorum is reached at a minimum of 80% of meetings of the governing body in a given year.

ORG-GOV-5.5
Any in-camera meetings are limited to confidential issues (for example, bargaining, contractual issues) and all decisions are clearly recorded.

ORG-GOV-5.6
Minutes of the governing body's meeting are documented in accordance with legal requirements.

ORG-GOV-5.7
Governing body members agree that the governing body makes decisions effectively, analyzes and learns from past decisions and resolves conflicts among its members.

ORG-GOV-6.1
The governing body determines the qualifications required of the chief executive based on the needs of the organization.
administration of the organization. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 3 out of 4 indicators must be met.

---

**ORG-GOV-6.2**

The governing body uses an objective and transparent recruitment and hiring process.

**Interview(s)**

Governing Body

---

**ORG-GOV-6.3**

A contingency plan for absences of the chief executive is in place and is reviewed at minimum annually.

**Interview(s)**

Staff - Chief Executive

---

**ORG-GOV-6.4**

The governing body and chief executive actively plan for succession of the chief executive position.

**Interview(s)**

Staff - Chief Executive

---

**MAN Standard**

**ORG-GOV-7**

The working relationship between the members of the governing body and the chief executive supports the organization’s goals and objectives. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 4 out of 4 indicators must be met.

---

**ORG-GOV-7.1**

Required

The governing body and the chief executive jointly establish the chief executive's performance objectives in writing.

**Survey(s)**

Board

**Interview(s)**

Staff - Chief Executive
The governing body conducts a performance review of the chief executive on the basis of a job description and performance objectives at minimum every two years.

The governing body approves the chief executive’s compensation package.

The chief executive reports to the governing body on the organization’s activities, operations and performance according to the governing body’s documented expectations.

Component: Stewardship

Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure. Organization that do not have a governing body should complete the ORG-OVR Component instead. Please inquire with CCA.

The organization complies with the legislation that governs its legal structure as a corporation. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure. This standard applies to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

General meetings and/or other member or shareholder meetings take place in accordance with the organization’s bylaws and policies that govern its legal structure as a corporation or organization.
only applies if the organization is incorporated.)

To achieve this standard, 4 out of 4 indicators must be met.

**ORG-STW-1.2**

Required

Written policies and procedures address voluntary dissolution of the corporation and at minimum cover how the organization’s assets and the interests of persons served and of staff are protected.

**ORG-STW-1.3**

Required

Annual and other corporate registrations and reports are filed as required.

Note: Requirements for filing corporate information vary from province to province. The organization is expected to provide written evidence that it has filed its corporate information annually and that it has made the appropriate government instance(s) aware of any changes to corporate information between annual filings (for example, a change of board members) within the timelines specified in the legislation that applies.

**ORG-STW-1.4**

Required

If the organization is a charity, it submits an annual return to the Canada Revenue Agency as required.

Note: The organization is expected to provide a copy of its last submitted CRA annual return.

If the organization is not a charity, this indicator is not applicable and may be skipped.

**ORG-STW-2.1**

Required

The governing body sets the requirements regarding the nature and frequency of reporting based on the organization’s compliance with legislation, policies and procedures.
only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 4 out of 4 indicators must be met.

**ORG-STW-2.2**

**Required**

The governing body receives a report, at minimum annually, concerning the organization's compliance with legislation, policies and procedures.

**ORG-STW-2.3**

**Required**

Bylaws are reviewed at least every five years to ensure they conform to changing circumstances and legislation.

**ORG-STW-2.4**

**Required**

The organization takes steps to ensure its programs and services meet current legislative, licensing and regulatory requirements, as well as guidelines for funded programs where applicable.

**ORG-STW-3.1**

**Required**

Written policies and procedures are consistent with generally accepted accounting principles and at minimum address:

- Appointment or election of signing officers - Cheque signing - Approval of expenses - Limits on expenditures, including when governing body approval is required - Petty cash management and process - Separation of duties - Purchase of goods and services - Procurement, including tendering - Accounts receivable - Accounts payable - Retention of financial records - Investment
<table>
<thead>
<tr>
<th>ORG-STW-3.2</th>
<th>Pre-Site Document(s)</th>
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<tbody>
<tr>
<td>Required</td>
<td>financial - policies/procedures</td>
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Policies and procedures specify that contracts entered into for purchase of goods and services must be in writing and include, at minimum, a clear description of the goods and services to be rendered and procedures for fee payment.

<table>
<thead>
<tr>
<th>ORG-STW-3.3</th>
<th>Pre-Site Document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td>financial - policies/procedures</td>
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</table>

Policies and procedures that address signing authority, chief executive compensation and authority to commit funds are approved by the governing body.

<table>
<thead>
<tr>
<th>ORG-STW-3.4</th>
<th>Interview(s)</th>
</tr>
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<tbody>
<tr>
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<tr>
<td></td>
<td>Staff/Manager(s)</td>
</tr>
<tr>
<td></td>
<td>On-Site Document</td>
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</tbody>
</table>

Practices comply with financial policies and procedures.
ORG-STW-3.5
Required

Accounting records are up to date and reconciled monthly.

ORG-STW-3.6
Required

Revenues and expenditures are tracked by program/service to inform cost analysis and planning.

MAN Standard

ORG-STW-4

The governing body oversees the organization’s financial performance. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

To achieve this standard, 4 out of 4 indicators must be met.

ORG-STW-4.1
Required

The governing body approves an annual budget that is aligned with the organization's priorities and operational plan.

ORG-STW-4.2
Required

The governing body reviews financial monitoring reports at least on a quarterly basis, including budgeted versus actual revenues and expenditures, with significant variances noted and explained.
ORG-STW-4.3
Required

An independent licensed public accountant audits all of the organization's accounts according to Generally Accepted Accounting Principles.

Note: Organizations with an annual operating budget of more than $1 million must have financial statements audited by an independent licensed public accountant. For organizations with an annual operating budget of $1 million or less, a review engagement is adequate unless an audit is required by the legislation that governs the organization.

ORG-STW-4.4
Required

The governing body reviews the audited statements; if the organization is incorporated, the audited statements are presented to members/shareholders, as required by law.

ORG-STW-5.1
Required

Major fundraising activities are only undertaken when a fundraising strategy is in place.

MAN Standard

ORG-STW-5

The organization has mechanisms in place to guide any major fundraising activities. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.

This standard only applies if the organization is involved in raising over $10,000 per year from fundraising activities (not including grants).)

To achieve this standard, 4 out of 4 indicators must be met.

ORG-STW-5.2
Required

The fundraising strategy, including cost-effectiveness, is monitored and revised as needed.
ORG-STW-5.3

Required

Written policies and procedures provide ethical guidelines for the fundraising activities conducted by, or on behalf of, the organization and at minimum include the following:

Guidelines for all fundraising activities to:
- Disclose the organization’s name and include an address or other contact information
- Accurately describe the organization’s activities and achievements
- Sensitive and fairly represent the people served by the organization, their needs and how these needs will be addressed
- Disclose the purpose for which funds are requested
- If a charity, disclose the organization’s policy with respect to issuing Official Income Tax receipts including any policy on minimum amounts for which a receipt will be issued
- If a charity, disclose the Canada Revenue Agency (CRA) registration number (BN)
- Disclose, upon request, whether the party seeking donations is a volunteer, employee or contracted third party and, if the fundraising activity is conducted face to face, ensure the individual has identification from the organization
- Honour any donor and prospective donor requests regarding frequency of contact, preferred method, receipt of printed material, discontinuing contact, and anonymity

Guidelines for gifts and sponsorships that address gift/sponsorship acceptance and the treatment of restricted or designated gifts

Guidelines for fundraising costs that stipulate that:
- All costs associated with fundraising activities are accurately disclosed
- Finder’s fees, commissions or percentage compensation based on contributions are not paid to fundraisers (directly or indirectly)

Guidelines on the organization’s donor list that stipulate that:
- The donor list may not be sold
- If a donor list is rented, exchanged or otherwise shared, the organization abides by the Canadian Marketing Association Code of Ethics and Standards of Practice
- Donor requests to be excluded from such a list are honoured
MAN Standard

ORG-STW-6

Any social (productive) enterprises of the organization are operated to advance its mission. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

This standard only applies to organizations that operate a social enterprise, defined as a business venture (selling goods or services) for the purpose of creating a blended return on investment, both financial and social. The profits of the social enterprise are returned to the business or to a social purpose, rather than maximizing profits to shareholders. If the only social enterprise is an Employee Assistance Program and the organization is using CCA’s EAP Module, then this standard does not apply.)

To achieve this standard, 5 out of 5 indicators must be met.

ORG-STW-5.4

Required

Fundraising practices are consistent with policies and procedures.

ORG-STW-6.1

Required

The organization has one or more business plans to manage social enterprises.

ORG-STW-6.2

Required

Social enterprises are guided by the organization’s mission and values.

ORG-STW-6.3

Required

Profits generated by social enterprises are used to support the organization’s programs and services.
ORG-STW-6.4
Required

The finances of social enterprises are recorded and reported separately from the finances of the rest of the organization.

ORG-STW-6.5
Required

The selection of management and staff for social enterprises considers the specific skills and experience needed for commercial success.

MAN Standard

ORG-STW-7

Where persons served are charged fees for programs or services, the organization has mechanisms to administer fees with objectivity and transparency. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure.)

This standard only applies to organizations where persons served are charged fees for a program or service.

To achieve this standard, 2 out of 2 indicators must be met.

ORG-STW-7.1
Required

Written policies and procedures on program and service fees address at minimum:

- Programs and services for which fees apply - Fee schedule - Conditions under which fees are charged or waived - Process to collect outstanding fees - Process for appeals

ORG-STW-7.2
Required

Individuals approaching the organization for fee-based services are informed of the fee policy and schedule at the start of service.
ORG-STW-8.1

Written policies and procedures on handling of client funds at minimum address:

- Mechanisms for handling of funds that allow for segregation of the funds of each client - Tracking and accountability mechanisms, including for financial record keeping for each client and sign off on transactions by client and staff person

ORG-STW-8.2

Funds are segregated, with separate financial records for each client.

Note: On-Site Document or observation/look at the financial record keeping system during the interview.

ORG-STW-8.3

Practices are consistent with policies and procedures.

Note: On-Site Document or observation/look at the financial record keeping systems during the interview.

ORG-STW-8.4

Financial records of clients are reviewed at least annually by a party other than staff who handle funds for the client.

ORG-STW-9.1

Required

A written record of minor capital assets including key...
and responsibly manages its facilities and equipment. (Note: Applies only to organizations that have a board of directors or body such as a steering committee, council or advisory group that acts as a governance structure. This standard only applies to organizations with more than 20 individual staff members.)

To achieve this standard, 2 out of 2 indicators must be met.

### ORG-STW-9.2

**Required**

Facilities and equipment are inspected, tested, maintained and replaced in a planned, systematic way.

---

**Component: Oversight and Stewardship**

### ORG-OVR-1

**Required**

A chief executive is recruited and hired to responsibly administer the organization. (Note: Applies only to organizations that do not have a board of directors or governing body.)

To achieve this standard, 3 out of 4 indicators must be met.

### ORG-OVR-1.1

**Required**

The qualifications required of the chief executive are determined based on the needs of the organization.

### ORG-OVR-1.2

**An objective and transparent chief executive recruitment and hiring process is used.**

---

**Pre-Site Document(s) suggested**
- reports
- schedule

**Interview(s)**
- Staff - Admin
- Staff/Manager(s)

---

**Pre-Site Document(s) suggested**
- governance - policies/procedures

**Narrative**
- Interview(s)
- Staff - Chief Executive
ORG-OVR-1.3

A contingency plan for absences of the chief executive is in place and is reviewed at minimum annually.

ORG-OVR-1.4

A succession plan for the chief executive is in place and is reviewed at minimum annually.

MAN Standard

ORG-OVR-2

There is a structure in place to manage and support the chief executive, in line with the organization’s goals and objectives. (Note: Applies only to organizations that do not have a board of directors or governing body.)

To achieve this standard, 5 out of 5 indicators must be met.

ORG-OVR-2.1

Required

The chief executive’s role and responsibilities are detailed in writing.

Note: May be detailed in written policy and/or in executive limitations and/or in a job description.

ORG-OVR-2.2

Required

The chief executive’s performance objectives are jointly established by the chief executive and his/her manager, in writing.
**ORG-OVR-2.3**  
**Required**

A performance review of the chief executive is conducted on the basis of a job description and performance objectives at minimum every two years.

**ORG-OVR-2.4**  
**Required**

The chief executive does not have approval over his or her own compensation package.

**ORG-OVR-2.5**  
**Required**

The chief executive reports on the organization's activities, operations and performance according to documented expectations.

**MAN Standard**  
**ORG-OVR-3**

The organization complies with the legislation that governs its legal structure as a corporation. (Note: Applies only to organizations that do not have a board of directors or governing body.)

This standard only applies if the organization is incorporated.

To achieve this standard, 4 out of 4 indicators must be met.

**ORG-OVR-3.1**  
**Required**

Annual general meetings and/or other member or shareholder meetings take place in accordance with the organization's bylaws and policies that govern its legal structure as a corporation or organization.
ORG-OVR-3.2

Required

Written policies and procedures address dissolution of the corporation and at minimum cover how the organization’s assets and the interests of persons served and of personnel are protected.

ORG-OVR-3.3

Required

Annual and other corporate registrations and reports are filed as required.

Note: Requirements for filing corporate information vary from province to province. The organization is expected to provide written evidence that it has filed its corporate information annually and that it has made the appropriate government instance(s) aware of any changes to corporate information between annual filings (for example, a change of board members) within the timelines specified in the legislation that applies.

ORG-OVR-3.4

Required

If the organization is a charity, it submits an annual return to the Canada Revenue Agency as required.

Note: The organization is expected to provide a copy of its last submitted CRA annual return.

MAN Standard

ORG-OVR-4

The organization monitors compliance with its by-laws, policies and procedures and with legislation in all the jurisdictions in which it operates. (Note: Applies only to organizations that do not have a board of directors or governing body.)

To achieve this standard,

ORG-OVR-4.1

Required

Expectations that the chief executive report on the organization’s compliance with legislation, policies and procedures are laid out in writing and include the nature and frequency of reporting.
3 out of 3 indicators must be met.

**ORG-OVR-4.2**

**Required**

The chief executive reports, at minimum annually, on the organization's compliance with legislation, policies and procedures.

Pre-Site Document(s)
- staff and team minutes reports

**ORG-OVR-4.3**

**Required**

The organization takes steps to ensure its programs and services meet current legislative, licensing and regulatory requirements, as well as guidelines for funded programs where applicable.

Pre-Site Document(s)
- staff and team minutes reports
- Interview(s)
  - Staff - Chief Executive

**MAN Standard**

**ORG-OVR-5**

The organization has effective financial management systems. (Note: Applies only to organizations that do not have a board of directors or governing body.)

To achieve this standard, 6 out of 6 indicators must be met.

**ORG-OVR-5.1**

**Required**

Written policies and procedures are consistent with generally accepted accounting principles and at minimum address:

- Appointment or election of signing officers - Cheque signing - Approval of expenses - Limits on expenditures, including when governing body approval is required - Petty cash management and process - Separation of duties - Purchase of goods and services - Procurement, including tendering - Accounts receivable - Accounts payable - Retention of financial records - Investment management

Pre-Site Document(s)
- financial - policies/procedures

**ORG-OVR-5.2**

**Required**

Policies and procedures specify that contracts entered into for purchase of goods and services must be in writing and include, at minimum, a clear description of the goods and services to be rendered and procedures for fee payment.

Pre-Site Document(s)
- financial - policies/procedures
ORG-OVR-5.3
Required

The chief executive does not have authority to approve policies and procedures that address signing authority, chief executive compensation and authority to commit funds.

ORG-OVR-5.4
Required

Practices comply with financial policies and procedures.

ORG-OVR-5.5
Required

Accounting records are up to date and reconciled monthly.

ORG-OVR-5.6
Required

Revenues and expenditures are tracked by program/service to inform cost analysis and planning.

ORG-OVR-6.1
Required

The organization has an annual budget that is aligned with its priorities and operational plan.
To achieve this standard, 4 out of 4 indicators must be met.

**ORG-OVR-6.2**

Required

Financial monitoring reports are produced and reviewed at least on a quarterly basis, and include budgeted versus actual revenues and expenditures, with significant variances noted and explained.

**ORG-OVR-6.3**

Required

An independent licensed public accountant audits all of the organization's accounts according to Generally Accepted Accounting Principles.

Note: Organizations with an annual operating budget of more than $1 million must have financial statements audited by an independent licensed public accountant. For organizations with an annual operating budget of $1 million or less, a review engagement is adequate unless an audit is required by the legislation that governs the organization. If the organization's finances are audited as part of a larger entity’s, that entity’s audited financial statements should be provided as evidence.

**ORG-OVR-6.4**

Required

The audited statements are presented to members/shareholders, as required by law.

**ORG-OVR-7.1**

Required

Major fundraising activities are only undertaken when a fundraising strategy is in place.
This standard only applies if the organization is involved in raising over $10,000 per year from fundraising activities (not including grants).

To achieve this standard, 3 out of 3 indicators must be met.

**ORG-OVR-7.2**
Required

The fundraising strategy, including cost-effectiveness, is monitored and revised as needed.

**ORG-OVR-7.3**
Required

Written policies and procedures provide ethical guidelines for the fundraising activities conducted by, or on behalf of, the organization and at minimum include the following:

Guidelines for all fundraising activities to:

- Disclose the organization’s name and include an address or other contact information
- Accurately describe the organization’s activities and achievements
- Sensitively and fairly represent the people served by the organization, their needs and how these needs will be addressed
- Disclose the purpose for which funds are requested
- If a charity, disclose the organization’s policy with respect to issuing Official Income Tax receipts including any policy on minimum amounts for which a receipt will be issued
- If a charity, disclose the Canada Revenue Agency (CRA) registration number (BN)
- Disclose, upon request, whether the party seeking donations is a volunteer, employee or contracted third party and, if the fundraising activity is conducted face to face, ensure the individual has identification from the organization
- Honour any donor and prospective donor requests regarding frequency of contact, preferred method, receipt of printed material, discontinuing contact, and anonymity
- Guidelines for gifts and sponsorships that address gift/sponsorship acceptance and the treatment of restricted or designated gifts
- Guidelines for fundraising costs that stipulate that:
  - All costs associated with fundraising activities are accurately disclosed
  - Finder’s fees, commissions or percentage
compensation based on contributions are not paid to fundraisers (directly or indirectly) Guidelines on the organization’s donor list that stipulate that: • The donor list may not be sold • If a donor list is rented, exchanged or otherwise shared, the organization abides by the Canadian Marketing Association Code of Ethics and Standards of Practice • Donor requests to be excluded from such a list are honoured

MAN Standard
ORG-OVR-8

Any social (productive) enterprises of the organization are operated to advance its mission. (Note: Applies only to organizations that do not have a board of directors or governing body.

This standard only applies to organizations that operate a social enterprise, defined as a business venture (selling goods or services) for the purpose of creating a blended return on investment, both financial and social. The profits of the social enterprise are returned to the business or to a social purpose, rather than maximizing profits to shareholders.

If the only social enterprise is an Employee Assistance Program and the organization is using CCA’s EAP Module, then this standard does not apply.)

To achieve this standard, 5 out of 5 indicators must be met.

---

ORG-OVR-8.1
Required

The organization has one or more business plans to manage social enterprises.

---

ORG-OVR-8.2
Required

Social enterprises are guided by the organization’s mission and values.

---

ORG-OVR-8.3
Required

Profits generated by social enterprises are used to support the organization’s programs and services.
ORG-OVR-8.4
Required

The finances of social enterprises are recorded and reported separately from the finances of the rest of the organization.

ORG-OVR-8.5
Required

The selection of management and staff for social enterprises considers the specific skills and experience needed for commercial success.

ORG-OVR-9.1
Required

Written policies and procedures on program and service fees address at minimum:
- Programs and services for which fees apply - Fee schedule - Conditions under which fees are charged or waived - Process to collect outstanding fees - Process for appeals

ORG-OVR-9.2
Required

Individuals approaching the organization for fee-based services are informed of the fee policy and schedule at the start of service.

ORG-OVR-10.1

Written policies and procedures on handling of client funds at minimum address:
responsibility for client funds, manages these funds transparently and responsibly.

(Note: This standard only applies to organizations that assume fiduciary responsibility for client funds, whether they hold, handle or disburse the client’s own funds or non-fee-for-service funds from another entity intended for the client.)

To achieve this standard, 4 out of 4 indicators must be met.

- Mechanisms for handling of funds that allow for segregation of the funds of each client - Tracking and accountability mechanisms, including for financial record keeping for each client and sign off on transactions by client and staff person

**ORG-OVR-10.2**

Funds are segregated, with separate financial records for each client.

**ORG-OVR-10.3**

Practices are consistent with policies and procedures.

**ORG-OVR-10.4**

Financial records of clients are reviewed at least annually by a party other than staff who handle funds for the client.

Note: On-Site Document or observation/look at financial record keeping during interview.

**MAN Standard**

**ORG-OVR-11**

The organization carefully and responsibly manages its facilities and equipment. (Note: Applies

A written record of minor capital assets including key equipment and computer hardware and software is updated according to an established timeline.
only to organizations that do not have a board of directors or governing body.

This standard only applies to organizations with more than 20 individual staff members.)

To achieve this standard, 2 out of 2 indicators must be met.

---

**Component: Risk and Safety**

**MAN Standard**

**ORG-RS-1**

The organization takes measures to protect itself, the persons it serves and its personnel from harm.

To achieve this standard, 6 out of 6 indicators must be met.

**ORG-RS-1.1**

Required

The organization has documented its strategies to identify and manage risks to persons served, to personnel, to property, to reputation and to financial and other resources.

**Pre-Site Document(s)**

risk and safety - policies, procedures, tools

**ORG-RS-1.2**

Required

Written policies and procedures outline processes for incident reporting and monitoring.

**Pre-Site Document(s)**

risk and safety - incident reports/tools
### ORG-RS-1.3
#### Required

Incidents are documented, and incident reports are reviewed and used to address issues and mitigate future risk.

<table>
<thead>
<tr>
<th>Pre-Site Document(s)</th>
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<tbody>
<tr>
<td>risk and safety - incident reports/tools</td>
</tr>
<tr>
<td>Interview(s) Staff - Staff Group (Cross-section)</td>
</tr>
</tbody>
</table>

### ORG-RS-1.4
#### Required

Written policies and procedures encourage individuals to come forward with information on illegal practices, professional misconduct/incompetence and violations of organizational policies, with the understanding that the organization will not retaliate against and will protect the confidentiality of individuals who make good-faith reports except when required by law.

<table>
<thead>
<tr>
<th>Pre-Site Document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>policies/procedures - other</td>
</tr>
</tbody>
</table>

### ORG-RS-1.5
#### Required

Insurance policies safeguard the organization from loss and liability and cover general liability, professional liability, directors' and officers' liability, property and bonding of appropriate personnel.

Note: As on-site document(s), the CCA review team will wish to consult the organization’s insurance policies. If the organization does not have a board of directors, the CCA review team will not expect to see proof of directors’ and officers’ liability insurance.

<table>
<thead>
<tr>
<th>On-Site Document</th>
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</table>

### ORG-RS-1.6
#### Required

The organization documents its risk management activities and reports to the governing body, at minimum annually, on risks identified, risk mitigation strategies, actions taken and the effectiveness of those actions.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group)
that acts as a governance structure, risk management reports should go to the manager or to the entity of which the organization is part.

---

**MAN Standard**

**ORG-RS-2**

The organization ensures its work environments are safe and healthy. (Note: Occupational health and safety (OHS) requirements vary from province to province. For purposes of CCA accreditation, the organization is expected to demonstrate its adherence, at minimum, to CCA’s OHS checklist for its province. Please see GoCCA’s Resource Library for provincial OHS Checklists.)

To achieve this standard, 4 out of 4 indicators must be met.

---

**ORG-RS-2.1**

**Required**

In accordance with applicable legislation, written policies and procedures address workplace health and safety, including workplace violence and harassment.

Note: Occupational health and safety (OHS) requirements vary from province to province. For purposes of CCA accreditation, the organization is expected to demonstrate its adherence, at minimum, to CCA’s OHS checklist for its province. Please see GoCCA’s Resource Library for provincial OHS Checklists.

---

**ORG-RS-2.2**

**Required**

A written plan outlines the measures and steps to follow in the event of emergencies including medical, fire, threat of harm, disaster and pandemic.

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**ORG-RS-2.3**

**Required**

The workplace is regularly inspected for hazards and measures are taken to address them as needed. The frequency of inspections should be aligned with the requirements of applicable health and safety legislation.

Note: The organization is expected to provide a summary report or summary reports of workplace inspections for the 12 months preceding the submission of its pre-site evidence in the GoCCA Web Tool.
Occupational health and safety (OHS) requirements vary from province to province. For purposes of CCA accreditation, the organization is expected to demonstrate its adherence, at minimum, to CCA’s OHS checklist for its province. Please see GoCCA’s Resource Library for provincial OHS Checklists.

**MAN Standard**

**ORG-RS-3**

The organization safeguards persons served and personnel from service-related risk.

To achieve this standard, 5 out of 5 indicators must be met.

**ORG-RS-2.4**

Required

Practices are consistent with the organization’s workplace health and safety policies and procedures.

Note: Occupational health and safety (OHS) requirements vary from province to province. For purposes of CCA accreditation, the organization is expected to demonstrate its adherence, at minimum, to CCA’s OHS checklist for its province. Please see GoCCA’s Resource Library for provincial OHS Checklists.

**ORG-RS-3.1**

Required

Written policies and procedures guide personnel in managing high-risk service situations appropriate to the service context and at minimum address:

- Recognition and reporting of child abuse
- Recognition and reporting of other vulnerable person abuse (for example, women, elderly, disabled)
- Management of violent, disruptive and other crisis situations (including threats to self and others)
- Handling of medical emergencies, including first aid and other procedures
- Transportation of persons served (including whether permitted and, if so, the conditions and limitations)
ORG-RS-3.2
Required

Service settings are planned with regard for the safety and the security of the individuals expected to use them.

ORG-RS-3.3
Required

Personnel are trained to recognize and manage high-risk service situations and, as appropriate to their job responsibilities, participate in ongoing training and education in crisis prevention and de-escalation.

ORG-RS-3.4
Required

Practices are consistent with policies and procedures on service safety.

ORG-RS-3.5
Required

The organization identifies and makes improvements to service safety where necessary.

MAN Standard
ORG-RS-4

The organization takes measures to address safety issues specific to home- and community-

ORG-RS-4.1
Required

Written policies and procedures address managing risks specific to service provided in the homes of persons served or in community settings, including but not...
based services. (Note: This standard only applies to organizations that offer services in homes and in community settings.)

To achieve this standard, 2 out of 2 indicators must be met.

limited to:

- Safety precautions to be taken on site - Mechanisms to ensure schedules of home and community visits are known by the organization - Communications, including the use of a cell phone or safety device such as a portable panic alarm - Steps to be taken when risk factors are identified on-site (for example, due to smoking, substance use and pets) - Circumstances in which home or community visits are contraindicated for safety reasons

ORG-RS-4.2
Required

Practices are consistent with policies and procedures.

ORG-RS-5.1

Written policies and procedures outline:

- How to make a complaint or raise a concern - How complaints will be handled - How and by when the organization will respond - How complaints are to be monitored and reported

ORG-RS-5.2

Procedures specify the timeframe within which the governing body is to be notified of complaints that may put the organization at risk.
ORG-RS-5.3

Information on how to make a complaint is readily accessible to persons served and to members of the public.

ORG-RS-5.4

The organization tracks the themes of the complaints, monitors the outcomes and reports to the governing body at minimum annually on complaints and actions taken.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, reports should go to the manager or to the entity of which the organization is part. Governing body minutes are not expected as evidence.

Component: Organizational Planning and Performance

MAN Standard

ORG-OPP-1

The organization is guided by a vision, mission and values that clearly articulate its purpose.

To achieve this standard, 4 out of 4 indicators must be met.

ORG-OPP-1.1

Required

The governing body reviews and approves the vision, mission and values of the organization with input from staff and key stakeholders.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, the organization is asked to provide a narrative or other documentation demonstrating that staff and stakeholder input is taken into account in the review of its vision, mission and values.
ORG-OPP-1.2
Required

A review of the vision, mission and values occurs at least every five years or earlier if there is a significant change in the environment, scope of services or mandate of the organization, and revisions are made as necessary.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, an on-site interview is not necessary.

ORG-OPP-1.3
Required

The vision, mission and values are shared with stakeholders.

ORG-OPP-1.4
Required

The vision, mission and values guide organizational planning, decision making, resource allocation and operations and the organization's relationships with internal and external stakeholders.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, on-site interviews will be limited to the Managers Group and the Chief Executive.

LP Standard
ORG-OPP-2

The organization is guided by a strategic plan.

To achieve this standard, 4 out of 6 indicators must be met.

ORG-OPP-2.1

The governing body ensures a strategic planning process takes place at least every five years by outlining timeframes and assigning responsibilities.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, it is expected that strategic planning is assured by the manager or entity of which the organization is part.
ORG-OPP-2.2

Strategic planning includes an environmental scan and a review of the characteristics, needs and strengths of persons and communities served.

Note: If the organization does not have a governing body, a narrative or document is suggested as evidence.

ORG-OPP-2.3

The strategic planning process includes seeking input from key stakeholders.

Note: If the organization does not have a governing body, a governing body interview does not apply.

ORG-OPP-2.4

The governing body develops and approves the organization's strategic goals or ends and reviews them annually.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, it is expected that strategic goals or ends are approved and reviewed by the manager or entity of which the organization is part. The organization is expected to provide minutes, planning documents or other documents demonstrating such review.

ORG-OPP-2.5

The strategic plan outlines multi-year strategic directions and goals or ends.
**ORG-OPP-2.6**

Strategic directions are communicated to stakeholders.

---

**ORG-OPP-3.1**

**Required**

Annual operational plans are aligned with the organization's mission and strategic directions or strategic plan.

---

**ORG-OPP-3.2**

**Required**

The organization’s annual operational plans are documented and include:

- Objectives
- Activities
- Timelines
- Responsibilities
- Resources (technological, physical, human and financial)
- Indicators for monitoring achievement

Note: In some organizations, these elements may be found in more than one document (for example, an organization-wide operational plan along with departmental level plans).

---

**ORG-OPP-3.3**

**Required**

Operational planning engages staff and takes into account information from a number of sources (for example, research, feedback of persons served, program and service data).
ORG-OPP-3.4

Required

Managers monitor the operational plan at minimum quarterly and make adjustments if needed.

Pre-Site Document(s)
- staff and team minutes
- Interview(s)
- Staff - Managers Group

ORG-OPP-3.5

Required

The governing body reviews, at least annually, the organization's progress in achieving operational objectives.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, it is expected that progress is reviewed by the manager or entity of which the organization is part. The organization is expected to provide minutes, planning documents or other documents demonstrating such review.

Pre-Site Document(s)
- governance - minutes

MAN/LP Standard

ORG-OPP-4

The organization is engaged in improving the quality of its services and operations. (Note: This standard is mandatory for organizations with more than 20 staff members and leading practice for organizations with 20 or fewer staff members.)

To achieve this standard, 3 out of 4 indicators must be met.

ORG-OPP-4.1

The organization's leaders clearly communicate their commitment to improving the quality of services and operations throughout the organization.

Note: If the organization does not have a governing body, a governing body interview does not apply.

Survey(s)
- Staff
- Interview(s)
- Staff - Chief Executive
- Governing Body

ORG-OPP-4.2

The governing body sets overall expectations for quality and performance across the organization’s programs, services and operations.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, it is expected that the setting of expectations for quality and performance is assured by the manager or entity of which the organization is part. The organization is expected to provide minutes and/or other documentation as evidence.

Pre-Site Document(s)
- governance - minutes
- Interview(s)
- Governing Body
ORG-OPP-4.3

A written plan outlines the organization's ongoing quality improvement processes and includes:

- Responsibility for leading quality improvement initiatives
- Each quality improvement initiative and its goals, targets for improvement, timelines and how results will be measured
- How progress is measured, analyzed and reported

ORG-OPP-4.4

The organization reports on quality and performance to staff, the governing body, the community and other stakeholders.

Note: The EAP Customer Survey is used as evidence only for reviews for which the Family Services Employee Assistance Standards module applies.

If the organization does not have a governing body, it is expected that reports on quality and performance are made to personnel, the community and other stakeholders. Among these stakeholders are the manager or entity of which the organization is part. The organization is asked to demonstrate this through a narrative or a document.

ORG-OPP-5.1

A written framework is in place to guide quality improvement initiatives and evaluation of programs and services across the organization.

To achieve this standard, 4 out of 6 indicators must be met.
ORG-OPP-5.2

Quality improvement initiatives and evaluations of programs and services include the perspectives of a range of sources (for example, persons served, personnel, community partners, program and service data).

Survey(s)
Community Partners
Pre-Site Document(s)
evaluation - results of client and/or community surveys
evaluation - summary reports
quality improvement - policies/plans

ORG-OPP-5.3

Feedback about programs, services and service quality is regularly sought from persons served (for example, through surveys, focus groups, suggestion boxes, learning circles).

Note: The EAP customer survey is used as evidence only for reviews using the Family Services Employee Assistance standards.

Survey(s)
EAP Customers
Pre-Site Document(s)
evaluation - results of client and/or community surveys
Interview(s)
Staff - Staff Group (Cross-section)
Staff - Managers Group

ORG-OPP-5.4

Evaluations measure program and service outcomes (for example, changes in the awareness, knowledge, skills, behaviour and well-being of persons receiving service).

Pre-Site Document(s)
evaluation - summary reports

ORG-OPP-5.5

Evaluations measure operational outcomes (for example, human resource and financial performance).
Lessons from quality improvement initiatives and from evaluations of programs and services are used to make improvements to programs, services and operations.

Staff and other stakeholders, as appropriate, are encouraged to reflect and identify opportunities for innovation and improvement in the organization’s work.

Individuals at all levels of the organization are given opportunities for ongoing learning and to exchange ideas and experiences.

Staff are encouraged to test new approaches as a means of fostering quality.

Component: Programs and Services

ORG-PS-1.1

Required

Pre-Site Document(s)
program/service - philosophy statement
program/service - policies/procedures
The organization’s approach to service is centred on the persons it serves and engages them in the service process.

To achieve this standard, 6 out of 6 indicators must be met.

Written policies and procedures address the organization’s service delivery philosophy and acknowledge the following:

- The needs and preferences of the persons served are at the centre of all considerations, respecting the uniqueness of each individual
- The rights of persons served to make decisions about service or support, including the right to refuse or discontinue service or support within the limits set by service agreements
- Respect for the values and beliefs of persons served
- A commitment to engaging persons served in shaping programs and services
- Recognition of the importance of the whole context, including an individual’s family, friends and community, as well as social, cultural and spiritual aspects

<table>
<thead>
<tr>
<th>ORG-PS-1.2</th>
<th>Pre-Site Document(s) suggested evaluation - results of client and/or community surveys Interview(s) Staff - Staff Group (Cross-section)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td>The approach to service is strength based and promotes autonomy, skill development and quality of life.</td>
</tr>
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<tr>
<th>ORG-PS-1.3</th>
<th>Narrative Pre-Site Document(s) program/service - policies/procedures Interview(s) Staff - Staff Group (Cross-section)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td>The diversity of persons served is respected and efforts are made to accommodate their uniqueness.</td>
</tr>
</tbody>
</table>
ORG-PS-1.4
Required

Communication with persons seeking and receiving service ensures that diverse needs, interests, cultural backgrounds, and language and communication skills are accommodated.

Note: Only organizations completing a CCA review in Family Services or a CCA review in Credit Counselling are required to provide completed CCA Staff Data Forms as evidence for this indicator.

ORG-PS-1.5
Required

The service delivery philosophy is articulated in writing and shared with persons served, personnel and other stakeholders.

ORG-PS-1.6
Required

Programs, services and practices are consistent with the organization’s approach to service.

ORG-PS-2.1
Required

Client rights are stated in writing and at minimum include the rights of persons served:

- To be treated with dignity and respect and without discrimination
- To privacy and confidentiality
- To a safe and secure service environment
- To make a complaint
ORG-PS-2.2
Required

Two or more mechanisms exist for informing persons served of their rights (for example, information packages/brochures, verbally in the intake/assessment process, client rights are posted).

ORG-PS-2.3
Required

Practices across the organization are consistent with the client rights policy.

Note: The CCA interview of clients is used only for organizations completing a CCA review in Child Welfare or a CCA review in Child and Youth Mental Health.

ORG-PS-3.1
Required

Facilities are accessible to persons with reduced mobility, or an alternate means of accessing service is available.

ORG-PS-3.2
Required

The locations and facilities of programs and services are consistent with the organization’s service philosophy, are welcoming and are appropriate for the cultural backgrounds, chronological ages, developmental levels and service needs of those served.
<table>
<thead>
<tr>
<th><strong>ORG-PS-3.3</strong></th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efforts are made to provide programs and services in languages and with communication that is inclusive and understandable to persons served.</td>
<td></td>
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| **Narrative** |
| Survey(s) |
| Community Partners |

<table>
<thead>
<tr>
<th><strong>ORG-PS-3.4</strong></th>
<th>Required</th>
</tr>
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<tbody>
<tr>
<td>Where relevant, the organization has an after-hours on-call system.</td>
<td></td>
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</table>

| **Narrative** |
| Pre-Site Document(s) |
| program/service - descriptions |

<table>
<thead>
<tr>
<th><strong>ORG-PS-3.5</strong></th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other strategies are used to remove barriers and make the organization's programs and services more accessible (for example, geographically accessible, hours of service, child care supports, transportation assistance, interpretation, home-based services, flexible client-led intake processes).</td>
<td></td>
</tr>
</tbody>
</table>

| **Narrative** |
| Pre-Site Document(s) |
| suggested program/service - policies/procedures |
| Interview(s) |
| Staff - Staff Group (Cross-section) |

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<thead>
<tr>
<th><strong>ORG-PS-3.6</strong></th>
<th>Required</th>
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</thead>
<tbody>
<tr>
<td>The organization continually assesses and improves the accessibility of its programs, services and resources.</td>
<td></td>
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</tbody>
</table>

| **Pre-Site Document(s) suggested** |
| evaluation - summary reports |
| Interview(s) |
| Staff - Managers Group |

<table>
<thead>
<tr>
<th><strong>ORG-PS-4.1</strong></th>
<th>Required</th>
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</thead>
<tbody>
<tr>
<td>Relevant staff receive initial and periodic Indigenous cultural competency training that:</td>
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</table>

| **Narrative** |
| Pre-Site Document(s) suggested orientation policies, procedures, tools |
| Interview(s) |
| Staff - Program-specific |
that are experienced as culturally safe by persons served. (Note: This standard applies to organizations that identify Aboriginal persons as part of their clientele. Aboriginal persons include First Nations, Inuit and Metis people.

Indigenous cultural safety is an outcome defined and experienced by Aboriginal persons based on:

- Respect for their beliefs, behaviours, and values
- Recognition of the role of socio-economic conditions, history, and politics in their health
- Involving them as partners in decision making about their health and well-being

See Glossary for fuller definition of Indigenous cultural safety.)

To achieve this standard, 3 out of 5 indicators must be met.

- Includes foundational training that provides an opportunity to explore biases about Aboriginal people, and consider strategies for working more effectively with them - Looks at cultural protocols in the local context - Includes content-specific training in the relevant program or service area - Is delivered by trainers validated by Aboriginal communities

Note: Cultural competence develops and evolves over time through regular opportunities for continuing professional development. The organization must demonstrate that it is delivering this training over time and that the participation of relevant staff is required.

**ORG-PS-4.2**

Intake and referral processes at minimum include:

- Formal and informal intake procedures and processes that reflect an understanding of Aboriginal cultural contexts - Opportunity for self-identification by Aboriginal people - Flexibility to meet diverse needs

**ORG-PS-4.3**

The physical setting is welcoming, respectful and reflective of local Aboriginal cultures.

**ORG-PS-4.4**

If traditional Aboriginal healing services are offered at the organization, these are provided in consultation with Aboriginal organizations/communities.
ORG-PS-4.5

The organization monitors whether service is experienced as culturally safe.

Narrative
Pre-Site Document(s) suggested evaluation - results of client and/or community surveys
Interview(s)
Staff - Program-specific Staff

ORG-PS-5.1

Required

Persons eligible to receive service are referred to the most appropriate program or service within the organization.

Pre-Site Document(s) suggested program/service - policies/procedures
Interview(s)
Staff - Staff Group (Cross-section)
Staff - Program-specific Staff

ORG-PS-5.2

Required

If the program or service is not available or if additional services from other community resources are needed to augment those provided, the organization facilitates referrals to the most appropriate available external community resource.

Pre-Site Document(s) suggested program/service - policies/procedures
Interview(s)
Staff - Program-specific Staff

ORG-PS-5.3

Required

An up-to-date list of appropriate external community resources is used to facilitate referrals.

Observation(s)
General
ORG-PS-5.4
Required

Referrals are made to appropriate resources such as Web sites, print material and other community resources/programs.

ORG-PS-5.5
Required

Barriers to referrals are identified and the organization seeks to address them.

ORG-PS-6.1
Required

Persons accepted for service receive orientation at start of service.

ORG-PS-6.2
Required

The orientation of persons served addresses at minimum:

- The rights and responsibilities of persons served
- The organization’s privacy policies and procedures
- Procedures for making a complaint

MAN Standard
ORG-PS-6

The organization orients persons accepted for service. (Note: The organization is expected to provide orientation commensurate with the service to be provided. For example, orientation for brief, one-time or some group services such as congregate dining would not be expected to be at the same level of depth as other program/service orientation.)

To achieve this standard, 3 out of 3 indicators must be met.
Component: Aboriginal Organizations

The standards in this component apply to organizations that are mandated to primarily serve Aboriginal persons and communities, including First Nations, Inuit and Métis people. During piloting, the use of this component is voluntary. Please inquire with CCA.

MAN Standard

**ORG-ABO-1**

The organization is committed to creating an environment and operating in a manner that support Indigenous cultural safety. (Note: Indigenous cultural safety is an outcome defined and experienced by Aboriginal persons based on:

- Respect for their beliefs, behaviours and values
- Recognition of the role of socioeconomic conditions, history, and politics in their health and well-being
- Involving them as partners in decision making about their health and well-being

(See Glossary for more.)

The standards in this component apply to organizations that are mandated to primarily serve Aboriginal persons and communities, including First Nations, Inuit and Métis people.

**ORG-PS-6.3**

Required

Confirmation that orientation has taken place is documented in the program record or in the record of the person served either by obtaining the signature of the person served or by a service provider’s notation.

Note: The Client Journey is used only for organizations completing a CCA review in Community-Based Primary Health Care and Community Mental Health and Addiction Services. On-site client file review is used only for organizations completing a CCA review in Child and Youth Mental Health, Community Support and Social Services, Child Welfare, Youth Justice, Family Services and/or Credit Counselling.

**ORG-ABO-1.1**

Required

A commitment to Indigenous cultural safety is reflected in the organization’s vision, mission, values and service philosophy.

**ORG-ABO-1.2**

Required

Strategic and service planning reflect the pursuit of Indigenous cultural safety in the organization’s environment, operations, human resources and services.
During piloting, the use of this component is voluntary.)

To achieve this standard, 4 out of 4 indicators must be met.

**ORG-ABO-1.3**

Required

Client rights include elements required to create culturally safe service provision (for example, respect, engagement as a partner in decision making, safety and security, respect for beliefs, behaviours and values, recognition of the role of socio-economic conditions, history and politics).

Note: See Glossary for definition of cultural safety and for reference to United Nations Declaration on the Rights of Indigenous Peoples.

**ORG-ABO-1.4**

Required

Members of the governing body, management and staff demonstrate a commitment to means of advancing cultural safety throughout the organization, in particular by building cultural competency.

Note: Cultural competency consists of the knowledge, awareness and skills that contribute to creating a culturally safe service environment. See Glossary for more.

**ORG-ABO-2**

The governing body operates in ways congruent with Aboriginal worldviews, values, traditions and leading practices informed by the local context. (Note: The standards in this component apply to organizations that are mandated to primarily serve Aboriginal persons and communities, including First Nations, Inuit and Metis people. During piloting, the use of this component is voluntary.)

To achieve this standard, 3 out of 5 indicators must be met.

**ORG-ABO-2.1**

A majority of governing body members are Aboriginal individuals from communities served.

**ORG-ABO-2.2**

Aboriginal individuals recruited to the governing body are selected by recognized structures within the communities served (for example, Aboriginal organizational boards, elder advisories, traditional societies, Band Councils).
ORG-ABO-2.3

Mechanisms are used to ensure that Aboriginal individuals recruited to the governing body have expertise and experience in the areas of the organization’s work, and are recognized, credible champions of the Aboriginal communities served.

ORG-ABO-2.4

Steps are taken to ensure that the Aboriginal individuals on the governing body are drawn from the diversity of Aboriginal communities and geographies being served, including as applicable First Nations, Inuit, Metis, and Status and non-Status people living on reserve, in Metis settlements and/or in rural, urban, isolated or remote areas.

ORG-ABO-2.5

The governing body uses traditional methods of communication, conflict resolution and decision making, as informed by the local context (for example, consensus building, talking sticks/circles/feathers, “Good-Mind” foundation, symbolic literacy, “Dish with one Spoon” Wampeen).

ORG-ABO-3.1

Active methods are used to reach out to, engage and involve the people and communities served.
2 out of 3 indicators must be met.

**ORG-ABO-3.2**

Regular, culturally congruent communication and reporting to communities served takes place through Aboriginal community networks.

**ORG-ABO-3.3**

To promote community health and well-being, the organization uses culturally safe and congruent strategies to build capacity in communities served (for example, leadership, resources, skills and knowledge).

**ORG-ABO-4.1**

Required

Services are provided in the context of holistic Aboriginal frameworks of health and well-being, integrating the physical, emotional, mental, spiritual and cultural areas of life.

Note: The Client Journey is used as evidence only for reviews for which the Community-Based Primary Health Care Standards and Community Mental Health and Addiction Standards apply. On-site client file review and client interviews are used in other sectors.

**ORG-ABO-4.2**

Required

Services integrate relationships with caregivers, family, extended family, community and Nation as appropriate and directed by the person served.

Note: The Client Journey is used as evidence only for reviews for which the Community-Based Primary Health Care Standards and Community Mental Health and Addiction Standards apply. On-site client file review and client interviews are used in other sectors.
ORG-ABO-4.3

Required

The majority of service providers (including professional providers such as counsellors, doctors and nurses) are Aboriginal.

Note: CCA will consider granting an accommodation on the interpretation of this indicator because there may be shortages of qualified Aboriginal candidates in some geographic areas and fields of practice. Achievement of this indicator will be considered in light of evidence the organization provides related to indicators ORG-ABO-8.1 and ORG-HR-1.4. Please review CCA’s Procedure ACC-PROC-05 Accommodations for Exceptions to Requirements of CCA Standards available by logging in to the CCA Web site.

ORG-ABO-4.4

Required

The organization encourages, embraces and celebrates diverse Aboriginal cultural practices such as smudging, pipe ceremonies, brushing off ceremonies, bringing bundles, and other practices relevant to persons served and the local context.

ORG-ABO-4.5

Required

Persons served experience culturally safe service in the context of holistic Aboriginal frameworks of health and well-being.

Note: The Client Journey is used as evidence only for reviews for which the Community-Based Primary Health Care Standards and Community Mental Health and Addiction Standards apply. On-site client file review and client interviews are used in other sectors.

ORG-ABO-5.1

The physical setting is welcoming, respectful and reflective of local Aboriginal cultures and ways of
To achieve this standard, 3 out of 4 indicators must be met.

**ORG-ABO-5.2**

Intake and referral processes are culturally safe, and at minimum include:

- Formal and informal intake procedures and processes that reflect cultural protocols
- Opportunity for self-identification by Indigenous people
- Flexibility to meet the diverse needs of people served

**Pre-Site Document(s)**

Suggested program/service - policies/procedures

Interview(s)

Staff - Program-specific Staff

**ORG-ABO-5.3**

Every effort is made to have qualified Aboriginal staff conduct the intake with Aboriginal clients.

**Interview(s)**

Staff - Program-specific Staff

Staff - Managers Group

**ORG-ABO-5.4**

Intake and referral processes are reviewed to ensure they are culturally safe.

**Pre-Site Document(s)**

Suggested reports

**ORG-ABO-6.1**

Written policies and procedures developed with the input of Aboriginal communities guide the use of...
traditional practitioners. (Note: The standards in this component apply to organizations that are mandated to primarily serve Aboriginal persons and communities, including First Nations, Inuit and Metis people. During piloting, the use of this component is voluntary.)

To achieve this standard, 3 out of 5 indicators must be met.

- Recruitment - Roles - Scope of practice

---

**ORG-ABO-6.2**

Practices around the recruitment, role and work of traditional practitioners and their helpers are consistent with policies and procedures.

---

**ORG-ABO-6.3**

There are processes in place to guide the proper and respectful acquisition, storage, handling and use of traditional medicines, if these are used in programs and services.

---

**ORG-ABO-6.4**

Facilities and equipment accommodate the use of diverse Aboriginal cultural practices such as smudging, pipe ceremonies, brushing off ceremonies, bringing bundles, and other practices relevant to persons served and the local context.
ORG-ABO-6.5

As part of a collaborative, professional and integrated care environment, there are mechanisms in place to include traditional resource people from the community (for example, Aunties, Uncles, drummers, singers, dancers, crafters, language speakers).

ORG-ABO-7.1

Required

Orientation for all staff, volunteers and students covers Indigenous culturally competent approaches to service delivery.

Note: The general requirements for orientation of staff, volunteers and students are addressed in CCA’s Organizational Standards module. An Aboriginal organization is also expected to meet these additional requirements.

ORG-ABO-7.2

Required

Initial and periodic training of staff, volunteers and students includes:

- Foundational cultural competency training that provides an opportunity to explore biases about Aboriginal people, and consider strategies for working more effectively with them - First Nation-specific training
- Cultural protocols in the local context - Content-specific training in the relevant program or service area

Note: Cultural competence develops and evolves over time through regular opportunities for continuing professional development. The organization must demonstrate that it is delivering this training over time and that participation is required.
ORG-ABO-7.3

Required

Training in Indigenous cultural competency is provided by professional organizations supported by Aboriginal communities and Indigenous scholars.

ORG-ABO-7.4

Required

Interview(s)
Staff - Staff Group
(Cross-section)

Staff have an enhanced understanding of local colonial history, the legacy of the residential schools, current Aboriginal community priorities, and areas where Aboriginal clients may experience risk or barriers.

ORG-ABO-7.5

Required

Interview(s)
Staff - Program-specific Staff

Staff are particularly aware of unique issues faced by Aboriginal women, children and youth within the local context.

ORG-ABO-7.6

Required

Pre-Site Document(s)
personnel - performance appraisal process and/or form
Interview(s)
Staff - Managers Group

Assessment of Indigenous cultural competency is part of staff performance appraisals.

ORG-ABO-8.1

Pre-Site Document(s)
personnel - policies/procedures
Interview(s)
Staff - Managers Group

Qualified Aboriginal candidates are given preference in staff, volunteer and student recruitment, hiring or placement, and retention.
Volunteers and students. (Note: The standards in this component apply to organizations that are mandated to primarily serve Aboriginal persons and communities, including First Nations, Inuit and Metis people. During piloting, the use of this component is voluntary.)

To achieve this standard, 2 out of 3 indicators must be met.

**ORG-ABO-8.2**

As part of a holistic approach to staff health and wellness, culturally-specific supports and resources are made available to Aboriginal staff (for example, access to traditional consultants, elders or Aboriginal support groups).

**ORG-ABO-8.3**

Aboriginal staff, volunteers and students are supported to develop the skills and capacities to take on progressively more demanding responsibilities.

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**Component: Community**

**LP Standard**

**ORG-COM-1**

The organization engages the communities it serves and is responsive to community needs.

To achieve this standard, 4 out of 5 indicators must be met.

**ORG-COM-1.1**

The organization's values reflect a commitment to meeting the unique and diverse needs of the communities it serves.

**ORG-COM-1.2**

Information on client and community trends is used to plan responsive programs and services.
ORG-COM-1.3

Formal and informal mechanisms are used to involve community members in planning and development.

ORG-COM-1.4

The organization assesses how effectively it has engaged the community.

ORG-COM-1.5

The organization has used community input to shape programs and services.

ORG-COM-2.1

The organization has partnerships, collaborations and/or linkages with other community services, and local or regional planning authorities relevant to its objectives.

To achieve this standard, 3 out of 5 indicators must be met.
ORG-COM-2.2

The organization participates in community planning to coordinate services (for example, identifying unmet needs or service gaps and reducing duplication of services).

Narrative
Survey(s)
Community Partners
Interview(s)
Staff - Managers Group
Staff - Chief Executive

ORG-COM-2.3

Information collected through collaboration with community partners is used to inform the organization's work.

Narrative
Interview(s)
Staff - Managers Group
Staff - Chief Executive

ORG-COM-2.4

Written agreements are in place for partnerships involving joint service delivery and the sharing of significant resources.

Narrative
Pre-Site Document(s)
contracts/agreements

ORG-COM-2.5

Partnerships and collaborations benefit the persons and communities served by the organization.

Survey(s)
Community Partners
Interview(s)
Staff - Managers Group

ORG-COM-3.1

Formal advisory mechanisms are used to obtain meaningful input to the governance of the organization from Aboriginal communities served.
Aboriginal communities and groups served. (Note: This standard applies to organizations that identify Aboriginal persons as part of their clientele. Aboriginal persons include First Nations, Inuit and Metis people.)

To achieve this standard, 2 out of 3 indicators must be met.

---

**ORG-COM-3.2**

Alliances are established to engage Aboriginal communities and organizations in leading service planning for their communities.

---

**ORG-COM-3.3**

The governing body makes every effort to have representation from the Aboriginal communities served, based on consultation with these communities.

---

**ORG-COM-4.1**

Information about the organization’s role, functions and services is made available to its various stakeholders.

---

**ORG-COM-4.2**

Relationships are cultivated with relevant elected officials, governmental entities, and First Nations band councils or Metis Councils.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, the on-site interview will be with the Chief Executive.
ORG-COM-4.3

Communication materials about the organization are presented in an accessible format and medium (for example, Web site, brochures, social media).

ORG-COM-5.1

The organization has a communications plan that outlines:

- Key messages are set and disseminated - Who are the authorized spokesperson(s) for the organization - Roles and responsibilities for creating and updating information, including online information, for example, on the organization’s Web site, Twitter feed and social-media page - Procedures for informing and responding to the media and the public - Policies personnel are to respect when representing the organization in the community - The process for dealing with an organizational crisis, detailing how decisions will be made

ORG-COM-5.2

Communications are aligned with the organization's plan.
ORG-COM-5.3

Practices are consistent with policies when personnel represent the organization in the community.

ORG-COM-5.4

The communications plan is reviewed at minimum annually.

ORG-COM-6.1

Public education activities (for example, presentations, speaking engagements, awareness campaigns) support organizational priorities and/or respond to community needs.

To achieve this standard, 2 out of 3 indicators must be met.

ORG-COM-6.2

Public education strategies and materials are tailored to target audiences to maximize accessibility, taking into account such factors as language, literacy level, culture and physical disability.
ORG-COM-6.3

The effectiveness of public education work is routinely assessed.

---

**ORG-COM-7.1**

The organization identifies and prioritizes advocacy issues to address the most significant challenges encountered by the persons it serves and by its community, and works to develop informed positions and strategies in response.

*Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, the on-site interview will be with the Chief Executive.*

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**ORG-COM-7.2**

Advocacy work is planned and done in collaboration with community members, and/or regional, provincial and/or national groups.

---

**ORG-COM-7.3**

Personnel are informed about and are given opportunities to be involved in the organization's advocacy initiatives.
Roles and responsibilities for managing advocacy initiatives are clearly outlined to ensure effectiveness and accountability.

The organization responds to issues within the community and acts as a support and/or change agent.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, on-site interviews will be with the Managers Group.

Component: Learning Environment

This component includes standards pertaining to student placements and research. Please consult the note that accompanies each standard to determine if it applies.

The organization provides a quality learning environment for its student placements. (Note: Standard only applies if organization currently offers, or has offered in the 14 months preceding their site visit, student placements, that is, placements for students participating in educational programs for purposes of a defined educational experience related to their program. Such placements may be offered by colleges, universities and secondary schools.)

To achieve this standard, 3 out of 4 indicators must be met.

The organization assesses its capacity to offer student placements based on its needs and available resources.

The organization enters into an agreement with the educational institution(s) that outlines mutual expectations for the learning opportunity for the student.
### ORG-LE-1.3

**Required**

Students are screened and selected according to the organizational policies (for example, interview, forms, references, certificates, police records check).

*Note: There are three types of police records check - criminal records check, criminal records and judicial matters check, vulnerable sector check.*

### ORG-LE-1.4

**A confidential record about each student on placement is maintained and at minimum includes:**

- Personal contact information
- Signed confidentiality agreement
- Police records check
- Learning contract with educational program

### MAN Standard

**ORG-LE-2**

The organization provides orientation, supervision and evaluation for student placements. *(Note: Standard only applies if the organization has offered, in the 14 months preceding their site visit, student placements, that is, placements for students participating in educational programs for purposes of a defined educational experience related to their program. Such placements may be offered by colleges, universities and secondary schools.)*

To achieve this standard, 6 out of 6 indicators must be met.

### ORG-LE-2.1

**Required**

Written policies and procedures address the orientation, supervision and evaluation of students.

### ORG-LE-2.2

**Required**

Responsibility for student placements is assigned to staff with relevant educational qualifications and experience.
ORG-LE-2.3
Required

Students are given a clear description of their assignment(s) as per the learning contract.

ORG-LE-2.4
Required

Students receive support and supervision as required by their educational program.

ORG-LE-2.5
Required

Students are evaluated as outlined in the learning contract.

ORG-LE-2.6
Required

Students are provided with opportunities to give feedback about their placement experience and the feedback is used to inform quality improvement.

ORG-LE-3.1
Required

Written research policies and procedures are aligned with the Tri-Council Policy Statement on ethical conduct in research, and at minimum describe:
which it participates. (Note: Standard only applies if the organization has been involved in a formal research study in the 14 months preceding their site visit, whether it initiated, led the study or was involved in a third party’s research, and regardless of whether the organization is named as one of the investigators. A research study is a systematic, methodical study conducted in order to test a hypothesis or answer a specific question for the advancement of knowledge.)

To achieve this standard, 5 out of 5 indicators must be met.

- Procedures for obtaining informed consent for direct participation in a research study - Procedures for obtaining informed consent for the use of confidential information as part of a research study - Security of research material and data during and following a study - Mechanisms to safeguard research participants from harm, abuse, exploitation and discrimination - A policy that persons served will not be denied service if they choose not to participate in a research study if asked

**ORG-LE-3.2**

Required

Written policies and procedures provide for an objective, ethical review of each research study that conforms to accepted research standards (for example, university ethics review committee, hospital ethics review committee, Institutional Review Board Services, research ethics board).

**ORG-LE-3.3**

Required

The process for deciding whether to participate in a research study considers the risks to the individuals involved and the benefits to the communities served.

**ORG-LE-3.4**

Required

The responsibility for overseeing research activities is clearly designated in the organization.
ORG-LE-3.5
Required
Practices are consistent with research policies and procedures.

ORG-LE-4.1
Required
Mechanisms are in place to ensure the primary investigator (internal or external) of each research study has knowledge of research design and methodology and the ability to competently perform the research.

ORG-LE-4.2
Required
Resources are allocated to support research activities.

ORG-LE-4.3
Required
Personnel conducting and/or participating in approved research studies are provided with sufficient support by the organization (for example, time, release from other duties, administrative support).

ORG-LE-5.1
Completed research is communicated in plain language to the research participants and any other intended audience.
applies if the organization has been involved in a formal research study in the 14 months preceding their site visit, whether it initiated, led the study or was involved in a third party’s research, and regardless of whether the organization is named as one of the investigators. A research study is a systematic, methodical study conducted in order to test a hypothesis or answer a specific question for the advancement of knowledge.)

To achieve this standard, 3 out of 5 indicators must be met.

### ORG-LE-5.2

Completed research is accessible to staff, persons served, community partners and other stakeholders.

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<th>Narrative Interview(s)</th>
<th>Staff - Staff Group (Cross-section)</th>
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<tbody>
<tr>
<td></td>
<td>Staff - Program-specific Manager(s)</td>
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</table>

### ORG-LE-5.3

Completed research is shared with the scientific community through means such as publications and presentations at conferences.

<table>
<thead>
<tr>
<th>Pre-Site Document(s) suggested research - reports/publications Interview(s)</th>
</tr>
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<tbody>
<tr>
<td>Staff - Program-specific Manager(s)</td>
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</table>

### ORG-LE-5.4

Research findings are used to inform the organization’s decision making and to improve operations, programs and services.

<table>
<thead>
<tr>
<th>Interview(s)</th>
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<td>Staff - Staff Group (Cross-section)</td>
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<tr>
<td>Staff - Managers Group</td>
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### ORG-LE-5.5

Required

Research findings are used to advocate for policy change and improved services and resources for persons and communities served.

<table>
<thead>
<tr>
<th>Narrative Interview(s)</th>
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<td>Staff - Managers Group</td>
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<tr>
<td>Staff - Chief Executive</td>
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**Component: Human Resources**

### ORG-HR-1.1

Human resource needs are regularly assessed based on

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<th>Narrative Interview(s)</th>
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<td>Staff - Managers Group</td>
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<tr>
<td>Staff - Chief Executive</td>
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</tbody>
</table>
The organization plans for and addresses its human resource needs. (Note: Human resources refer to the organization's personnel, including staff, volunteers and students, if any.)

To achieve this standard, 3 out of 4 indicators must be met.

**ORG-HR-1.2**

Succession plans are in place for key positions.

**ORG-HR-1.3**

Changes are made based on an analysis of human resource needs.

**ORG-HR-1.4**

Reasonable effort is made to recruit human resources that reflect the communities served.

**ORG-HR-2.1**

Written policies and procedures address:

- Diversity and inclusion - Anti-discrimination -
To achieve this standard, 4 out of 4 indicators must be met.

Harassment - Confidentiality - Conflict of interest - Conflict resolution - Ethical conduct

**ORG-HR-2.2**
Required

Staff sign a statement acknowledging that they understand and will abide by the policies and procedures on confidentiality.

**ORG-HR-2.3**
Required

Personnel are supported when dealing with ethical issues and potentially difficult situations (for example, conflict of interest, confidentiality, service issues).

**ORG-HR-2.4**
Required

Practices are consistent with policies and procedures addressing conduct.

**ORG-HR-3.1**

Orientation of personnel addresses the following topics:
- Mission, vision and values
- Programs and services
- Policies and procedures
- Client rights
- Workplace health
role.

To achieve this standard, 2 out of 3 indicators must be met.

and safety - Appropriate and safe use of equipment and supplies - Roles and responsibilities - Culturally competent service delivery, as appropriate to the local context

ORG-HR-3.2

Completion of the orientation for all personnel is documented and dated.

Audit(s) of Files
Employee
Volunteer
Pre-Site Document(s)
CCA HR Records
Checklist - employee
CCA HR Records
Checklist - volunteer

ORG-HR-3.3

Personnel receive orientation in a timely manner.

Survey(s)
Staff
Volunteers
Interview(s)
Staff - Staff Group (Cross-section)

MAN Standard
ORG-HR-4

The organization has clear lines of accountability and communication.

To achieve this standard, 4 out of 4 indicators must be met.

The organizational structure is clearly defined and documented.

Pre-Site Document(s)
organizational chart
ORG-HR-4.2
Required

The roles, responsibilities and accountability of all personnel are outlined.

ORG-HR-4.3
Required

There is a clearly defined process for delegating responsibility and authority, including for coverage of key positions during anticipated and unexpected leaves.

ORG-HR-4.4
Required

Personnel understand the lines of accountability and communication.

ORG-HR-5

LP Standard

The organization promotes a positive work environment for staff.

To achieve this standard, 3 out of 5 indicators must be met.

ORG-HR-5.1

Strategies are in place to promote a positive work environment, work-life integration and staff wellness.
ORG-HR-5.2
Staff are recognized for their contributions.

ORG-HR-5.3
Staff are encouraged to provide feedback on job satisfaction and to suggest improvements to the work environment.

ORG-HR-5.4
Various mechanisms are used to monitor the quality of the work environment (for example, surveys, focus groups and assessment of indicators such as absenteeism, turnover, Employee Assistance Program use and grievances).

ORG-HR-5.5
Results are used to make improvements that support a positive work environment.

MAN Standard
ORG-HR-6
The organization has an objective, transparent and respectful human resource system.

ORG-HR-6.1
Written employment policies and procedures and collective agreements, where applicable, address at minimum:

Pre-Site Document(s)
personnel - collective agreement
personnel - policies/procedures
To achieve this standard, 3 out of 3 indicators must be met.

- Conditions of employment (for full-time, part-time, casual, permanent, temporary and contract staff) - Staff recruitment, selection and hiring - Screening of candidates, including reference checks, police records check and driver’s license checks, where appropriate - Verification of credentials, licenses, registration, certification and/or professional liability insurance required for the position - Mechanisms for annual confirmation of licenses and professional liability insurance, if applicable - Compensation, including overtime and on-call time - Benefits - Vacation and leave - Performance appraisal - Termination - Confidentiality of, and access to, employee records - Employee access to their file, including how to access and request changes to information contained in their file - Grievances or appeals

Note: There are three types of police records check - criminal records check, criminal records and judicial matters check, vulnerable sector check.

**ORG-HR-6.2**

Required

Human resource policies and procedures and, where applicable, collective agreements comply with legislation.

**ORG-HR-6.3**

Required

Practices are consistent with human resource policies and procedures.

**ORG-HR-7.1**

Required

All staff positions have job descriptions that include at
descriptions that clearly outline their roles and responsibilities.

To achieve this standard, 4 out of 4 indicators must be met.

minimum:

- Position title - Qualifications - Responsibilities - Lines of accountability - Scope of practice, and any registration, certification or licensing required for regulated professionals, where applicable to the position

Note: The organization is expected to provide a sample of job descriptions that represents a cross-section of roles across the organization.

**ORG-HR-7.2**

Required

Staff are provided with a job description at hiring and when revisions are made.

**Survey(s)**

Staff

**ORG-HR-7.3**

Required

Staff have input into the regular review of their job description.

**Survey(s)**

Staff

**ORG-HR-7.4**

Required

Job descriptions are up to date.

Note: The organization is expected to provide a sample of job descriptions that represents a cross-section of roles across the organization.

**ORG-HR-8.1**

Written policies and procedures address training and development for all staff.

**Pre-Site Document(s)**

personnel - policies/procedures
of staff.

To achieve this standard, 2 out of 3 indicators must be met.

**ORG-HR-8.2**

Training and development are planned as part of both the staff performance appraisal process and as a reflection of organizational needs.

**ORG-HR-8.3**

Staff participate in professional development.

---

**ORG-HR-9**

Staff have the resources, guidance and support to carry out their duties effectively.

To achieve this standard, 3 out of 5 indicators must be met.

**ORG-HR-9.1**

Written policies and procedures address staff supervision and support.

**ORG-HR-9.2**

Staff have the supervision, mentoring and support they need to carry out their jobs.
ORG-HR-9.3

Supervisors delegate authority and responsibility in a clear and supportive manner.

ORG-HR-9.4

Supervisors provide ongoing support and feedback on job performance.

ORG-HR-9.5

Space and equipment are allocated to staff to perform their duties.

ORG-HR-10.1

Staff performance appraisal is a joint process that includes:

- Review of performance against the expectations of the position
- Setting of goals for training and/or professional development
- Production of a written appraisal document for the employee's file
- Written acknowledgement by the employee indicating he/she has read the appraisal
- Opportunity for the employee to provide feedback on the results
ORG-HR-10.2

Staff performance appraisals are conducted at minimum every two years.

ORG-HR-11.1

Required

Mechanisms are in place to maintain and safeguard confidential employee information.

To achieve this standard, 2 out of 2 indicators must be met.

ORG-HR-11.2

Required

A complete and up-to-date confidential record is maintained on each employee that includes:

- Employee contact information
- Emergency contact information
- Current contract or letter of offer, including employment conditions
- Job description for current position
- Evidence employee received staff orientation (for example, signed orientation checklist)
- Payroll information (anniversary date, salary level, approval of pay decisions, leave records, benefits information)
- Proof of qualifications as required by the position
- Proof of professional licenses or registration as required by the position
- Proof of check of professional standing at hiring (where standing is required by the position)
- Signed oath of confidentiality
- Copy of driver's license, consistent with organization's policies
- Copy of police records check, consistent with organization's policies
- Verification of professional liability insurance if employee not covered under organization's insurance
- Performance appraisal completed within timeframe specified by organization's policies
- Evidence of training and professional
development - Documentation relating to grievance and/or disciplinary process, if any

Note: Employee records may be kept in more than one file (for example, payroll records are often in one place, while hiring documentation is in another).

There are three types of police records check - criminal records check, criminal records and judicial matters check, vulnerable sector check.

Component: Volunteers

The standards in this component apply only to organizations that have engaged volunteers, in the 14 months preceding their site visit, in any one of the following ways: - Use volunteers on an ongoing basis - Volunteers sometimes have direct contact with persons served - Volunteers sometimes have access to confidential information - Volunteers sometimes handle money - Ten or more volunteers have worked together at an event.

LP Standard

ORG-HRV-1

The organization has systems in place to guide how it recruits, selects and manages volunteers. (Note: The standards in this component apply only to organizations that have engaged volunteers, in the 14 months preceding their site visit, in any one of the following ways:

- Use volunteers on an ongoing basis - Volunteers sometimes have direct contact with persons served - Volunteers sometimes have access to confidential information - Volunteers sometimes handle money - Ten or more volunteers have worked together at an event)

To achieve this standard, 3 out of 4 indicators must be met.

ORG-HRV-1.1

Written volunteer policies and procedures address:

- Recruitment application and selection - Recruitment of current or past staff and persons served - Screening, including how and when the following are done: reference checks, police records check and verification of licenses (including driver's licence if applicable) - Supervision and support - Evaluation of volunteers - Circumstances under which a volunteer may be released from duties and procedures to follow - Volunteer access to his/her information on file with the organization

Note: There are three types of police records check - criminal records check, criminal records and judicial matters check, vulnerable sector check.

ORG-HRV-1.2

Confidential information on each volunteer is maintained on file, and at minimum includes the elements listed in one of the following two lists, depending on how the volunteer is engaged with the organization.
For volunteers involved on an ongoing basis, for volunteers who have direct contact with persons served, for volunteers who have access to confidential information, and for volunteers who handle money, information on file includes:
- Volunteer’s contact information including emergency contact information
- Application to volunteer
- References, where required
- Signed confidentiality agreement
- Record of and date that orientation was completed
- Police records check, where required
- Driver’s abstract, driver’s licence and proof of auto insurance, where required
- For volunteers in ongoing assignments and for volunteers who have contact with persons served, most recent evaluation, consistent with organization’s policies
- For one-time or occasional volunteers:
  - Volunteer’s contact information including emergency contact information
  - Record of the volunteer orientation provided

**ORG-HRV-1.3**

Practices are consistent with volunteer policies and procedures.

**ORG-HRV-1.4**

Required

Volunteers are recruited and selected according to the position's requirements, in compliance with applicable legislation and the organization's policies, and according to the position's level of risk.

**ORG-HRV-2.1**

Staff are assigned to coordinate and manage volunteers.
component apply only to organizations that have engaged volunteers, in the 14 months preceding their site visit, in any one of the following ways:

- Use volunteers on an ongoing basis
- Volunteers sometimes have direct contact with persons served
- Volunteers sometimes have access to confidential information
- Volunteers sometimes handle money
- Ten or more volunteers have worked together at an event)

To achieve this standard, 3 out of 4 indicators must be met.

### ORG-HRV-2.2
**Required**

Volunteers receive support, supervision and recognition according to the volunteer assignment.

<table>
<thead>
<tr>
<th>Survey(s)</th>
<th>Volunteers Interview(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff - Program-specific Staff</td>
<td></td>
</tr>
<tr>
<td>Staff - Program-specific Manager(s)</td>
<td></td>
</tr>
</tbody>
</table>

### ORG-HRV-2.3
**Required**

Volunteers involved in ongoing assignments and volunteers who have contact with persons served are evaluated at minimum annually and the results of the evaluation are documented.

<table>
<thead>
<tr>
<th>Audit(s) of Files</th>
<th>Volunteer Pre-Site Document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>personnel - performance appraisal process and/or form</td>
<td></td>
</tr>
<tr>
<td>CCA HR Records Checklist - volunteer</td>
<td></td>
</tr>
</tbody>
</table>

### ORG-HRV-2.4

Volunteers have access to the training needed to carry out their duties.

<table>
<thead>
<tr>
<th>Narrative Survey(s)</th>
<th>Volunteers Interview(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff - Program-specific Staff</td>
<td></td>
</tr>
<tr>
<td>Staff - Program-specific Manager(s)</td>
<td></td>
</tr>
</tbody>
</table>

### ORG-HRV-3.1

Relevant data about volunteer services is collected, recorded and analyzed (for example, number of active volunteers, number of persons served by volunteers, number of kilometres driven by volunteers, number of hours of volunteer service).

<table>
<thead>
<tr>
<th>Pre-Site Document(s)</th>
<th>data/statistical reports Interview(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff - Program-specific Staff</td>
<td></td>
</tr>
<tr>
<td>Staff - Program-specific Manager(s)</td>
<td></td>
</tr>
</tbody>
</table>
Volunteers sometimes have access to confidential information - Volunteers sometimes handle money - Ten or more volunteers have worked together at an event

To achieve this standard, 2 out of 3 indicators must be met.

**ORG-HRV-3.2**

Volunteers are encouraged to provide feedback on their volunteer experience.

Narrative
Survey(s)
Volunteers
Interview(s)
Staff - Program-specific
Staff
Staff - Program-specific
Manager(s)

**ORG-HRV-3.3**

Collected volunteer data and feedback are used to make improvements to the volunteer program.

Narrative
Interview(s)
Staff - Program-specific
Staff
Staff - Program-specific
Manager(s)

**Component: Systems and Structure**

**MAN Standard**

**ORG-SYS-1**

Required

The organization’s operations are guided by a framework of relevant and up-to-date policies and procedures.

To achieve this standard, 5 out of 5 indicators must be met.

**ORG-SYS-1.1**

Written policies and procedures address the following elements pertaining to the development, implementation and regular review of policies and procedures:

- Process for development and regular review of policies and procedures - Frequency of review - Roles and responsibilities for oversight, initiating reviews, consultation - Approval of policies and procedures - How changes to policies and procedures are communicated - Version control, including maintenance of documentation and archiving of versions

Pre-Site Document(s)
policies/procedures - other
ORG-SYS-1.2
Required

Personnel and members of the governing body have input into the development and review of the policies and procedures that affect them.

Note: If the organization does not have a board of directors or body (such as a steering committee, council or advisory group) that acts as a governance structure, this indicator should be interpreted to mean personnel have input and a governing body survey would not apply.

ORG-SYS-1.3
Required

When there are changes to policies and procedures that affect them, individuals are informed.

ORG-SYS-1.4
Required

Policies and procedures are readily accessible to staff, volunteers and students in a format that is secure.

ORG-SYS-1.5
Required

The organization reviews its policies and procedures at minimum every four years.

ORG-SYS-2.1
Required

Pre-Site Document(s) suggested
privacy policies, procedures, forms
The organization has a system that guides the collection, use and release of personal information.

To achieve this standard, 5 out of 5 indicators must be met.

Written privacy policies and procedures guiding the collection, use and release of personal information comply with provincial and federal legislation and address at minimum:

- Obtaining the informed consent of persons served for the collection, use and release of their personal information, except where permitted or required by law
- How information will be used (for example, for routine management, professional supervision and quality assurance purposes, including accreditation)
- Obtaining the consent of a substitute decision maker if needed
- Handling withdrawal of consent, withholding of consent or limits placed on use of the personal information, including informing persons served of implications for service (for example, limits to treatment, loss of third-party benefits)
- Limiting use of personal information to the purposes for which the information was provided
- Preventing unauthorized access to personal information held by the organization
- Responding to police and other third-party requests for personal information
- Notifying persons served in the case of theft, loss, or unauthorized use or release of their personal information
- Permitting persons served to access their personal information, to request a correction, and to request a copy of their personal information
- Providing procedures for complaints regarding a breach of privacy
- Appointing a privacy officer

**ORG-SYS-2.2**

Required

A written statement is made available to the public containing:

- A description of the organization’s practices to protect privacy and safeguard personal information
- Circumstances in which information may be disclosed (for example, for routine management and professional supervision, for quality assurance purposes, including accreditation)
- How to contact the organization’s privacy contact person
- The procedure for making a
complaint regarding a breach of privacy

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**ORG-SYS-2.3**

Required

Support in understanding the organization’s privacy policies and practices is provided for persons served for whom English and/or French language facility or literacy is an issue.

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**ORG-SYS-2.4**

Required

When releasing personal information of person(s) served, the organization documents the person’s or persons’ express consent, including:

- Their name(s) - Organization and name of staff person releasing the information - Organization or name of person receiving the information Specific information being released - Purpose of the release - Date of consent - Any limits on the consent (for example, time period, limits on use)

Note: On-site client file review is used only for organizations completing a CCA review in Child and Youth Mental Health, Community Support and Social Services, Child Welfare, Youth Justice, Family Services and/or Credit Counselling.
ORG-SYS-2.5
Required

Practices are consistent with the organization's policies and procedures for the collection, use and release of personal information.

Note: The Client Journey is used only for organizations completing a CCA review in Community-Based Primary Health Care and Community Mental Health and Addiction Services. On-site client file review is used only for organizations completing a CCA review in Child and Youth Mental Health, Community Support and Social Services, Child Welfare, Youth Justice, Family Services and/or Credit Counselling.

ORG-SYS-3.1
Required

Written policies and procedures address access to and security of the organization's records, including corporate records, board records, financial records, employment records and client records. They at minimum cover the following:

- Storage - Access to records - Protection against exposure and unauthorized access - Protection against loss and destruction - Tracking when records are removed - Retention and destruction of records (including time frame and method)

Note: This indicator applies to records in paper and electronic forms.

ORG-SYS-3.2
Required

Written policies and procedures on information systems address:

- Roles, responsibilities and accountabilities for management of information systems - Provision, maintenance, update and care of information systems - Measures to protect the integrity of systems and data (for example, through limits on file downloading and software installation) - Access, use and password protection of computers, tablets, cellular phones, fax
and voice-mail system - Systems security, including through measures such as firewalls, use of SSL, anti-virus software and a secure user-password system - Security of email communications - Secure use of portable electronic storage such as USB data savers and external hard drives

**ORG-SYS-3.3**

Required

Practices are consistent with policies and procedures.

**ORG-SYS-3.4**

Required

The physical environment contributes to assuring the privacy of persons served and personnel.

**ORG-SYS-3.5**

Required

Other measures are used to protect the confidentiality of persons served (for example, protocols for telephone communications with persons served and use of blocked caller identification).

**ORG-SYS-4.1**

Written policies and procedures address:

- Whether email, text, instant messaging and other forms of electronic communications can be used as a
means of communication between persons served and service providers - Parameters under which personnel may use email, text, instant messaging and other forms of electronic communications to communicate with persons served - Measures to reduce the risk of a breach of the privacy of persons served if electronic communications are used (for example, refraining from sharing identifying or sensitive information electronically) - Prohibited use of the organization’s information systems to access, transmit or store offensive material (for example, pornographic, racist, slanderous and threatening material) or for any purpose that may promote illegal activity

**ORG-SYS-4.2**

Persons served are informed of the organization’s guidelines on using email, text, instant messaging and other forms of electronic communications to communicate about their service and are made aware of the risks to privacy and confidentiality.

**ORG-SYS-4.3**

Practices are consistent with policies and procedures.

**ORG-SYS-5.1**

Written partnership agreements are in place and cover the following:

- Roles - Responsibilities - Accountabilities - Liability - Financial details - Dispute resolution
been, in the 14 months preceding their site visit, part of a formal partnership that integrates an administrative function such as information systems, human resource and financial management. A formal partnership exists if the organization has a written agreement with one or more organizations outlining mutual expectations of each partner in relation to shared or integrated administrative functions.)

To achieve this standard, 2 out of 2 indicators must be met.

**ORG-SYS-5.2**

**Required**

The impact of the partnership in achieving its objectives is periodically assessed.

---

**Narrative**

**Interview(s)**

**Staff - Admin Staff/Manager(s)**
Component: Knowledge and Learning

MAN Standard

PSS-KL-1
The organization strives to provide programs and services that are evidence informed.

To achieve this standard, 3 out of 3 indicators must be met.

PSS-KL-1.1
Required

The children’s mental health programs/services are designed to reflect the relevant knowledge and evidence that is currently available.

Pre-Site Document(s)
suggested
program/service - descriptions
Interview(s)
Staff - Program-specific Staff
Staff - Program-specific Manager(s)

PSS-KL-1.2
Required

Programs are reviewed periodically, in light of the current knowledge and available research, on a schedule determined by the organization.

Narrative
Pre-Site Document(s)
suggested
program/service - plans
Interview(s)
Staff - Managers Group

PSS-KL-1.3
Required

Documentation describes how programs and services are informed by evidence.

Pre-Site Document(s)
staff and team minutes
program/service - plans
program/service - descriptions

LP Standard

PSS-KL-2
The organization promotes learning and improvement in evidence-informed practices.

To achieve this standard, 3 out of 4 indicators must

PSS-KL-2.1

The impact of evidence-informed practices is measured and evaluated periodically, as resources permit.

Pre-Site Document(s)
staff and team minutes reports
Interview(s)
Staff - Program-specific Staff
Staff - Program-specific Manager(s)
PSS-KL-2.2

Staff have opportunities to participate in professional development regarding evidence-informed practices.

Survey(s)
Staff
Pre-Site Document(s)
suggested
t raining and development
plan/schedule
Interview(s)
Staff - Managers Group

PSS-KL-2.3

Staff have opportunities to exchange knowledge to support evidence-informed practices.

Narrative
Survey(s)
Staff

PSS-KL-2.4

Innovations are encouraged in introducing new evidence-informed practices and, once implemented, are evaluated.

Note: This indicator only applies if the organization has originated a new practice.

Narrative
Pre-Site Document(s)
suggested
evaluation - summary reports
Interview(s)
Staff - Staff Group
(Cross-section)
Staff - Managers Group

PSS-KL-3.1

Required

Policies and procedures outline the expectations for clinical supervision, including the circumstances under which supervision must be sought for persons served at risk (for example, suicide, family violence, abuse, risk of harm) and the frequency of supervision.

Pre-Site Document(s)
program/service - policies/procedures
Interview(s)
Staff - Staff Group
(Cross-section)
Staff - Managers Group
PSS-KL-3.2
Staff and consultants assigned supervisory responsibilities are qualified by training, skills and experience to supervise.

PSS-KL-3.3
The supervisory process fosters mutual trust and respect between supervisor and supervisee.

PSS-KL-3.4
Supervisors and supervisees are accessible to one another.

PSS-KL-3.5
There are opportunities to cover clinical, programming, administrative and professional development issues in the supervisory process.
PSS-KL-3.6

The frequency of supervision is determined by the organization to meet staff, client and organizational needs.

PSS-KL-3.7

Mutual feedback about the supervisory process takes place and efforts are made to resolve conflicts.

PSS-KL-3.8

Supervisors and supervisees have access to a third party to address any serious conflicts that cannot be resolved.

PSS-KL-3.9

The supervision system supports development regarding evidence-informed practice.

PSS-KL-4.1

The client data collected includes at minimum:

- The number of persons served referred
- The number of persons served registered in a program or service
To achieve this standard, 1 out of 2 indicators must be met.

The number of persons served by age, gender and geographic location - The number of persons served by presenting problem(s) - The number of persons served whose case has been closed

Note: As part of observation, the CCA review team will want to see a demonstration of the client information management system.

**PSS-KL-4.2**

A system is used to collect aggregate data that describes the children, youth and families served for the purposes of planning, evaluation, research and reporting requirements for funders.

Note: As on-site documents, the organization is expected to provide data/statistical reports.

**PSS-KL-5.1**

Required

There is a management information system that collects clinical and outcome data at the client level.

Note: As on-site documentation, the organization is expected to provide data/statistical reports.

**PSS-KL-5.2**

Data collected is used to make client-related, program, organizational and systems decisions.
**PSS-KL-5.3**

Results are analyzed against established targets.

**Pre-Site Document(s)**
- staff and team minutes reports
- Interview(s)
  - Staff - Managers Group
  - Staff - Chief Executive

---

**PSS-KL-5.4**

Data analysis focuses on outcomes and effectiveness of services.

**Pre-Site Document(s)**
- staff and team minutes reports
- Interview(s)
  - Staff - Managers Group
  - Staff - Chief Executive

---

**LP Standard**

**PSS-KL-6**

The organization carefully selects which evidence-based programs will be implemented. (Note: This standard only applies if the organization provides one or more established evidence-based programs. See glossary definition for evidence-based program.)

To achieve this standard, 2 out of 3 indicators must be met.

---

**PSS-KL-6.1**

The specific area, disorder or population that will be the focus of the evidence-based program implementation is identified.

**Pre-Site Document(s)**
- suggested reports
- research - literature and/or literature reviews
- Interview(s)
  - Staff - Managers Group

---

**PSS-KL-6.2**

The literature is consulted or an existing formal literature review is used to inform or confirm the selection of the evidence-based program.

**Narrative**

**Pre-Site Document(s)**
- suggested reports
- research - literature and/or literature reviews
- Interview(s)
  - Staff - Managers Group
PSS-KL-6.3

Client needs, values, preferences and circumstances are taken into account when selecting or reviewing the appropriateness of an evidence-based program.

PSS-KL-7.1

Required

When beginning the implementation of an evidence-based program, the organization develops a documented plan. When implementation is already underway and has begun without a plan, the organization reviews the experience to date and creates a plan to help guide future activities. The implementation plan includes:

- Time frames - Goals - Responsibility for essential activities - Leadership for the implementation - Resources, supports and strategies for successful implementation

PSS-KL-7.2

The leadership for the implementation works with the developers of the evidence-based program, if feasible, and changes organizational structures and functions, if required, to fully support the use of the evidence-based program.

PSS-KL-7.3

There is a process for monitoring the implementation process and updating practices as the clinical literature evolves over time.
PSS-KL-8

The organization promotes and supports the implementation of evidence-based programs by establishing effective and sustainable structures and resources. (Note: Only applies if the organization provides one or more established evidence-based programs. See glossary definition for evidence-based program.)

To achieve this standard, 4 out of 6 indicators must be met.

PSS-KL-8.1
Required

The governing body supports management’s active participation in the implementation.

PSS-KL-8.2

The knowledge and skill development needs for staff that are or will deliver the evidence-based program and their supervisors are identified.

PSS-KL-8.3

When beginning the implementation of an evidence-based program, initial training is provided.

PSS-KL-8.4

Ongoing education and development is provided and staff are supported to share their learning and experiences and seek input from others who are implementing the same or similar evidence-based programs (for example, community of practice).
PSS-KL-8.5

Appropriate ongoing supervision/coaching is provided to staff, reinforcing skill development, allowing for personal styles of the staff and providing extra support when needed.

PSS-KL-8.6

Staff are given time to incorporate the new practices.

PSS-KL-9.1

An assessment of how well the practice has adhered to the evidence-based program is done and fidelity is monitored (if fidelity measures exist for the evidence-based program).

To achieve this standard, 2 out of 3 indicators must be met.

PSS-KL-9.2

Steps are taken to strive for fidelity and measure outcomes before making adaptations to the evidence-based program.
When necessary, adaptations are made, taking care to ensure that the core intervention components of the evidence based program are not modified and that adaptations are documented.

There is a documented plan to periodically evaluate the implementation of evidence-based programs.

Client outcomes are measured for the evidence-based program to determine whether similar outcomes are achieved to those suggested by the research and variances are examined and analyzed.

Client and, if applicable, community feedback regarding the implementation of evidence-based programs is collected.

The organization defines its eligibility criteria, process for screening and program/service - policies/procedures

Written policies and procedures define eligibility criteria (for example, ages, problem type, geographic location).
admitting persons served and the community’s methods of accessing services.

To achieve this standard, 6 out of 6 indicators must be met.

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**PSS-ICO-1.2**  
**Required**

There is a written description of the processes by which potential service participants can access services (for example, through the organization’s own intake, through centralized access).

---

**PSS-ICO-1.3**  
**Required**

Written policies and procedures describe the screening process to determine if individuals meet eligibility requirements and include:

- Priority populations/groups
- Parameters for screening the level of risk and level of need
- Special considerations at intake, such as bereavement or depression, that may affect eligibility or priority

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**PSS-ICO-1.4**  
**Required**

Eligibility criteria and processes are reviewed periodically to ensure that they address emerging and priority needs of the population/community.

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**PSS-ICO-1.5**  
**Required**

Clients are prioritized for service and immediate crisis support/response is either provided to those in crisis (for example, impulsive, self-harming behaviour) or efforts are made to help them find access to immediate services.
PSS-ICO-1.6
Required

Procedures for informing community members about how to receive help in an emergency or crisis situation are clearly defined.

PSS-ICO-2.1
Required

The essential information to be gathered from all registered service participants at intake is defined in written policies and procedures.

PSS-ICO-2.2
Required

Written policies and procedures describe processes to be implemented, including the use of standardized intake tools as applicable.

PSS-ICO-2.3
Required

Written policies and procedures outline the implementation of the triage and prioritization process, which includes providing access or direction to alternative or interim services if there is a wait period.
PSS-ICO-2.4
Required

Written policies and procedures outline other intake responsibilities (for example, consent forms, use of personal or health information).

PSS-ICO-2.5
Required

Written policies and procedures define relationship and referral process to other intake processes in the service system (for example, centralized intake, intake for specialized program at another organization).

PSS-ICO-2.6
Required

Intake practices are consistent with policies and procedures.

MAN Standard
PSS-ICO-3

When there is a waiting list for service, the organization monitors its response times and takes measures to improve access to services, where possible. (Note: Applies to child and youth mental health programs for which there is a waiting list.)

To achieve this standard, 3 out of 3 indicators must be met.

PSS-ICO-3.1
Required

Measures are in place to track and monitor response times for services for which individuals must wait.

Note: As on-site documentation, the organization is expected to show data/statistical reports.
PSS-ICO-3.2
Required

Measures, where possible, are taken to improve access to services and reduce wait times (for example, alternate service models, shifting of resources).

Narrative
Pre-Site Document(s)
program/service - descriptions reports
Interview(s)
Staff - Program-specific Manager(s)

PSS-ICO-3.3
Required

Persons served are informed about how to inquire about waiting list status.

Interview(s)
Staff - Program-specific Staff

PSS-ICO-4.1
Policy or procedures outline the agency’s expectations for the completion of intake tools (for example, frequency, timing, format).

Pre-Site Document(s)
program/service - policies/procedures
Interview(s)
Staff - Program-specific Staff

PSS-ICO-4.2
Compliance with agency expectations is monitored.

Narrative
Interview(s)
Staff - Program-specific Manager(s)
**PSS-ICO-4.3**

Data integrity is monitored and maintained systematically and measures are put in place to address any data integrity or compliance concerns.

**PSS-ICO-4.4**

Data is available to clinicians for assessment and priority rating.

**PSS-ICO-5.1**

Required

Client orientation about how diverse cultural backgrounds are accommodated is provided.

**PSS-ICO-5.2**

Required

At minimum, client orientation covers how to make a complaint and how personal health information and individuals’ rights and safety are protected.

**Component: Service Delivery**

**PSS-SD-1.1**

Required

Written policies and procedures outline case management/service coordination expectations within
To achieve this standard, 5 out of 5 indicators must be met.

### PSS-SD-1.2
**Required**

Case management/service coordination takes place through collaboration with internal and community service providers and respects the preferences of persons served.

**Survey(s)**  
Community Partners  
Pre-Site Document(s) suggested  
program/service - policies/procedures  
Interview(s)  
Staff - Program-specific Staff  
Client Interviews - Clients - Children/Youth  
Client Interviews - Clients - Parents/Family

### PSS-SD-1.3
**Required**

Responsibility for case management/service coordination is clearly understood by the service providers involved and by persons served.

**On-Site file review(s)**  
Client  
Survey(s)  
Community Partners  
Interview(s)  
Staff - Program-specific Staff  
Client Interviews - Clients - Children/Youth  
Client Interviews - Clients - Parents/Family

### PSS-SD-1.4
**Required**

The roles and responsibilities of all service providers involved are outlined and are communicated with one another and the client.

**On-Site file review(s)**  
Client  
Survey(s)  
Community Partners
PSS-SD-1.5
Required
Case management/service coordination practices promote continuity of service delivery for the client to the fullest extent possible.

PSS-SD-2.1
Required
The needs of the specific client determine the disciplines to be involved in service delivery.

PSS-SD-2.2
Required
An integrated plan addresses the nature and timing of services to be delivered.

PSS-SD-2.3
Required
For each case, the staff person with overall case responsibility facilitates service coordination and the multidisciplinary process, where required, including discussion, conflict resolution and decision making. That person ensures that everyone has the opportunity to participate, especially the client and the person working most directly with the client.

PSS-SD-3.1
Required
A multidisciplinary process is available, internally or externally, for professional input during the treatment
multidisciplinary perspective. To achieve this standard, 5 out of 5 indicators must be met.

process, including assessment, planning, implementation, review, and case closure.

PSS-SD-3.2
Required

Written policies and procedures describe the multidisciplinary process and include the organization’s philosophy of how the process is to be used and circumstances under which multidisciplinary consultation must be sought for persons served in risk situations (for example, suicide, family violence, abuse).

PSS-SD-3.3
Required

Access to different disciplines is available either on site, in the community (for example, through a contractual or consulting arrangement) or through other means such as telepsychiatry

PSS-SD-3.4
Required

The design and implementation of the multidisciplinary process is consistent with local needs and/or resources.
PSS-SD-3.5
Required

Staff are familiar with the process for accessing multidisciplinary input.

PSS-SD-4.1
Required

Job descriptions outline the minimum qualifications and expectations regarding licensing and/or registration for staff in professional positions.

PSS-SD-4.2
Required

A range of multidisciplinary professionals that reflects the needs of the individuals served are employed or are on contract.

PSS-SD-4.3
Required

Staff who are legally required to be licensed or registered meet the requirements as outlined in applicable legislation and regulation.

PSS-SD-5.1

The approach to the client’s community service coordination is documented and outlines the roles and expectations of service partners.
agencies and/or informal supports, services are coordinated and integrated where possible. (Note: Only applies when the organization takes a lead or substantive role in a community intervention/treatment plan, whether or not the organization is providing intervention/treatment services, such as a formal community case management role or a wraparound process.)

To achieve this standard, 3 out of 4 indicators must be met.

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<th>PSS-SD-5.2</th>
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| The nature and timing of delivery of specific services is coordinated.

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<th>PSS-SD-5.3</th>
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| A service coordinator or facilitator is identified and named in the file.

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<th>PSS-SD-5.4</th>
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| With the consent of the client (as required), staff and external service provider(s) share information, coordinate intervention/treatment and, where possible, integrate services on behalf of and with the client.

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| **Required**

**Written agreement(s) describe:**

- The nature of the relationship - Goals of the collaboration - Expectations/responsibilities of each partner in terms of hiring/training and supervision/discipline of staff, insurance coverage, liability of the governing bodies and accountability to funders.
To achieve this standard, 2 out of 3 indicators must be met.

**PSS-SD-6.2**

Mechanisms by which any conflict may be resolved are in place.

---

**PSS-SD-6.3**

Partners review and evaluate the impact of the partnership/collaboration in achieving stated goals relative to the dedicated resources.

---

**PSS-SD-7.1**

Past or current participants in services are invited to participate in activities beyond the planning and review of their services (for example, focus groups, advisory committees, fundraising activities, volunteering, advocacy efforts, board and/or committees).

---

**PSS-SD-7.2**

The individual’s role in such activities is clearly defined and understood.

---

**Component: Clinical Records and Service Participant Records**

**MAN Standard**

**PSS-REC-1**

Required

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**PSS-REC-1.1**

Required

---

**Pre-Site Document(s)**

Client file format/content guidelines

**Interview(s)**

Staff - Program-specific
There is a comprehensive clinical records system for persons served receiving intervention/treatment services.

To achieve this standard, 3 out of 3 indicators must be met.

Policies and procedures define:
- When a clinical record regarding a client is created - The required contents of clinical records and any variations among the organization’s programs - Time frame for recording in clinical records - Information to be entered in the client information management system

PSS-REC-1.2

Required

Clinical records are kept up to date according to the organization’s defined time frames for recording.

PSS-REC-1.3

Required

A system is in place to ensure that clinical records contain current, accurate and complete information (for example, through supervision or a regular audit of client records).

PSS-REC-2.1

Written policies and procedures define:
- Circumstances under which participant records are kept (for example, educational group program, drop-in, employment program) - Minimum information required in the participant record - Time frame for recording and updating participant records - Information to be entered in the client information management system, if any

LP Standard

PSS-REC-2

There is a system for recording service participant information in circumstances where a clinical record is not required.

To achieve this standard, 2 out of 2 indicators must be met.
Component: Assessment

MAN Standard

PSS-AP-1

There is a comprehensive assessment process that is adapted according to the intervention/treatment needs of the child or youth and family.

To achieve this standard, 2 out of 2 indicators must be met.

PSS-AP-1.1

Required

There is an assessment policy or policies that address:

- The nature of the assessment to be conducted to support referral to specific types of intervention/treatment (for example, differing levels/types of assessment would be used for an early intervention program, time-limited intervention, day treatment) - Which professionals, in accordance with their scope of practice, perform specific types of assessments - Specific assessment tools and under what circumstances they are utilized - Who coordinates assessments from multiple sources to support intervention/treatment planning - The time frame for pulling together, formulating and recording initial assessments and communicating the results to clients

PSS-AP-1.2

Required

The type(s) of assessment is matched appropriately to the level of client need and intensity of the likely intervention/treatment method to be used.

PSS-AP-2.1

Required

On-Site file review(s)
Client

Pre-Site Document(s)
client file format/content guidelines

MAN Standard

PSS-AP-2

On-Site file review(s)
Client

Pre-Site Document(s)
Client file format/content guidelines

Narrative

Pre-Site Document(s)
program/service - client needs assessment

Interview(s)

Staff - Program-specific Staff

Staff - Program-specific Manager(s)
An assessment summary report contains an evaluation of the strengths, needs and resources of the child or youth and family (such as medical, social, environmental, cultural) that are directly relevant to the nature of the service request and identified problems. For time-limited intervention/treatment, client or problem history is explored only to the extent required to address the request for service.

**PSS-AP-2.2**
Required

The assessment summary documents the views of staff and other professionals as well as those of the child or youth and family. When needed or requested, this occurs with the support of a person familiar with their language and culture.

**PSS-AP-2.3**
Required

The disciplines involved in initial and subsequent assessments are determined by the specific needs of the client.

**PSS-AP-2.4**
Required

The background and circumstances unique to the child or youth and family (such as culture, religion, language and ethnicity) are recognized and accommodated in the assessment process.
PSS-AP-2.5

Required

Assessment information from relevant sources is pulled together into a written report that includes a clinical formulation. For time-limited intervention/treatment, documentation includes, at minimum, the timing and nature of the service request, an understanding of presenting problem(s), who was involved and the suggestions/recommendations or plan.

PSS-AP-3.1

Assessment findings are communicated in a manner that can easily be understood by the specific client (for example, using plain language, visual representations). For early intervention and time-limited services, including crisis, “assessment findings” will be limited and appropriate to the type of service provided.

PSS-AP-3.2

Opportunities are provided for the client to ask questions or seek clarification when findings are first shared and later on request.

PSS-AP-3.3

When needed or requested, a person familiar with the client’s language and culture is available.
**PSS-AP-3.4**

The child or youth and family are offered a written copy of the assessment findings, and any exceptions are explained in the file (for example, child’s age or developmental level might influence how assessment findings are shared). For time-limited interventions, the client is offered a brief report or letter outlining the nature of the contact, understanding of problems and plan/suggestions.

**PSS-AP-4.1**

**Required**

Persons served are asked about services they may have received in the previous two years and/or may be currently receiving from other community service providers that may be relevant to the current assessment and intervention/treatment process.

**PSS-AP-4.2**

**Required**

The benefits of accessing previous or current assessment and intervention/treatment information from other community service providers are discussed with the client, with due respect for the client’s preference and informed consent.

**PSS-AP-4.3**

**Required**

With client consent, assessment reports identify and summarize any known relevant services received by the client within the previous two years. For time-limited intervention/treatment, the nature of client need and service being delivered determines whether and how previous service providers are contacted. For crisis response, the file refers to requests for prompt telephone information from relevant service providers as time allows.
Component: Intervention/Treatment Planning, Implementation and Review

MAN Standard

**PSS-PIR-1**

**Required**

Individuals are oriented to each service as they begin receiving an ongoing course of treatment or service.

To achieve this standard, 6 out of 6 indicators must be met.

---

**PSS-AP-4.4**

**Required**

There are copies of consents and requests for information from other relevant service providers in the client’s file as appropriate.

---

**PSS-PIR-1.1**

**Required**

Orientation for each type of service received covers how service will be delivered and coordinated.

---

**PSS-PIR-1.2**

**Required**

The orientation process is modified as appropriate to type(s) of service to be offered (for example, crisis, drop-in, single session).

---

**PSS-PIR-1.3**

**Required**

Persons served are informed about intervention/treatment options, possible benefits and risks of the treatment(s) under consideration and the likely consequences of not having the treatment(s). For time-limited intervention/treatment, particularly crisis response, the information communicated may be limited to what is essential, given the situation.
PSS-PIR-1.4
Required

The methods for addressing benefits/risks fit the specific intervention/treatment options under consideration at the time (for example, brochure, orientation meeting at the residence, telephone discussion during crisis response).

PSS-PIR-1.5
Required

Where appropriate, parents and child or youth who are registered persons served give their informed consent to receive voluntary service(s). Good practice suggests documentation of consent whenever possible, with adequate explanation in the file if consent is not documented.

PSS-PIR-1.6
Required

Staff remind children or youth and parents about the steps they can take to receive help in an emergency or crisis situation.

PSS-PIR-2.1
Required

The written intervention/treatment plan reflects careful consideration of the assessment findings and formulation and may be modified over time in response to changes in the assessment and formulation. For early intervention or time-limited intervention/treatment, the treatment plan may consist of brief recommendations or suggestions.
### PSS-PIR-2.2
**Required**

The plan defines the purpose of the intervention and what success will look like (for example, the parent being able to resume care of the child or the youth returning to community school). The definition of success and/or goals may change over the course of treatment.

### PSS-PIR-2.3
**Required**

The plan addresses succinctly the agreed-upon intervention/treatment methods to be used and how they are expected to contribute to success (for example, family therapy so that the parents are better able to support their child to attend day treatment regularly in preparation for return to community school).

### PSS-PIR-2.4
**Required**

The plan indicates the person with overall case responsibility in order to provide a contact person for clients receiving ongoing service and for other service providers.

### PSS-PIR-2.5
**Required**

To help ensure that service is integrated, if multiple staff of the organization are involved the names and/or roles or titles of those who have been assigned to provide components of the treatment/service plan are specified in the plan.
PSS-PIR-2.6
Required

The plan indicates the initial/current time frame for treatment/service as negotiated and contracted with the client.

PSS-PIR-3.1
Required

Staff support persons served in providing input and opinions during the intervention/treatment planning and review process.

To achieve this standard, 5 out of 5 indicators must be met.

PSS-PIR-3.2
Required

The intervention/treatment planning and review process focuses on the child, youth or family’s strengths and resources, what the client wants to achieve, management of safety and risk issues and what can reasonably be achieved based on the assessment.

PSS-PIR-3.3
Required

Participation of all relevant parties at review and planning meetings or discussions is encouraged and documented in the client file; any alternate means of gathering input is also documented.
### PSS-PIR-3.4
**Required**

Client files explain the circumstances in which a child or youth and family have not participated in review and planning meetings or discussions.

### PSS-PIR-3.5
**Required**

Persons served are oriented to their rights and responsibilities during treatment whenever the intervention/treatment changes.

### PSS-PIR-4.1
**Required**

The intervention/treatment plan is communicated in a manner that can easily be understood by the specific client (for example, using plain language, visual representations).

To achieve this standard, 3 out of 4 indicators must be met.

### PSS-PIR-4.2
**Required**

Opportunities are provided for the client to ask questions or seek clarification when the intervention/treatment plan is first shared and later on request.
### PSS-PIR-4.3

When needed or requested, a person familiar with the client’s language and culture is available.

**Interview(s)**
- Staff - Program-specific Staff
- Client Interviews - Clients - Children/Youth
- Client Interviews - Clients - Parents/Family

### PSS-PIR-4.4

The child or youth and family are offered a written copy of the intervention/treatment plan and any exceptions are explained in the file (for example, child’s age or developmental level might influence how the plan is shared). For time-limited interventions, the client is offered a brief report or letter outlining the nature of the contact, understanding of problems and suggestions, recommendations or plan.

**On-Site file review(s)**
- Client

**Interview(s)**
- Staff - Program-specific Staff
- Client Interviews - Clients - Children/Youth
- Client Interviews - Clients - Parents/Family

### PSS-PIR-5.1

There is a policy that requires review and recording in the file of a person receiving intervention/treatment at least every six months, unless the file is closed before six months.

**Pre-Site Document(s)**
- client file format/content guidelines

### PSS-PIR-5.2

Files reflect review of client needs and goals and intervention/treatment methods at least every six months, unless the file is closed before six months.

**On-Site file review(s)**
- Client
**PSS-PIR-5.3**

Current safety and risk issues are highlighted in the file with plan specified.

**PSS-PIR-5.4**

Progress is measured and results, including updated standardized measures, if used, are reflected in the files.

**PSS-PIR-6.1**

There is evidence that the intervention/treatment plan is modified as necessary over time in accordance with review of intervention/treatment, particularly if progress is not as expected and/or new problems develop (specifically, modified goals; methods; safety/risk issues; time frame; updated standardized measures, if used).

**PSS-PIR-6.2**

If needed, the modified plan identifies referrals to be made to other/alternate services.

---

**Component: Case Closure**

**PSS-CC-1.1**

Required

**LP Standard**

**PSS-PIR-6**

The review of intervention/treatment is used to modify the intervention/ treatment plan, if necessary.

To achieve this standard, 2 out of 2 indicators must be met.

---

**MAN Standard**

**PSS-CC-1**

Required
When case closure is a planned process, staff and the child or youth and family negotiate a plan for case closure.

To achieve this standard, 5 out of 5 indicators must be met.

Case closure planning takes into consideration successes achieved, ongoing or anticipated client needs, resources available and the preferences of the child or youth and family.

**PSS-CC-1.2**

**Required**

The case closure plan is developed in partnership with the child or youth and family and key others where appropriate. Exceptions to client involvement may occur where client capacity and/or availability to participate is limited, with documentation in the file. In time-limited intervention/treatment, case closure is addressed implicitly or explicitly from the beginning of service. It would not be unusual for the case to close at the first and only session.

**PSS-CC-1.3**

**Required**

The case closure plan supports and enables relevant persons (for example, the child’s or youth’s parents, guardians, teachers, employers) to assist in meeting the child’s or youth's needs once the case has been closed.

**PSS-CC-1.4**

**Required**

Persons served are referred to, or provided with, information regarding alternate or additional services and community supports that may be appropriate to sustain achieved successes or support ongoing coping and adaptation (for example, following the resumption of school or at the onset of adolescence).
PSS-CC-1.5
Required

Persons served are provided with information regarding options and methods for contacting the organization for future support.

PSS-CC-2.1

Where case closure is unplanned (for example, client drops out or leaves service unexpectedly), client needs and service history determine the extent and nature of effort expected to contact the client to offer or suggest further or alternate services if appropriate.

PSS-CC-2.2

When possible and appropriate, persons served are informed that the case is closed.

PSS-CC-2.3

When possible and appropriate, persons served are informed about how to contact the organization for services in the future, if needed.

PSS-CC-3.1

Recording policy and procedures address requirements for closing reports regarding various types of services.
To achieve this standard, 3 out of 4 indicators must be met.

**PSS-CC-3.2**

The written closing report summarizes reasons for service, treatment goal(s) and strategies, services provided, achievements/progress (including results of standardized measures of progress if used), most and least effective intervention/treatment methods and reasons for closing. For time-limited intervention/treatments, the brief closing/summary report includes, at minimum:

- The nature of the request for service
- Brief formulation/understanding of problems/needs
- Suggestions/recommendations
- The nature of the services provided
- The plan at closing
- If goals have been identified, comments on the achievement of goals

**PSS-CC-3.3**

The closing report is written collaboratively or discussed with the client whenever possible.

**PSS-CC-3.4**

The client is offered a written copy of the closing report. For some time-limited services (for example, crisis response), this might not be practical.
Component: Prevention

The standards in this component apply only to child and youth mental health organizations that offer a Prevention program. Prevention seeks to avert mental health problems through interventions. Interventions include activities geared towards reducing factors leading to mental health problems. See CCA Glossary for further details.

**LP Standard**

**SSS-PRE-1**

When Prevention programs are offered, they are designed to address specific individual and/or community needs with appropriate goals and activities.

(Note: The standards in this component apply only to child and youth mental health organizations that offer a Prevention program. Prevention seeks to avert mental health problems through interventions. Interventions include activities geared towards reducing factors leading to mental health problems. See CCA Glossary for further details.)

To achieve this standard, 2 out of 2 indicators must be met.

**SSS-PRE-1.1**

Prevention programs empower children, youth and/or parents to better address children’s mental health issues by changing attitudes and behaviours, building skills and competencies, and/or creating awareness and resiliency.

Note: Applies only to child and youth mental health organizations that offer a Prevention program. Prevention seeks to avert mental health problems through interventions. Interventions include activities geared towards reducing factors leading to mental health problems. See CCA Glossary for further details.

**SSS-PRE-1.2**

Service delivery for prevention programs is coordinated with other service providers, as appropriate.

**LP Standard**

**SSS-PRE-2**

Prevention programs are evaluated and improvements are made, if required.

(Note: Applies only to child and youth mental health organizations that offer a Prevention program.)

**SSS-PRE-2.1**

Prevention activities are evaluated and modified based on evaluation results, if required.

(Pre-Site Document(s) suggested data/statistical reports evaluation - summary reports Interview(s) Staff - Program-specific Manager(s))
Program. Prevention seeks to avert mental health problems through interventions. Interventions include activities geared towards reducing factors leading to mental health problems. See CCA Glossary for further details.)

To achieve this standard, 2 out of 3 indicators must be met.

SSS-PRE-2.2

Participatory methods are used to evaluate the outcomes of prevention programs to the extent possible. Participatory methods involve staff and participants in data collection and feedback.

SSS-PRE-2.3

Evaluation incorporates the feedback of community partners, if applicable.

Component: Groups

This component applies only to organizations that offer group programs in child and youth mental health.

LP Standard

SSS-GP-1

The organization plans, provides and evaluates group programs for clients and the community for purposes of treatment and/or prevention.

(Note: Applies only to organizations that offer group programs in child and youth mental health.)

To achieve this standard, 3 out of 4 indicators must be met.

SSS-GP-1.1

Group programs have a written description that clearly articulates their purpose (such as treatment, psycho-educational), target population and rationale.

SSS-GP-1.2

Each group program has written goals.
SSS-GP-1.3

Each group program has a written outline or activity plan describing how the goals will be achieved.

SSS-GP-1.4

Data on group outcomes is collected, reviewed and used for program decision-making or modification.

SSS-GP-2.1

Treatment group involvement is consistent with the client’s assessed needs and treatment plan.

SSS-GP-2.2

When clients are involved in treatment groups as well as other services either at the organization or elsewhere, treatment group service is coordinated with other components of the client’s treatment plan.
SSS-GP-2.3

Treatment group involvement is reviewed periodically along with other components of the client’s treatment.

SSS-GP-2.4

Treatment group involvement is reflected in the client’s file as appropriate (for example, in the treatment plan, in the context of reviews).

**Component: Consultation**

This standard only applies to organizations that provide consultation to other community service providers.

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<td>Client Interview(s)</td>
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<td>Staff - Program-specific Staff</td>
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SSS-CON-1.1

Formal client-specific consultation is provided to community partners on the issues of a specific child or youth.

Note: Applies only to organizations that provide consultation to other community service providers. Consultation can be client specific or program specific.

SSS-CON-1.2

A consultation summary is developed to identify recommended actions to the community partner(s) to address the child or youth’s needs.

Note: For on-site document review, the CCA review team will expect to review records of consultations, for example, case notes and meeting minutes.

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SSS-CON-2.1


The organization provides issue and/or program-specific consultation on children’s mental health issues to teams, groups, and organizations.

(Note: Applies only to organizations that provide program-specific and/or issue-specific consultation to other community service providers.)

To achieve this standard, 2 out of 3 indicators must be met.

**SSS-CON-2.2**

Issue-specific consultation is provided to teams and/or groups about how they can better understand and address the needs of their clients, and may involve skills-building, knowledge-development or strategies on addressing mental health issues generally, or with a particular problem (for example, bullying).

Note: For on-site document review, the CCA review team will expect to review records of consultations, for example, case notes and meeting minutes.

**SSS-CON-2.3**

Program-specific consultation is provided to organizations to help shape and implement programs or services that are responsive to children and youth mental health issues.

Note: For on-site document review, the CCA review team will expect to review records of consultations, for example, case notes and meeting minutes.

**Component: Respite**

This component only applies to organizations that offer respite services. Respite services provide temporary family relief from caring for children or youth. The primary purpose is support for families, including foster families and kinship care.

**SSS-RSP-1.1**

The need to collect sufficient intake information is balanced with limiting the amount of paperwork in order to minimize barriers for families.
(Note: Only applies to organizations that offer respite services. Respite services provide temporary family relief from caring for children or youth. The primary purpose is support for families, including foster families and kinship care.)

To achieve this standard, 2 out of 3 indicators must be met.

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**SSS-RSP-1.2**

Respite services are designed to respond flexibly to the unique needs of each family with respect to duration and frequency of service use.

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**SSS-RSP-1.3**

Respite provides the child or youth the opportunity to participate in positive, structured activities.

---

**SSS-RSP-2**

The organization maintains brief written records of the respite services provided and reviews the family’s respite plan regularly.

(Note: Only applies to organizations that offer respite services. Respite services provide temporary family relief from caring for children or youth. The primary purpose is support for families, including foster families and kinship care.)

To achieve this standard, 3 out of 4 indicators must be met.

---

**SSS-RSP-2.1**

There is a written plan or contract with the family that outlines the nature, duration and frequency of the respite service to be provided.

Note: As on-site documentation, the organization will be expected to provide examples of program/service plans and/or service agreements.

---

**SSS-RSP-2.2**

If respite services take place over an extended period of time, the respite plan or contract is reviewed with the family periodically and modifications are made as required.

Note: As on-site documentation, the organization is expected to provide examples program/service plans and/or service agreements.
SSS-RSP-2.3

Brief records of the child or youth’s participation in the respite program are kept (for example, case notes).

Note: As on-site documentation, the organization is expected to provide examples of case notes.

SSS-RSP-2.4

There is a written activity plan for the respite program in which the child or youth participated.

Note: As on-site documentation, the organization is expected to provide examples of written activity plans.

SSS-RSP-3

The organization provides appropriate organizational supports that are applicable to the type of respite program, population served, and the setting.

(Note: Only applies to organizations that offer respite services. Respite services provide temporary family relief from caring for children or youth. The primary purpose is support for families, including foster families and kinship care.)

To achieve this standard, 2 out of 3 indicators must be met.

SSS-RSP-3.1

If respite is provided in a setting that requires it, licensing standards are met (for example, child care centre or a residence).

Pre-Site Document(s)
licences
Interview(s)
Staff - Program-specific Manager(s)

SSS-RSP-3.2

There is a rationale for the provider-to-child ratio, appropriate to the setting and needs of the population served.

Narrative Interview(s)
Staff - Program-specific Manager(s)
SSS-RSP-3.3

Respite provider training and ongoing education provide the necessary skills to care for and develop activities for the children or youth served.

Note: An on-site document is optional. Suggested on-site documents include training plans and schedules.

Component: Youth Engagement

The component applies only to organizations that undertake Youth Engagement programming. Through special Youth Engagement initiatives, organizations become more accountable to the youth they serve and provide opportunities for youth between the ages of 13 and 25 to address and make decisions about issues that affect them personally and/or that they believe to be important. Youth engagement activities may extend to youth who are current or former clients, volunteers and in some situations, staff of the organization.

MAN Standard

  SSS-YE-1

Procedures are in place to ensure the safety and emotional well-being of youth who are engaged within the agency.

(Note: Applies only to organizations that undertake Youth Engagement programming. Through special Youth Engagement initiatives, organizations become more accountable to the youth they serve and provide opportunities for youth between the ages of 13 and 25 to address and make decisions about issues that affect them personally and/or that they believe to be important. Youth engagement activities may extend to youth who are current or former clients, volunteers and in some situations, staff of the organization.)

To achieve this standard, 4 out of 4 indicators must be met.

SSS-YE-1.1

There is a written policy and/or procedure to assist engaged youth to access mental health support, if required, either at the organization or in the community.

SSS-YE-1.2

There is a written policy and/or procedure for youth to bring forward concerns regarding physical and emotional safety.

SSS-YE-1.3

A program environment is provided in which youth are physically and emotionally safe and respected.
### SSS-YE-1.4

Hours that youth work support their education and healthy development.

---

### SSS-YE-2.1

**Required**

There are policies that define who can be engaged, their roles, responsibilities, boundaries, and recognition/compensation for youth engaged in program planning and implementation.

() Note: Applies only to organizations that undertake Youth Engagement programming. Through special Youth Engagement initiatives, organizations become more accountable to the youth they serve and provide opportunities for youth between the ages of 13 and 25 to address and make decisions about issues that affect them personally and/or that they believe to be important. Youth engagement activities may extend to youth who are current or former clients, volunteers and in some situations, staff of the organization.

To achieve this standard, 4 out of 7 indicators must be met.

---

### SSS-YE-2.2

Youth volunteers reflect the diversity of the community and programs of the agency.

---

### SSS-YE-2.3

Youth are provided with a youth-friendly orientation to the organization and program in which they are involved.
SSS-YE-2.4

**Required**

Adult allies seek, encourage and use input from youth before making decisions about program goals and delivery to ensure programs are meeting the needs and concerns of youth.

SSS-YE-2.5

Adult allies provide opportunities and support for youth to take on substantive leadership responsibilities within programs.

SSS-YE-2.6

Youth are assisted as their roles change (for example, when they are no longer youth, or are transitioning from volunteer to a mentor).

SSS-YE-2.7

Youth engagement initiatives are evaluated in partnership with youth.

SSS-YE-3.1

Youth help to frame the message, and design the public education and mental health promotion strategy (for example, Children’s Mental Health Week, anti-stigma
(Note: Applies only to organizations that undertake Youth Engagement programming. Through special Youth Engagement initiatives, organizations become more accountable to the youth they serve and provide opportunities for youth between the ages of 13 and 25 to address and make decisions about issues that affect them personally and/or that they believe to be important. Youth engagement activities may extend to youth who are current or former clients, volunteers and in some situations, staff of the organization.)

To achieve this standard, 3 out of 5 indicators must be met.

### SSS-YE-3.2

Adult allies are assigned to prepare youth in public speaking skills, messaging, and media relations.

<table>
<thead>
<tr>
<th>Narrative Survey(s)</th>
<th>Youth in Youth Engagement Program Pre-Site Document(s) suggested training and development - plan/schedule Interview(s)</th>
<th>Staff - Program-specific Staff Youth in Youth Engagement Program</th>
</tr>
</thead>
</table>

### SSS-YE-3.3

Youth are provided with clear guidelines and expectations.

<table>
<thead>
<tr>
<th>Narrative Survey(s)</th>
<th>Youth in Youth Engagement Program Pre-Site Document(s) suggested training and development - plan/schedule Interview(s)</th>
<th>Staff - Program-specific Staff Youth in Youth Engagement Program</th>
</tr>
</thead>
</table>

### SSS-YE-3.4

Required

Youth understand the risks and benefits of sharing their story in public.

<table>
<thead>
<tr>
<th>Survey(s)</th>
<th>Youth in Youth Engagement Program Interview(s)</th>
<th>Staff - Program-specific Staff Youth in Youth Engagement Program</th>
</tr>
</thead>
</table>

SSS-YE-3.5
Required
Youth who share personal experiences through public speaking will give their informed consent and receive thorough preparation, support and debriefing.

SSS-YE-4.1
Required
There is a policy (or policies) that define roles and responsibilities of youth within the governance process.

SSS-YE-4.2

If the governing body includes youth as members, a policy specifies whether, how, and under what circumstances current and/or former clients can be members.

SSS-YE-4.3

Two or more youth provide input into the governance process either as members of the governing body or as advisors to the governance process.

LP Standard

SSS-YE-4

The governing body has a strategy that provides engagement opportunities with youth in the governance process.

(Note: Applies only to organizations that undertake Youth Engagement programming. Through special Youth Engagement initiatives, organizations become more accountable to the youth they serve and provide opportunities for youth between the ages of 13 and 25 to address and make decisions about issues that affect them personally and/or that they believe to be important. Youth engagement activities may extend to youth who are current or former clients, volunteers and in some situations, staff of the organization.)

To achieve this standard, 5 out of 9 indicators must be met.
**SSS-YE-4.4**  
Required  

Adult allies are assigned to support youth.

**SSS-YE-4.5**

Youth are provided with clear guidelines and expectations for their role(s).

**SSS-YE-4.6**  
Required  

Youth are provided with a youth-friendly orientation to the governance process.

**SSS-YE-4.7**

Both youth and adults are oriented on youth engagement practices as they relate to governance.
**SSS-YE-4.8**

Meetings and materials are youth friendly and encourage young people to participate and contribute.

**SSS-YE-4.9**

Youth participate in assessing the effectiveness of the youth engagement strategy within the governance process.

**Component: Community and Home-Based**

This component only applies if the organization offers child and youth mental health services in a community-based and/or home-based setting.

**LP Standard**

**SSS-CHB-1**

Home and community-based services are flexible, collaborative and responsive to the unique circumstances of the family and child or youth. (Note: Only applies if the organization offers child and youth mental health services in a community-based and/or home-based setting.)

To achieve this standard, 3 out of 5 indicators must be met.

**SSS-CHB-1.1**

Home and community-based services staff engage and collaboratively involve the caregiver, as well as the child or youth, in treatment planning and goal setting.

**SSS-CHB-1.2**

When outlined in the intervention/treatment plan, staff provide assistance and advocacy to provide for concrete family needs such as food, transportation, child care and housing.
SSS-CHB-1.3

Services are provided on a flexible schedule, at times and locations negotiated with the family and child or youth.

SSS-CHB-1.4

Staff understand and respect the unique culture of each family and child or youth and modify services appropriately.

SSS-CHB-1.5

Staff receive education and training to identify specific caregiver issues that will have major impact for intervention/treatment planning, including caregiver mental health problems, substance abuse, marital conflict and family violence in the home or community environment.

SSS-CHB-2.1

Staff work with families and children or youth to assess the adequacy of current support systems.

LP Standard

SSS-CHB-2

Home and community-based services link with other community resources to develop and enhance social support systems for families and children or youth. (Note: Only applies if the organization offers child and youth mental health services in a community-based and/or home-based setting.)

To achieve this standard, 2 out of 3 indicators must be met.
**SSS-CHB-2.2**

Staff collaborate with families to identify and engage ongoing social, community, family and professional supports or services to address the needs of persons served.

**SSS-CHB-2.3**

Staff provide a link between home and community settings, supporting children or youth in their child care, school or recreational or other community settings as required.

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**Component: School, Early Learning and Child Care**

The component only applies if the organization provides child and youth mental health services in schools, early learning or child care centres.

**SSS-SCH-1.1**

Staff develop and maintain a professional collegial relationship with school, early learning or child care centre personnel.

**SSS-SCH-1.2**

Staff provide specialized children’s mental health services distinct from the educational or other focus provided by the setting.
### SSS-SCH-1.3

The role of children’s mental health staff delivering services in these settings is defined and documented.

<table>
<thead>
<tr>
<th>Pre-Site Document(s) suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>program/service - descriptions</td>
</tr>
<tr>
<td>service agreements</td>
</tr>
</tbody>
</table>

| Interview(s) |
| Staff - Program-specific Staff |

### SSS-SCH-2.1

Children or youth in school-based services that will require treatment or support during school breaks are identified.

| Narrative |
| Interview(s) |
| Staff - Program-specific Staff |

### SSS-SCH-2.2

All persons served are provided with information about where to access community support services during school breaks should the need arise.

| Narrative |
| Interview(s) |
| Staff - Program-specific Staff |

### SSS-SCH-2.3

Continuous service during school breaks is provided or referrals or linkages to community supports are made, as required.

| Narrative |
| Interview(s) |
| Staff - Program-specific Staff |

### Component: Day Treatment

This component only applies if the organization offers child and youth mental health day treatment.

#### MAN Standard

**SSS-DT-1**

The organization has a

| Pre-Site Document(s) |
| program/service - policies/procedures |

| Interview(s) |
| Staff - Program-specific Staff |
comprehensive system to promote the use of positive, safe methods to intervene in crisis situations with children or youth at high risk in day treatment. (Note: Only applies if the organization offers child and youth mental health day treatment.)

To achieve this standard, 2 out of 2 indicators must be met.

### SSS-DT-1.2

**Required**

All-day treatment staff participate in training and ongoing education with an emphasis on:

- Identification of risk factors (for example, suicide/self-harm, stalker threatening security of the program) and development and implementation of safety plans - Crisis prevention and de-escalation - Strategies to avoid restraints, when possible, and safe and appropriate use of physical restraints (when warranted) - Debriefing processes to be used following a crisis

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### SSS-DT-2.1

Children or youth attend day treatment during normal school hours.

### SSS-DT-2.2

For programs located in a community school, children or youth in day treatment participate to the extent possible in the normal school-wide activities (for example, assemblies, recess, special events).

Note: Only applies if the organization offers child and youth mental health day treatment in a community school.
SSS-DT-2.3

Group activities are modified to match the needs of individual persons served.

SSS-DT-3.1

Staff work “moment to moment” with children or youth, using situations that arise daily in the day treatment program as opportunities to intervene.

SSS-DT-3.2

Staff promote the assimilation of learning and transference to future situations.

SSS-DT-3.3

Staff demonstrate proficiency in applying behaviour techniques appropriate to the child’s or youth’s development and level of understanding (such as use of the environment, social reinforcement, cueing, encouraging, structuring rules and routines, applying natural and logical consequences, negotiating and restorative approaches).
SSS-DT-3.4

The physical environment is set up to promote opportunities for learning and growth.

SSS-DT-4.1

Admission to day treatment takes place on a planned basis, whenever possible.

SSS-DT-4.2

The child’s or youth’s transition to the day treatment program is managed with sensitivity, respect, transparency and, as far as possible, in a manner that reflects the preferences of the child or youth and parents/caregivers.

SSS-DT-4.3

Staff understand and work with the separation issues present for children or youth moving into a day treatment setting.
SSS-DT-4.4

Relevant history, assessment findings and known risk factors are communicated to day treatment staff in a timely manner, preferably prior to admission.

SSS-DT-4.5

A primary worker, case coordinator or primary contact person is responsible for the child’s or youth’s care.

SSS-DT-4.6

The program staff inform children or youth and parents/caregivers of the practices used to prevent crises and to intervene in crisis or risk situations.

SSS-DT-4.7

Whenever possible, at least one visit takes place at the day treatment program prior to admission.

SSS-DT-5.1

A team approach is observable through staff interaction, support and backup in the day treatment setting.
the broader multidisciplinary team.  
(Note: Only applies if the organization offers child and youth mental health day treatment.)

To achieve this standard, 2 out of 3 indicators must be met.

**SSS-DT-5.2**

Time is made available for day treatment staff to communicate regularly with other members of the multidisciplinary team in order to coordinate and implement treatment plans.

**SSS-DT-5.3**

Ongoing communication and team building is fostered through activities such as staff meetings, communication books, supervision, case reviews and team retreats.

**SSS-DT-6.1**

Day treatment staff have regular, scheduled supervision to address clinical, program and learning issues.

**SSS-DT-6.2**

Day treatment staff participate in mandatory training that includes first aid and cardiopulmonary resuscitation, in addition to crisis intervention and safety planning for children and youth presenting risk.
**SSS-DT-6.3**

Day treatment staff participate in ongoing learning and skill development relevant to their role and to the needs of the children or youth served.

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**SSS-DT-7.1**

Discharge planning begins as early as possible.

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**SSS-DT-7.2**

To achieve this standard, 3 out of 4 indicators must be met.

**SSS-DT-7.3**

Staff understand and work with the child’s or youth’s separation issues to facilitate a therapeutic discharge process.

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**SSS-DT-7.4**

Whenever possible, there is at least one visit for the child or youth to the new school placement prior to the transition.
Whenever possible, there is at least one contact prior to discharge between day treatment staff and the person(s) who will work with the child or youth after discharge from day treatment to inform them about the treatment the child or youth has received and to support the transition.

**Component: Treatment Foster Care**

This component only applies if the organization offers child and youth mental health treatment foster care.

**MAN Standard**

**SSS-TFC-1**

Treatment foster parents are trained to understand and meet the treatment needs of the children or youth served. (Note: Only applies if the organization offers child and youth mental health treatment foster care.)

To achieve this standard, 4 out of 4 indicators must be met.

**SSS-TFC-1.1**

Initial training that focuses on the treatment needs and behaviours of the children or youth served is provided to treatment foster parents.

**SSS-TFC-1.2**

Treatment foster parents receive ongoing children's mental health education regarding a broad range of topics including:

- Specific children's mental health disorders
- Effects of abuse and trauma
- Attachment issues/loss and grieving
- Lifestyle balance/well-being
- Specialized parenting skills/behavioural interventions for children with significant mental health problems

**SSS-TFC-1.3**

Treatment foster parents have access to written information about children's mental health problems and intervention strategies.
SSS-TFC-1.4
Required

Clinical staff are available to consult with treatment foster parents to provide support, information and coaching as required.

SSS-TFC-2.1

Treatment foster parents receive regular clinical support from the organization’s clinical staff.

SSS-TFC-2.2

A 24-hour on-call service is available.

SSS-TFC-2.3

A crisis plan, which may include respite, is developed.
SSS-TFC-2.4

The development of formal and/or informal support networks among treatment foster parents at the organization and beyond is actively fostered by the organization’s staff and management.

SSS-TFC-2.5

Feedback to treatment foster parents is provided regularly.

SSS-TFC-3.1

Clinical resources from the professional disciplines necessary to meet their assessment and treatment needs are available to all children and youth and, as appropriate, their families.

To achieve this standard, 3 out of 4 indicators must be met.

SSS-TFC-3.2

A professional staff member is designated as a case manager/service coordinator for each child or youth.
**SSS-TFC-3.3**

Professional staff in the treatment foster care program are assigned a limited number of cases.

**SSS-TFC-3.4**

The treatment needs of the children or youth served, the level of intensity of services required, as well as the skills and experience of the treatment foster parents determine and limit the number of children placed in each home.

**SSS-TFC-4.1**

Clinical support is provided to assist children or youth during transitions.

**SSS-TFC-4.2**

The views, preferences, cultural and spiritual needs of the child or youth are identified before admission and are accommodated whenever possible.
SSS-TFC-4.3
Where respite is available, planning takes place to ensure that the child or youth is familiarized with all eligible respite providers and that respite providers can provide the level and type of care required by the child or youth.

SSS-TFC-4.4
Discharge planning begins as soon after placement as possible and at least one visit to the new living situation takes place before discharge, where appropriate and possible.

Component: Residential
The component only applies if the organization offers a child and youth mental health residential program.

MAN Standard

SSS-RES-1
The organization has a comprehensive system to promote the use of positive, safe methods to intervene in crisis situations with children or youth at high risk in residence. (Note: Only applies if the organization offers a child and youth mental health residential program.)

To achieve this standard, 3 out of 3 indicators must be met.

SSS-RES-1.1
Required
Written policies and procedures provide clear direction when significant risk factors are identified and they cover expectations regarding multidisciplinary consultation, communication with parents/caregivers, child welfare and police or other authorities.

SSS-RES-1.2
Required
All residential staff participate in training and ongoing education with an emphasis on:

- Identification of risk factors (for example, suicide/self-harm, stalker threatening security of the residence) and development and implementation of safety plans - Crisis prevention and de-escalation - Strategies to avoid restraints, when possible, and safe and appropriate use of physical restraints (when warranted) - Debriefing
processes to be used following a crisis

<table>
<thead>
<tr>
<th>LP Standard</th>
<th>SSS-RES-2</th>
</tr>
</thead>
</table>

The residential program provides a supportive milieu that is designed to meet the needs of the children or youth served. (Note: Only applies if the organization offers a child and youth mental health residential program.)

To achieve this standard, 3 out of 4 indicators must be met.

<table>
<thead>
<tr>
<th>SSS-RES-1.3</th>
<th>Required</th>
</tr>
</thead>
</table>

There is a 24-hour on-call service available to support residential programs.

<table>
<thead>
<tr>
<th>SSS-RES-2.1</th>
<th>Staff implement practices that demonstrate the program philosophy or approach.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SSS-RES-2.2</th>
<th>Structured group and individual intervention activities are evident and take place at a level of intensity appropriate to client needs.</th>
</tr>
</thead>
</table>

Note: A document is optional. It is suggested the organization may wish to provide a schedule of activities.
SSS-RES-2.3

A balance between intervention activities, work, play, structured and free activities, privacy and group involvement is evident.

Note: A document is optional. It is suggested the organization may wish to provide a schedule of activities.

SSS-RES-2.4

Efforts to safeguard confidentiality and privacy are demonstrated, particularly in view of the group living situation.

SSS-RES-3.1

Staff work “moment to moment” with children or youth, using situations that arise in daily living and in the therapeutic milieu as opportunities to intervene.

(Note: Only applies if the organization offers a child and youth mental health residential program.)

To achieve this standard, 3 out of 4 indicators must be met.

SSS-RES-3.2

Staff promote the assimilation of learning and transference to future situations.
SSS-RES-3.3

Staff demonstrate proficiency in applying behaviour techniques appropriate to the child’s or youth’s development and level of understanding (such as use of the environment, social reinforcement, cueing, encouraging, structuring rules and routines, applying natural and logical consequences, negotiating and restorative approaches).

SSS-RES-3.4

The physical environment is set up to promote opportunities for learning and growth.

SSS-RES-4

Whenever possible, admission takes place in a manner that promotes continuity of services. (Note: Only applies if the organization offers a child and youth mental health residential program.)

To achieve this standard, 5 out of 7 indicators must be met.

SSS-RES-4.1

Admission to residence takes place on a planned basis, whenever possible.

SSS-RES-4.2

The child’s or youth’s transition to the residence is managed with sensitivity, respect, transparency and, as far as possible, in a manner that reflects the preferences of the child or youth and parents/caregivers.
SSS-RES-4.3

Staff understand and work with the separation issues present for children or youth moving into a residential setting.

SSS-RES-4.4

Relevant history, assessment findings and known risk factors are communicated to residential staff in a timely manner, preferably prior to admission.

SSS-RES-4.5

A primary worker, case coordinator or primary contact person is responsible for the child’s or youth’s care.

SSS-RES-4.6

The program staff inform children or youth and parents/caregivers of the practices used to prevent crises and to intervene in crisis or risk situations.
SSS-RES-4.7

Whenever possible, at least one visit takes place at the residence prior to admission.

SSS-RES-5.1

A team approach is observable through staff interaction, support and backup in the residential unit.

SSS-RES-5.2

Time is made available for residential staff to communicate regularly with other members of the multidisciplinary team (as applicable) to coordinate and implement intervention/treatment plans.

SSS-RES-5.3

Ongoing communication and team building are fostered through activities such as shift change discussions, staff meetings, communication books, supervision, case reviews and team retreats.

SSS-RES-6.1

A primary worker, case coordinator or person with a similar role is assigned to each child or youth.
SSS-RES-6.2

Continuity of care is accommodated to the extent possible through the shift schedule. For time-limited residential programs (for example, crisis, short-term shelter) this indicator may be not applicable.

SSS-RES-7.1

Residential staff participate in mandatory training that includes first aid, cardiopulmonary resuscitation and health needs of residents, in addition to crisis intervention and safety planning for children and youth presenting risk.

SSS-RES-7.2

Residential staff participate in ongoing learning and skill development relevant to their role and to the needs of the children or youth served.

SSS-RES-8.1

Discharge planning begins as early as possible.
SSS-RES-8.2

Staff understand and work with the child’s or youth’s separation issues to facilitate a therapeutic discharge process.

SSS-RES-8.3

Whenever possible there is at least one visit for the child or youth to the new living situation prior to the transition.

SSS-RES-8.4

Whenever possible, there is at least one contact prior to discharge between residential staff and the person(s) who will work with the child or youth after discharge from residence to inform them about the treatment the child or youth has received and to support the transition.

SSS-RES-8.5

For youth who will be living independently after discharge, the transition plan focuses on development of an individualized support network for the youth and provides information and support regarding employment, education, housing, budgeting, the legal system and how to access social services.