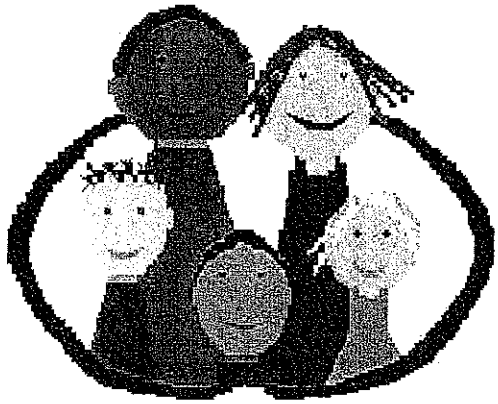
Program Overview

Project SAFE



RSVP/RCM

Recovery Specialist Voluntary Program

Recovery Case Management Services

Staff Handbook

Advanced Behavioral Health, Inc.
213 Court Street
Middletown, CT 06457

Project SAFE
Recovery Specialist Voluntary Program
Recovery Case Management Services
Employee Handbook

Table of Contents

I. Program Overview

II. Documentation

III. Forms

IV. Policies and Procedures

V. Client Drug Screening Protocol (RSVP)

VI. Information on Substance Abuse

VII. Understanding DCF

VIII. Understanding the Juvenile Court Process

IX. Resources

X. Lead Recovery Specialists

XI. Case Management Liaison

XII. Project SAFE

XIII. Workforce Development

XIV. Other

Project SAFE

Recovery Specialist Voluntary Program
Recovery Case Management

Program Overview

This handbook is designed to provide general information and serve as a guide for Project SAFE's Recovery Specialist Voluntary Program (RSVP) and Recovery Case Management Services (RCM). These guidelines endorse how employees are expected to perform their job as Recovery Specialists (RS) and Recovery Case Managers (RCM) and what can be expected from supervisors. Some parts of this handbook are applicable to both RSVP and RCM, others are specific to one program or the other. This handbook should be used in conjunction with ABH's Employee Handbook.

I. Advanced Behavioral Health (ABH):

Advanced Behavioral Health, Inc., (ABH) is a nonprofit, behavioral health care company. Incorporated in 1995, ABH designs and implements innovative managed care delivery models and behavioral health information technology to enhance service delivery. ABH recognizes that our successful collaboration with the provider community, state agencies, and others helps to develop client-focused solutions and improve the delivery of behavioral health care services. ABH's mission is:

"To manage and provide a continuum of behavioral health care and related services that ensures high quality, accessible, cost-effective services that improve the quality of life for those served."

II. Project SAFE:

The Department of Children and Families (DCF) began funding Project SAFE (Substance Abuse Family Evaluation) at ABH in 1995 to coordinate central intake and priority access to drug screening, evaluation, and ambulatory treatment for primary caregivers involved in child protective services who were suspected of abusing substances. DCF began collaborating with the Department of Mental Health and Addiction Services (DMHAS) in October 1999 to identify and effectively address substance abuse issues and to connect its child protection system with the adult substance abuse treatment system. Project SAFE provides:

- Statewide priority access to drug screening, substance abuse evaluations and outpatient treatment services
- Statewide 24 hour 1-800 line to process referrals for services to participatory providers
- Centralized administrative services including: intake and referral, data collection, utilization, financial reporting, and electronic claims processing

Clients are eligible for Project SAFE services if they meet the following criteria:

- Parent or Primary Caregiver (can be an individual under 18 years old)
- DCF has completed a Substance Abuse Screen, and suspects that a substance abuse problem may be affecting the ability to parent effectively;
- Referral made by DCF Social Worker for Project Safe Services

A. Project SAFE Program Structure/Staffing

ABH CEO/Project SAFE Director – Sam Moy, Ph.D.

Project SAFE Assistant Program Director – Holly Hassett, MA, MA, NCC, LPC

- **ABH Call Center**
  - **Project SAFE Intake Coordinators** (PS Referral Line 1-800-272-0097)
- **Project SAFE Utilization Management** – Ellie Quinn, LCSW
- **Recovery Specialist Voluntary Program (RSVP) Pilot Sites**
  - Bridgeport
  - New Britain
  - Norwalk
  - Willimantic
- **Recovery Case Management Services (RCM) Sites**
  - Bridgeport
  - Middletown
  - New Britain
  - Norwalk
  - Norwich
  - Willimantic

B. RSVP/RCM

RSVP/RCM exist to support parents/caregivers with substance abuse problems involved in the child welfare system by:

- Removing barriers to AOD treatment
- Facilitating entry into treatment
- Supporting and encouraging parents to complete treatment
- Supporting and encouraging parents to increase their recovery capital

1. Recovery Specialist Voluntary Program (RSVP)

RSVP was developed through collaboration between CT's Department of Children and Families (DCF), Department of Mental Health and Addiction Services (DMHAS) and the Judicial Branch with support from an In Depth Technical Assistance (IDTA) Grant received from The National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is an initiative of the Department of Health and Human Services and jointly funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Administration on Children,

Youth and Families (ACYF), Children's Bureau's Office on Child Abuse and Neglect (OCAN) The RSVP program is being administered by Advanced Behavioral Health, Inc.

RSVP is a free, voluntary program for parents/caregivers who have had a child removed by an Order of Temporary Custody (OTC) and need support for recovery from drug and/or alcohol abuse. Implemented in the Spring of 2009, RSVP is being piloted in three Connecticut areas – Bridgeport, New Britain, and Willimantic In December, 2010, Norwalk was added as an RSVP site. The anticipated length of stay is 6 – 9 months

2. Recovery Case Management Services

Recovery Case Managers provide in home, community based services to engage and retain clients in services, provide recovery supports, coordinate services, and support clients in increasing her/his recovery capital. RCM services are available for parents/caregivers with a current or history of substance abuse problems that are referred by the Bridgeport*, Middletown, New Britain*, Norwalk*, Norwich, and Willimantic* DCF offices. The average length of stay is six to nine months

*RCM availability is affected by the RSVP census in these sites.

3. RSVP/RCM Staffing

- **Project SAFE Assistant Program Director** – Manages RSVP/RCM and assists with the management of Project SAFE.

- **Case Management Liaison (CML)**
  The Case Management Liaison oversees various technical and administrative activities that support Project SAFE's RSVP and RCM Programs and performs quality assurance activities related to these programs.

- **Lead Recovery Specialists (LRS)**
  The Lead Recovery Specialists (LRS) are responsible for supervising a local team of Recovery Specialists (RS) whose primary goal is to help clients overcome barriers to engaging in substance abuse services and to support them in complying with the requirements of the RSVP/RCM program. The LRS is responsible for day to day supervision related to all cases assigned to RS within the team. The LRS will oversee and monitor case management activity of all client cases within the region, working closely with the Case Management Liaison (CML) and Assistant Program Director. The LRS serves as a primary contact with regional behavioral health providers, regional DCF offices, and the local juvenile courts and is also responsible for a small caseload of active cases.

- **Recovery Specialists (RS)**
  Recovery Specialists facilitate the parent's engagement and participation in substance abuse treatment and recovery. The RS will submit regular reports to the Court, DCF, attorneys of record and treatment providers on the client's participation with the program. The RS will attend all court proceedings and DCF meetings related to the case

The primary responsibilities of the Recovery Specialists are to:

- Assist parents in engaging in SA treatment
- Conduct random drug screens
- Support parents in increasing their recovery capital through recovery 'coaching'
- Provide regular documentation to DCF, courts, and attorneys

- **Recovery Case Managers/Bilingual Recovery Case Manager (RCM)**
  Recovery Case Managers focus on supporting the individuals referred to engage with treatment, build/enhance their recovery capital, and/or link with needed supports The primary responsibilities of the RCMs are to:

  - Assist parents in engaging and remaining engaged in SA treatment
  - Support parents in increasing their recovery capital through recovery 'coaching'
  - Provide regular documentation to DCF

In the RSVP pilot sites, staff are cross trained to provide both RSVP and RCM services.

E. RSVP/RCM Teams

1. **Bridgeport/Norwalk (RSVP/RCM)**
   - Lead Recovery Specialist
     - Recovery Specialist/Recovery Case Manager - Bridgeport
     - Bilingual Recovery Specialist/Recovery Case Manager – Norwalk

2. **Middletown (RCM)**
     - Recovery Case Manager
     - Recovery Case Manager

3. **New Britain (RSVP/RCM)**
   - Lead Recovery Specialist
     - Bilingual Recovery Case Manager/Recovery Specialist
     - Recovery Case Manager/Recovery Specialist

4. **Willimantic/Norwich (RSVP)**
   - Lead Recovery Specialist
     - Recovery Specialist/Recovery Case Manager - Willimantic
     - Recovery Specialist/Recovery Case Manager – Norwich

Project SAFE – Outreach and Engagement Services – RSVP and RCM Staff Expectations

Recovery Specialists/Recovery Case Managers

Daily

- Check in with Team Leader (review daily schedule; problem solve urgent needs/issues; review any safety concerns)
- Update Calendar in Microsoft Outlook
- Read/respond to Email
- Conduct daily appointments/phone calls
- Document all case related activities in the database
- Review and respond to Voice Mail
- RSVP Drug Testing (M, W, F)

Biweekly

- Supervision with Lead Recovery Specialist or Project SAFE Assistant Program Director (See Case Review format)
- Threshold hours and court waiting hours (RSVP) to TL to CML on day time card due
- Submit mileage with time card to Assistant Program Director (TL will collect for each Team)

Monthly

- RSVP/RCM Staff Meetings
- RCM Monthly Updates to DCF – These should be reviewed by the Project SAFE Assistant Program Director, Lead Recovery Specialist, or designee prior to being sent to DCF
- RSVP Monthly Updates - These **must** be reviewed by the Project SAFE Assistant Program Director, Lead Recovery Specialist, or designee prior to the Case Status Conference at the court.

Other

- Complete discharge summaries on cases closed – Team Leader reviews, then notifies Case Management Liaison that there is a discharge in the database. CML reviews and notifies staff person of any documentation that needs revision; Ass't PD reviews and signs. [NOTE – Format for RSVP discharges TBD].
- Provide coverage for necessary and/or urgent tasks if co-worker out.

Team Leaders (all applicable items noted above, plus:)

Daily

- Review daily schedules and update calendar with RS/RCMs; arrange check in times throughout the day.
- Day to Day supervision of assigned staff and problem solving regarding scheduling and service delivery.

Weekly

- Primary contact person for meeting prospective RSVP clients at the court on day OTCs are heard

Project SAFE – Outreach and Engagement Services – RSVP and RCM Staff Expectations

Biweekly

- Case Review with RS (See Case Review format); document in the database – ensure that documentation is current and meets the program standards.
- Individual or Group Supervision with Project SAFE Assistant Program Director– Case Review as well as Leadership and Program Development

Other

- Contact PS Assistant Program Director immediately on any critical or safety issues.
- Contact PS Assistant Program Director as needed on pertinent issues that arise in the area.
- Coordinate with CML regarding Case Assignment
- Community Networking and Resource Development, particularly with the local DCF office and local Superior Court for Juvenile Matters
- Identification of unmet needs and systems issues
- Provide back up coverage for RS
- Track data requested by PS Assistant Program Director
- Ensure office is organized and conducive to a positive working atmosphere.
- Anticipate supply needs, particularly with regard to RSVP drug testing, and notify PS Assistant Program Director when supplies need to be ordered
- Review RS/RCM documentation of cases and discharges
- Assist with orientation of new staff

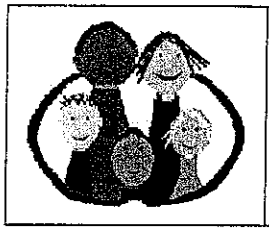
Documentation

Project SAFE

RSVP/RCM Documentation

Table of Contents

I. Overview to Documentation
II. Service Plan
III. Activity Codes Defined
IV. Drop Downs for Activity Notes in Database
V. Level of care Screening Criteria
VI. Database Screen Prints



Project SAFE

Project SAFE's RSVP/RCM Services Overview to Documentation/Case Files

Recovery Specialists (RS) and Recovery Case Managers (RCM) will use the following guide in documenting their work with clients:

I. CLIENT FILE

A hard copy file of each client will be kept in a secure file cabinet at the office. Discharged cases will be archived on site as space permits. Each file will contain the following documents:

All charts:

- Project SAFE referral
- All Release(s) of Information (ROI)
- Informed consent signed by the client
- Service Plan (signed by client and RS/RCM)
- Copy of any correspondence to the client and/or DCF and/or collaterals
- Receipt of Privacy Practices (signed by the client)

RSVP only:

- Signed Copy of RSVP Client Agreements (court and program)
- Copy of specific court steps
- Copies of Alcohol and Drug Testing results
- Copies of RSVP reports for Case Status Conferences
- Copy of RSVP Drug Testing Agreement
- Verification of Treatment Attendance and Self Help Groups
- Copies of Certificates given to clients for 90 day/180 day Full Compliance

II. DATABASE

The majority of the RSVP/RCM documentation is entered in Project SAFE's Outreach and Engagement Services database. This includes the following information:

A. Demographic info

These fields are populated with information obtained when the Project SAFE referral was made; RS/RCM will update this information (e.g., change in address or DCF SW) as changes occur

B. Intake

The RS/RCM enters in the data base information gathered from the client at intake.

C. Screening

Completed at Intake, then every 30 days and at discharge

D. Service Plans

- Goals identified should include the reason the client was referred as well as her/his identified goals. Goals should be measurable, observable, realistic, relevant, and appropriate.
- Goals for RSVP clients should reflect the requirements of the phase of the program s/he is in.
- Service plans should be printed out and signed by the RS/RCM and client. A copy should be given to the client and one kept in the client's file.
- Goals can, ***and should***, be revised as needed
- Completed goals should indicate the date completed.

E. Activity Log/Progress Notes

- All activities should be entered within 48 hours
- DAP format for progress notes
  - Data - *(Client's self-report, observations, interventions, current issues/stressors, functioning, motivation, progress as reported)*
  - Assessment - *(Progress, evaluation of intervention, obstacles or barriers)*
  - Plan - *(Current plan, i.e., tasks to be completed between sessions, objectives for next session, changes, recommendations, date of next session, plan for termination, etc.)*
- List each activity and # of units (15 minute increments), including Supervision/Case Review with Lead Recovery Specialist or Assistant Program Director.

F. RCM Monthly Updates (*see format attached*)

- Completed every Month as long as the case is open with DCF.
- Log time to complete report under Activities as "DCF Contact"
- Save in the Department Drive under the appropriate RCM site's folder, e.g., Middletown/Omar/Client (name and date)
- Once reviewed by the supervisor, the RCM will send/deliver updates to DCF
- If DCF closes the case prior to RCM closing the case, monthly updates are not needed for the time period from DCF closure until RCM discharge

G. RSVP Updates

- Prepared for Case Status Conferences (initial at 2 weeks, then every month)
- Log time to complete report under Activities as "Court Contact"
- Until the reports are automated, save in the Department Drive under the appropriate RSVP site's folder, e.g., Bridgeport/Greg/Client (last name and date)
- Once reviewed by the supervisor, the RS will make copies and bring to the Case Status Conference
- When there is a significant gap between case status conferences, the RS should provide DCF and the CSO with copies of the monthly update between CSCs

H. Supervision/Case Review

- LRS/Assistant Program Director documents regularly scheduled case reviews/supervision with the RS/RCM under the Supervision/Case Review tab, including brief update on recommendations and directives made to RS/RCM.
- LRS/Assistant Program Director will add a case review note when an urgent situation or potential safety issue is discussed with staff.

I. Discharge from RCM/RSVP

When a client is discharged, the RS/RCM will complete the following:

A Discharge LOC Screening

B Completion of the Service Plan, i.e., outcomes on goals

C RCM Discharge Summary
A brief summary of the case, written in complete sentences, that includes:

- The reason that the client was referred to RCM
- Any barriers the client had to completing prior referrals to Project SAFE.
- The client's progress on, or completion of, goals for which s/he was referred and O/E involvement in this.
- The outcomes of any other service plan goals and RCM assistance with these.
- Recommendations at discharge.
- Signature, credentials and title of the RCM

D. RSVP discharge
   - o Brief summary of client's participation with RSVP and progress toward goals
   - o Reason for discharge
   - o Any Recommendations
   - o Signature, credentials and title of the RS

Once the RSVP/RCM discharge is completed, the LRS or Assistant Program Director (Middletown) will review the discharge information and then inform the Case Management Liaison that there is a discharge. The CML will review the discharge summary prior to the final review and signature by the Assistant Program Director.

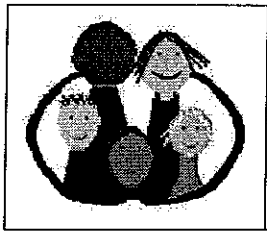
RCM Forms

RCM Services

Forms

Table of Contents

- Notice of Privacy Practices (English)
- Notice of Privacy Practices (Spanish)
- ABH Consent to Services
- Information Sheet for Intake
- Release of Information (English)
- Release of Information (Spanish)
- Verification of Treatment Attendance (monthly)
- Support Group Verification Form
- Monthly Update to DCF
- Client Satisfaction Survey
- DCF Satisfaction Survey
- Provider Survey
- Certificate of Completion
- Introduction Letter (English and Spanish)
- No Contact Letter (English and Spanish)
- RCM Hard Copy of Chart set up



Project SAFE

Recovery Case Management Program (RCM)

Participant Guidelines and Agreement

The Recovery Case Management Program (RSVP) is designed to support you in your recovery, assist you in getting into substance abuse treatment, and monitor your progress and success.

RCM is funded by the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS) and administered by Advanced Behavioral Health, Inc. The release of information you have signed to enter this program allows RCM staff to speak with your treatment provider and DCF to coordinate services and to report on your progress in RCM to DCF.

As an RCM participant, you have the following responsibilities: *(Please check that you have read and understand each of these):*

- ☐ I will be honest with RCM staff.
- ☐ I will maintain regular contact with my RCM.
- ☐ I will contact my RCM in a timely manner if I will not be available for an appointment.
- ☐ I will notify my RCM of any changes in where I live, my phone number, and/or legal status.
- ☐ I understand that it is my responsibility to report for treatment to the provider DCF has referred me to. If I need assistance in getting to treatment, I will let my RCM know.
- ☐ If I feel that I need more intensive treatment, or my treatment provider recommends a higher or different level of care, I will work with my treatment provider and my Recovery Case Manager to connect with these services.
- ☐ I understand that my RCM will provide monthly reports on my participation with RCM and my attendance at treatment to my DCF Social Worker.

_____ _____

RCM Participant Date

As your Recovery Case Manager, I will do my utmost to:

- ☐ Treat you with respect and dignity at all times.
- ☐ Provide guidance and support to you in your efforts to comply with your treatment program and RCM requirements.
- ☐ Respond to your needs and questions in a timely and professional manner.
- ☐ Be respectful of your time and contact you if I need to reschedule an appointment.
- ☐ Support you in your recovery.

_____ _____

RCM Recovery Case Manager Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CALL ADVANCED BEHAVIORAL HEALTH INC. AT (860) 638-5309 TO SPEAK WITH OUR PRIVACY OFFICER.

ADVANCED BEHAVIORAL HEALTH

Middlesex Corporate Center
213 Court Street
Middletown, CT 06457

Phone: 860.638.5309
Facsimile 860.638.5302

www.ABHCT.com

ABH has adopted the following policies and procedures for protection of the privacy of the people we serve.

Our Obligation to You

We at ABH respect your privacy. We are required by law to maintain the privacy of "protected health information" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected health information" means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use and Disclosure of Information about You

In the course of the activities that ABH performs, there may be times when it is necessary to use and disclose information about you to other persons or agencies. The purpose of this disclosure may be to assist you in accessing or receiving treatment services, to help arrange for payment of services for you, or as necessary to perform the operations of our company.

It is our policy to obtain specific written permission for any disclosure of protected health information to third parties. You will be asked to sign an Authorization or Release of Information form for disclosure to each person or organization that receives the information.

Here are some examples of how and when we might use and disclose your protected health information to others as necessary without your written consent:

- If there is an emergency, we will disclose your protected health information as needed to enable people to care for you.
- Various members of our staff may see your clinical record in the course of our providing service to you. This includes licensed behavioral health professionals, physicians and administrative support staff.
- We may contact you to remind you of appointments.
- We may contact you to tell you about treatment services that we offer that might be of benefit to you.
- We may provide limited information to a treatment provider in order to arrange for a referral or clinical consultation.

- We are legally obligated to disclose protected health information to certain government agencies, including the federal Department of Health and Human Services.

- It may also be necessary to use or disclose protected health information for our health care operations. For example, our quality assurance staff reviews records to be sure that we deliver appropriate treatment of high quality. Your health plan may wish to review your records to be sure that we meet national standards for quality of care.

- We will disclose protected health information as needed to comply with state law requiring reports of suspected incidents of abuse or neglect of a child, elderly or disabled person.

- We will use or disclose your protected health information as needed to arrange for payment for service to you. For example, information about your diagnosis and the service we render is included in the information that we submit to the State agency or health plan. The State agency or health plan may require health information in order to confirm that the service rendered is covered by your benefit program and medically necessary.

- There are other circumstances in which we may be required by law to disclose protected health information without your permission. They include disclosures made:
    - Pursuant to court order;
    - To public health authorities;
    - To federal officials for lawful military or intelligence activities;
    - To researchers involved in approved research projects; and
    - As otherwise required by law.

We will follow the provisions of Federal confidentiality laws (42 CFR, Part 2) governing disclosure of protected health information. Except for the circumstances described above, we will not disclose protected health information to a third party without your written permission of the individual or a court order. If a request for disclosure of your patient record is received, you will be contacted and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you, we will not disclose your information without a court order.

There may be situations where we will need to provide your protected health information to a third party to arrange for treatment or payment for services provided to you. Here are some examples of situations which will require your written consent before disclosure is made:

- We may disclose protected health information to a health care provider such as a hospital or community-based clinic in order to arrange for treatment or for payment for the services provided to you.

- If you are an adult, emancipated minor, or, in some cases, a minor over the age of 14, you have the right to control disclosure of information about you to any other person, including family members or friends. No disclosure of information will be made to family members or friends unless you specifically provide written permission for us to do so.

Your Legal Rights

Right to request confidential communications. You may request that communications to you, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide us with a way to contact you.

Right to request restrictions on use and disclosure of your information. You have the right to request restrictions on our use of your protected health information for particular purposes, or our disclosure of that information to certain third parties. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to revoke a Consent or Authorization. You may revoke a written Consent or Release of Information for us to use or disclose your protected health information. The revocation will not affect any previous use or disclosure of your information.

Right to review and copy record. You have the right to see records used to make decisions about you. We will allow you to review your record unless a clinical professional determines that this would create a substantial risk of physical or emotional harm to you or someone else. If another person provided information about you to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information about other people.

At your request, we will make a copy of your record for you. We will charge a reasonable fee for this service.

Right to "amend" record. If you believe your records contain an error, you may ask us to amend it. If there is a mistake, a note will be entered in the record to correct the error. If not, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.

Right to an accounting. You have the right to an accounting of some disclosures of your protected health information to third parties. This does not include disclosures that you authorize, or disclosures that occur in the context of treatment, payment or health care operations. We will provide an accounting of other disclosures made in the preceding six years, beginning April 14, 2003. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

Right to a paper copy of this Notice. You have the right to a paper copy of any Notice of Privacy Practices posted on our web site.

How to Exercise Your Rights

Questions about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our staff by calling (860) 638-5309. Your call will be directed to staff associated with the ABH contract providing services to you, or to the Privacy Officer.

Personal representatives. A "personal representative" of a patient may act on their behalf in exercising their privacy rights. This includes the parent or legal guardian of a minor. In some cases, adolescents who are "mature minors" may make their own decisions about receiving treatment and disclosure of protected health information about them. If an adult is incapable of acting on his or her own behalf, the personal representative would ordinarily be his or her spouse or another member of the immediate family. An individual can also grant another person the right to act as his or her personal representative in an advance directive or living will.

Disclosure of protected health information to personal representatives may be limited in cases of domestic or child abuse.

Complaints

If you have any complaints or concerns about our privacy policies or practices, please submit a Complaint to our Privacy Officer either by phone at (860) 638-5309 or by mail to:

Advanced Behavioral Health, Inc.
213 Court Street, 10th floor
Middletown, CT 06457
Att: Privacy Officer

If you wish, any staff member of ABH will give you a form that you can use to submit a Complaint.

You can also submit a complaint to the United States Department of Health and Human Services. Send your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
Government Center
J. F. Kennedy Federal Building
Room 1875
Boston, MA 02203
Voice: 1-617-565-1340
Fax: 1-617-565-3809
TDD: 1-617-565-1343

We will never retaliate against you for filing a complaint.

Policy Review and Change

ABH privacy practices are reviewed regularly to ensure compliance with all State and Federal regulations. We reserve the right to change our practices and to make the new provisions effective for all health information we maintain and collect. If changes to our privacy practices are made, we will make revisions available to you by posting it in our office and on our website at www.abhct.com. You may also contact us to request a mailed copy of the current practices.

Advanced Behavioral Health, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Advanced Behavioral Health, Inc.(ABH).

_____ _____

Signature Date

_____

Print Name

Notificación de prácticas de protección de la privacidad

ESTA NOTIFICACIÓN DESCRIBE CÓMO SU INFORMACIÓN MÉDICA PERSONAL CONFIDENCIAL PODRÍA SER UTILIZADA Y REVELADA, Y LAS FORMAS MEDIANTE LAS CUALES USTED PODRÁ TENER ACCESO A DICHA INFORMACIÓN. FAVOR DE LEERLA CON TODO ATENCIÓN. SI TIENE ALGUNA PREGUNTA ACERCA DE ESTA NOTIFICACIÓN, FAVOR DE LLAMAR A ADVANCED BEHAVIORAL HEALTH INC. AL (860) 638-5309, PARA HABLAR CON NUESTRO FUNCIONARIO DE PROTECCIÓN DE LA PRIVACIDAD (PRIVACY OFFICER).

ABH ha adoptado las siguientes normas y procedimientos para la protección de la privacidad de los pacientes a los que sirve.

Nuestro compromiso con usted

En ABH respetamos su privacidad. Las leyes nos requieren mantener la confidencialidad de su información médica y la de todos nuestros pacientes, y de informarle acerca de nuestros deberes y sus derechos, así como acatar las normas de protección de su privacidad contenidas en esta notificación. "Por "información médica" deberá entenderse cualquier información originada o recibida en esta institución, que pueda identificarle o se relacione con su salud o el pago por servicios a su favor.

Uso y divulgación de información acerca de usted

En el desempeño de sus funciones, habrá ocasiones en que ABH tendrá que usar y revelar información acerca de usted a otras personas o agencias. El propósito de esta declaración es facilitar el recibo de sus tratamientos, ayudarle a hacer arreglos de pago por servicios prestados a usted, o cuando corresponda, durante las operaciones propias de esta empresa.

Es nuestra norma obtener permisos específicos por escrito antes de transmitir a terceros cualquier información médica confidencial. Se le pedirá firmar una autorización de divulgación de su información médica, antes de que la transmitamos a terceros

He aquí algunos ejemplos de cómo y cuándo podríamos utilizar y revelar a otros su información médica confidencial, en caso de necesidad, sin su consentimiento escrito:

* En caso de emergencia, transmitiremos su información médica confidencial en la medida de lo necesario, a los encargados de tratar su caso

* Ciertos miembros de nuestro personal podrían tener acceso a su expediente médico durante la prestación de sus servicios a usted. Esto incluye a profesionales licenciados en el campo de la salud mental, a médicos y a personal auxiliar administrativo.

* Podríamos contactarle para recordarle sus citas médicas.

* Podríamos contactarle para hablarle acerca de tratamientos ofrecidos por nosotros, que podrían ser de beneficio para usted.

* Podríamos informarle acerca de proveedores de tratamientos, a fin de hacer arreglos para un referimiento o una consulta clínica.

* Estamos legalmente obligados a revelar su información médica confidencial a ciertas agencias del gobierno, incluyendo al Departamento federal de salud y servicios humanos (Department of Health and Human Services).

* Podría también resultar necesario hacer uso o revelar su información médica confidencial, en el curso de nuestras actividades u operaciones normales de asistencia médica. Por ejemplo, nuestro personal de control de calidad revisa los expedientes para asegurarse de que estamos prestando tratamientos del más alto nivel. Su seguro de salud podría desear examinar su expediente para asegurarse de que llenamos los requisitos nacionales de calidad en la prestación de servicios médicos.

* Revelaremos su información médica confidencial en la medida de lo necesario, en cumplimiento de la legislación estatal que requiere informes acerca de posibles incidentes de maltrato o negligencia contra niños, ancianos o discapacitados.

* Utilizaremos o revelaremos su información médica confidencial, en la medida de lo necesario, a fin de hacer los arreglos de pago por los servicios prestados a usted. Por ejemplo, la información acerca de su diagnóstico y el servicio prestado a usted será incluida en los datos entregados a la agencia estatal o al seguro de salud. La agencia estatal o el seguro podrán requerir dicha información médica para confirmar que el servicio prestado está cubierto por su seguro, y es medicinalmente necesario.

* Podría haber otras circunstancias en las que podríamos vernos legalmente obligados a revelar, sin su permiso, su información médica confidencial. Éstas incluyen revelaciones hechas:
* Por orden judicial;
* A las autoridades de salud pública;
* A funcionarios federales, en sus actividades legítimas militares o de inteligencia;
* A investigadores que participen en proyectos de investigación aprobados; y
* Cuando las leyes así lo requieran.

Acataremos las disposiciones de la legislación federal (42 CFR, Parte 2), que rige la revelación de información médica confidencial. Salvo en los casos indicados anteriormente, no revelaremos a terceros su información médica confidencial sin su permiso escrito o una orden judicial. De recibirse una solicitud de envío de su expediente médico, será contactado y se le pedirá el permiso de autorización de la revelación. Si se niega a autorizar la revelación, o si no podremos contactarle, no revelaremos su información sin una orden judicial.

Puede que haya situaciones en las que tendremos que revelar a terceros su información médica confidencial, a fin de hacer arreglos de tratamientos o pagos por servicios prestados a usted. He aquí algunos ejemplos de situaciones que requerirán su consentimiento escrito antes de cualquier revelación de nuestra parte:

* Podremos revelar información médica confidencial acerca de usted a proveedores de servicios de salud, como hospitales o clínicas comunitarias, para hacer arreglos de tratamientos o pagos por servicios prestados a usted.

* Si usted es un adulto, menor emancipado o, en algunos casos, un menor mayor de 14 años, tendrá el derecho a fiscalizar la revelación de su información médica confidencial a cualquier otra persona, incluyendo parientes y amigos. No revelaremos información acerca de usted a parientes o amigos, a menos que usted explícitamente lo permita por escrito.

Sus derechos ante la ley

Derecho a exigir confidencialidad en sus comunicaciones. Podrá solicitar que cualquier comunicación dirigida a usted, como, por ejemplo, recordatorios de citas médicas, facturas, o explicación de los beneficios de su seguro, le sea transmitida en forma confidencial. Haremos los arreglos para complacerle, siempre y cuando nos facilite la información necesaria para contactarle.

Derecho a exigir restricciones en cuanto al uso y revelación de su información médica. Tendrá derecho a exigir restricciones en cuanto a nuestro uso de su información médica confidencial en ciertos determinados

casos, o transmisión por parte nuestra de dicha información a terceros. No estaremos obligados a cumplir con las restricciones que usted pueda solicitar, aunque consideraremos sus solicitudes

Derecho a revocar una declaración de consentimiento o autorización. Podrá revocar un consentimiento en el que nos haya permitido el uso y revelación de su información médica confidencial. La revocación no afectará los usos o revelaciones antes permitidos por usted.

Derecho a examinar y copiar su expediente. Usted tiene el derecho a examinar los expedientes utilizados en la toma de decisiones que puedan afectarle. Le permitiremos examinar su expediente, a menos que un clínico profesional determine que ello crearía un serio peligro físico o emocional para usted o cualquier otra persona. Si otra persona aportó información acerca de usted a un empleado nuestro, bajo condiciones de estricta confidencialidad, esa información podrá ser sacada de su expediente antes de ser compartida con usted. Borraremos también cualquier información médica confidencial acerca de otras personas.

Si lo solicita, haremos una copia de su expediente para usted. Cobraremos un cargo razonable por este servicio.

Derecho a enmendar su expediente. Si cree que su expediente contiene algún error, podrá solicitarnos su corrección. De haber algún error, una nota de corrección será ingresada al expediente. De lo contrario, se le avisará, y permitirá la oportunidad de agregar una breve aclaración explicando el porqué cree que el expediente es inexacto. Esta información será incluida como parte integral del expediente, y compartida con otras personas, debido a que podría influir en decisiones que podrían afectarle.

Derecho a una rendición de cuentas. Tendrá derecho a una rendición de cuentas relacionada con las divulgaciones a terceros de su información médica confidencial. Esto no incluirá las revelaciones autorizadas por usted, o las ocurridas en el contexto de sus tratamientos, pagos o pormenores de su atención médica. Ofreceremos una rendición de cuentas de otras revelaciones hechas durante los seis años anteriores, empezando por el 14 de abril del 2003. A solicitud de las autoridades policíacas que estén llevando a cabo una investigación penal, nos abstendremos de rendir cuentas de las revelaciones hechas a ellas.

Derecho a una copia impresa de esta notificación. Usted tendrá derecho a recibir una copia impresa de cualquier notificación de prácticas de respeto a la privacidad que aparezca en nuestra página Web.

Cómo ejercer sus derechos

Las preguntas acerca de nuestras normas y procedimientos, solicitudes de ejercicio de derechos individuales, y las quejas deberán ser dirigidas a nuestro personal, llamando al (860) 638-5309. Su llamada será dirigida al personal adscrito al contrato con ABH, que es el que rige los servicios prestados a usted, o al funcionario encargado de la protección de la privacidad.

Representantes personales. Los "representantes personales" de los pacientes pueden actuar en sus nombres ejerciendo su derecho a la privacidad. Esto incluye los padres o tutores legales de menores de edad. En algunos casos, los adolescentes declarados "menores maduros" podrán tomar sus propias decisiones en cuanto a tratamientos y autorizar la revelación de sus expedientes médicos confidenciales. En caso de que un adulto sea incapaz de actuar por su cuenta, su representante personal será, por lo regular, su cónyuge o cualquier otro miembro de su familia inmediata. Una persona podrá también conceder a otra persona el derecho a actuar como su representante personal, en directivas para casos de extrema gravedad o testamentos para vivientes.

La revelación de información médica confidencial a los representantes personales podrá limitarse en casos de maltrato intrafamiliar o a menores.

Quejas

Si tiene alguna queja o preocupación acerca de nuestras normas o prácticas de protección a la privacidad, favor de someterlas a la atención del funcionario encargado de la protección de la privacidad (Privacy Officer), por teléfono, llamando al (860) 638-5309, o por correo, a:

Advanced Behavioral Health, Inc
213 Court Street, 10th Floor
Middletown, CT 06457
Att: Privacy Officer

Si lo desea, cualquier miembro del personal de ABH le dará un formulario para la presentación de sus quejas.

Podrá también someter una queja ante el Departamento de salud y servicios humanos de los Estados Unidos (United States Department of Health and Human Services). Envíe su queja a:

Office for Civil Rights
U.S. Department of Health and Human Services
(Departamento de Salud y Servicios Humanos de los Estados Unidos)
Government Center
J. F. Kennedy Federal Building
Room 1875
Boston, MA 02203
Teléfono: 1-617-565-1340
Fax: 1-617-565-3809
TDD - Dispositivo de telecomunicación para sordos: 1-617-565-1343

Nunca tomaremos represalias contra usted por haber presentado una queja.

Revisiones y cambios en las normas

Las prácticas de protección de la privacidad de ABH son revisadas regularmente para asegurar su conformidad con las reglamentaciones estatales y federales. Nos reservamos el derecho a modificar nuestras prácticas y de hacer valer nuevas disposiciones con relación a la información médica confidencial que mantenemos y recibimos. De haber cambios en nuestras prácticas de protección de la privacidad, se los daremos a conocer exponiéndolos en nuestra oficina y en nuestra página Web de www abhct com Podrá también contactarnos para solicitar el envío por correo de una copia de nuestras prácticas vigentes.

Advance Behavioral Health, Inc.

Reconocimiento de Recibo de la Nota de Prácticas de Intimidad

He recibido una copia de la Nota de Prácticas de Intimidad de Advanced Behavioral Health, Inc. (ABH)

_____ _____

Firma Fecha

_____

Escriba Nombre en Letra de Molde

Advanced Behavioral Health (ABH)

Consent to Services

Subject to the statements below, I, the undersigned, hereby consent to the provision of Recovery Case Management Services and authorize Advanced Behavioral Health and its staff to use my medical, protected health information, and, if applicable, protected drug and/or alcohol abuse, confidential HIV-related and psychiatric information for the purpose of treatment, payment and health care operations. I understand that I may revoke this consent at any time, except to the extent that the program has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

_____

(Specific date or event)

_____ _____

Client Signature Date

_____ _____

Witness Date

_____ _____

Client Legal Representative (if applicable) Date

_____ _____

Print Name of Legal Representative Relationship to client

Any information released by ABH to authorized persons is subject to the following notices:

Psychiatric Information: In the event that information released or obtained constitutes confidential psychiatric information protected under Connecticut law. State law prohibits ABH from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to who it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information: In the event that information released or obtained is protected by his HHS Confidentiality of Alcohol and Drug Abuse Client Records regulation the Federal rules prohibit ABH from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV-Related Information: In the event that information released or obtained constitutes confidential HIV-related information protected under Connecticut law, State law prohibits ABH from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as other wise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PROJECT SAFE
Recovery Specialist Voluntary Program (RSVP)
Recovery Case Management (RCM) Services
Information Sheet for Intake

CLIENT: _____ **DATE:** _____

A. Current Living Environment:

With whom: _____

Length of time residence: _____

Rental Assistance/Section 8: ☐yes ☐no

Risk of Eviction?: ☐yes ☐no

B. Marital Status: ☐Cohabitating ☐Married ☐Separate ☐Divorced ☐Widowed ☐Single, Never Married

C. Education:

Highest level completed: _____

D. Current Monthly income:

Source: _____

Number of dependents: _____

E. Entitlements:

☐ Medicaid- CTBHP ☐ Title 19/ LIA
☐ Private Insurance ☐ SSD
☐ SSI
☐ Title 19/Medicaid
☐ None

F. Employment:

Currently employed? ☐yes ☐no

If yes, current position/employer _____
Number of hours/week: _____ Shift: _____
Longest length of employment _____
Ever lost a job or work opportunity due to use: ☐Yes ☐No If yes: how many? _____

Do you have any special work skills? _____

Do you have a car? ☐Yes ☐No
Do you have a valid driver's license? ☐Yes ☐No
Has your license ever been suspended? ☐Yes ☐No

G. Pertinent Medical History

Current Medical Problems? ☐Yes (explain: _____)

☐No

Currently Pregnant?: ☐Yes ☐No ☐Unknown ☐ N/A

History of, or currently receiving, mental health services? ☐Yes ☐No

If yes, Type of Mental Illness: _____

Provider/Agency: _____ Current Tx? ☐Yes ☐No
Clinician: _____
Phone: _____

Current Medications: _____

H. **Legal Information/History:**
☐Pending charges ☐Parole ☐Probation ☐Transitional Supervision ☐None

Probation/Parole contact and #: _____

# of Arrests _____ # of Convictions_____

Completed probation/parole? ☐Yes ☐No

History of violence/assault? ☐Yes ☐No

History of Domestic Violence? ☐Yes ☐No Specify Perp or Victim: _____

Attorney for DCF case: _____

I. Spirituality/ Faith Background:

Are you currently involved with a church/faith community? ☐Yes (type _____) ☐No

What spiritual/faith practices do you currently use?
- ☐ Prayer
- ☐ Going to church, synagogue, mosque, other house of faith
- ☐ Reading scripture, religious writings
- ☐ Singing in a choir
- ☐ Meditation
- ☐ Religious dance or playing religious music
- ☐ Other: _____
- ☐ None or N/A

J. Family Member Information

Children

Name		M/F	Age	Relationship	Currently living (with client, with family member, in foster care, in residential tx, etc)

Other Individuals Currently Living in the Home

Name		M/F	Age	Relationship	Comments		

Family History:

Substance Abuse: ☐yes ☐no ☐unknown

Mental Health: ☐yes ☐no ☐unknown

K. Substance Use History					
Substance	**Amt/Freq.**	**Last Used**	**Age First used**	**Route**	**Length of Use**
ETOH					
THC					
Cocaine/Crack					
Opioids					
Amphetamines					
Hallucinogens					
Inhalants					
PCP					
Sedatives					
Club Drugs					
Other					

Past SA Treatment:

Date(s)	**Provider**	**Level of Care (outpt, IOP, residential, etc.)**	**Comments**

Most recent period of sobriety: _____

Longest period of sobriety: _____When? _____

L. Client's Recovery Resources/Supports:

M. Client's Strengths:

N. Client's Goals:

O. Additional Information:

Project SAFE Program
Consent to Release and Exchange of Information and Records

I, _____, DOB:_____, ABH#_____
SS#_____, as a participant in the Project SAFE Program, understand that my case planning for child protective services, and treatment and support services will be coordinated. I authorize:

1. Advanced Behavioral Health, Inc., (ABH)
2. The Department of Children and Families, (DCF)
3. The Department of Mental Health and Addiction Services (DMHAS)
4. _____
   [**Required:** Name of treatment program making disclosure]
5. _____
   [**Address:** Address of treatment program making disclosure]

to communicate about my care with one another and to disclose to and receive from one another the following information: records accessible through the ABH, DCF, and DMHAS information systems, my name, address, age, gender, Social Security Number, mental status, psychiatric and/or substance abuse diagnoses, my reason for treatment, treatment and illness history, treatment plan, medication(s), substance(s) used, drug screen results (including urine and hair tests) clinical risk, relapse potential, legal status, progress in care, natural supports and personal strengths, the type and outcome of services I receive and such other information as is necessary to provide for case planning for child protective services and effective coordination of the treatment and services I receive (excluding HIV-related information unless such disclosure is specifically authorized by me or required by law). In addition, the following information may be disclosed:

_____
[Describe any additional information]

The purpose of the disclosure authorized herein is to facilitate case planning for child protective services, the provision, coordination and monitoring of my care and support services, and to evaluate the Project SAFE program and the care and services I receive. In addition, the disclosure is made to achieve the following purpose(s):

_____
[**OPTIONAL:** Any additional purpose of disclosure]

I understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Chapter 899 of the Connecticut General Statutes, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I have received a summary of the federal law protecting this information and a statement of the intended use of this information. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that the disclosure may occur in face-to-face contact, telephonically, via mail, and/or facsimile. Unless revoked by me, this consent shall expire **180 days** from my date of discharge from Recovery Specialist Voluntary Services (RSVP) or Recovery Case Management (RCM) services.

Date: _____ _____
(Signature of Participant)

_____
(Signature of parent, guardian or authorized representative where required)

PROHIBITION ON RESDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT
This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Proyecto SAFE

CONSENTIMIENTO A LA REVELACIÓN E INTERCAMBIO DE INFORMACIÓN Y EXPEDIENTES

Por este medio, yo, _____, Fecha de nacimiento:_____,
Número de ABH _____ Número del Seguro Social _____, en mi calidad de
(**REQUERIDOS**: Nombre del paciente, Fecha de nacimiento, Número de ABH y Número del Seguro Social)
participante del programa SAFE, entiendo que la planificación de mi caso, en cuanto a servicios de protección de la niñez, de tratamiento y soporte será coordinada. Autorizo a:

1. Advanced Behavioral Health, Inc., (ABH)
2. Departamento de niños, adolescentes y familias (Department of Children and Families (DCF)
3. Departamento de salud mental y servicios contra la adicción (Department of Mental Health and Addiction Services (DMHAS))
4. _____
   [**Requerido:** Nombre del programa de tratamientos que hace o hará la revelación]
5. _____
   [**Dirección:** Dirección del programa de tratamiento autorizado a hacer la revelación]

a comunicarse entre sí con relación a mi tratamiento e intercambiarse la siguiente información: expedientes accesibles por medio del sistema de información de ABH, DCF y el DMHAS, mi nombre, dirección, edad, género, número del Seguro Social, estado de salud mental, diagnósticos psiquiátricos y/o relacionados con la drogadicción, razones para tratarme, historial del tratamiento y la enfermedad, plan de tratamiento, medicamentos utilizados, resultados de análisis de detección de drogas (incluyendo los de orina y pelo), potencial de recaída, situación legal, progreso bajo tratamiento, soportes naturales y puntos de fuerza personales, tipo y resultados de servicios por mí recibidos y cualquier otra información necesaria para una efectiva coordinación de los tratamientos y servicios que recibo (excluyendo información relacionada con el VIH/SIDA, a menos que su revelación haya sido expresamente autorizada por mí o por las leyes vigentes). Además, la siguiente información podrá ser transmitida:

_____
[Describa la información adicional]

El propósito de la revelación de información autorizada en este documento es facilitar la prestación, coordinación y control de servicios de protección de la niñez, la prestación, coordinación y control de mis servicios de tratamiento y soporte, así como evaluar el proyecto SAFE y la calidad de servicios por mí recibidos. Además, la revelación se hará con los siguientes propósitos:

_____
[**OPCIONAL**: Cualquier razón adicional para la divulgación]

Queda entendido que mi expediente está protegido por disposiciones federales que rigen la confidencialidad de la información relacionada con el alcoholismo o el consumo de estupefacientes, de conformidad con el 42 CFR Parte 2 y el Capítulo 899 de los Estatutos Generales de Connecticut, y que no podrá ser divulgado sin mi consentimiento escrito, a menos que las regulaciones o estatutos vigentes así lo permitan. He recibido un compendio de la legislación federal que protege esta información, así como una declaración del uso que se dará a esta información. Queda asimismo entendido que podré revocar este consentimiento en cualquier momento, salvo en los casos en que se hayan iniciado acciones o procedimientos amparados en el mismo. Queda entendido que la transmisión de información podrá ocurrir personalmente, telefónicamente, por correo o fax. A menos que haya sido anteriormente revocado por mí, este consentimiento se vencerá automáticamente al momento de mi dada de alta de mi actual tratamiento o:

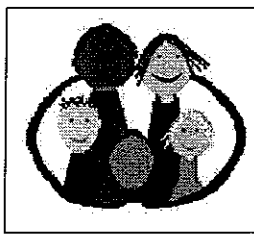
_____
[Fecha, evento, o condición determinados, de cancelación de este consentimiento, en caso de no ser los mismos que los indicados anteriormente]

Fecha: _____ _____
(Firma del participante)

_____
(Firma del padre o madre, tutor o representante autorizado, cuando corresponda)

PROHIBICIÓN DE DIVULGACIÓN ULTERIOR DE INFORMACIÓN RELACIONADA CON LOS HÁBITOS DE CONSUMO DE BEBIDAS ALCOHÓLICAS O ESTUPEFACIENTES DEL PACIENTE

Este aviso acompaña una pieza de información relacionada con el tratamiento del paciente por consumo de bebidas alcohólicas o estupefacientes, transmitida a usted con el consentimiento del paciente interesado. Esta información ha sido transmitida a usted procedente de registros protegidos por las leyes federales de protección de la privacidad (42 CFR Parte 2). La normativa federal le prohíbe hacer revelaciones ulteriores de esta información, a menos que sean expresamente permitidas mediante consentimiento escrito del paciente interesado, o permitidas por la 42 CFR Parte 2. Las autorizaciones de tipo general para la divulgación o revelación de expedientes médicos o de otro tipo NO son suficientes en este caso. Las leyes federales restringen el uso de información médica confidencial para investigar penalmente o encausar a alcohólicos o drogadictos.



Project SAFE

Recovery Specialist Voluntary Program (RSVP)

Verification of Treatment Attendance (monthly)

Client Name: _____

Provider: _____ Phone #: _____

Month / Year =	# of Scheduled Sessions	# of Sessions Attended	# of Sessions Excused	# of Absences /No Shows
Week ending =				
Week ending =				
Week ending =				
Week ending =				

Comments:

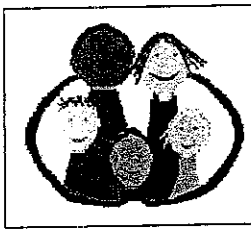
_____

_____

_____

_____ _____

Provider Signature/Position Date



Project SAFE

Recovery Case Management Services

AA/NA/CA/Support Group Verification Form

The person with this form is encouraged by our program to provide documentation of their attendance at AA/NA/CA or other approved self-help meetings. We understand and respect that anonymity is a principle of all recovery programs. By providing a signature with your first name and last initial you are verifying that the individual named below was on time and attended the entire meeting. ***Thank You!***

Client: _____

Date of Meeting	Time of Meeting	Location	Topic	Signature

Project SAFE Recovery Case Management Update

Advanced Behavioral Health, Inc

Date of Report: _____
Reporting Period (Month/Year): _____
Client Name: _____ **ABH#:** _____
Recovery Case Manager: _____ **Contact #:**_____
DCF Link#: _____ **DCF Worker:**_____
Date of Referral: _____
Date Case Assigned to RCM: _____

Number of Scheduled Visits with RCM: _____
Number of Missed Appointments with RCM:_____
Number of Phone Contacts with RCM: _____
Number of RCM Outreach Attempts: _____

Case Summary:

☐ Client is currently engaged in RCM services.

☐ Project SAFE evaluation:
- ☐ Scheduled for _____
- ☐ Completed on_____ at _____
  Recommended treatment: _____

☐ Substance Abuse Treatment
- ☐ Currently in treatment at _____
  Level of Care _____
  Attendance at treatment: _____
- ☐ Awaiting recommendation from evaluation
- ☐ Has intake scheduled on_____ at _____
- ☐ Currently on wait list for residential treatment at _____

☐Other goals client is currently working on with RCM:

☐Housing/Shelter	☐Vocational training	☐ Other _____
☐Transportation	☐Employment	
☐Basic Needs	☐Self-Help meetings	
☐Educational	☐Peer supports	
☐Childcare	☐Children's services	

Current Agencies to which the client/child(ren) have been referred :

_____

Additional Comments:

Project SAFE

Recovery Case Management Program (RCM)

Client Satisfaction Survey

In our ongoing efforts to provide quality services, we value your feedback about your experience with RCM. ***Thank you*** for taking the time to complete this survey.

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. The Recovery Case Manager explained to me the expectations of the program.					
2. The Recovery Case Manager helped me connect with substance abuse treatment and monitored my attendance.					
3. The Recovery Case Manager helped me connect with community supports to meet my needs.					
4. The Recovery Case Manager helped me meet my goals.					
5. The Recovery Case Manager treated me with respect at all times.					
6. The Recovery Case Manager supported me in my recovery.					
7. The Recover Case Management program was helpful to me.					
8. I would recommend the Recovery Case Management program to others.					

What was the most helpful part of RCM for you? _____

_____

How could the RCM program improve? _____

_____

Additional Comments:

_____

_____ Date: _____

Advanced Behavioral Health, Inc.

Date of Discharge_____

In our ongoing efforts to provide quality service for our funders and providers, we have created this survey. Please take a moment to read and respond to the following statements. Your input is important to us.

RCM
Site _____

DCF Satisfaction Survey

ABH# _____

Client Name_____

Please "circle the number " that best describes your thought about each of the following statements:

30,60 ,90, 120 review

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Don't Know
1. The RCM made him/herself available to DCF.	1	2	3	4	5	6
2. The RCM was effective in supporting the client in his/her recovery process.	1	2	3	4	5	6
3. The RCM acted in a professional manner.	1	2	3	4	5	6
4. The RCM was helpful in getting clients to their evaluation/treatment.	1	2	3	4	5	6
5. Overall, I was pleased with RCM services.	1	2	3	4	5	6
6. The RCM collaborated with DCF and provided updates.	1	2	3	4	5	6
7. I would recommend RCM services to other social workers/ clinicians.	1	2	3	4	5	6

DCF SW Name:

#

Dates LM:

Please feel free to make additional comments:

Please "check" the appropriate response to the following questions:

At Referral

A. Does the client have primary care of their children? ___Yes ___No

Total Number of Children ____ _____

if **No**, why?

___ TPR.
___ Foster Care
___ Residential DCF
___ Group Home
___ Shelter
___ Volunteer Placement

30 Days

A. Does the client have primary care of their children? ___Yes ___No

Total Number of Children ____ _____

if **No**, why?

___ TPR.
___ Foster Care
___ Residential DCF
___ Group Home
___ Shelter
___ Volunteer Placement

Is the case still open?

60 Days

A. Does the client have primary care of their children? ___Yes ___No

Total Number of Children ____ _____

if **No**, why?

___ TPR.
___ Foster Care
___ Residential DCF
___ Group Home
___ Shelter
___ Volunteer Placement

Is the case still open?

90 Days

A. Does the client have primary care of their children? ___Yes ___No

Total Number of Children ____ _____

if **No**, why?

___ TPR.
___ Foster Care
___ Residential DCF
___ Group Home
___ Shelter
___ Volunteer Placement

Is the case still open?

120 Days

A. Does the client have primary care of their children? ___Yes ___No

Total Number of Children ____ _____

if **No**, why?

___ TPR.
___ Foster Care
___ Residential DCF
___ Group Home
___ Shelter
___ Volunteer Placement

Is the case still open?

B. Has DCF received another hotline referral for this client in the past 30, 60 ,90, days ? ___Yes ___No

if **Yes**,

___ Case was substantiated
___ Case was unsubstantiated
___ No investigation required

C. Does the client have stable housing ? ___ Yes ___ No ____Unknown

Is the client currently employed? ___Yes ___No ____ Unknown

Does the client currently have medical coverage ? ___Yes ___No ___Unknown

Advanced Behavioral
Health, Inc.

Certificate of Completion

Project Safe Outreach and Engagement Services

THIS IS TO CERTIFY THAT

_____

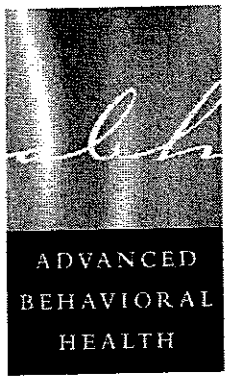
has successfully completed
Recovery Case Management Services

Recovery Case Manager

Program Manager

Date of Completion

BEST WISHES IN YOUR RECOVERY!



Middlesex Corporate Center
213 Court Street
Middletown, Connecticut 06457

Phone 860.638.5309
Facsimile 860.638.5302
www.ABHCI.com

To:_____

Address: .

_____

RE: Recovery Case Management Services

Date: _____

Dear:_____

My name is _____, I am the Recovery Case Manager assigned to your case. Your DCF worker _____ has referred you to our program. I hope that you and your family are doing well and taking advantage of the supports available to you.

This letter is to notify you that I would like to speak with you and arrange an intake appointment to explain our program and services. I have enclosed a brochure for your review.

If you are interested in finding out more about our program and services, please call me at _____ (office) or _____(cell).

Sincerely,

_____
Recovery Case Manager

cc:

Fecha; _____

A: _____

Dirección: _____

Asunto: _____

Sr.,/Sra., _____

Mi nombre es _____, soy la persona asignada como Manejador de su Caso. Su trabajador Social del Departamento de Niños y Familias le ha referido a este programa. Espero que Ud. y su familia estén bien y coja ventaja de este apoyo adicional que le ofrecemos.

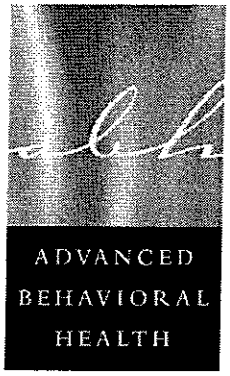
Esta carta es para avisarle que Ud. tiene que comunicarse conmigo para hacer arreglos de una cita y yo poder explicarle los servicios que ofrece este programa, Adjunto un panfleto para que Ud. lo revise.

Si Ud. esta interesado en saber mas acerca de nuestro programa y servicios, por favor llámame al siguiente teléfono _____ (oficina) o _____ (celular).

Sinceramente,

_____
Outreach & Engagement Professional

cc DCF



Middlesex Corporate Center

213 Court Street

Middletown, Connecticut 06457

Phone 860 638 5309

Facsimile 860 638 5302

www.ABHCT.com

Date:

To:

Address:

RE: _____

Dear: _____

Please note that we have not met for _____ several weeks. I am interested in how you are doing and would like to set a meeting time with you. Please contact me at _____. If I do not hear from you by _____, I will presume that you are no longer in need of services and will close your case.

If you feel that in the future you would like to pursue services please contact your DCF worker and request a referral for Recovery Case Management Services.

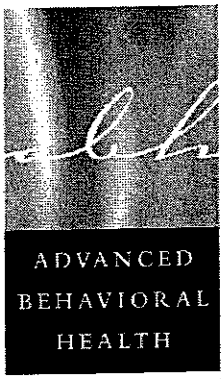
I wish you well and hope that things are working out for you.

Sincerely;

_____

Recovery Case Manager

cc _____, DCF SW



Middlesex Corporate Center

213 Court Street

Middletown, Connecticut 06457

Phone 860 638 5309

Facsimile 860 638 5302

www.ABHCI.com

Date: _____

Dirección: _____

Re: _____

Fecha: _____

Estimado/a: _____

Espero que cuando reciba esta carta, por favor se comunique con _____. Estamos muy interesado/a en proveerle los servicios necesarios a usted. Si usted esta interesado/a en recibir estos servicios comuníquese conmigo antes de la fecha del _____. Si no recibo ninguna noticia de parte de usted, vamos a suponer que usted no estas interesado/a en los servicios disponibles y su caso será cerrado.

Si usted en el futuro se encuentra en necesidad de estos servicios, por favor póngase en contacto con su trabajador social en la agencia de DCF y llene la petición de readmisión al programa.

Le deseamos lo mejor y esperamos que logre encontrar soluciones a todas sus preocupaciones.

Sinceramente,

_____

cc _____, DCF

Project SAFE RSVP/RCM Chart Set Up				
Client Name:	**Chart Review Check List (Hard Copy)**			
Date of Review:	**N/A**	**Yes**	**No**	**Date Corrected (If No)**
Section I				
DCF Release of Informations present and updated				
ABH Informed Consent/Consent to Participate in RSVP				
ABH Notice of Privacy Practices				
All other ROI's				
Section 2				
Client Referral				
Information Sheet for Intake				
Court Contact Info form				
Service Plan(s) with Client's Signature				
Section 3				
RSVP/ RCM Case Status Reports				
TX Verification Forms				
Support Group Verification Forms				
Section 4				
RSVP AOD Screening Forms				
RSVP Drug tests				
Section 5				
Letter introducing RCM				
No Contact Letter				
Closure Letter				
Correspondence with Court Officials				
Any other correspondence				
Section 6				
Discharge Summary				

Project SAFE's Recovery Specialist Voluntary Program and Recovery Case Management Services Service Plans

CATEGORY	GOALS	OBJECTIVES
I. Engagement	1. Engage in RSVP Services 2. Engage in RCM Services	1. Meet w/ RS at least 2x a week 2. Meet with RS/RCM at least 1X per week 3. Maintain Contact with RS/RCM as scheduled. 4.
II. Treatment	A. Begin/continue Substance Abuse treatment	1. Connect to Treatment Provider 2. Attend evaluation appointment 3. Attend UDS appointment 4. Attend treatment intake 5. Attend Hair test 6. Comply with treatment
	B. Complete SA Tx	1. Comply with treatment
	C. Begin/continue treatment for co-occurring disorders	1. Connect to treatment provider 2. Attend treatment intake 3. Comply with treatment
	D. Begin/continue mental health treatment	1. Connect to treatment provider 2. Attend evaluation 3. Comply with treatment
	E. Referral to Residential Tx. Program	1. Connect to Tx Provider 2. Complete intake 3. Complete medical screening 4. Comply with Treatment
	F. Comply with RSVP Drug Screening	1. Comply with drug screening at least 2x/week 2. Comply with drug screening at least 1x /week 3. Comply with drug screening at least 2x/month.

Project SAFE's Recovery Specialist Voluntary Program and Recovery Case Management Services Service Plans

CATEGORY	GOALS	OBJECTIVES
III. Housing	A. Improve current living situation	1. Contact landlord 2. Contact Housing Authority 3. Connect with Housing Advocacy 4. Connect with Legal Aid 5. Contact Health Dept. 6. Improve current housekeeping
	B. Move to improved housing	1. Apply for Section 8 2. Apply to low income/subsidized housing 3. Apply for supportive housing 4. Apply for Transitional housing 5. Apply for Emergency Shelter 6. Locate new housing
	B. Find permanent housing	1. Apply for Section 8 2. Apply to low income/subsidized housing 3. Apply for supportive housing 4. Locate new housing
	C. Work on eviction process	1. Identify stage of Eviction process 2. Obtain legal advice 3. Contact the landlord 4. Connect with eviction prevention program
	D. To get current on Rent	1. Make a payment on rent 2. Apply for rent assistance

Project SAFE's Recovery Specialist Voluntary Program and Recovery Case Management Services Service Plans

CATEGORY	GOALS	OBJECTIVES
IV. Recovery Supports	A. Obtain basic needs	1. Apply for Basic Needs 2. Apply for community resources
	B. Attend Self Help Groups	1. Attend AA/NA or other approved self help group at least 2X per week.
	B. Become involved in community supports	1. Connect to cultural organization 2. Connect to religious or spiritual organization 3. Connect to community services 4.
	C. Obtain benefits	1. Apply for Medical Benefits 2. Apply for Cash Benefits 3. Apply for Food stamps 4. Apply for SSI/SSDI
	D. Establish a Budget	1. Review finances and set up budget. 2. Maintain budget 3. Obtain a Representative payee.
	E. Make use of Family/Natural Supports	1. Increase involvement with positive family/natural supports 2. Connect with childcare supports
V. Children	A. Comply with DCF	1. Set up Childcare/after School 2. Set up Activities/recreational activities 3. Attend school meetings/functions 4. Take children to medical/dental/thera appt. 5. Get child/ren into school/preschool 6. Attend DCF visits 7. Comply with DCF plans
	B. Learn parenting skills	1. Attend parenting skills classes
	C. Find special needs programs	1. Connect to program for child with special needs.

Project SAFE's Recovery Specialist Voluntary Program and Recovery Case Management Services Service Plans

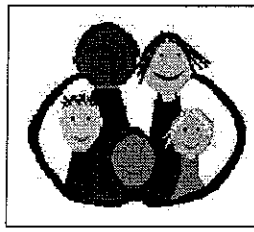
CATEGORY	GOALS	OB JECTIVES
VI. Vocational	A. Gain employment	1. Get/fill out/return application for employment 2. Get transportation to employment interview 3. Improve interview skills 4 Develop a resume
	B. Obtain job training	1. Connect with BRS/CT Job Works 2. Get/fill out/return application(s) for training program 3. Obtain transportation to training program 4. Begin job training program
	C. Change jobs.	1. Get/fill out/return application for employment 2. Improve interview skills 3. Develop a resume
VII. Educational	A. Begin/Continue Education	1. Connect to GED program 2. Complete GED 3. Connect to Higher Education Program 4. Begin voc/college classes 5. Apply for Financial Aid
VIII. Transportation	Obtain transportation	1. Obtain bus passes 2. Medical cab 3. Find resources to purchase transportation 4. Find alternative transportation
IX. Medical Treatment	A. Begin/continue medical treatment/prenatal care	1. Connect to treatment provider 2. Comply with treatment 3. Connect to prenatal care
	B. Complete medical tx	1. Comply with treatment

Project SAFE

Recovery Specialist Voluntary Program (RSVP)
Recovery Case Management (RCM)

Activity Codes Defined	
99533	**Case Conference with Client Present** - Staff meet face-to-face with behavioral health treatment professionals or DCF worker. *Client present*
99507	**Case Conference with Clinician** – Staff meet face-to-face with behavioral health treatment professionals. *Client not present*
99530	**Child Related Referral** - Staff member provides face-to-face, telephone, liaison or collateral assistance to client for the purpose of connecting client's child(ren) to needed services.
99529	**Client No Show** - Client and Staff made a scheduled home or community based visit and the client was not home, or did not show, for the scheduled appointment.
99521	**Client Support System Contact** – Staff member face-to face, telephone, liaison or collateral assistance that help client to maintain contact with family, friends, spiritual advisors, members of the recovery community and significant others. *Client not present*
99506	**Client Transportation** – Staff provides transportation for the client to services or referral
99525	**Community Linkage** – Staff conducts face to face, telephone, liaison or provide collateral assistance that assist the client to obtain supports through religious affiliation, 12 step meetings, peer supports, and/ or other community supports
99527	**Community Networking** - collaboration, research, presentations with community providers to develop a resource network for client.
99531	**Correspondence** – Staff sent correspondence to a client or to another party regarding a client (e.g., client's attorney for whom the client has signed a release of information)
99532	**Court Contact** – Staff have contact with court or the client's attorney regarding an open case, i.e., subpoenaed to testify and /or time spent preparing RSVP updates for court.
99534	**Court Contact with Client Present-** Staff have contact with court with **client present** regarding an open case, i.e., subpoenaed to testify, OTC, etc.)
99535	**RSVP Drug Screen-** Documentation of outcome of randomly scheduled drug screen with RSVP includes: staff meeting with client to conduct a drug screen and outcome as well as 'No Shows' for drug screens.
08001	**Crisis Intervention** – Staff member face to face, telephone, liaison or collateral activities that assist the client in recovering personal control during acute or behaviorally turbulent episodes.
99519	**Department of Children and Families (DCF) Contact** – Staff member face-to face, telephone, liaison or collateral activities that serve to link client with appropriate DCF services
99509	**Employment Referral** - Staff member face-to-face, telephone, liaison or collateral assistance to client for the purpose of contacting potential employers or employment development agents. *Client not present.*
99513	**Face to Face O & E Attempt** – Staff makes a face to face outreach attempt to connect with client.

99523	**Family Service-** Staff provided service to others living in the household (i.e. children, significant other)
99511	**Health Care Referral** - Staff member face-to-face, telephone, liaison or collateral assistance to clients for the purpose of contacting potential medical health care providers *Client not present*
99350	**Home Visit** - Staff member conducts a session at the client's place of residence, including shelter if applicable
99510	**Housing Referrals** - Staff member face-to-face, telephone, liaison or collateral assistance to client for the purpose of contacting potential landlords or housing development agents. *Client not present.*
99501	**Intake Screening** – Staff member completed formal intake screening with client utilizing designated form
99504	**Meeting with Client in Community Setting** - any face-to-face meeting with the client in a setting other than the client's place of residence or treatment setting. *Client Present*
99505	**Meeting with Client in Treatment Setting** - any face-to-face meeting with a client in a behavioral health setting including staff office, medical care or community agency and not better-classified elsewhere. *Client present.*
99503	**Phone Contact With Client** -Telephone contact between staff member and client.
99373	**Phone contact with Treatment Providers** - Staff member telephone contact with behavioral health treatment professionals to plan client service interventions and solve treatment problems. *Client may or may not be present.*
99528	**Phone O & E Attempt** – Staff attempt to contact client by phone. Document if a message was left or not
99514	**Probation/Parole Contact** - Staff member face-to-face, telephone, liaison or collateral activities that assist client with probation/parole responsibilities.
99512	**Referral to ATR-** Staff member activities that facilitate client's request(s) for Basic Needs supports
99517	**Referral to Behavioral Health Provider** – Staff conducts face to face, telephone, liaison or collateral assistance to client in locating and securing appropriate behavioral health provider treatment services. *Client not present.*
99518	**Social Services Referral** – Staff member face-to face, telephone, liaison or collateral activities that serve to link client with appropriate DSS services.
99526	**Staff Commute** – Staff time commuting to meet with client or to attend a meeting with client's tx provider or DCF. *Client not present.*
99522	**Supervision/Case Review-** review of service plan and intervention with Lead Recovery Specialist or Assistant Program Director. *Client not present*
99524	**Transportation Referral** – Staff arranged transportation of client including public transport, med cab, or through the Basic Needs Program or provider/community based agency transportation. *Client not present.*
99520	**Referral for Substance Abuse Treatment-** Staff member face-to face, telephone, liaison or collateral activities that serve to link client with appropriate Substance Abuse Treatment.
99536	**Verification of Support Group Attendance-** Staff member face-to face, telephone, liaison or collateral activities that serve to verify Support Group attendance
99537	**Verification of TX Attendance-** Staff member face-to face, telephone, liaison or collateral activities that serve to verify TX attendance



Project SAFE

Recovery Specialist Voluntary Program (RSVP)
Recovery Case Management (RCM)

Drop Downs for Activity Notes in Database

Code	Activity	Drop Downs
99529	Client No Show	Client did not show for scheduled home visit
99506	Client Transportation	o Transported client to/from Tx Provider o Transported client to/from DCF Office o Transported client to/from medical appointment o Transported client to/from community resource(s) o Transported client to look for housing o Transported client to look for work
99531	Correspondence	o Sent client letter of Introduction to O &E/ RCM with cc to DCF SW o Sent client no contact letter with cc to DCF SW
99519	DCF Contact	o Phoned DCF SW, left voice mail message o Phoned DCF SW, unable to leave voice mail message o Phoned DCF Supervisor, left message o Completed and sent Biweekly Update to DCF o Completed OE discharge summary
99534	Court Contact With Client Present	o Met With Client to review RSPV Program o Attended CSC at court with client o Accompanied client to court hearing
99535	RSVP Drug Screen	o Excused o Negative Test o No Show for Test o Positive o Refused to Test o Unable to Test

Code	Activity	Drop Downs
99513	Face to Face Attempt	o Made face to face attempt, client not at home o Made face to face attempt, unable to locate client*s home
99528	Phone O & E Attempt	o Phoned client, left message o Phoned client, unable to leave message o Phoned client, phone not in service
99526	Staff Commute	o To/From Client's home o To/From Community Setting o To/From DCF Office
99522	Supervision/Case Review	o Reviewed case with Team Leader {type in any pertinent details} o Reviewed case with Program Manager {type in any pertinent details}
99537	Verification of Treatment	o Individual o Group o Individual and Group o IOP o PHP o Residential o Inpatient o MMTP

Project SAFE
Recovery Specialist Voluntary Program
Recovery Case Management
Level of Care Screening Criteria

1st Domain - Thinking and Cognition, Concentration, Task Performance

Refers to thought processes, or cognition, memory and overall intellectual functioning, as well as the ability to sustain focused attention for long enough periods of time to permit the completion of tasks commonly needed at home or in structured situations such as school or work.

Severe 4	Moderate 3	Mild 2	None 1
• Requires prompts and/or assistance to complete tasks with multiple steps • Serious memory impairments, e.g., cannot recall steps of tasks, cannot identify or recall medications or when to take them, etc. • Frequent episodes of disorganized thinking. • Cognitive/intellectual impairment that interferes with daily functioning.	• Can complete multi-step tasks but may require frequent assistance (prompts, reminders of steps) due to poor concentration, e.g., do laundry, make grocery list and wash dishes. • Moderate memory problems that do not seriously impact functioning. • Occasional episodes of disorganized thinking. • Mild cognitive/intellectual difficulties apparent.	• Able to concentrate and complete tasks in reasonable timeframes with some assistance in developing a plan to complete tasks.	• Thinking and concentration are sound • Able to comprehend written and verbal information • No cognitive/intellectual difficulties apparent

2nd Domain- Substance Abuse Refers to the client's and/or collateral contacts' report and/or OEP's observations of client's use of substances.			
Severe 4	**Moderate 3**	**Mild 2**	**None 1**
• Continued substance use/addictive behavior despite significant medical and/or psychosocial problems. • Unable to recognize significant difficulty in daily functioning related to substance use/abuse. • Evidence of recent substance use in client's home (e.g., empty beer bottles, drug paraphernalia).	• Reports current abuse of substances. • Engaged in or willing to engage in treatment. • In recovery and reports recent relapse. • In early recovery, has few supports.	• History of substance use/abuse. • Denies current abuse of substances or any difficulty in daily functioning related to substance use. • Client is stable in recovery as confirmed by client report, current treatment provider(s) and/or consistent negative drug screens. • Has and uses appropriate recovery supports.	• Denies any past hx or present substance use. • No evidence of substances in client's home.

3rd Domain – Mental Health/Trauma History Refers to the client's report and/or collateral observations of client's mental health needs and/or trauma history.			
Severe 4	**Moderate 3**	**Mild 2**	**None 1**
• Current suicidal/homicidal ideation. [***Note:*** *If client reports a current suicidality, RS/RCM to refer for clinical assessment in ED, with Mobile Crisis, or current clinician.]* • History of serious harmful behavior to self or others with current potential for repeating event. • Client reports trauma history, with significant impact on day to day functioning. • Recent Psychiatric hospitalization (< 6 months) or hx of multiple psychiatric hospitalizations and/or significant MH disorder that is currently untreated.	• Client is in mental health tx, but is still experiencing mild to moderate symptoms. • Past hx of suicidal or homicidal ideation, no current ideation or intent. • Client has moderate impairment due to mental health problems and needs a referral to mental health or co-occurring disorder treatment, but may be reluctant to engage in tx. • Client reports trauma history, with moderate impact on day to day functioning. • Hx of psychiatric hospitalization(s) (1+ year ago).	• Client is in mental health treatment/recovery and currently stable. • Client has mild mental health problems with no impairment in day to day functioning. • Client needs a referral to mental health or co- occurring disorder treatment and is willing to engage. • Client reports trauma history, no apparent impact on day to day functioning.	• Client reports no mental health problems; collateral contacts concur.

4th Domain – Participation in Treatment

Refers to the client's ability to follow through on substance abuse, psychiatric, and/or medical treatment, including accessing emergency services.

Severe 4	Moderate 3	Mild 2	None 1
• Refuses to comply with Project SAFE Referral. • Refuses to participate in recommended SA treatment. • Denies the need for recommended treatment/Precontemplation. • Significant MH issues which interfere with client's ability to comply with PS referral and/or engage with treatment	• Reluctant/ambivalent to comply with Project SAFE referral/recommended SA treatment. • Completes PS referral and/or participates in treatment only with assertive outreach i.e., recovery specialist/case manager needs to transport and accompany to appointments. • MH issues interfere with client's ability to comply with PS referral and/or attend treatment (e.g., depression)	• Participates in treatment with minimal support. • Willing to comply with Project SAFE/treatment referral, but needs some assistance (e.g., transportation/childcare)	• Participates in treatment independently. • Willing to comply with Project SAFE referral and has means to do so independently. • Completed Project SAFE referral, no treatment recommended

5th Domain - Medical and Physical

Refers to the extent to which the individual requires assistance due to illness or injuries that interfere with functioning.

Severe 4	Moderate 3	Mild 2	None 1
• Medical problem(s) severely limits client's functioning, e.g., work, physical mobility, ability to leave home, parenting, etc.	• Client reports frequent health problems that limit his/her functioning. • Assistance is occasionally required to complete some tasks, i.e., cannot perform some activities of daily living without physical assistance from others.	• Client reports acute and/or chronic medical problems that do not interfere with daily functioning. • Client needs assistance and/or a referral to access needed medical care, but condition(s) do not interfere with daily functioning.	• Client reports he/she is generally in good health.

6th Domain - Self Care/Activities of Daily Living

Includes activities such as tending to personal hygiene, parenting activities, laundering, clothes, cleaning one's living environment, and the ability to prepare and/or eat foods using reasonably healthy and sanitary methods. Also refers to personal money management, e.g., the ability to budget and pay essential bills, or cooperate with assistance in these areas.

Severe 4	Moderate 3	Mild 2	None 1
• Unable to perform the majority of activities of daily living, e.g., cannot prepare meals, launder clothes, identify/recall medications or when to take them and/or maintain hygiene, unable to budget. • Unable to use public transportation.	• Client is struggling or inconsistent with ADL's, i.e., needs assistance to maintain apartment, hygiene, budget, etc. • Able to use public transportation with prompts/assistance.	• Performs activities of daily living with minimal reminders/assistance, e.g., is able to self-administer medications, manage money and use transportation with minimal supports.	• Is independent with all activities of daily living.

7th Domain - Risk or Crisis

Refers to the level of dangerousness/risk for the client or others, including suicidal or homicidal thoughts or actions, history of psychiatric hospitalizations, history of assaults, recent crisis contacts, and/or domestic violence.

Severe 4	Moderate 3	Mild 2	None 1
• Frequent suicidal or homicidal ideation (at least weekly) but no current plan. [***Note:*** *If client reports a current homicidal or suicidal plan or ideation, RS/RCM to refer for clinical assessment in ED, with Mobile Crisis, or current clinician.]* • History of serious harmful behavior to self or others with current potential for repeating event. • Frequent contacts with emergency room or crisis program (at least monthly). • Individual often (at least monthly) places self in life threatening situations e.g., repeated involvement with physically abusive partner, allowing exploitative individuals into home, or to obtain or sell drugs, etc.	• Frequent contacts with emergency room or crisis program (at least quarterly). • History of harmful behavior to self or others but current potential for repeating this is low. • History of DV in current relationship.	• Infrequent thoughts of hurting self or others with no reported history of self injurious or assaultive behavior. • History of self-injurious behavior is not serious and/or incidents were infrequent and minor. • Infrequent and appropriate contacts with emergency room or crisis program (< 2X a year) • Hx of Domestic violence in past relationships. • If client has MH disorder, client is currently stable and in treatment.	• No risk factors identified.

8th Domain - Relationships refers to the client's ability to interact and communicate effectively with others and to get along with household, family, friends, service providers, and community members. Strengths are reflected in the client's ability to actively participate in relationships that support her/his recovery, initiate social contact and to participate in groups, cooperate with others and to be considerate of others. Deficits are reflected in avoidance of interpersonal relationships and social isolation, and/or poor parenting performance.

Severe 4	Moderate 3	Mild 2	None 1
• Significant isolation (prefers solitary activities but can tolerate social interaction when assisted) • Service provider(s) is primary support • No support network • Family/relations undermine recovery as characterized by enmeshment, enabling, victimization, sabotaging, high emotional reactivity, etc. • No social or leisure activities • Active Domestic Violence issues	• Attends social or recreational activities in unsupervised settings but interacts minimally • With assistance, can form and maintain a limited number of relationships • Family and/or other relationships are not fully supportive of recovery and are intermittently marked by conflict, estrangement, etc. • Recent Domestic Violence precipitating DCF involvement	• Participates in positive social or recreational activities with minimal encouragement • Client generally maintains a satisfactory social network with minimal assistance	• Interacts positively with others • Has positive community and family supports in place

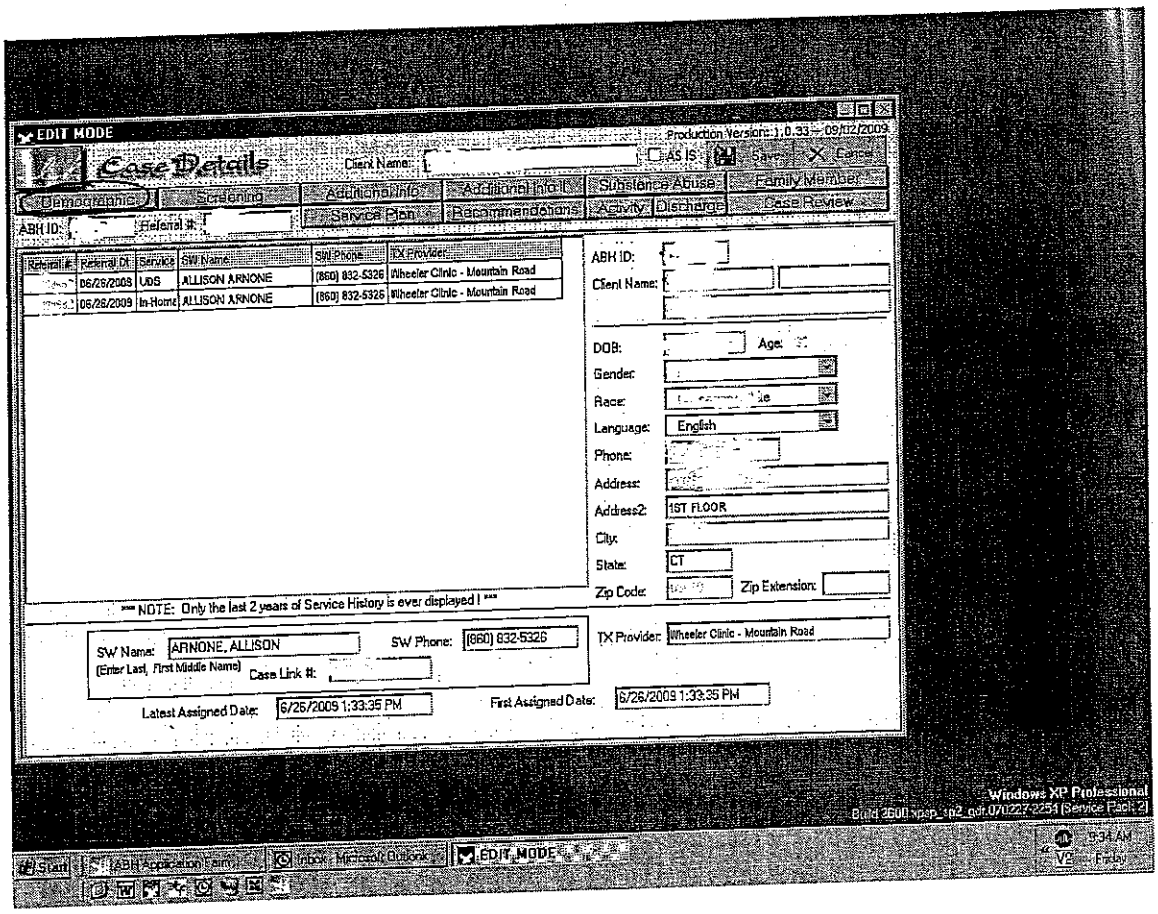
9th Domain - Legal refers to the individual's ability to maintain conduct within the limits of the law.

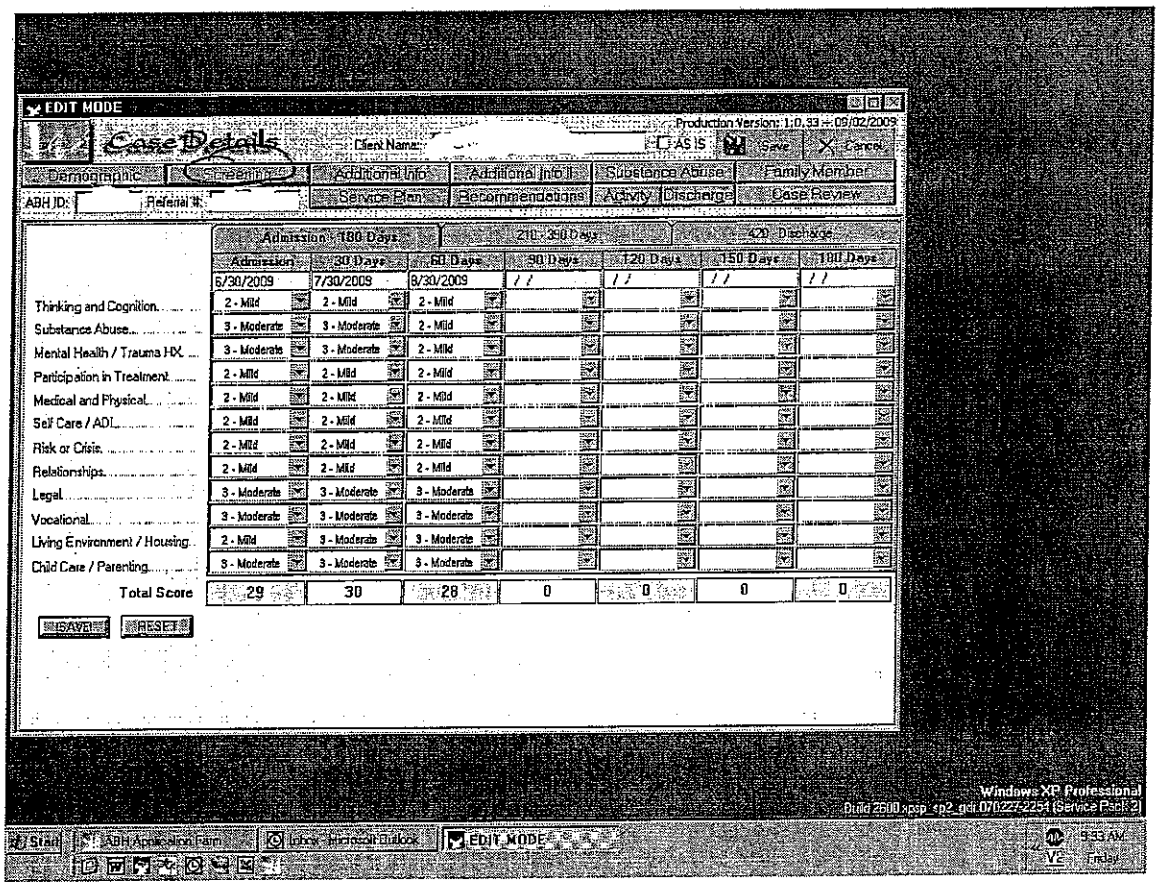
Severe 4	Moderate 3	Mild 2	None 1
• History of criminal behavior of a serious nature, and related arrests and incarcerations • Frequent monitoring via probation or parole or is not keeping appointments with parole/probation officer. • Criminal behavior jeopardizes the safety of others, e.g., assaultive behavior, driving while intoxicated, etc. • Hx of significant destruction of property	• History of criminal behavior of a less serious nature, and related arrests and incarcerations. • Moderate monitoring via probation or parole • Minimally adheres to laws unless confronted with consequences, e.g., does not pay rent until confronted with eviction, ignores probation requirements until threatened with incarceration, etc. • Currently using illicit substances.	• Generally adheres to laws • Consistently complies with probation • History of legal involvement is minimal • Ongoing DCF case with abuse/neglect substantiated and/or DV. • Hx of using illicit substances.	• Adheres to laws • No criminal history

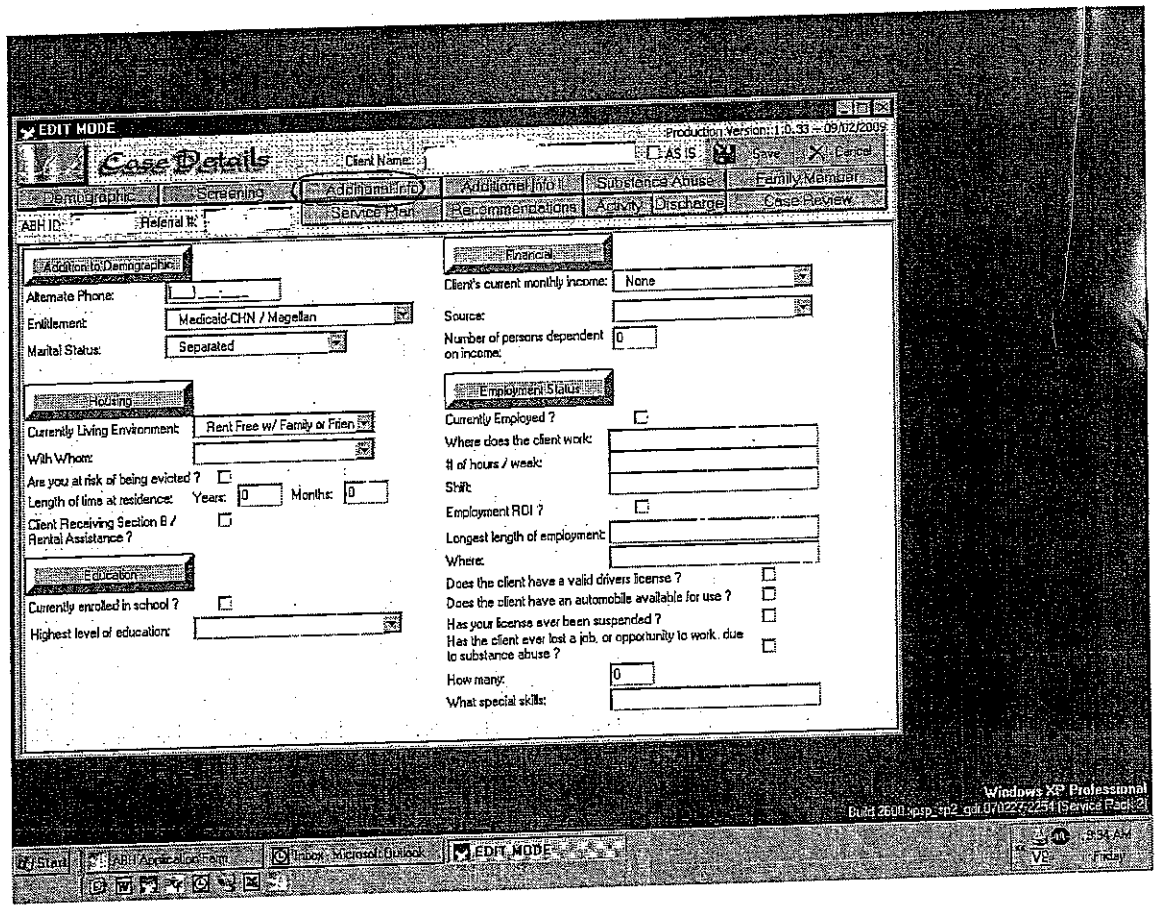
10th Domain - Vocational refers to the capacity to obtain and maintain employment and includes work history, potential vocational skills and aptitudes.			
Severe 4	**Moderate 3**	**Mild 2**	**None 1**
• Limited work history • For sustained periods, is only able to participate in prevocational training and education in a supervised setting • Unable to work or participate in training • No work history • No known vocational skills or aptitudes	• Has work history but job is frequently in jeopardy and client is unable to keep the same job for six months or more • Can maintain community employment with support from vocational services	• Works independently with minimal supports other than vocational services • Historically, has had some difficulty maintaining employment over time, i.e. keeping the same job for one year or more	• Works independently • Retired/ Disabled • Not in labor force, e.g., caring for children, etc.

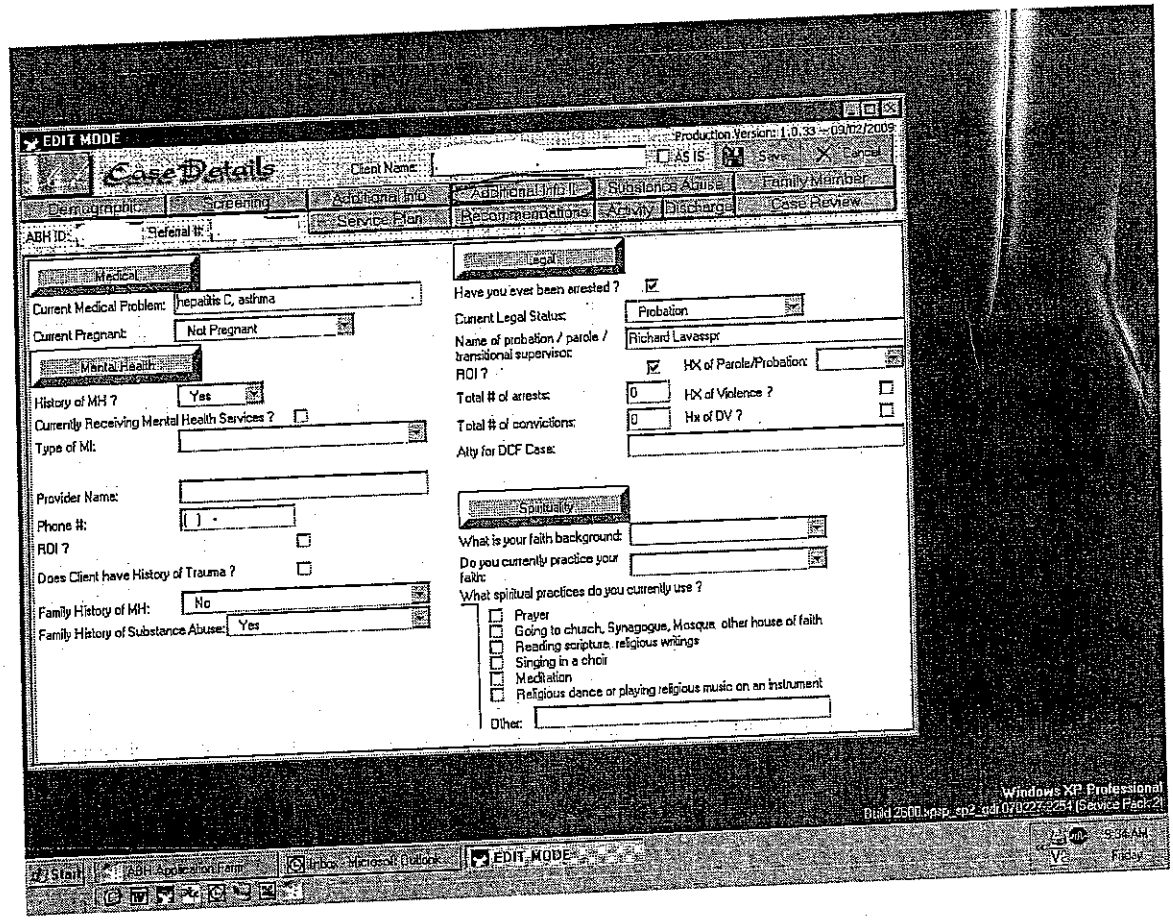
11th Domain - Living Environment and Housing Refers to the individual's current living situation, taking into consideration safety, comfort, affordability and the individual's satisfaction with their housing.			
Severe 4	**Moderate 3**	**Mild 2**	**None 1**
• Client has no permanent housing but has temporary shelter, e.g., staying in a shelter, doubled up with a relative or friend • Housing is not conducive to recovery, e.g., substandard housing, ongoing substance abuse or violence on premises or in proximity to housing • Eviction is imminent. • Living situation is extremely unsafe, e.g., unfit for human habitation, criminal behavior on premises that threatens individual's and children's safety, etc.	• Inadequate shelter or housing, or housing may not be conductive to recovery e.g., substandard housing, ongoing substance abuse or violence on premises or in proximity to housing, or housing is not affordable • Moderately dissatisfied with living environment • Potential risk of eviction • No history of independent living • Home is very unkempt.	• Mild dissatisfaction with housing • Episodic conflicts with other household members or tenants • Institutionalized or living with extended family or friends • Difficulty affording current housing.	• Housing is stable and conducive to recovery

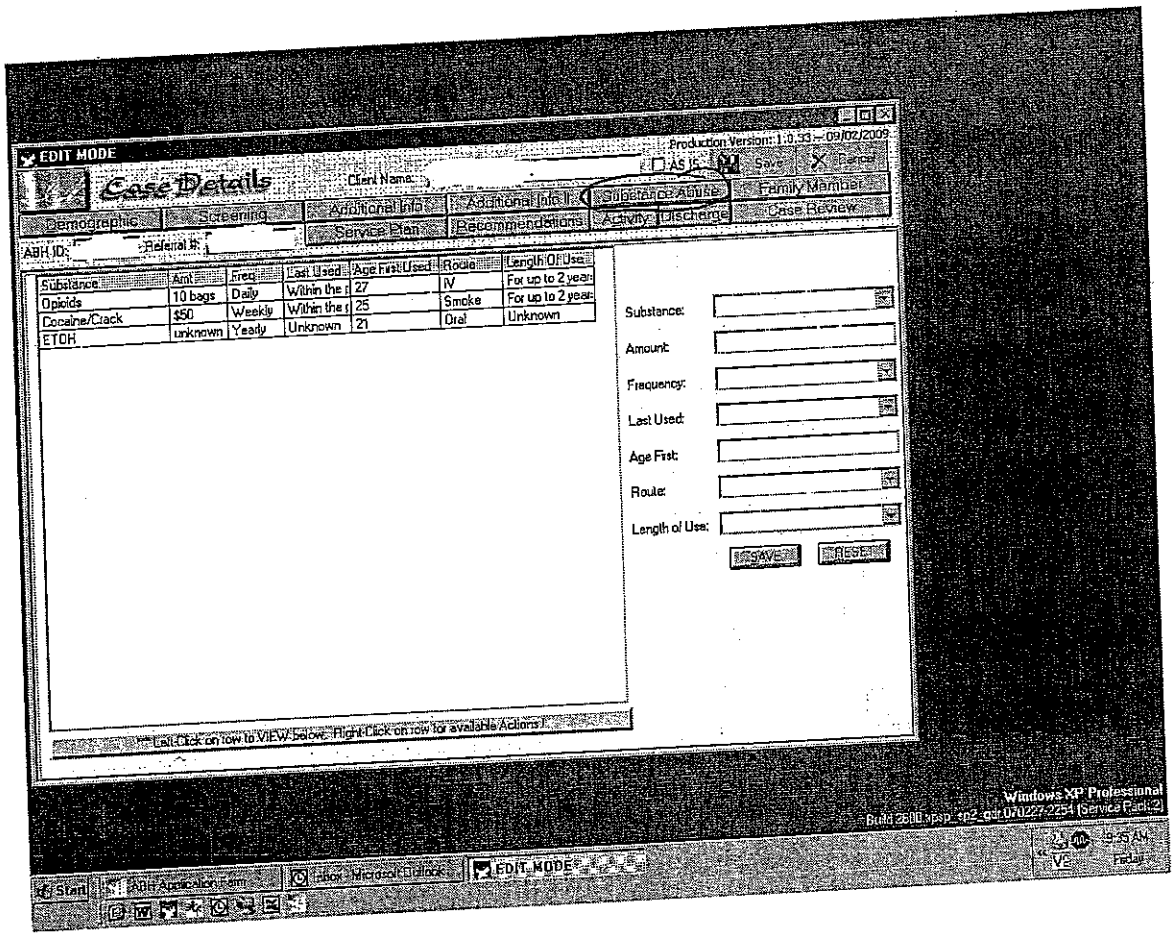
12th Domain – Childcare/parenting performance			
Severe 4	**Moderate 3**	**Mild 2**	**None 1**
• Severe difficulty caring for children and/or significant others leads to neglect in child rearing responsibilities, physical and/or sexual abuse, abandonment, etc. • Repeat Hotline call, neglect or abuse substantiated. • Child <2 year old or multiple children < 5 in the home, parent is struggling with day to day responsibilities and/or actively abusing substances with DCF report of impact on children. • Children removed by DCF/courts, parent is not attending visitation with child(ren)	• Moderate difficulty caring for child(ren) leading to decreased involvement in child rearing responsibilities, and/or risk of abuse or neglect • Repeat Hotline call, not substantiated. • Child <2 year old or multiple children < 5 in the home, parent able to cope with assistance. If client is currently using/recently used substances, no impact on children reported by DCF. • Child(ren) out of the home, parent actively working towards plan of reunification/attending visitation, etc.	• Needs assistance with childcare issues • Children living at home with minimal external supports • Child <2 year old or multiple children < 5 in the home, parent able to cope with current supports.	• Childcare needs are met

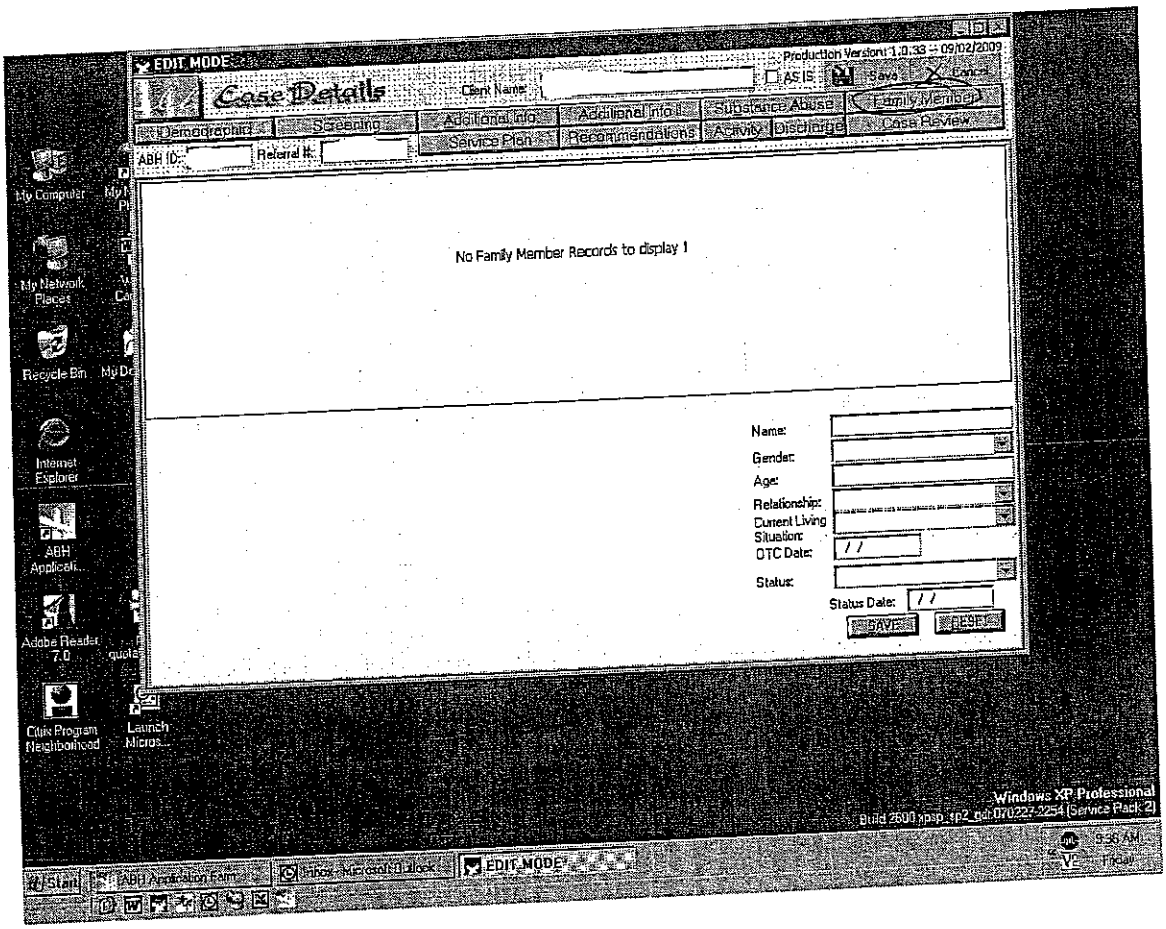

EDIT MODE
Production Version: 1.0.33 - 09/02/2009
Case Details
Client Name:
AS IS
Save
Cancel
Demographics
Screening
Additional Info
Additional Info I
Substance Abuse
Family Member
Service Plan
Recommendations
Activity
Discharge
Case Review
ABH ID:
Referral #:
Referral # | Referral Dt | Service | SW Name | SW Phone | TX Provider
06/26/2009 | UDS | ALLISON ARNONE | (860) 832-5326 | Wheeler Clinic - Mountain Road
06/26/2009 | In-Home | ALLISON ARNONE | (860) 832-5326 | Wheeler Clinic - Mountain Road
*** NOTE: Only the last 2 years of Service History is ever displayed ! ***
ABH ID:
Client Name:
DOB:
Age:
Gender:
Race:
Language: English
Phone:
Address:
Address2: 1ST FLOOR
City:
State: CT
Zip Code:
Zip Extension:
SW Name: ARNONE, ALLISON
(Enter Last, First Middle Name)
SW Phone: (860) 832-5326
TX Provider: Wheeler Clinic - Mountain Road
Case Link #:
Latest Assigned Date: 6/25/2009 1:33:35 PM
First Assigned Date: 6/26/2009 1:33:35 PM
Windows XP Professional
Start
EDIT MODE

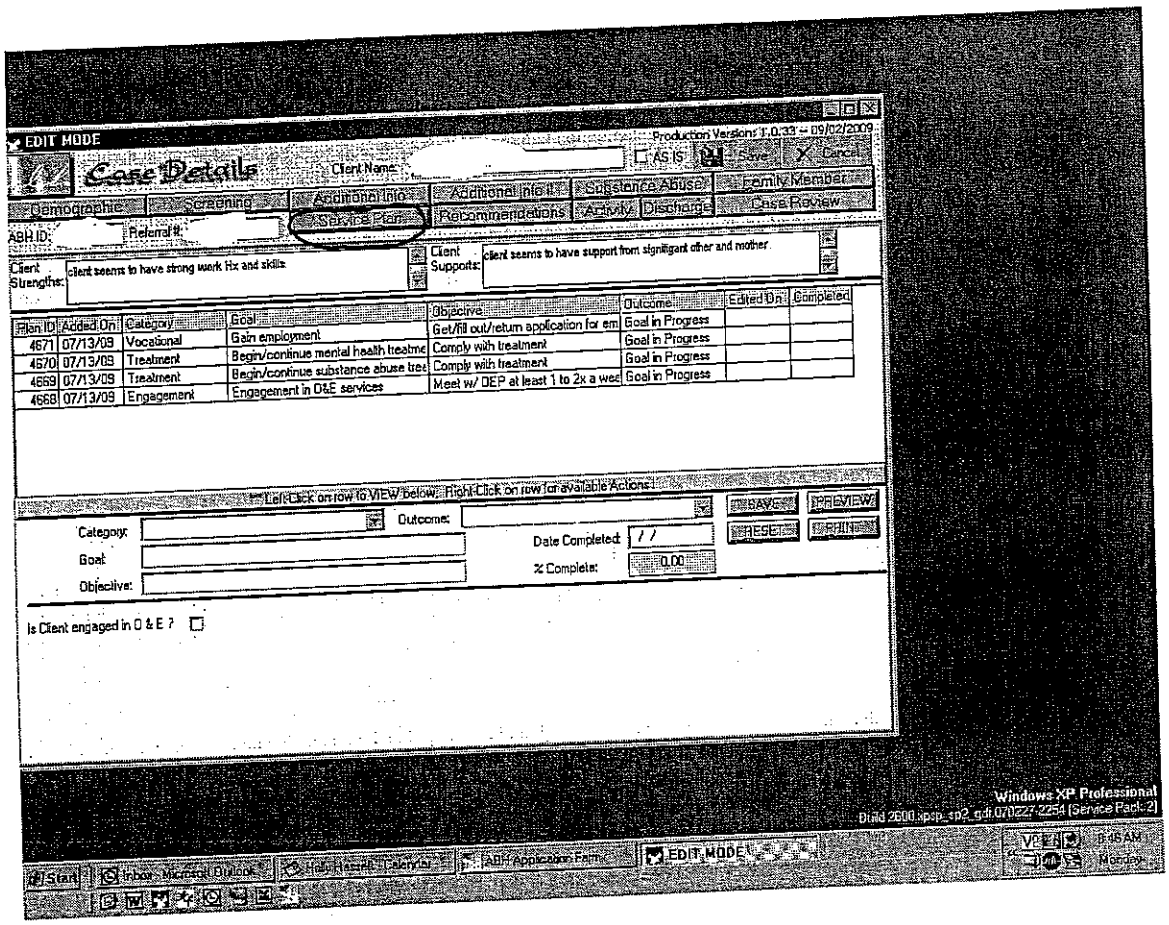

EDIT MODE
Case Details
Client Name:
AS IS
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Review
Admission - 180 Days
210 - 360 Days
420 - Discharge
Admission
30 Days
60 Days
90 Days
120 Days
150 Days
180 Days
6/30/2009
7/30/2009
8/30/2009
Thinking and Cognition
Substance Abuse
Mental Health / Trauma HX
Participation in Treatment
Medical and Physical
Self Care / ADL
Risk or Crisis
Relationships
Legal
Vocational
Living Environment / Housing
Child Care / Parenting
Total Score
29
30
28
0
0
0
0
SAVE
RESET
Windows XP Professional
Build 2600.xpsp_sp2_gdr.070227-2254 (Service Pack 2)
Start
ABH Application Form
Inbox - Microsoft Outlook
EDIT MODE
9:33 AM
Friday

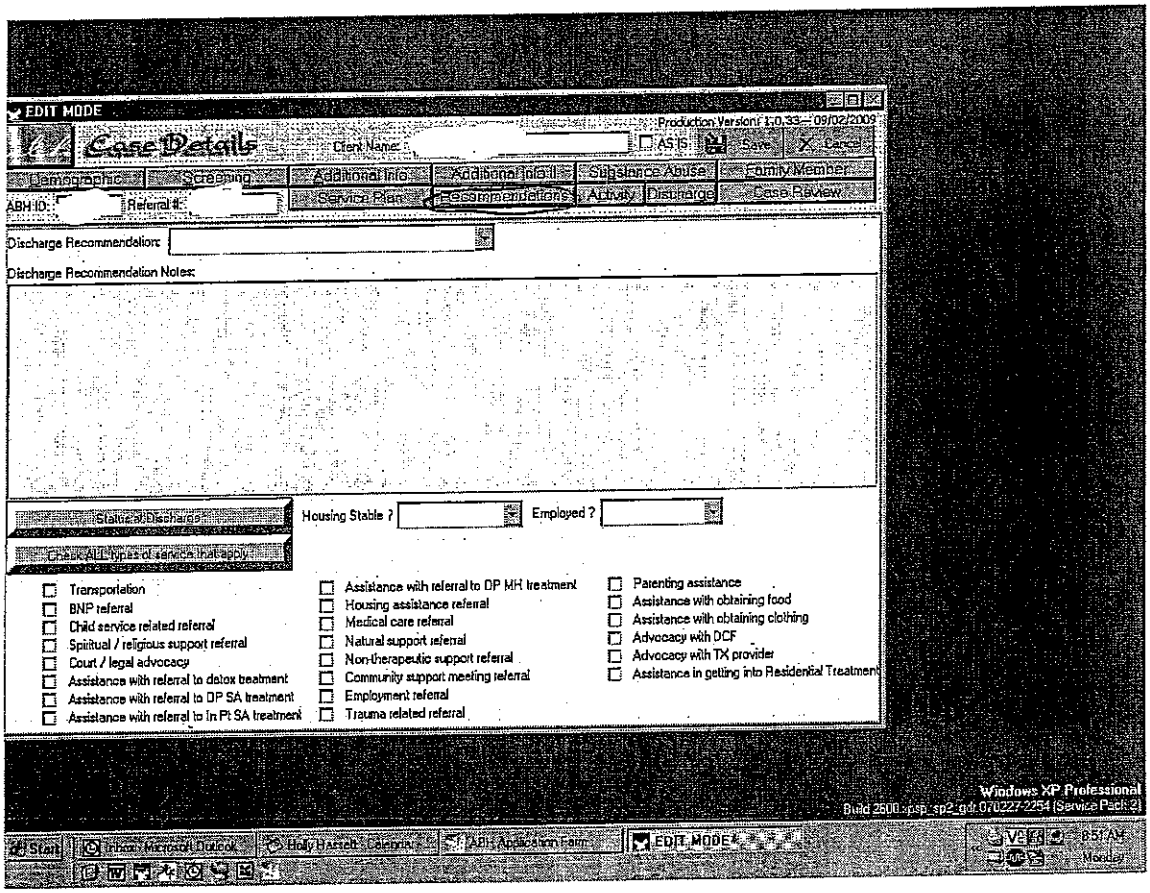

EDIT MODE
Production Version: 1.0.33 - 09/02/2009
Case Details
Client Name:
AS IS
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
Service Plan
Recommendations
Activity
Discharge
Case Review
ABH ID:
Referral #:
Additional Demographics
Alternate Phone:
Entitlement:
Medicaid-CHN / Magellan
Marital Status:
Separated
Housing
Currently Living Environment:
Rent Free w/ Family or Frien
With Whom:
Are you at risk of being evicted ?
Length of time at residence:
Years:
Months:
Client Receiving Section 8 / Rental Assistance ?
Education
Currently enrolled in school ?
Highest level of education:
Financial
Client's current monthly income:
None
Source:
Number of persons dependent on income:
Employment Status
Currently Employed ?
Where does the client work:
# of hours / week:
Shift:
Employment ROI ?
Longest length of employment:
Where:
Does the client have a valid drivers license ?
Does the client have an automobile available for use ?
Has your license ever been suspended ?
Has the client ever lost a job, or opportunity to work, due to substance abuse ?
How many:
What special skills:
Windows XP Professional
Start
EDIT MODE
9:34 AM
Friday

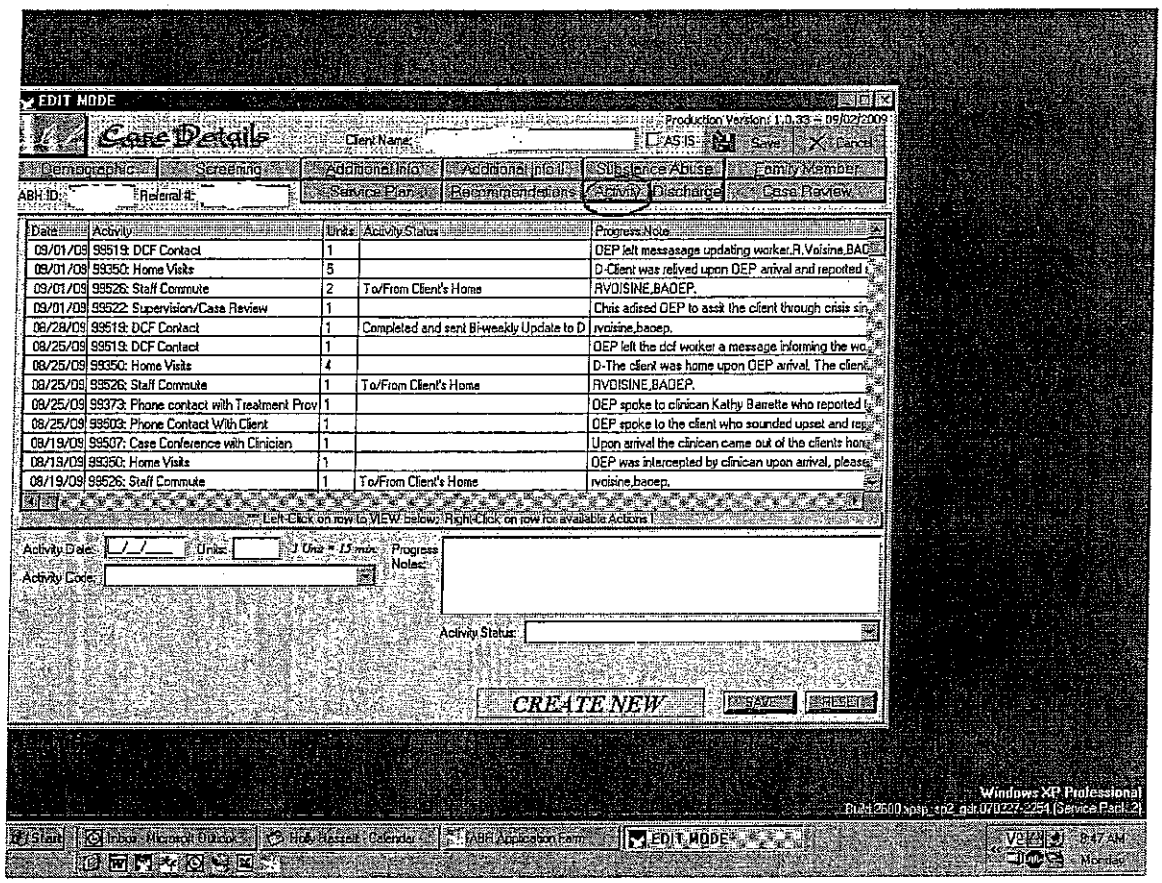

EDIT MODE
Production Version: 1.0.33 -- 09/02/2009
Case Details
Client Name:
AS IS
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
Service Plan
Recommendations
Activity
Discharge
Case Review
ABH ID:
Referral #:
Medical
Current Medical Problem: hepatitis C, asthma
Current Pregnant: Not Pregnant
Mental Health
History of MH ?: Yes
Currently Receiving Mental Health Services ?
Type of MI:
Provider Name:
Phone #:
ROI ?
Does Client have History of Trauma ?
Family History of MH: No
Family History of Substance Abuse: Yes
Legal
Have you ever been arrested ?
Current Legal Status: Probation
Name of probation / parole / transitional supervisor: Richard Lavesspr
ROI ?
HX of Parole/Probation:
Total # of arrests: 0
HX of Violence ?
Total # of convictions: 0
Hx of DV ?
Atty for DCF Case:
Spirituality
What is your faith background:
Do you currently practice your faith:
What spiritual practices do you currently use ?
Prayer
Going to church, Synagogue, Mosque, other house of faith
Reading scripture, religious writings
Singing in a choir
Meditation
Religious dance or playing religious music on an instrument
Other:
Windows XP Professional
Build 2600.xpsp_sp2_gdr.070227-2254 (Service Pack 2)
Start
ABH Application Form
Inbox - Microsoft Outlook
EDIT MODE
9:36 AM
Friday

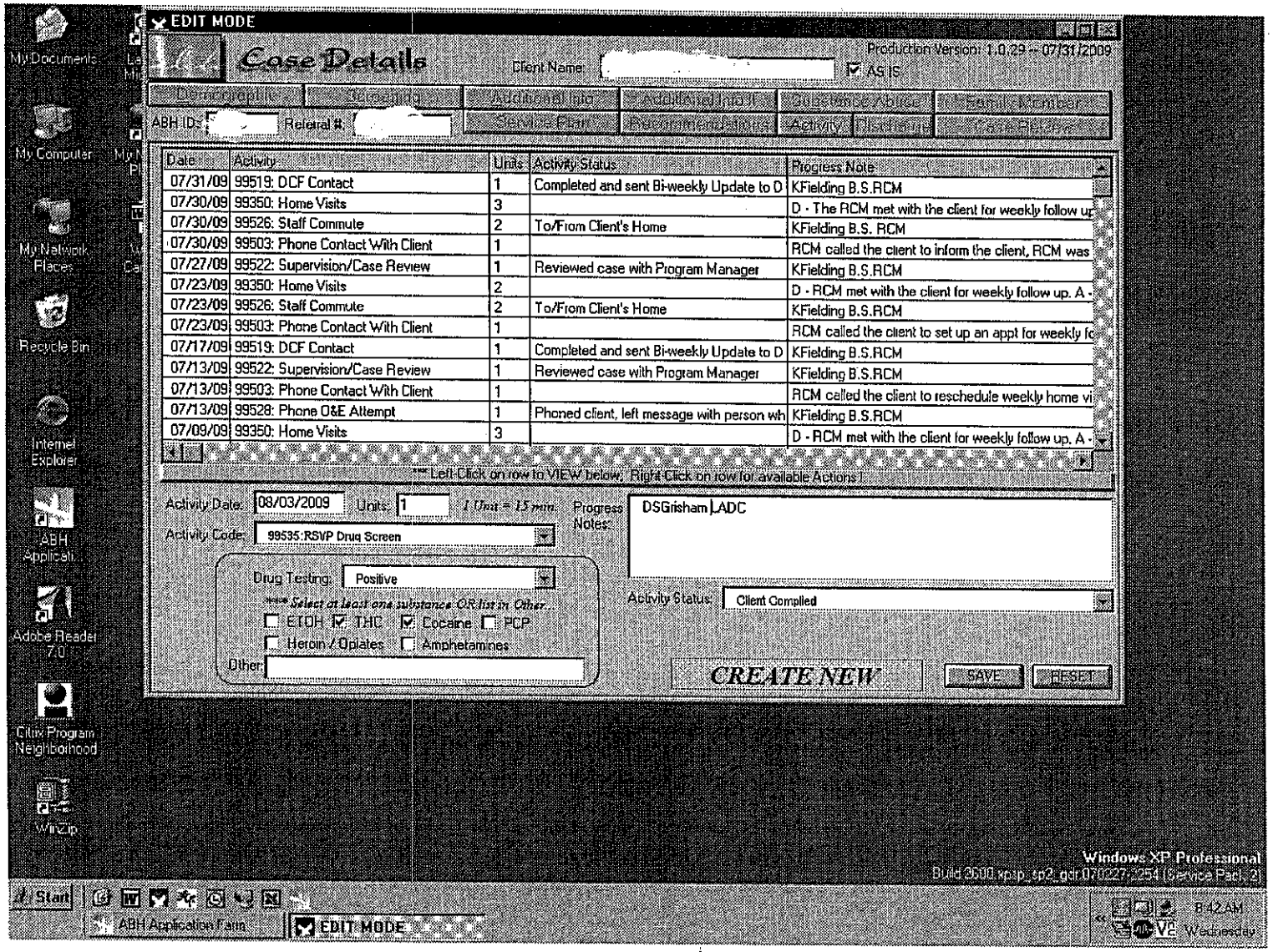

EDIT MODE
Production Version: 1.0.93 -- 09/02/2009
Case Details
Client Name:
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
Service Plan
Recommendations
Activity / Discharge
Case Review
ABH ID:
Referral #:
Substance
Amt
Freq
Last Used
Age First Used
Route
Length Of Use
Opioids
10 bags
Daily
Within the
27
IV
For up to 2 years
Cocaine/Crack
$50
Weekly
Within the
25
Smoke
For up to 2 years
ETOH
unknown
Yeady
Unknown
21
Oral
Unknown
Substance:
Amount:
Frequency:
Last Used:
Age First:
Route:
Length of Use:
SAVE
RESET
Left Click on row to VIEW below; Right Click on row for available Actions
Windows XP Professional
Start
EDIT MODE
9:55 AM
Friday

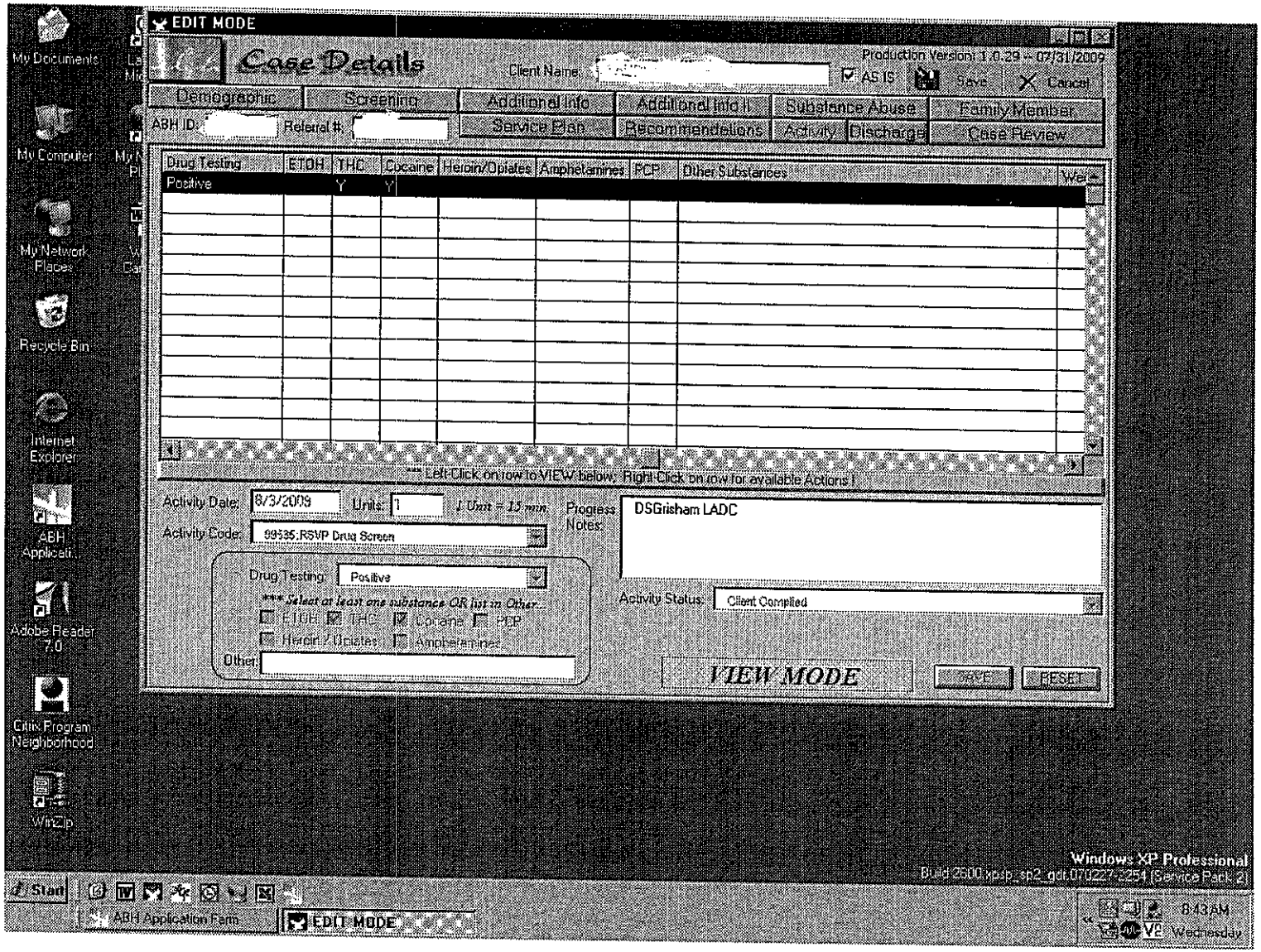

EDIT_MODE
Production Version:1.0.33 -- 09/02/2009
Case Details
Client Name:
AS IS
Save
Cancel
Demographics
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
Service Plan
Recommendations
Activity
Discharge
Case Review
ABH ID:
Referral #:
No Family Member Records to display !
Name:
Gender:
Age:
Relationship:
Current Living Situation:
DTC Date:
Status:
Status Date:
SAVE
RESET
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicati...
Adobe Reader 7.0
Citrix Program Neighborhood
Launch Micros...
Windows XP Professional
Start
EDIT_MODE
9:36 AM

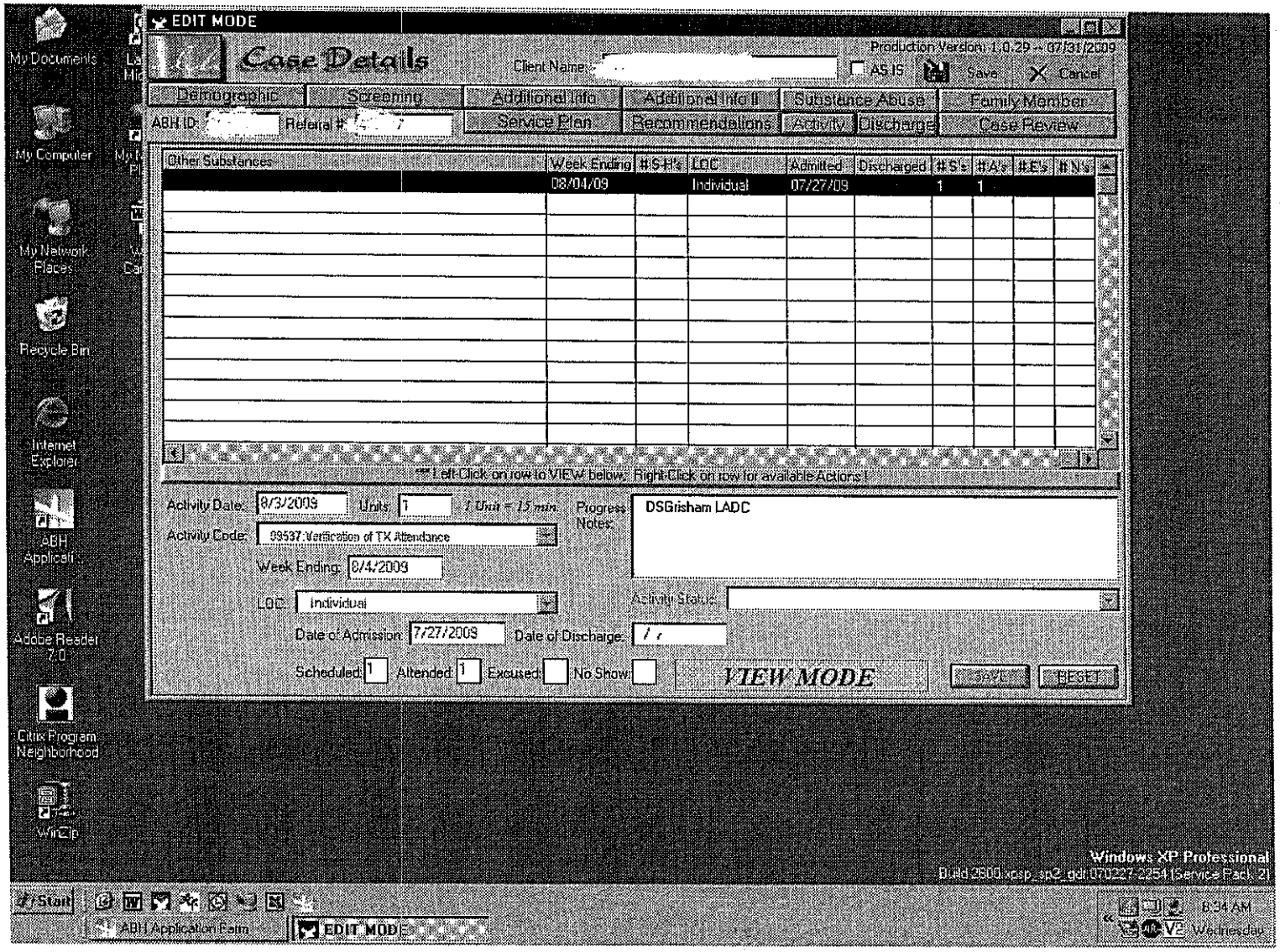

EDIT MODE
Production Version: 1.0.33 -- 09/02/2009
Case Details
Client Name:
AS IS
Save
Cancel
Demographics
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
Service Plan
Recommendations
Activity
Discharge
Case Review
ABH ID:
Referral #:
Client Strengths:
client seems to have strong work ttx and skills
Client Supports:
client seems to have support from significant other and mother
Plan ID
Added On
Category
Goal
Objective
Outcome
Edited On
Completed
4671 07/13/09 Vocational Gain employment Get/fill out/return application for em Goal in Progress
4670 07/13/09 Treatment Begin/continue mental health treatme Comply with treatment Goal in Progress
4669 07/13/09 Treatment Begin/continue substance abuse trea Comply with treatment Goal in Progress
4668 07/13/09 Engagement Engagement in D&E services Meet w/ DEP at least 1 to 2x a wee Goal in Progress
Left-Click on row to VIEW below; Right-Click on row for available Actions
SAVE
PREVIEW
RESET
PRINT
Category:
Outcome:
Goal:
Date Completed:
Objective:
% Complete:
0.00
Is Client engaged in D & E ?
Windows XP Professional
Build 2600.xpsp_sp2_gdr.070227-2254 [Service Pack 2]
Start
Inbox - Microsoft Outlook
ABH Application Forms
EDIT MODE
9:48 AM
Monday

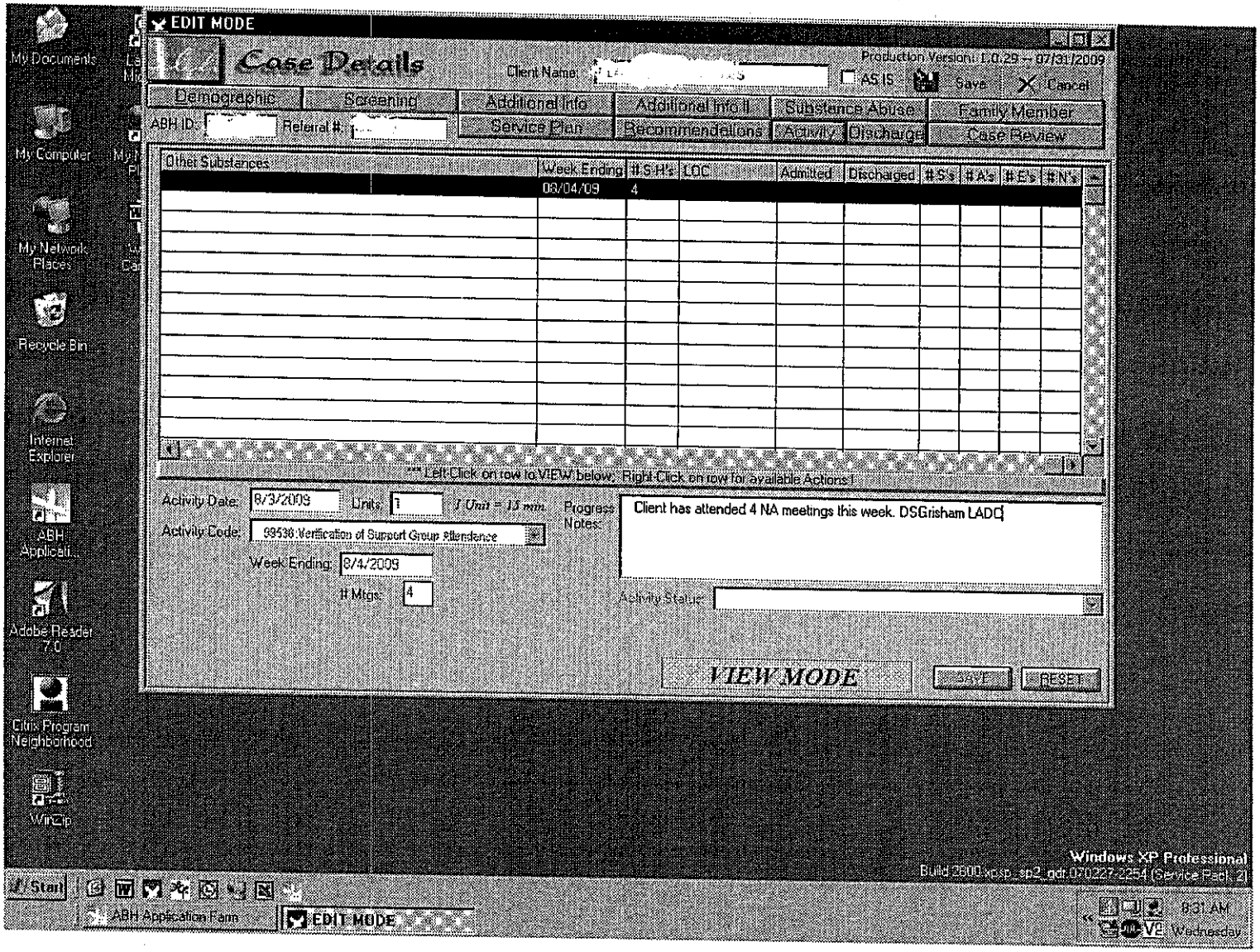

EDIT MODE
Case Details
Client Name:
AS IS
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Review
Discharge Recommendation:
Discharge Recommendation Notes:
Status at Discharge
Housing Stable ?
Employed ?
Check All Types of service that apply
Transportation
BNP referral
Child service related referral
Spiritual / religious support referral
Court / legal advocacy
Assistance with referral to detox treatment
Assistance with referral to OP SA treatment
Assistance with referral to In Pt SA treatment
Assistance with referral to OP MH treatment
Housing assistance referral
Medical care referral
Natural support referral
Non-therapeutic support referral
Community support meeting referral
Employment referral
Trauma related referral
Parenting assistance
Assistance with obtaining food
Assistance with obtaining clothing
Advocacy with DCF
Advocacy with TX provider
Assistance in getting into Residential Treatment
Windows XP Professional
Start
EDIT MODE

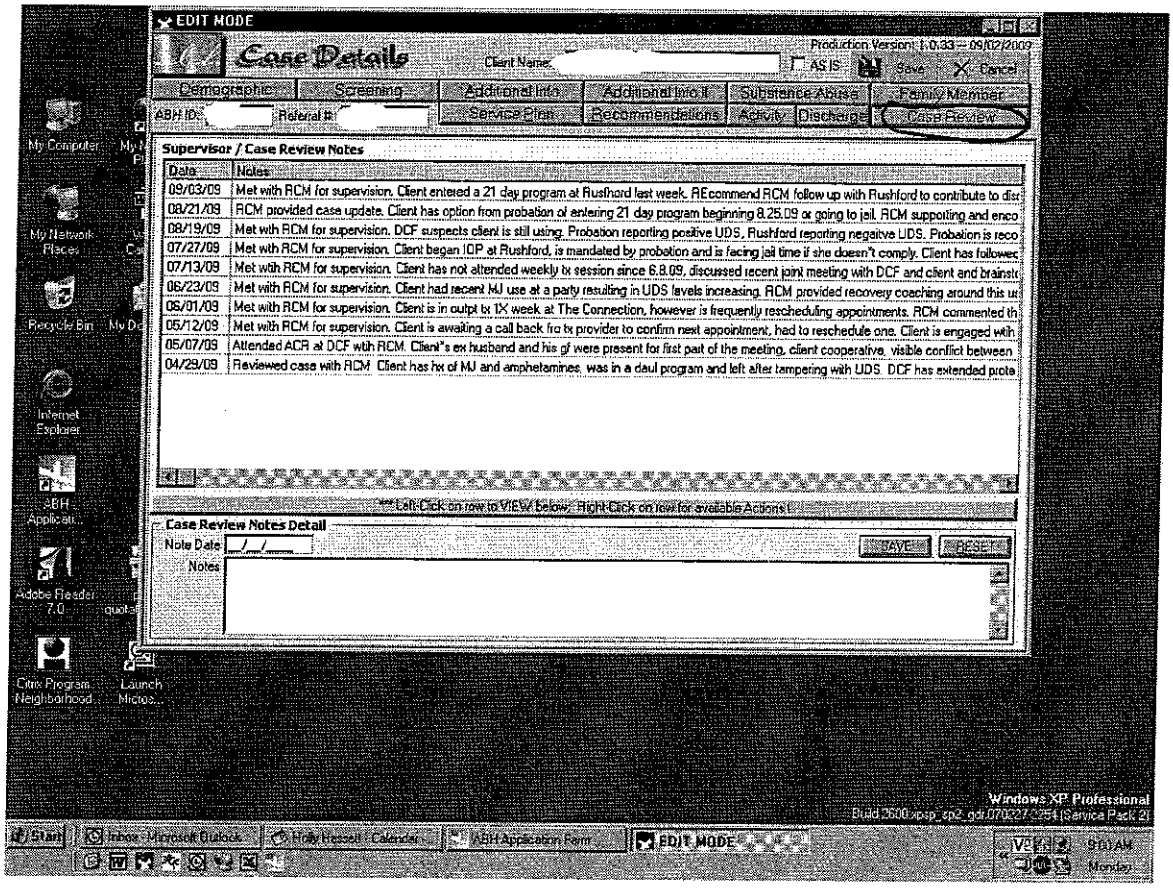

EDIT MODE
Case Details
Client Name:
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Review
Date
Activity
Units
Activity Status
Progress Note
09/01/09 99519: DCF Contact 1 DEP left messasage updating worker.R.Voisine,BAC
09/01/09 99350: Home Visits 5 D-Client was relived upon DEP arrival and reported
09/01/09 99526: Staff Commute 2 To/From Client's Home RVOISINE,BAOEP,
09/01/09 99522: Supervision/Case Review 1 Chris adised OEP to assit the client through crisis si
08/28/09 99519: DCF Contact 1 Completed and sent Bi-weekly Update to D rvoisine,baoep,
08/25/09 99519: DCF Contact 1 OEP left the dcf worker a message informing the wo
08/25/09 99350: Home Visits 4 D-The client was home upon OEP arrival. The client
08/25/09 99526: Staff Commute 1 To/From Client's Home RVOISINE,BAOEP,
08/25/09 99373: Phone contact with Treatment Prov 1 OEP spoke to clinican Kathy Barrette who reported
08/25/09 99503: Phone Contact With Client 1 OEP spoke to the client who sounded upset and re
08/19/09 99507: Case Conference with Clinician 1 Upon arrival the clinican came out of the clients hon
08/19/09 99350: Home Visits 1 OEP was intercepted by clinican upon arrival, pleas
08/19/09 99526: Staff Commute 1 To/From Client's Home rvoisine,baoep,
Left-Click on row to VIEW Below; Right-Click on row for available Actions
Activity Date:
Units:
1 Unit = 15 min
Progress Notes:
Activity Code:
Activity Status:
CREATE NEW
SAVE
RESET
Windows XP Professional
Start
EDIT MODE*
8:47 AM


EDIT MODE
Case Details
Client Name:
Production Version 1.0.29 -- 07/31/2009
AS IS
Demographics
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Closure
Date | Activity | Units | Activity Status | Progress Note
07/31/09 | 99519: DCF Contact | 1 | Completed and sent Bi-weekly Update to D | KFielding B.S.RCM
07/30/09 | 99350: Home Visits | 3 | | D - The RCM met with the client for weekly follow up
07/30/09 | 99526: Staff Commute | 2 | To/From Client's Home | KFielding B.S. RCM
07/30/09 | 99503: Phone Contact With Client | 1 | | RCM called the client to inform the client, RCM was
07/27/09 | 99522: Supervision/Case Review | 1 | Reviewed case with Program Manager | KFielding B.S.RCM
07/23/09 | 99350: Home Visits | 2 | | D - RCM met with the client for weekly follow up. A -
07/23/09 | 99526: Staff Commute | 2 | To/From Client's Home | KFielding B.S.RCM
07/23/09 | 99503: Phone Contact With Client | 1 | | RCM called the client to set up an appt for weekly fo
07/17/09 | 99519: DCF Contact | 1 | Completed and sent Bi-weekly Update to D | KFielding B.S.RCM
07/13/09 | 99522: Supervision/Case Review | 1 | Reviewed case with Program Manager | KFielding B.S.RCM
07/13/09 | 99503: Phone Contact With Client | 1 | | RCM called the client to reschedule weekly home vi
07/13/09 | 99528: Phone O&E Attempt | 1 | Phoned client, left message with person wh | KFielding B.S.RCM
07/09/09 | 99350: Home Visits | 3 | | D - RCM met with the client for weekly follow up. A -
** Left Click on row to VIEW below; Right Click on row for available Actions!
Activity Date: 08/03/2009
Units: 1
1 Unit = 15 min.
Progress Notes: DSGrisham LADC
Activity Code: 99535:RSVP Drug Screen
Drug Testing: Positive
**** Select at least one substance OR list in Other ****
ETOH THC Cocaine PCP
Heroin / Opiates Amphetamines
Other:
Activity Status: Client Complied
CREATE NEW
SAVE
RESET
My Documents
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicati...
Adobe Reader 7.0
Citrix Program Neighborhood
WinZip
Windows XP Professional
Start
ABH Application Farm
EDIT MODE
8:42 AM
Wednesday


EDIT MODE
Case Details
Client Name:
Production Version: 1.0.29 - 07/31/2009
AS IS
Save
Cancel
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral fr:
Service Plan
Recommendations
Activity
Discharge
Case Review
Drug Testing
ETOH
THC
Cocaine
Heroin/Opiates
Amphetamines
PCP
Other Substances
Positive
Y
Y
*** Left-Click on row to VIEW below; Right-Click on row for available Actions ! ***
Activity Date:
8/3/2009
Units:
1
1 Unit = 15 min
Activity Code:
99385:RSVP Drug Screen
Progress Notes:
DSGrisham LADC
Drug Testing:
Positive
*** Select at least one substance OR list in Other ***
ETOH
THC
Cocaine
PCP
Heroin / Opiates
Amphetamines
Other
Activity Status:
Client Complied
VIEW MODE
SAVE
RESET
My Documents
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicati...
Adobe Reader 7.0
Citrix Program Neighborhood
WinZip
Windows XP Professional
Build 2600.xpsp_sp2_gdr.070227-2254 Service Pack 2
Start
ABH Application Form
EDIT MODE
8:43 AM
Wednesday


EDIT MODE
Case Details
Client Name:
AS IS
Save
Cancel
Production Version: 1.0.29 -- 07/31/2009
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referal #
Service Plan
Recommendations
Activity
Discharge
Case Review
Other Substances
Week Ending
S H's
LOC
Admitted
Discharged
S's
A's
E's
N's
08/04/09
Individual
07/27/09
1
1
Left-Click on row to VIEW below; Right-Click on row for available Actions !
Activity Date:
8/3/2009
Units:
1
1 Unit = 15 min.
Progress Notes:
DSGrisham LADC
Activity Code:
99537:Verification of TX Attendance
Week Ending:
8/4/2009
LOC:
Individual
Activity Status:
Date of Admission:
7/27/2009
Date of Discharge:
Scheduled:
1
Attended:
1
Excused:
No Show:
VIEW MODE
SAVE
RESET
My Documents
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicati
Adobe Reader 7.0
Citrix Program Neighborhood
WinZip
Windows XP Professional
Start
ABH Application Form
EDIT MODE
8:34 AM
Wednesday


EDIT MODE
Case Details
Client Name:
AS IS
Save
Cancel
Production Version: 1.0.29 -- 07/31/2009
Demographic
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Review
Other Substances
Week Ending
S.H's
LOC
Admitted
Discharged
S's
A's
E's
N's
08/04/09
4
*** Left Click on row to VIEW below; Right Click on row for available Actions!
Activity Date:
8/3/2009
Units:
1
1 Unit = 15 min.
Activity Code:
99538:Verification of Support Group Attendance
Week Ending:
8/4/2009
Mtgs:
4
Progress Notes:
Client has attended 4 NA meetings this week. DSGrisham LADC
Activity Status:
VIEW MODE
SAVE
RESET
My Documents
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicati...
Adobe Reader 7.0
Citrix Program Neighborhood
WinZip
Windows XP Professional
Start
ABH Application Farm
EDIT MODE
8:31 AM
Wednesday


EDIT MODE
Case Details
Client Name:
Production Version: 1.0.33 -- 09/02/2009
AS IS
Save
Cancel
Demographics
Screening
Additional Info
Additional Info II
Substance Abuse
Family Member
ABH ID:
Referral #:
Service Plan
Recommendations
Activity
Discharge
Case Review
Supervisor / Case Review Notes
Date
Notes
09/03/09 Met with RCM for supervision. Client entered a 21 day program at Rushford last week. REcommend RCM follow up with Rushford to contribute to dis
08/21/09 RCM provided case update. Client has option from probation of entering 21 day program beginning 8.25.09 or going to jail. RCM supporting and enco
08/19/09 Met with RCM for supervision. DCF suspects client is still using. Probation reporting positive UDS, Rushford reporting negaitve UDS. Probation is reco
07/27/09 Met with RCM for supervision. Client began IOP at Rushford, is mandated by probation and is facing jail time if she doesn't comply. Client has followec
07/13/09 Met with RCM for supervision. Client has not attended weekly tx session since 6.8.09, discussed recent joint meeting with DCF and client and brainstc
06/23/09 Met with RCM for supervision. Client had recent MJ use at a party resulting in UDS levels increasing. RCM provided recovery coaching around this us
06/01/09 Met with RCM for supervision. Client is in outpt tx 1X week at The Connection, however is frequently rescheduling appointments. RCM commented th
05/12/09 Met with RCM for supervision. Client is awaiting a call back fro tx provider to confirm next appointment, had to reschedule one. Client is engaged with
05/07/09 Attended ACR at DCF with RCM. Client"s ex husband and his gf were present for first part of the meeting, client cooperative, visible conflict between
04/29/09 Reviewed case with RCM Client has hx of MJ and amphetamines, was in a daul program and left after tampering with UDS. DCF has extended prote
*** Left-Click on row to VIEW below, Right-Click on row for available Actions ***
Case Review Notes Detail
Note Date:
Notes:
SAVE
RESET
My Computer
My Network Places
Recycle Bin
Internet Explorer
ABH Applicatio...
Adobe Reader 7.0
Citrix Program Neighborhood
Launch Micros...
Windows XP Professional
Build 2600.xpsp_sp2_gdr.070227-2254 Service Pack 2
Start
Inbox - Microsoft Outlook
Holly Hassell - Calendar
ABH Application Form
EDIT MODE
9:01 AM
Monday

Policies

Advanced Behavioral Health, Inc.
Project SAFE's Outreach and Engagement Services
CHILD SUPERVISION POLICY

POLICY:

Outreach and Engagement Professionals may assist the client in completing a Project SAFE evaluation, UDS, and/or hair test by supervising a client's child(ren) while the client completes an intake/evaluation at a provider agency.

PROCEDURE:

1. The Outreach and Engagement Professional will encourage the client to make suitable childcare arrangements in order to attend the scheduled evaluation. The OEP will advocate with the client to allow the infant in the room during the evaluation

2. When other childcare options are not available when a client's evaluation, UDS, or hair test is scheduled, and it is not feasible for the child to attend the appointment with the parent, the Outreach and Engagement Professional will obtain the client's permission to supervise her/his child during the evaluation. The OEP will ask the client to make sure the child(ren) has/have been fed and had a diaper change/been toileted prior to the appointment. The OEP will clarify with the client that they will not feed the child(ren) while client is in the appointment.

3 The Outreach and Engagement Professional will inform the client and clinician at the agency that if the child(ren) needs the parent's prompt attention due to behavioral or medical reasons, the OEP will ask the agency staff to interrupt the evaluation so that the client can attend to her/his child(ren)'s needs

4 The Outreach and Engagement Professional will remain at the provider agency in a public place (e.g., waiting room) with the child(ren) while the client completes the evaluation. The O & E will establish the location of a waiting room, lobby or other public space in which to supervise the child(ren) If there is no public space, the OEP will not provide child supervision during an appointment.

5. The Outreach and Engagement Professional will only transport a client's child with the client. [*See O & E Safety Policy – Transporting Clients.]* When possible, the parent will travel in the back seat with the child(ren)

6 If the child(ren)'s needs are more than the OEP can reasonably manage, the OEP will work with the client to make other arrangements for the child(ren).

7. If the client needs childcare in order to obtain ongoing treatment, the Outreach and Engagement Professional will assist the client in addressing this barrier through referrals and/or problem solving with the client and/or DCF.

New:	1/16/2007
Reviewed without change (date):	
Revised (date):	4/11/07
Original Effective Date:	1/16/07
Scheduled Review Date:	1/3/08

Advanced Behavioral Health, Inc.
Project SAFE Outreach and Engagement Services
Contact with Former Clients

POLICY:
When former clients initiate contact, OEPs will respond in an appropriate manner to assist them.

PROCEDURE:

- When a former client contacts the OEP by phone, the OEP will respond to her/him in the following manner:
    - If the client is calling to touch base with the OEP and report on her/his progress, the OEP will keep the call brief, acknowledge the progress and wish the client continued success in her/his recovery.
    - If the client is calling with a specific need or seeking a referral, the OEP will:
        - Ask if the client is still involved with DCF. If yes, the OEP will refer the client back to her/his DCF Social Worker for the appropriate referral.
        - If the client is no longer involved with DCF, the OEP will provide information on the resources the client is requesting, e.g., housing assistance, treatment providers, etc., and/or refer the client to InfoLine – 211 for assistance.

- If an OEP has contact with a former client in a community setting, the OEP will maintain professional boundaries and client confidentiality and respond as described above.

- OEPs will not initiate face to face contacts with former clients.

- OEPs will not transport former clients.

New:	7/5/07
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	7/6/08

Advanced Behavioral Health, Inc.
Project SAFE Outreach and Engagement Services
Petty Cash

POLICY: O & E will utilize the following guidelines to insure the appropriate use and documentation of discretionary monies spent in serving active clients.

PROCEDURE:

- Petty cash can be used to reimburse O & E staff for incidental purchases incurred in the process of engaging and/or servicing active O & E/RCM clients (ex., purchasing a cup of coffee for a client; buying a client lunch when transporting client to an intake at a great distance; purchasing a pocket calendar to assist the client in organizing her/his schedule).
- If the OEP/RCM is unsure if an expense is eligible for reimbursement through petty cash, s/he should contact the Program Manager prior to incurring the expense.
- To receive reimbursement, the OEP/RCM must submit an itemized, dated receipt to the Program Manager with a brief explanation of the reason for the expenditure.
- The Program Manager will review the receipt and approve or deny the request. If approved, the PM will reimburse the OEP/RCM using funds from petty cash.
- The Program Manager will track reimbursements from petty cash as required by ABH's Accounting Department and submit documentation of expenditures incurred on a regular basis.
- Petty Cash can only be utilized for expenses incurred on an active client's behalf, it cannot be used to reimburse the OEP/RCM for other expenses (e.g., the OEP/RCM's lunch).
- As funds are limited, OEPs/RCMs will use them only when needed.

New:	2/26/08
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	2/26/09

Advanced Behavioral Health, Inc.
Project SAFE's Outreach and Engagement Services
Critical Incidents

POLICY:

The primary goal of identifying events as Critical Incidents is focused on identification of events that may reflect quality of care issues, including, but not limited to, those occurring directly as a result of services performed by ABH.

PROCEDURE:

A. Definition and Criteria

A Critical Incident is any event that results in the death of a person, serious injury or risk of injury to a recipient, any serious adverse treatment response, or serious impact on service delivery. The critical incident may include, but is not limited to:

- **Client abuse alleged**
- **Death of a client**, on-duty staff member, or visitor to the facility/agency, including any client death that occurs within 30 days of discharge from treatment, if known.
- **Emergency Evacuation** of program premises, other than for the purpose to conduct a drill.
- **Escape** from a hospital of any client under the jurisdiction of the Psychiatric Security Review Board (PSRB), or any client confined pursuant to Sec. 54-56d of the Conn. General Statutes, or any person during a correctional transfer or treatment with DMHAS as a result of a correctional transfer, who is still under sentence at the time of escape
- **Federal Notification**: Emergency situations resulting in the notification of federal offices. The sub-types are: 1) US Secret Service (threat to the President);2) FBI (kidnapping, terrorist threat, etc); 3) Other notification.
- **Loss/Damage:** Significant loss or allegations of theft.
- **Medical event:** An unexpected medical event with serious or potentially serious consequences to a client, staff or visitor on the premises or during involvement in program activity <u>which results in an admission to a medical/surgical inpatient unit</u>.
- **Missing:** The unauthorized absence of a client from a treatment program when the whereabouts of the client are unknown. There are three sub-types: 1) missing inpatient client considered dangerous to self or others; 2) missing outpatient client considered dangerous to self or others; 3) missing client (inpatient or outpatient) who is not considered dangerous and has had a 'missing person' report officially made to police.
- **Serious Crime Alleged:** Serious behaviors that are committed or allegedly committed on or by clients, on-duty staff, or visitors to a facility or program that have resulted or may result in an arrest.
- **Serious Suicide Attempt:** Includes attempts (if known) that occur up to 30 days after discharge from any program. This category is <u>not</u> used to report all cases of suicidal ideation or gestures. A public attempt with attendant media publicity should be reported even if there are no serious injuries. There are two sub-types: 1) During program enrollment or 2) within 30 days post-program discharge from any program level any serious attempt that results in admission to a medical/surgical facility for treatment of injury and/or civil commitment.
- **Threats:** Threats by a client assessed to represent a serious risk to the staff, other clients, or others.
- **Other:** Any serious incident not easily classifiable under above categories, including events previously reported as Media Publicity and not meeting criteria for any other type of Critical Incident.

2. **Notification**

- Outreach and Engagement staff should notify the O/E Program Manager or designee as soon as possible that a Critical Incident has occurred

- The O/E Program Manager or designee will verbally notify DMHAS' Health Care Systems Unit via the Critical Incident Report Line within three (3) hours of the identification of the Critical Incident The Critical Incident Report Line provides a voice mailbox to leave information with instructions on what information to provide and when and how to directly reach a DMHAS staff person.
- The O/E Program Manager or designee will collect and document all pertinent information on *DMHAS' Critical Incident Report* and fax the report to DMHAS OOC/Health Care Systems within one (1) business day of the identification of the incident. A copy of the critical incident report will be forwarded to the ABH Project SAFE Senior Program Manager and ABH QM director.

3. Review

Internal and external reviews are conducted using the data collected

- Internally, the O/E Program Manager will review the Critical Incident with the Project SAFE Senior Program Manager. The ABH QM Director will review the Critical Incident to ensure that the notification meets criteria as well as identifying quality issues If a quality or care issue is identified, the Program Manager will develop a plan of corrective action
- Externally, DMHAS Quality Assurance staff review the information collected to identify quality of care issues and to ensure that services provided by a DMHAS-contracted agency meet currently accepted quality of care standards.

Attachments: DMHAS Critical Incident Reporting Guide
DMHAS Critical Incident Report

New:	12/22/06
Reviewed without change (date):	
Revised (date):	2/13/07
Original Effective Date:	12/22/06
Scheduled Review Date:	12/22/07 1/31/08

Critical Incident Reporting
User Guide

INTRODUCTION

Critical Incident Reporting (CIR) provides a permanent record of the management of critical incidents that involve DMHAS agencies and/or persons connected with these agencies. DMHAS considers that a part of clinical governance is the ability to manage critical incidents. The key aspects to managing critical incidents are:

- Prompt, sensitive and professional handling of incidents
- Prompt action to report incidents to relevant authorities
- A methodical and detailed investigation process into major incidents
- A plan to ensure the organization learns from incidents

Under Connecticut Statute 17a-452b, the authority for overseeing the quality of services for DMHAS clients, facilities and funded agencies is designated to the Medical Director. The reporting and review of critical incidents is an important component of the ongoing evaluation and improvement of the quality of care and services.

CRITICAL INCIDENT REPORT FORM

The Critical Incident Report (CIR) form is divided into three sections: (a) The Incident; (b) The Person(s); (c) Review/Closure. The classification (type) of incident determines which section(s) must be completed. Section (a) must be completed for ALL incidents. Section (B) is completed for all incidents involving distinct persons, i.e. not an agency-wide incident such as a fire in which all persons are evacuated. Section (C) is completed when the incident is reviewed.

The CIR form details the areas and categories of information necessary for the DMHAS Office of the Commissioner to process information in a consistent manner statewide. This allows for more meaningful analyses. Therefore, this form should be used to communicate a critical incident to the OOC when an event becomes known and is determined to meet the definition for a critical incident (*also see categories below*).

Many of the items are self-explanatory. The items that may need further explanation are explained herein, with the numer matching to the item on the actual form

Section A: The Incident

2. Responsible Regional Organization

For a mental health agency, this would be the lead administrative agency such as WCMHN for an incident that occurred at GWMHA or any of their affiliate agencies such as Waterbury Hospital; or CVH for an incident at Whiting.

For a substance abuse agency, this would be the agency where the incident occurred.

7. Location Type

Choose one of seven categories listed on the form. Some categories are less obvious and are clarified as noted:

- inpatient unit, DMHAS operated - i.e., CVH, CRH, CMHC, SWCMHS, CRMHC (includes any residential programs located on hospital grounds);
- inpatient unit, non-DMHAS operated - any other hospital, i.e., Natchaug, Backus, Stamford, etc.;
- other 24/7 institution - which provides on-site staff supervision, includes nursing homes, group homes, residential programs and supervised apartments with 24/7 staff availability
- program premises, non-inpatient - agency property or office plus any supported residential program where staff is not continuously available.

9. & 10. Critical Incident Categories and Subcategories

The Commissioner's Policy statement defines critical incidents as incidents which may have a serious impact on DMHAS clients, staff, facilities, funded agencies or the public, or bring about adverse publicity.

This is a broad definition intended to give discretion to the reporting organization as to what types of incidents are critical and when an ordinary incident reaches the threshold of critical. An agency may have additional criteria for critical incidents, and the DMHAS OOC reporting is not intended to replace that process.

Client Abuse Alleged: Allegations of improper verbal or physical treatment of client by staff that have serious consequences or potentially serious consequences – includes patient rights and confidentiality issues. The sub-types are:

CL1 – Physical abuse alleged
CL2 – Verbal abuse alleged
CL3 – Violation of patient rights with significant consequences alleged
CL4 – Breach of confidentiality with significant consequences alleged

Alleged violation of patient rights or breach of confidentiality must meet a standard of 'significant consequences'. For an event to be reportable as a critical incident, a judgment must be made that 'significant consequences' are possible and/or likely – e.g., revealing a client's HIV status, a threatened or potential lawsuit, a missing patient medical record not found after an exhaustive search, etc.

Death: Death of a client, on-duty staff member, or visitor to the facility/agency -includes client deaths (if known) that occur up to 30 days after discharge from any program level. For purposes of aggregation, deaths are divided into five sub-types:

DE1 – suicide
DE2 – homicide
DE3 – accident

DE4 – due to medical condition / illness or old age
DE5 – type not yet determined

When a death is first reported, often the details are unclear. The reporting agency should use their best judgment based on the information available. A category of DE1 through DE4 which best describes the type of death should be initially chosen. DE5 is provided when a report must be made to OOC for which there is insufficient information to categorize the type of death at the time of the first report, however, additional information that clarifies the type of death must be reported to DMHAS/OOC as soon as possible.

Emergency Evacuation: Evacuation of program premises, other than for the purpose to conduct a drill. The three sub-types are:

EV1 – Fire
EV2 – Bomb threat
EV3 – Other

Any situation which requires the evacuation of program premises should be reported as a Critical Incident, even if no serious damage occurs (e.g., wastebasket fire). Judgment must be used to determine what constitutes a serious situation. Programs with cooking facilities which trigger a smoke alarm leading to an evacuation for a very short time with little disruption of program services and no damage need not report this as a Critical Incident.

Escape: When a client is missing who is under the jurisdiction of the PSRB, patients confined pursuant to Section 54-56d CGS (competency restoration), or during a correctional transfer. There are three sub-types:

ES1 – PSRB patient
ES2 – Correctional transfer (DOC)
ES3 – 54-56d commitment (competency restoration)

All three sub-types refer to clients who legally have been made the responsibility of DMHAS through a judicial process and who have a distinct legal status. Any DOC inmate who has been accepted for treatment at a DMHAS facility and who then goes missing or AWOL should be treated as an Escape.

Federal Notification: Emergency situations resulting in the notification of federal offices. The sub-types are:

FN1 – US Secret Service (threat to the President)
FN2 – FBI (kidnapping, terrorist threat, etc.)
FN3 – Other notification

Loss / Damage: Significant loss or allegations of theft. The two sub-types are:

LD1 – Loss / damage / theft that has compromised or could have compromised staff or patient safety
LD2 – Significant loss / damage / theft of property > $1,000

The distinction between these two sub-types is that LD1 is safety-related and LD2 is not. An LD1 sub-type takes precedence over an LD2 sub-type even if both are true. For example, a vehicle that

crashes into a program site may cause damages over $1,000 but the structural damage may compromise staff/client safety; this incident would be reported as an LD1 type. Theft of computer equipment valued at over $1,000 may be reported as an LD2 but if the computer contains confidential client information which is easily accessible, then it might more properly be categorized as a CL4 - breach of confidentiality with serious consequences.

Medical Event: An unexpected medical event with serious or potentially serious consequences to a client, staff, or visitor on the premises or during involvement in program activity which results in an admission to a medical / surgical inpatient unit. The four sub-types are:

- *ME1* – Any serious injury related to program activity which results in the admission of the person to a medical or surgical inpatient unit (includes non-suicidal self-injurious behavior)
- *ME2* – Accidental alcohol or drug overdose – includes prescribed medication, over-the-counter medications, and illegal substances resulting in admission to inpatient unit
- *ME3* – Medication error (not client caused) or adverse drug reaction resulting in admission to inpatient unit
- *ME4* – Other medical event (e.g., non-fatal heart attack, diabetic coma, etc.) during involvement in program activity resulting in admission to inpatient unit

The serious injury or medical event must have occurred either on the program site or during organized program activity off-site. Serious self-injurious behavior not intended as suicidal is also reported if it results in injuries severe enough to require inpatient admission.

Missing: The unauthorized absence of a client from a treatment program when the whereabouts of the client are unknown. The three sub-types are:

- *MC1* – Missing inpatient client considered dangerous to self or other
- *MC2* – Missing outpatient considered dangerous to self or others
- *MC3* – Missing client – client (inpatient or outpatient) who is not considered dangerous and has had a 'missing person' report officially made to police,

The judgment of dangerousness may have been made prior to the person become missing, or at the time the person is declared missing, when there is reasonable evidence to substantiate the claim. A client may not be considered immediately dangerous, but may have a history of behaviors that negatively impact their ability to function safely when not on psychotropic medication. If this is the case, then the client should be considered as dangerous to self or others.

Each agency may use its own criteria to determine when a client as missing. This determination may be based on factors such as a client's usual patterns and behaviors, as well as the situation or setting from which the client is missing.

Serious Crime Alleged: Serious behaviors that are committed or allegedly committed on or by clients, on-duty staff, or visitors to a facility or program that have resulted or may result in an arrest. The sub-types are:

- *SC1* – Physical assault alleged
- *SC2* – Sexual assault alleged
- *SC3* – Risk of injury to a minor alleged
- *SC4* – Arson alleged
- *SC5* – Incidents involving firearms alleged
- *SC6* – Hostage taking alleged

SC7 – Sale of illegal substances on program premises alleged
SC8 – Homicide / manslaughter alleged
SC9 – Other (e.g., robbery, theft, embezzlement) alleged

Judgment must be used to avoid over-reporting as well as under-reporting. Altercations between clients may occur, an event tat is terminated by staff intervention without the involvement of police or injury to any parties is not necessarily a reportable incident. If the police are called and someone is arrested, then this should be reported as a Critical Incident. Sexual assaults and serious physical assaults, even if the victim does not press charges, are reportable events.

When the media reports an alleged incident which involves the arrest of a client for one of the above sub-types, this could also be reported as a Critical Incident. The Office of the Commissioner should be aware of potential media coverage even if the client is not identified as a person receiving mental health or substance abuse services.

Serious Suicide Attempt: Includes attempts (if known) that occur up to 30 days after discharge from any program.

This category is not used to report all cases of suicidal ideation or gestures. The clinician must determine that the client has made a very serious attempt to end their life. An event of this type may be reportable if the Client's actions results in an admission to a medical / surgical inpatient unit or a psychiatric inpatient unit. A public attempt with attendant media publicity should be reported even if there are no serious injuries. The two sub-types are:

SA1 – During program enrollment – any serious attempt that results in admission to a medical/surgical facility for treatment of injury and/or civil commitment
SA2 – Any serious attempt (if known) within 30 days post-program discharge from any program level that results in admission to a medical/surgical facility for treatment of injury and/or civil commitment

It may be difficult to distinguish a Serious Suicide Attempt from a Medical Event ME2 (Accidental drug overdose). Clinical judgment should weigh the intent of the client. If an agency becomes aware (newspaper article, reports by current clients, former client's family, etc.) that a former client who was recently discharged (within 30 days) has made a serious suicide attempt as defined above, this should be reported as a Critical Incident.

Threats: Threats by a client, assessed to represent a serious risk to the staff, other clients, or others. There are two sub-types:

TH1 – Against agency or program (not a specific person) by a client assessed by staff to represent a serious risk
TH2 – Against a person (staff, another client, visitor, client's relative, etc.) by a client assessed by staff to represent a serious risk

The key to both of these sub-types is that agency has made an assessment that there is a likelihood that threats made by the client could be or would be carried out if no action is taken "Someday person x is going to get what they deserve" may or may not be considered a serious threat depending upon history, context, current symptomatology, etc. If a Tarasoff warning is appropriate, then that situation should be reported as a Critical Incident.

Other: Any serious incident not easily classifiable under above categories

Any other event, which in the opinion of the responsible reporting organization constitutes a Critical Incident, is classified as Other. Events previously reported as Media Publicity (and not meeting criteria for any other type of Critical Incident) may be reported as OT1.

14. Responsible Reporting Organization:

This may or may not be the same as #2. If the region has an administrative body such as SWCMHS or WCMHN, item #2 would indicate this and item #14 would then be the LMHA such as Dubois or GWMHA respectively. In all other cases, including addiction service providers, #'s 2 and 14 would be the same.

15. Agency Providing Service:

Indicate the agency by formal name (per contract); include specific program and site to assist with proper assignment of the incident. Program associated w/ incident.

16. Care Intensity:

The level of care for the program that is reporting the incident. Sources for this information would be the DMHAS contract and the DMHAS Provider Access System (DPAS) Report CC810 – "Programs and LOC".

17. Does it appear that one or more of the following substances was a direct cause or a contributory cause of the incident?

The Responsible Reporting Agency must use its best judgment based upon what is known at the time the incident is reported. It may not be possible to answer this question definitively until the Incident Review occurs. It may be left blank until an answer is available, but it should then be reported to the Office of the Commissioner.

20. Media Coverage:

When submitting the report by fax, please include copies of any related media. Note: a death notification by itself in the local paper does not constitute media coverage.

21. Incident Detailed Description:

Provide a brief yet detailed description of the event(s) determined to meeting the criteria for a critical incident. Do not use client identifiers in this portion of the report, replacing the client's name with "client" or "patient". If more than one person is involved, this may be worded "client #1" or "primary". Section "B" collects the identifying information on all parties involved.

Section B: The Person

When an incident is facility-wide or does not involve specific persons, only #1 needs to be checked for "agency". Examples include any event that would result in the need to evacuate clients and staff for a prolonged period of time such as a fire or loss of electricity.

In most cases, a critical incident involves a client and/or other persons. All information should be provided using a separate Section B page for each client involved. When persons other than clients are involved, only #1 and #16 must be completed.

4. DPAS ID/BHIS MPI#:

These unique client identifier identification numbers may be found in the DPAS. Using your "search" option, locate the client. This identifier information may be found on the demographics page.

Section C: DMHAS Critical Incident Review /Closure

5. Primary Review Chairperson:

The name of the person chairing the incident review should be used to complete this field.

8. & 9. Review Findings and Corrective Action Plans:

See the Commissioner's Policy Statement No. 81: Critical Incidents for content advice.

11. & 12. Final Incident Category and Sub-Category:

Most often this will be the same as when reported. On occasion, additional information collected after the initial report may lead to a need to re-classify the incident, and this may be done here.

DMHAS Critical Incident Report

Directions:

- ☐ DMHAS-Operated facilities, LMHA's or Substance Abuse Providers should make a Verbal Report to DMHAS within (3) hours of learning of an incident: the Critical Incident Line is 860-418-8750.
- ☐ Within (1) business day, written report should be submitted using these forms to DMHAS, Office of the Commissioner.
- ☐ Sections A and B should be submitted to report the incident.
- ☐ Sections A, B and C should be submitted to report the critical incident review, usually within 30-60 days post incident. Note: all sections are requested for the review to assure matching of appropriate information.
- ☐ Completed forms should be faxed to 860-418-6730

Contact Person & Telephone Number: _____

Date of this Report: _____

Section A: The Incident

1. General Service (based on funding source): ☐ **MH** ☐ **SA**

2. Responsible Regional Organization: _____
(DMHAS-Op Hosp, Network or LMHA, Private Non-Profit LMHA or SA Provider)

3. Date of Incident: _____ **4. Time of Incident:** ____:____ ☐ AM ☐ PM

5. Alternate Incident ID: (if applicable) _____

6. Town of Incident: _____

7. Location Type:

☐ All Other Locations	☐ Inpt. Unit, Non-DMHAS	☐ Program Premises: non-Inpt
☐ Client's Residence	☐ Jail	
☐ Inpt. Unit, DMHAS-Op	☐ Other 24/7 Institution	

8. Location Description: (optional) _____

9. Incident Category: (check one)

☐ client abuse alleged (CL)	☐ fed. notification (FN)	☐ other (OT)
☐ death (DE)	☐ loss/damage (LD)	☐ serious crime alleged (SC)
☐ emergency evac.(EV)	☐ med. event (ME)	☐ serious suicide attempt (SA)
☐ escape(ES)	☐ missing client (MC)	☐ threats (TH)

10. Incident Subcategory: (circle one from group coded above and see attachment for additional information)

DE1 suicide
DE2 homicide
DE3 accident / med err
DE4 med / ill / age
DE5 insuff info

SA1 suicide attmpt
SA2 sui. attmpt - post d/c

TH1 threats to agency
TH2 threats to person

ES1 escape - PSRB
ES2 escape - DOC
ES3 escape – comp rest

MC1 missing inpt - dngr
MC2 missing outpt - dngr
MC3 missing person

LD1 loss/damage - safety
LD2 loss/damage > $1000

CL1 client abuse - physical
CL2 client abuse - verbal
CL3 pt rights violation
CL4 confidentiality breach

FN1 Fed notice - Secr Srv
FN2 Fed notice – FBI
FN3 Fed notice - other

SC1 phys assault
SC2 sexual assault
SC3 risk injry minor
SC4 arson
SC5 firearms
SC6 hostage
SC7 drug sale / pgm
SC8 homicide / mnslghtr
SC9 other serious crime

EV1 evac - fire
EV3 evac - bomb
EV3 evac - other

ME1 acdntl injury
ME2 acdntl OD
ME3 med reaction err
ME4 med evnt - other

OT1 other incident

11. Did the incident occur: (check one)
☐ at agency/program site ☐ during agency/program activity off-site ☐ not related to agency/program activity

12. Monitoring Region: (indicate 1- 5) _____

13. Service Type: (check one) ☐ **SO LMHA/Hosp** ☐ **PNP LMHA** ☐ **SA Only**

14. Responsible Reporting Organization: _____
(DMHAS-Op Hosp. or LMHA; PNP LMHA or SA Provider Holding a DMHAS Contract)

15. Agency Providing Service: _____

16. Care Intensity (specify level of care as designated in the DPAS cc810 report): _____

17. Does it appear that one or more of the following substances was a direct cause or a contributory cause of incident?
☐ Alcohol ☐ Illicit drug ☐ Prescribed medication ☐ Over-the-counter medication ☐ No evidence

18. Is there any evidence that the incident may have been a result of an alcohol / drug / medication overdose?
☐ Y ☐ N

19. Is incident related to use of restraint or seclusion? ☐ Y ☐N

20. Media coverage: (check one) ☐ reported _____ ☐ possible report ☐ unlikely
If media coverage has occurred, indicate source, date and brief summary of content as part of narrative below. Attach a copy of printed media

21. Incident Detailed Description:

DMHAS Critical Incident Report

ction B: The Person(s) (include a separate page for each client involved; if non-client is involved, complete Item #16)

1. **Classification:** ☐ agency ☐ client ☐ other ☐ staff ☐ visitor

2. **Role** *(if indicated)*: ☐ perpetrator ☐ victim ☐ N/A

3. **SSN#:** _____ - _____ - _____ 4. **DPAS ID:** _____ / **BHIS MPI #:** _____
(located on demographics page in DPAS) *(for state-operated programs only)*

5. **Client First Name:** _____ **Last Name:** _____

6. **DOB:** ____/____/____ 7. **Gender:** ☐ M ☐ F

8. **Legal status:**
☐ competency restored ☐ PEC ☐ voluntary (most clients)
☐ correctional transfer ☐ PSRB

9. **Person's Relationship to Agency:**
☐ client-acting as staff ☐ other ☐ visitor
☐ client-active ☐ staff
☐ client-former, non-active ☐ staff of agency

10. **Race:**
☐ Amer. Ind / Alask. Native ☐ Black/African ☐ Mixed
☐ Asian ☐ Caucasian ☐ Native Haw./Pacif. Isl

11. **Ethnicity:**
☐ Hispanic ☐ Non-Hispanic ☐ Not spec / Unknown

12. **Injuries** (if any):
☐ death ☐ minor ☐ to visitor
☐ hospitalization ☐ no injuries ☐ unknown
☐ med. intervention required ☐ to staff

13. **MH Diagnoses:** (numeric and text)
_____
_____

14. **SA Diagnoses:** (numeric and text)
_____
_____

15. **Current Medical Conditions** *(if relevant)*:
_____

16. **Staff, Visitors, Others Involved:**
Person #1 __ Staff __ Visitor __ Other **Role:** __ Victim __ Perpetrator __ N/A **Injuries:**(see #12) _____
Person #2 __ Staff __ Visitor __ Other**Role:** __ Victim __ Perpetrator __ N/A **Injuries:** _____
rson #3 __ Staff __ Visitor __ Other**Role:** __ Victim __ Perpetrator __ N/A **Injuries:** _____

7. **Additional Programs Enrolled:** *(list all providers, programs and the levels of care in which the client is active)*
_____
_____

DMHAS Critical Incident Report

Section C: REVIEW/CLOSURE

1. Date of Initial Review: _____ **2. Date of Final Review:** _____

3. Recommended Date for Closure: _____

4. Primary Review Method *(indicate when one of the following methods is used)*:

- ☐ Administrative Review
- ☐ Case Conference
- ☐ Critical Incident Review
- ☐ Human Resources Review
- ☐ Other
- ☐ Root Cause Analysis

5. Primary Review Chairperson *(if indicated)*: _____

6. Service Type:

- ☐ ABH
- ☐ State Op LMHA/Hosp.
- ☐ Private-Not-For-Profit LMHA
- ☐ Substance Abuse Only

7. Responsible Reporting Organization: _____
(DMHAS-Op Hosp., or LMHA; PNP LMHA or SA Provider Holding a DMHAS Contract)

Agency Providing Service:

- ☐ Same as # 7
- ☐ Specify if different: _____

9. Review Findings:

10. Corrective Actions Proposed/Completed : incl specific actions, dates and responsible person(s)

For # 11 and #12, refer to Section A, #9 and #10 for available types and indicate category based on findings of review (in most cases does not change).

11. Final Incident Category: _____

12. Final Sub Category: _____

13. Basis for Final Cause of Death *(when incident involves death):*

- ☐ Autopsy
- ☐ Evident from Circumstances
- ☐ Family Report
- ☐ Media Report
- ☐ Other
- ☐ Physician Involved
- ☐ Police Report
- ☐ Provider report
- ☐ Death Certificate

14. Cause of Death *(when incident involves death):* _____

ATTACHMENT "A": INCIDENT TYPES

Death	*(intentional)*	**DE1** – suicide
		DE2 – homicide
	(unintentional)	**DE3** – accident / medication error
		DE4 – due to medical condition / illness or old age
	(no information)	**DE5** – insufficient information to determine type
Serious Suicide Attempt		**SA1** – During program enrollment – any serious attempt which results in admission to a medical/surgical facility for treatment of injury and/or civil commitment
		SA2 – Within 30 days post-program discharge from any program level – any serious attempt (if known) which results in admission to a medical/surgical facility for treatment of injury and/or civil commitment
Escape		**ES1** – Psychiatric Security Review Board patient
		ES2 – Correctional transfer (Dept. of Correction)
		ES3 – 54-56d commitment (competency restoration)
Missing Client		**MC1** – Missing inpatient client considered dangerous to self or other
		MC2 – Missing outpatient considered dangerous to self or others
		MC3 – Missing client – inpatient or outpatient client who has had a 'missing person' report officially made to police, not considered dangerous
Medical Event / Serious Injury w/ admission to medical / surgical unit		**ME1** – Any accidental serious injury related to program activity which results in the admission of the person to a medical or surgical inpatient unit – includes transportation accidents and non-suicidal self-injurious behavior
		ME2 – Accidental alcohol or drug overdose - includes prescribed meds, over-the-counter meds, & illegal substances resulting in admission to a medical / surgical inpatient unit
		ME3 – Medication error (not client caused) or adverse drug reaction resulting in admission to a medical / surgical inpatient unit
		ME4 – Other medical event unit (e.g., non-fatal heart attack, diabetic coma, etc.) during involvement in program activity resulting in admission to medical / surgical inpatient unit
Client Abuse Alleged		**CL1** – Physical abuse alleged
		CL2 – Verbal abuse alleged
		CL3 – Violation of patient rights with significant consequences alleged
		CL4 – Breach of confidentiality with significant consequences alleged
Federal Notification		**FN1** – US Secret Service
		FN2 – FBI – kidnapping, terrorist threat, etc,
		FN3 – Other notification
Loss / Damage		**LD1** – Loss / damage / theft that has compromised or could have compromised staff or patient safety
		LD2 – Significant loss / damage / theft of property > $1,000
Serious Crime Alleged		May or may not result in an arrest of alleged perpetrator(s)
		SC1 – Physical assault alleged
		SC2 – Sexual assault alleged
		SC3 – Risk of injury to a minor alleged
		SC4 – Arson alleged
		SC5 – Incidents involving firearms alleged
		SC6 – Hostage taking alleged
		SC7 – Sale of illegal substances on program premises alleged
		SC8 – Homicide / manslaughter alleged
		SC9 – Other serious crime (e.g., robbery, theft, embezzlement) alleged
Emergency Evacuation		**EV1** – Fire
		EV2 – Bomb threat
		EV3 – Other
Threats		**TH1** – Against agency or program (not a specific person) by a client assessed by staff to represent a serious risk
		TH2 – Against another person by a client assessed by staff to represent a serious risk
Other		**OT1** – Any serious incident not easily classifiable under above categories

Advanced Behavioral Health, Inc.
Project SAFE's Outreach and Engagement Services
Policy - Reporting of Suspected Child Abuse or Neglect

POLICY:
Advanced Behavioral Health (ABH) employees will maintain an understanding and operation of the current standards and practice of mandated reporting laws regarding suspected child abuse or neglect.

PURPOSE:

All ABH Outreach and Engagement staffs are mandated reporters of child abuse and neglect. There is an obligation to include ongoing training that educates staff on how to identify and understand the process of reporting and legal guidelines

PROCEDURE:

- All O & E staff will participate in scheduled trainings on mandated reporting.
- DCF resources may be used in training O & E staff
- Additional individual or group training may be arranged as a result of issues identified by supervisors.
- All suspected cases of abuse should be discussed by the OEP with the Program Manager and/or Team Leader before any documentation is submitted to DCF. If the Program Manager or Team Leader are unavailable, the OEP should contact Project SAFE's Senior Program Manager to discuss the situation.
- Any and all concerns regarding client's children will be discussed with DCF and documented in ABH's O/E database.
- Following discussion with the supervisory staff when a report of suspected child abuse or neglect is filed, the OEP should discuss with the client (unless contraindicated, e.g., potential safety issue for OEP) and contact the DCF SW to inform them that a report of suspected child abuse or neglect has been filed and document this in the O & E database
- Mandated reporters must report orally to the Department of Children and Families' (DCF) 24-hour Hotline, 1-800-842-2288, or a law enforcement agency within 12 hours of suspecting that a child has been abused or neglected and must submit a written report (DCF-136 form) to DCF within 48 hours of making the oral report.
- When making a report, a mandated reporter is required to provide the following information, if known:
    - Names and addresses of the child and his parents or responsible caregiver(s)
    - Child's age and gender
    - Nature and extent of injury, maltreatment or neglect
    - Approximate date and time the injury, maltreatment or neglect occurred
    - The circumstances in which the injuries, maltreatment or neglect became known to the reporter
    - Previous injury, maltreatment or neglect of the child or siblings
    - Name of the person suspected to have caused the injury, maltreatment or neglect
    - Any action taken to treat or help the child
    - Any other information the reporter believes would be helpful

Attachments:

- DCF: What Mandated Reporters Need to Know
- DCF – 136 Form

New:	
Reviewed without change (date):	
Revised (date):	2/12/07
Original Effective Date:	
Scheduled Review Date:	2/12/08 1/31/09

Department of Children and Families

What Mandated Reporters Need to Know

Summary of Connecticut's Child Abuse Reporting Laws

The following is an outline of the legal requirements of "mandated reporters," those professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect. For a complete copy of the law, refer to Sections 17a-101 through 17a-103a, inclusive of the Connecticut General Statutes.

Who Must Report

Connecticut law requires certain citizens to report suspected child abuse and neglect. These mandated reporters are people in professions or occupations that have contact with children or whose primary focus is children. The law requires that they report suspected child abuse or neglect. Under Section 17a-101 of the Connecticut General Statutes, the following are considered mandated reporters:

- Any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home which is licensed by the State.
- Battered Women's Counselors
- Chiropractors
- Dental Hygienists
- Dentists
- Department of Children and Families Employees
- Department of Public Health employees responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps.
- Licensed/Certified Alcohol and Drug Counselors
- Licensed/Certified Emergency Medical Services Providers
- Licensed Marital and Family Therapists
- Licensed or Unlicensed Resident Interns
- Licensed or Unlicensed Resident Physicians
- Licensed Physicians
- Licensed Practical Nurses
- Licensed Professional Counselors
- Licensed Surgeons
- Medical Examiners
- Members of the Clergy
- Mental Health Professionals
- Optometrists
- Parole Officers (Juvenile or Adult)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Police Officers
- Probation Officers (Juvenile or Adult)
- Psychologists
- Registered Nurses
- School Guidance Counselors
- School Paraprofessionals
- School Principals
- School Teachers
- Sexual Assault Counselors

- Social Workers
- School Coaches or Coaches of Intramural or Interscholastic Athletics
- The Child Advocate and any employee of the Office of the Child Advocate.

What Must Be Reported

Mandated reporters are required to report or cause a report to be made when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm. (Connecticut General Statutes §17a-101a)

Child abuse occurs where a child has had physical injury inflicted upon him or her other than by accidental means, has injuries at variance with history given of them, or is in a condition resulting in maltreatment, such as, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment. (Connecticut General Statutes §46b-120)

Child neglect occurs where a child has been abandoned, is being denied proper care and attention physically, emotionally, or morally, or is being permitted to live under conditions, circumstances or associations injurious to his well-being. (Connecticut General Statutes §46b-120)

When making a report, a mandated reporter is required to provide the following information, if known:

- names and addresses of the child and his parents or responsible caregiver(s)
- child's age and gender
- nature and extent of injury, maltreatment or neglect
- approximate date and time the injury, maltreatment or neglect occurred
- the circumstances in which the injuries, maltreatment or neglect became known to the reporter
- previous injury, maltreatment or neglect of the child or siblings
- name of the person suspected to have caused the injury, maltreatment or neglect
- any action taken to treat or help the child
- any other information the reporter believes would be helpful

Mandated reporters who, outside the ordinary course of their employment or profession, have reasonable cause to suspect or believe that a child under the age of 18 is in imminent risk of being abused or has been abused or neglected, can and should make a report to the Hotline.

How to Report

Mandated reporters must report orally to the Department of Children and Families' (DCF) Hotline or a law enforcement agency within 12 hours of suspecting that a child has been abused or neglected and must submit a written report (DCF-136 form) to DCF within 48 hours of making the oral report. DCF is required to tape record all reports to the Hotline.

Special reporting requirements may apply for staff members of a public or private institution or facility that cares for such child, or a public or private school. (See pages 4-5).

Police must report to DCF immediately upon receipt of any oral report of abuse or neglect.

Upon receipt of any oral report alleging sexual abuse or serious physical abuse or serious neglect, DCF must report to the appropriate state or local law enforcement agency within 12 hours.

Anonymity

Mandated reporters are required to give their name when they make a report to DCF, however, reporters may request anonymity to protect their privacy. This means that DCF would not disclose their name or identity unless mandated to do so by law (Connecticut General Statutes, Sections 17a-28 and 17a-101). Unless a reporter gives written consent, his or her name will not be disclosed except to:

- a DCF employee
- a law enforcement officer
- an appropriate state's attorney
- an appropriate assistant attorney general
- a judge and all necessary parties in a court proceeding
- a state child care licensing agency, executive director of any institution, school or facility or superintendent of schools

If DCF suspects or knows that the reporter knowingly makes a false report, his or her identity shall be disclosed to the appropriate law enforcement agency and the person may be subject to the penalty described in the next section.

Immunity and Penalty

Immunity from civil or criminal liability is granted to people who make required reports in good faith. Immunity is also granted to people who in good faith have not reported. However, failure to report could result in fines, which range from $500 to $2,500 and the individual will be required to participate in an educational and training program. In addition, mandated reporters could also be sued for damages if further injury is caused to the child because they did not act.

Anyone who knowingly makes a false report of child abuse or neglect shall be fined up to $2,000 or imprisoned for not more than one year, or both. The identity of any such person shall be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.

Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or testifying in an abuse or neglect proceeding. The Attorney General can bring a court action against any employer who violates this provision, and the court can assess a civil penalty of up to $2,500 plus other equitable relief.

Informing the Family

Mandated reporters are under no legal obligation to inform parents that they have made a report to DCF about their child. However, depending on the circumstances, it may be necessary and/or beneficial to do so.

- When a child is suspected of being abused, neglected or placed at imminent risk of serious harm by a member of the staff of a private or public school or an institution that cares for the child, the person in charge of the school or facility must notify the child's parent or other person responsible for the child's care that a report has been made. It is DCF's responsibility to notify the head of such school, facility or institution that a report has been made.
- Health care professionals may need to talk with parents to assess the cause of the child's injury(ies). Mental health professionals or members of the clergy may want to talk with the parents to offer support and guidance.

However, in cases of serious physical abuse or sexual abuse, it may not be wise to talk with

parents before reporting the case to DCF. This may put the child at greater risk and could interfere with a potential criminal investigation.

Investigation of Abuse or Neglect Report

DCF is responsible for immediately evaluating and classifying all reports of suspected abuse/ neglect/imminent risk. If the report contains information to warrant an investigation, DCF must make its best effort to begin an investigation within two hours if there is an imminent risk of physical harm to a child or another emergency; and within three days for all other reports. In all cases, DCF must complete the investigation in 30 calendar days.

When conducting a child abuse or neglect investigation, DCF or a law enforcement agency must coordinate activities to minimize the number of interviews with any child.

DCF must obtain consent from the parent, guardian or person responsible for the child's care for any interview, unless DCF has reason to believe such person or a member of the child's household is the alleged perpetrator. When such consent is not required, the interview must be conducted in the presence of a 'disinterested adult' (typically, a person who is impartial and has no self-interest in the case) If a disinterested adult is not available after reasonable search and immediate access is necessary to protect the child from imminent risk of serious harm, DCF or a law enforcement agency will still interview the child.

If, after the investigation has been completed, serious physical abuse or sexual abuse is substantiated, DCF must notify the local police, and either the Chief State's Attorney/designee or a state's attorney in the judicial district in which the child resides or in which the abuse occurred. A copy of the investigation report must also be sent.

Suspected Abuse By a School Employee

Mandated reporters are required to report any suspected child abuse, neglect or imminent risk of serious harm directly to DCF or the police. This includes situations when the alleged perpetrator is a school employee. DCF must notify the head of the school that a report has been made, unless such person is the alleged perpetrator.

Investigations of suspected child abuse, neglect or imminent risk of serious harm by a school employee are conducted by DCF. If, after such investigation, DCF has reasonable cause to believe that a child has been abused by a certified public school employee (in a position requiring a certificate), DCF shall notify the Superintendent of such finding and shall provide him or her with records concerning such investigation.

The Superintendent must suspend such employee. The suspension shall be with pay and will not diminish or terminate the employee's benefits. Within 72 hours after such suspension, the Superintendent shall notify the local or regional board of education and the Commissioner of Education of the reasons for and conditions of the suspension. The Superintendent shall disclose the DCF records to the Commissioner of Education and local or regional boards of education or their attorney for purposes of review of employment status or certification. The suspension must remain in effect until the local Board of Education takes action.

If the employee's contract is terminated, the Superintendent shall notify the Commissioner of Education or his representative within 72 hours. The Commissioner of Education may then commence certification revocation proceedings.

The Superintendent may suspend any other school staff member in similar circumstances.

The State's Attorney must notify the Superintendent, or supervising agent of a non-public school,

and the Commissioner of Education when a certified school employee, or any person holding a certificate issued by the State Board of Education, is convicted or a crime involving an act of child abuse or neglect.

Suspected Abuse By a Member of An Institution or Facility Providing Child Care

Mandated reporters are also required to report when they have reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for children. DCF must notify the head of the institution or facility providing child care that a report has been made, except in circumstances when such person is the alleged perpetrator.

Whenever DCF, based on the results of an investigation, has reasonable cause to believe that that a child has been abused or neglected by a staff member of a public or private institution or facility providing child care, DCF shall notify the institution, school or facility and provide records concerning the investigation to the executive director. If the facility is licensed by the state for the caring of children, DCF shall notify the state agency that licenses it and provide records concerning the investigation.

The institution may suspend the employee. The suspension must be with pay, not diminish or terminate the employee's benefits and remain in effect until resolved by the person's employer.

Where to Call

The Department has a single point of contact statewide for the reporting of suspected child abuse and neglect. This Child Abuse and Neglect Hotline operates 24 hours a day and seven days a week. Anyone who suspects that a child has been abused or neglected or is in danger of abuse or neglect is strongly encouraged to call the Hotline.

DCF Child Abuse and Neglect Hotline: 1-800-842-2288

TDD Number: 1-800-624-5518

The Hotline is staffed by full-time, highly-skilled professionals of the Department who receive and process reports of alleged child abuse and neglect. The Hotline worker gathers critical information from the caller to determine if a report meets Connecticut's statutory criteria for child abuse or neglect. Those reports that meet the criteria are forwarded to a DCF case investigator for prompt and appropriate action.

Content Last Modified on 8/2/2006 8:14:36 AM

Advanced Behavioral Health, Inc.

REPORT OF SUSPECTED CHILD ABUSE/NEGLECT

DCF-136
10/01/02 (Rev)

HOTLINE
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit a written report (DCF-136) to the Hotline
See the reverse side of this form for a summary of Connecticut law concerning the protection of children

Please print or type

CHILD'S NAME	☐ Male ☐ Female	AGE OR BIRTH DATE
CHILD'S ADDRESS		
NAME OF PARENTS OR OTHER PERSON RESPONSIBLE FOR CHILD'S CARE	ADDRESS	PHONE NUMBER
WHERE IS THE CHILD STAYING PRESENTLY IF NOT AT HOME?	PHONE NUMBER	DATE PROBLEM(S) NOTED
NAME OF HOTLINE WORKER TO WHOM ORAL REPORT WAS MADE	DATE OF ORAL REPORT	DATE AND TIME OF SUSPECTED ABUSE/NEGLECT
NAME OF SUSPECTED PERPETRATOR IF KNOWN	ADDRESS AND/OR PHONE NUMBER IF KNOWN	RELATIONSHIP TO CHILD

NATURE AND EXTENT OF THE CHILD'S INJURY(IES) MALTREATMENT OR NEGLECT.

INFORMATION CONCERNING ANY PREVIOUS INJURY(IES), MALTREATMENT OR NEGLECT OF THE CHILD OR HIS/HER SIBLINGS.

LIST NAMES AND AGES OF SIBLINGS, IF KNOWN

DESCRIBE THE CIRCUMSTANCES IN WHICH THE INJURY(IES) MALTREATMENT OR NEGLECT CAME TO BE KNOWN TO THE REPORTER.

WHAT ACTION, IF ANY HAS BEEN TAKEN TO TREAT PROVIDE SHELTER OR OTHERWISE ASSIST THE CHILD?

REPORTER'S NAME AND AGENCY	ADDRESS	PHONE NUMBER
REPORTER'S SIGNATURE	POSITION	DATE

WHITE COPY: TO DCF HOTLINE, 505 Hudson Street, Hartford, CT 06106 *YELLOW COPY: REPORTER'S COPY*

SUMMARY OF LEGAL REQUIREMENTS CONCERNING CHILD ABUSE/NEGLECT

PUBLIC POLICY OF THE STATE OF CONNECTICUT

To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse, investigation of such reports by a social agency and provision of services where needed to such child and family

WHO IS MANDATED TO REPORT CHILD ABUSE/NEGLECT?

Battered Women's Counselors
Chiropractors
Dental Hygienists
Dentists
Department of Children and Families Employees
Licensed/Certified Alcohol and Drug Counselors
Licensed/Certified Emergency Medical Services Providers
Licensed Marital and Family Therapists
Licensed or Unlicensed Resident Interns
Licensed or Unlicensed Resident Physicians
Licensed Physicians
Licensed Practical Nurses
Licensed Professional Counselors
Licensed Surgeons
Medical Examiners
Members of the Clergy
Mental Health Professionals
Optometrists
Parole Officers (Juvenile or Adult)
Pharmacists
Physical Therapists
Physician Assistants
Podiatrists
Police Officers
Probation Officers (Juvenile or Adult)
Psychologists
Registered Nurses
School Coaches
School Guidance Counselors
School Paraprofessionals
School Principals
School Teachers
Sexual Assault Counselors
Social Workers

Any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home which is licensed by the State
Department of Public Health employees responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps.
The Child Advocate and any employee of the Office of the Child Advocate

DO THOSE MANDATED TO REPORT INCUR LIABILITY?

No. Any person, institution or agency which, in good faith, makes or does not make a report, shall be immune from any civil or criminal liability provided such person did not perpetrate or cause such abuse or neglect

IS THERE A PENALTY FOR NOT REPORTING?

Yes. Any person, institution or agency required to report who fails to do so shall be fined $500 00 - $2 500 00 and shall be required to participate in an educational and training program.

IS THERE A PENALTY FOR MAKING A FALSE REPORT?

Yes. Any person, institution or agency who knowingly makes a false report of child abuse or neglect shall be fined not more than $2,000 00 or imprisoned not more than one year or both. The identity of such person shall be disclosed to the appropriate law enforcement agency and to the alleged perpetrator of the abuse

WHAT ARE THE REPORTING REQUIREMENTS?

- An oral report shall be made by a mandated reporter by telephone or in person to the DCF Hotline or to a law enforcement agency as soon as practicable, but not later than 12 hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm. If a law enforcement agency receives an oral report, it shall immediately notify Hotline Oral reports to the Hotline shall be recorded on tape

- Within forty-eight hours of making an oral report a mandated reporter shall submit a written report to the DCF Hotline

- When the report concerns an employee of a facility or institution which is licensed by the State, the mandated reporter shall also send a copy of the written report to the executive head of the state licensing agency

DEFINITIONS OF ABUSE AND NEGLECT

Child Abuse: any child or youth who has a non-accidental physical injury, or injuries which are at variance with the history given of such injuries, or is in a condition which is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation deprivation of necessities, emotional maltreatment or cruel punishment

Child Neglect: any child or youth who has been abandoned or is being denied proper care and attention, physically, educationally, emotionally, or morally or is being permitted to live under conditions, circumstances or associations injurious to his well-being

Exception: The treatment of any child by an accredited Christian Science practitioner shall not of itself constitute neglect or maltreatment

Child Under 13 with Venereal Disease: a physician or facility must report to Hotline upon the consultation examination or treatment for venereal disease of any child not more than twelve (12) years old

DO PRIVATE CITIZENS HAVE A RESPONSIBILITY FOR REPORTING?

Yes. Any person having reasonable cause to suspect or believe that any child or youth under the age of eighteen (18) is in danger of being abused or has been abused or neglected, may cause a written or oral report to be made to the Hotline or a law enforcement agency A person making the report in good faith is also immune from any liability, civil or criminal However the person is subject to the penalty for making a false claim.

WHAT IS THE AUTHORITY AND RESPONSIBILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)?

All children's protective services are the responsibility of the Department of Children and Families

Upon the receipt of a child abuse/neglect report, the Hotline shall cause the report to be classified, evaluated immediately and forwarded to the appropriate investigation unit for the commencement of an investigation within timelines specified by statute and policy

If the investigation produces evidence of child abuse/neglect the Department shall take such measures as it deems necessary to protect the child, and any other children similarly situated including, but not limited to, immediate notification to the appropriate law enforcement agency, and the removal of the child or children from his home with the consent of the parents or guardian or by order of the Superior Court, Juvenile Matters

If the Department has probable cause to believe that the child or any other child in the household is in imminent risk of physical harm from his surroundings, and that immediate removal from such surroundings is necessary to ensure the child's safety, the Commissioner or designee shall authorize any employee of the Department or any law enforcement officer to remove the child and any other child similarly situated from such surroundings without the consent of the child's parent or guardian The removal of a child shall not exceed ninety-six (96) hours If the child is not returned home within such ninety-six hour period with or without protective services, the Department shall file a petition for custody with the Superior Court Juvenile Matters.

WHAT MEANS ARE AVAILABLE FOR REMOVING A CHILD FROM HIS HOME?

- 96-Hour Hold by the Commissioner of DCF (see above)

- 96-Hour Hold by a Hospital – Any physician examining a child with respect to whom abuse or neglect is suspected shall have the right to keep such child in the custody of a hospital for no longer than ninety-six hours in order to perform diagnostic tests and procedures necessary to the detection of child abuse or neglect and to provide necessary medical care with or without the consent of such child's parents or guardian or other person responsible for the child's care, provided the physician has made reasonable attempts to (1) advise such child's parents or guardian or other person responsible for the child's care that he suspects the child has been abused or neglected and (2) obtain consent of such child's parents or guardian or other person responsible for the child's care. In addition, such physician may take or cause to be taken photographs of the area of trauma visible on a child who is the subject of such report without the consent of such child's parent's or guardian or other person responsible for the child's care All such photographs or copies thereof shall be sent to the local police department and the Department of Children and Families

- Custody Order – Whenever any person is arrested and charged with an offense under Section 53-20 or 53-21 or under Part V, VI, or VII of Chapter 952, as amended, the victim of which offense was a minor residing with the defendant, any judge of the Superior Court may, if it appears that the child's condition or circumstances surrounding his case so require, issue an order to the Commissioner of the Department of Children and Families to assume immediate custody of such child and, if the circumstances so require, any other children residing with the defendant and to proceed thereon as in cases reported

WHAT IS THE CHILD ABUSE CENTRAL REGISTRY?

The Department of Children and Families maintains a registry of reports received and permits its use on a twenty-four hour daily basis to prevent or discover child abuse of children Required confidentiality is ensured

DCF CHILD ABUSE AND NEGLECT HOTLINE: 1-800-842-2288

STATUTORY REFERENCES: §17a-28; §17a-101 et seq.; §46b-120

Advanced Behavioral Health, Inc.
Project SAFE's Outreach and Engagement Services
Safety Policy – Home Visits

POLICY: Outreach and Engagement staff will assess the safety of conducting a home visit prior to the visit. Ongoing safety assessment will take place while on the home visit.

PROCEDURE:

1) All O/E staff working in the community will be assigned an ABH cell phone for business purposes. O/E staff will carry the cell phone with them at all times and ensure that it is charged regularly and in working order.

2) All OEPs will keep the Team Leader and/or co-workers updated on their daily schedule (e g., calendar on Outlook) and will check-in with one another throughout the day. If no contact is made with OEP as agreed, the TL/OEP will initiate contact via cell phone.

3) If there is any question regarding risk/safety, staff will review details with the Team Leader and/or Program Manager prior to conducting a visit to the client's residence. As a result, the following options may be put in place:

   a. The Outreach and Engagement Professional (OEP) may ask the DCF Social Worker to attend the visit.
   b. Another OEP may accompany the assigned OEP to the visit.
   c It may be determined that the visit will happen at a location other than the client's home.
   d. It may be determined that the visit not occur.

4) If the safety issues present while on a home visit, staff will remove themselves from the situation and request police back up, if needed. In such cases, staff should notify their supervisor immediately following the incident

5) If there are any other individuals in the client's residence at the time of the visit that presents a safety risk, the visit will be rescheduled and another location considered.

6) Reports of safety issues should be reviewed with the Team Leader and/or Program Manager who will document this under the Case Review section of the O/E database.

New:	12/22/06
Reviewed without change (date):	
Revised (date):	1/3/07
Original Effective Date:	1/3/07
Scheduled Review Date:	12/22/07

Advanced Behavioral Health, Inc.
Project SAFE's Outreach and Engagement Services
Safety Policy – Transporting Clients

POLICY: Outreach and Engagement Staff will maximize the safety and health of staff and clients during vehicle transport

PROCEDURE:

1) Transportation Requirement
   - All Project SAFE Outreach and Engagement staff that transport clients will have an active, valid CT Drivers License.
   - All Project SAFE Outreach and Engagement staff transport clients will adhere to all vehicle safety laws and regulations
   - All Project SAFE Outreach and Engagement staff will carry the minimum auto insurance required by Advanced Behavioral Health and provide a copy of the current policy to Human Resources at hire and thereafter at least annually.

2) Assessment Requirement
   - All Project SAFE Outreach and Engagement staff will <u>not</u> transport clients under the following conditions:
     - During periods of inclement and unsafe weather (i.e. blizzard, hurricane).
     - When a client is under the influence of substances.
     - When a client's behavior is assessed to pose a potential safety risk (e.g., client is actively psychotic, agitated, etc.).
     - In a medical emergency.
   - In the event that a client is deemed at-risk or unsafe to transport, Project SAFE Outreach and Engagement staff will work with the client to explore safe alternatives.

3) Seating Requirement
   - The safest situation is for the client to sit in the front passenger seat

4) Safety Belts
   Project SAFE Outreach and Engagement staff must adhere to CT seat belt laws.
   Drivers and front seat passengers must wear safety belts.
   All rear seat passengers ages 4 – 16 must wear safety belts.

   Note: It is strongly recommended that <u>all</u> passengers in an OEP's car wear a safety belt at <u>all</u> times when the vehicle is in operation

5) Infant/Child Car Seats
   - When transporting a client and her/his child, Project SAFE Outreach and Engagement staff must adhere to Connecticut's Child Passenger Safety Laws and transport the child in the appropriate car seat
     - Infants must remain in a rear-facing car seat until they are both 20 pounds and at least one year old.
     - Toddlers must be in a car seat until they are 40 pounds.
     - Children must be in a booster seat (or car seat with harness straps weighted for children over 60 pounds) until the children are both over 6 years old and 60 pounds. Children who ride in a booster seat must use a lap and shoulder belt.
   - Children under 13 should ride in the back seat of the vehicle.

6) Requests to Transport Others
   - Requests to transport a client's spouse or significant other with the client should be assessed by the OEP for safety and necessity before providing transportation.
   - Requests to transport family members other than a spouse/significant other or child or another person who is not a client of the program will be denied.

7) Medical or Psychiatric Emergencies Requirement
   - In the event that a medical or psychiatric emergency occurs during a transport, the following may be considered in choosing a course of action:
     - Staff stops and parks the vehicle in a safe location.
     - Staff immediately accesses emergency assistance by calling 911 and/or yelling for help.
     - Staff intervenes only to the extent that they are formally trained and prepared
     - To avoid injury to staff and/or clients, staff does not attempt to intervene without adequate resources.

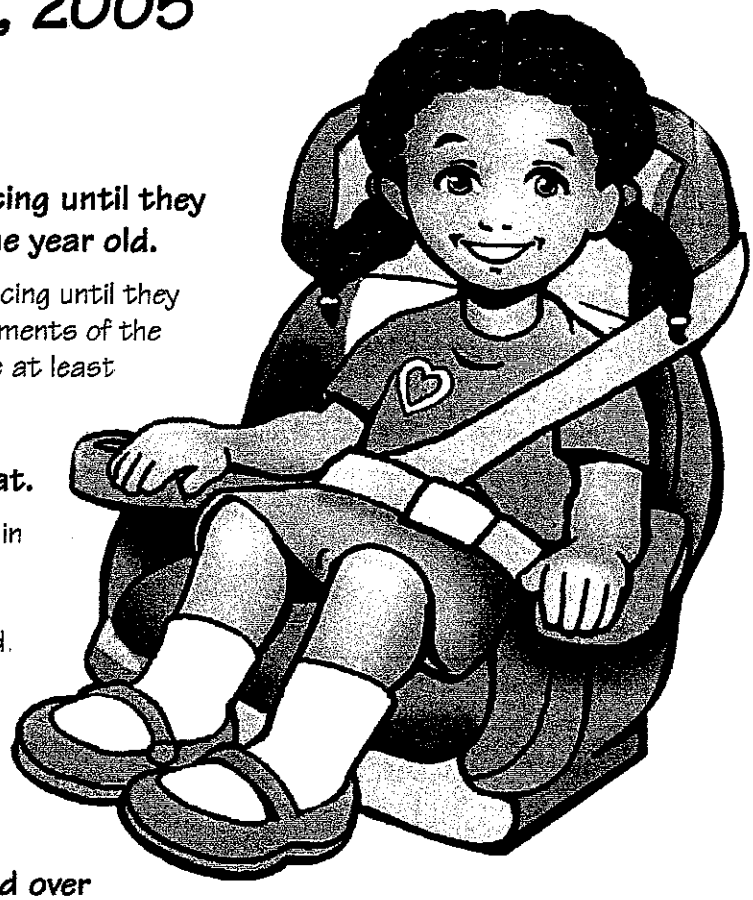
8) Accident Requirement
   In the event of an accident during working hours, Project SAFE Outreach and Engagement staff should:

   - Contact local police.
   - Notify supervisor as soon as possible.
   - Complete an ABH incident report as soon as possible.

New:	1/16/2007
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	1/16/07
Scheduled Review Date:	1/16/2008 1/31/09

Child Passenger Safety Laws in Connecticut Effective October 1, 2005

PUBLIC ACT 05-58



LAW: Infants must remain rear-facing until they are both 20 pounds and at least one year old.

Further recommended: Keep infants rear-facing until they meet the maximum height or weight requirements of the car seat when it is rear-facing and they are at least one year old and 20 pounds.

LAW: Toddlers must be in a car seat.

Further recommended: Children should remain in a car seat until they are 40 pounds. Additionally, don't use a car seat that has been in a crash or is more than six years old.

LAW: Children must be in a booster seat (or car seat with harness straps weighted for children over 60 pounds) until the children are both over 6 years old and over 60 pounds. Children who ride in a booster seat must use a lap and shoulder belt.

Further recommended: Children should continue to ride in a booster seat until they are 4'9".

LAW: Children, tweens and teens must be in a seat belt wherever they ride in the vehicle.

Further recommended: Children should ride in the back seat until they are 13 years old. All people and objects should be properly restrained wherever they are in the vehicle.

For more information, please contact Connecticut SAFE KIDS at www.ctsafekids.org or 860-545-9988.

or your local SAFE KIDS Chapter or Coalition:
Fairfield County 203-853-7115
Greater Waterbury 203-346-3908
New London County 860-442-0733
Valley Parish Nurse 203-732-7584
Windham County 860-456-6978

Connecticut SAFE KIDS
Supported by: Connecticut Children's Medical Center

Connecticut Children's Medical Center

Connecticut Elks Association
Elks

ADVANCED BEHAVIORAL HEALTH, Inc.
Project SAFE Outreach and Engagement Services
SAFETY MANUAL

INTRODUCTION

Safety is of paramount importance in Project SAFE's Outreach and Engagement Program. We want to do what we can to minimize risks to our Outreach and Engagement Professionals as well as to the clients we serve. Over the years, outreach based behavioral health services have become more aware of potential on-the job risks to staff and the day-to-day living risks to our clients and have learned more about decreasing these risks. This applies to risks that exist between family members, risks to us within the client's residence, and risks existing in the client's immediate neighborhood. We've also become aware of risks to us involved in getting to and from our clients' homes. Attached is an overview of safety/risk issues. Included is a broad range of potential risks that staff may encounter. Some are very unlikely to occur; however they are included so that staff can be educated and prepared, just in case.

It is important to note that there is a long tradition of home-based service provision that has been proven to be an effective and efficient way to service clients. Every day numerous case managers, recovery managers, drug treatment advocates, outreach workers, etc. make visits to clients' places of residence. Almost always, these visits go without incident. However, we need to be prepared. Please read the attached and think safety. **Remember Project SAFE Outreach and Engagement Professionals are not expected to take undue risks. If the risk to you appears to be high, it is a good idea to consult with your supervisor and do whatever you need to do in order to maintain your own safety.** There is a point at which risks become high enough that our involvement must cease and police involvement must begin.

TABLE OF CONTENTS

- **CONDUCTING A HOME VISIT** 3
  - Initial Contact
  - Initial Outreach/Subsequent visits
  - Approaching Client's Residence
  - Entering/When in Client's Residence
- **IN YOUR CAR** 5
- **TO AND FROM YOUR CAR** 7
- **WHEN WALKING** 8
- **UNSAFE NEIGHBORHOODS** 9
- **OTHER CIRCUMSTANCES** 10
  - Meeting with an erratic, unpredictable person
  - Client making subtle or overt sexual advances
  - Police involvement

CONDUCTING HOME VISITS

Staff performing outreach and engagement services meet with clients in their homes and other community settings. Remember, when invited into a client's home, you are a guest and should behave accordingly

A. Initial Contact:

1. Prior to meeting with the client, contact the DCF Social Worker to obtain relevant information, including pertinent safety information.

2. Try to establish contact with the client on the phone or via the DCF Social Worker prior to the first home visit. Allow plenty of time for the conversation. Use lots of active listening. Try to establish a relationship prior to the first face-to-face meeting.

3. If you have concerns about meeting the client at her/his residence based on information from the DCF SW or treatment provider discuss this with the Team Leader and/or Program Manager. Consider meeting the client at a neutral location (ex. coffee shop or library), with the DCF worker at the DCF office, or team with another OEP.

4. Keep your Outlook calendar up to date with the schedule of your appointments including who (client initials), when, and where noted. The O/E Team Leader, Program Manager, and on-site co-workers should have access to your calendar.

B. During initial outreach (and subsequent) visits to client's residence

1. Carry I.D. at all times on your person (ex. driver's license, business card).

2. Carry your cell phone at all times. Be sure it is charged. Know if you have a signal, or not, at the site you are visiting.

3. Lock your car.

4. Drive around block/neighborhood. Note any potential dangers such as abandoned buildings, dark streets, noises of fighting, congregations of people indicating gang activity, gang graffiti, drug evidence on the ground, substance impaired persons, etc.

5. Park your car in a visible location as close as possible to the client's home so that accessing your car is easy.

6. Stay alert; look around 360° to and from your car.

7. Lock your car.

8. Keep your car keys readily accessible (ex. in your pocket).

C. Approaching Client's Residence

1. As you approach the home, stay alert.
   a. Note the location of exits, including windows.
   b. Are there any neighbors around? Consider if neighbors may or may not be a safety spot.

2. LISTEN before you knock.

3. Try to adapt your eyes to the lighting conditions inside the building

4. Stand to the side of the door so that anyone coming out won't run in to you.

5. Wait for the client to come to the door and invite you in. Don't walk in if a voice calls out "come in" but you can't see anyone. Don't just walk in if door is open

6. Do not enter the home if the client is not there

7. If the client is not at home, assess the risk of waiting in your car versus going to a safe spot to wait and/or call the client. Leave program information/your business card in a sealed non-identifying envelope addressed to the client

D. Entering/When in Client's Residence

If the client is at home and invites you in:

1. Choose a "safe place" to sit.

   a. Try to sit near the exit with your back to a wall.
   b. Notice exits/possible escape routes.
   c. Living rooms are the safest places to meet. Bedrooms should be avoided. Kitchens contain all kinds of potential weapons.
   d. If possible, leave a door open.

2. Observe the home for potential weapons.

3. At all costs, avoid confrontations:
   a. Be respectful, calm, and agreeable.
   b. Be alert to clients' physical cues of escalation, e.g., facial expression, muscle tension, posture, breathing, complexion changes, etc. If the situation begins to escalate, try to de-escalate it.
      - Stop teaching, problem solving, or directing—and **ACTIVELY LISTEN**.
      - Change the direction of a conversation to a non-threatening topic.
      - Distract from the current issue with creative time-outs, e.g., requesting to go to the bathroom.
      - State your concerns using "I" messages, including consequences for violence.
      - Consider relocating to a neutral location.

   c. if you are feeling unsafe, leave the client's home.
      - Go to a safety spot.
      - Call supervisor/police
      - Have the address of the client's home available or memorized
      - Review the case/safety issues with a supervisor before conducting another outreach/home visit.

IN YOUR CAR

The following are suggestions for ways to think/act preventatively as well as suggestions if you experience difficulties:

1. Keep your car mechanically maintained.
2. Make sure your gas tank is full.
3. Carry a cellular phone at all times.
4. Lock the car doors when you are in the car, as well as when you leave it
5. Take care of personal needs (i.e. going to bathroom) before leaving for a home visit.
6. Know where you are going. Drive from A->B->A without stopping—especially at night (keep written directions in car).
7. Stay on main roads in urban areas—especially in poor weather, late at night, or when having car trouble. In rural areas, choose roads you think will maximize the chance you'll be helped if your car breaks down.
8. Ride around clients' neighborhood and check for safety spots: stores/phones/gas stations.
9. Don't ask a group of people on a corner for directions
10. Know how to change a tire (taking out jack, etc.).
11. Buy a can of tire sealant (for flat tires).
12. Make sure your spare tire is full.
13. Make sure your trunk is equipped with a flashlight, blanket, city maps, and jumper cables (know how to use). In the winter, add a snack and liquid, ice scraper, rock salt or sand, shovel, snow chains.
14. Have the number of emergency road service in your car (consider an emergency road service such as AAA).
15. Keep items such as baseball hat or Sports Illustrated magazine visible in the car.
16. **Do not** leave valuable items in the car, particularly in plain sight. Carry your purse/wallet with you, or lock it in the trunk. Avoid carrying large sums of money.
17. If you're being followed, drive to the nearest safety spot to get help—don't drive directly to work or home so you're not followed to your home or work.
    a. Take the time (when being followed) to observe the vehicle and occupants for descriptions (i.e., license plate number, color and size of car, number of occupants, male/female, color of clothing, facial hair). Stay calm.
    b. Note the direction vehicle is traveling when you're in a safety spot.
    c. Call for help (i.e. Police).

18 If your car experiences mechanical difficulties and/or you get in accident:

a. Pull to the right side of road, if possible.
b. Put flashers on.
c. Call for assistance (911/AAA/Towing service)
d. Open hood.
e Get back in car, lock doors.
f While waiting for assistance, review self-protection skills.
g. If someone stops to assist you, talk through the open window only. Ask them to assist you in contacting emergency personnel/towing services if you have not been able to reach them (ex No cell phone service).
h. Don't accept rides without considering the risks to your safety.
i. If you leave your car for assistance, leave the car door unlocked so you can re-enter quickly, if needed.
j. Observe the person offering assistance (is there smell of alcohol, any physical cues that make you feel unsafe).
k. Trust your gut feelings to turn down a ride. Embarrassment has no place when considering safety.

TO AND FROM YOUR CAR

1. Drive around block/neighborhood. Note potential dangers such as abandoned buildings, dark streets, noises of fighting, congregations of people indicating gang activity, gang graffiti, drug evidence on the ground, substance impaired persons, etc.
2. Park your car in a visible location. Lock your car.
3. Stay alert; look around 360° to and from your car.
4. Have house or car keys in your hand/available.
5. Leave any distracting thoughts in the car—once you leave the car, pay attention; be alert and aware of your surroundings.
6. If the client is not at home, assess the risk of waiting in your car versus going to a safe spot to wait and/or call family.
7. Ask the client and/or family members to observe you as you go to the car, particularly at night.
8. Look in back seat before getting in your car (leave back seat bare of items so you can see).
9. Go to a safe spot to write notes and/or use cellular phone after sessions.
10. Because driving while preoccupied can be dangerous, after an upsetting and/or difficult session, before driving home find a safe spot and call to debrief with your supervisor.

WHEN WALKING

1. Walk in a focused manner at a quick pace.
2. Stay on main streets.
3. Face traffic
4. Don't carry a purse, if possible, or carry it close to your body.
5. Don't carry charge cards.
6. Carry your cell phone. Be sure it is charged.
7. Notice safety spots along the way (phone booths, stores).
8. Be alert, look around, keep your head up while walking.
9. If you sense danger and/or feel unsafe, leave immediately, change direction, go to a safety spot and/or your car Call for help
10. Don't ask a group of people on the corner for directions.

IF YOUR CLIENT LIVES IN AN UNSAFE NEIGHBORHOOD

1. Discuss with your client the safest time to meet.

   a. Consider meeting in a safer location.
   b. Ask if they will watch the street for your arrival.

2. Let supervisor know your route and destination address and when you anticipate your return home. Develop a check-in contingency plan.

3. On the way, get your bearings or locate aids (e.g., phones, neighbors or business which may or may not be helpful, etc.).

4 Travel main streets as much as possible; check your car for good operating condition, gas, etc

5. Carry your cell phone in an accessible area. Remember to keep it charged. Try not to use it in a dangerous neighborhood in order to decrease the possibility that observers misunderstand your job or observers decide they want the phone.

6. Leave the area if it immediately appears too dangerous; call your supervisor from a safe phone

7. Park close to the client's home, ensuring easy access to the car and an easy drive out.

8. Keep alert and on the lookout when walking to/from the home.

   a. Leave your purse and jewelry in the trunk (or at home).
   b. Carry your keys or a rolled magazine so that either could function as a "weapon".
   c. Have the car door key in your grasp.
   d. Walk confidently.
   e. When leaving the home, ask someone to walk you to the car or to watch that you get into your car safely

OTHER CIRCUMSTANCES

A. Meeting with an erratic, unpredictable, allegedly violent person

1. Don't meet alone until you've established a relationship Conduct a joint visit with the DCF Social Worker or another OEP.
2. Consider meeting at a public place.
3. Do not provide transportation Help to arrange transportation using bus lines, etc
4. Consult with supervisor and consider having another staff accompany you during the meeting.

B. Client Making Subtle Or Overt Sexual Advances

1. Use an "I" message: "I'm uncomfortable with (this) and I want you to (sit over there, use my name instead of "Dear," etc.)
2. Do not schedule another appointment alone with client. Meet in a public place and or conduct a joint visit.
3. Consult with your supervisor immediately.

C. Police Involvement

If police raid the client's home while you are there:

1. Stay as calm as possible.
2. **Do** exactly what police say.
3. **Do not** reach in your pockets/purse/or briefcase for I.D until directed by the police to do so.
4. Establish who you are later, when things are calm and/or you are at police station.
5. Inform the Team Leader/Program Manager following the incident

Advanced Behavioral Health, Inc.
Project SAFE
Subpoena Policy

POLICY: To ensure that all subpoenas served to ABH's Project SAFE are responded to in a timely and appropriate manner.

PROCEDURE:

1. All subpoenas are to be delivered to the front desk of ABH, 213 Court Street Address, 10th floor, Middletown, CT. If a [marshal] attempts to deliver a subpoena to an off-site office, ABH staff will direct her/him to ABH's main office in Middletown The ABH staff (desk) person receiving the subpoena immediately contacts Project SAFE's Director or designee

2. The PS Director or designee immediately retrieves the subpoena

3. The PS Director or designee reviews the subpoena for all appropriate material, including:
   - Ex parte
   - Release of Information signed by the client
   - Petitioner's Motion for Qualified Protective Order
   - Order for Qualified Protective Order
   - Notice
   - Order for Disclosure of Records Pursuant to Qualified Protective Order

4. The PS Director or designee contacts the attorney to review any of the above documents not received and to explain the Project SAFE and/or Outreach and Engagement Program. Often the information provided verbally to the attorney about the program will be sufficient and the attorney will state that nothing further is needed.

If the necessary documents are in place and the attorney continues to request the information [and/or if the attorney cannot be reached via the telephone], the Senior Program Manager or designee will proceed as follows:

5 If a signed release of information is not included, but the order for disclosure of records is, records can be sealed and brought to the court The PS Director or designee will prepare the records to include:
   - Copy of Project SAFE referral
   - In addition, for Outreach and Engagement Services:
     - Copies of Outreach and Engagement Biweekly Summaries to DCF, to date
     - Copy of Outreach and Engagement discharge summary and recommendations, if applicable

6. The PS Director or designee will deliver the records in a sealed document to the courthouse by the specified time.

7. If specific ABH staff are named in the subpoena/asked to testify, the PS Director or designee contacts them to discuss the case and contacts the Assistant Attorney General's Office to inquire if the OEP can be placed on call. If the OEP is subpoenaed to testify, the Senior Program Manager or O/E Program Manager may accompany the OEP to the court. If the OEP goes to the court unaccompanied, s/he will provide the O/E Program Manager an update when the court hearing has concluded.

8. The PS Director or designee will track subpoenas received.

New:	7/16/07
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	7/16/08

Project SAFE – Outreach and Engagement Services Supervision Policy

POLICY:

It is the policy of Project SAFE's Outreach and Engagement Services to assure ongoing supervision to all Outreach and Engagement staff.

PURPOSE:

All Outreach and Engagement staff will receive supervision in support of their assigned cases to assure quality care is being provided to the clients and that O&E staff are supported in their work as case managers.

PROCEDURE:

All Outreach and Engagement staff will receive supervision from the Program Manager and/or Team Leader. Supervision will be delivered in the following manner:

a. Weekly case review with the on-site Team Leader. In the absence of a Team Leader, the Program Manager will perform this function.

b. Bi-weekly administrative group supervision with the Program Manager.

c. Biweekly individual or group clinical supervision with the Program Manager.

d. On site observation and chart audit to be determined by the Program Manager based on appropriateness and need.

e. Program Manager will utilize data to monitor OEP activity.

Supervision notes related to specific cases will be documented in the OE database under the "Case Review" tab. Supervision notes with regard to individual employee's productivity and work performance will be kept by the Program Manager in a secure file

New:	
Reviewed without change (date):	
Revised (date):	12/22/06
Scheduled Review Date:	~~12/22/07~~ 1/31/08

Project SAFE

Recovery Specialist Voluntary Program (RSVP)

Alcohol and Drug Screening Protocol

Overview: In the first 90 days, RSVP clients will be screened for drugs and alcohol on a random basis at least twice per week at the Recovery Specialist's office using the following protocol. Following the first 90 days, RSVP clients will be drug screened randomly at least once per week until their discharge from the program. The results of the drug screens will be graphed and shared with the clients as well as with DCF and the Treatment Provider as described below [see - *Notification of Positive Tests and Failures to Test*]

Online Training forNobel Split Specimen Cup:
http://www.noblemedical.com/training/Noble_Split_Specimen_Cup.html

1. The Recovery Specialist (RS) or designee will inquire about the client's use of alcohol and drugs since the last screening. The RS will record this information on the RSVP Alcohol and Drug Screening Form.

2. If the client admits to any drug use other than Marijuana (THC), the client will be asked to sign an admittance form indicating this and will not be asked to provide a urine specimen.

3. The Recovery Specialist or designee will test for the presence of alcohol of each client using the Breathalyzer and record the results on the RSVP Screening History form.

4. If alcohol is present above the legal limit (0.08) and the client drove him/herself to the office, the client will be asked for her/his car keys and offered assistance in arranging transportation home. If the client refuses this and insists on driving, s/he will be informed that the RS will contact the local police to inform them the individual is driving while under the influence.

5. Unless the client has admitted to drug use other than Marijuana (THC) and signed an admittance form, the Recovery Specialist will then request that the client provide a urine specimen for a drug screen. The Recovery Specialist or designee will accompany the client to the restroom and observe the client deposit a specimen into the specimen bottle. At no time shall the Recovery Specialist lose custody of the specimen bottle.

6. When a specimen has been provided, the Recovery Specialist or designee will follow the instructions provided on each test to read the results of the drug screen and photocopy the results for inclusion in the RSVP Screening History logbook and the client's file.

7 The Recovery Specialist will discuss the results of the breathalyzer and drug screen with the client. If the drug screen was positive **and** the client challenges the results, then the Recovery Specialist will label the bottle and deposit the bottle into the Toxicology envelope for lab-based GC/MS confirmation. The RS will contact the carrier for pickup.

8. If the client admits to substance use at this point and signs an admittance form, the RS will ask the client to flush the specimen and the test strip and bottle will be discarded by the Recovery Specialist. The client will be provided with a copy of his/her statement admitting to drug or ETOH use.

9. If the test reveals a negative result, the RS will photocopy the results and ask the client to flush the specimen. The Recovery Specialist will discard the test strip and bottle. The client will be provided with a negative test receipt.

10. The Recovery Specialist will use the test results and client report to discuss the client's recovery with him/her.

11. The Recovery Specialist will provide a monthly report to DCF, Superior Court for Juvenile Matters, the client's attorney, and the child's attorney that includes a summary of the results of all of the alcohol and drug tests conducted in the past month.

Notification of Positive Tests and Failures to Test

The Recovery Specialist is required to inform the DCF Social Worker, Treatment Provider and RSVP Supervisor of all positive tests and failure to tests within 24 hours. Ideally, this will be done with the client.

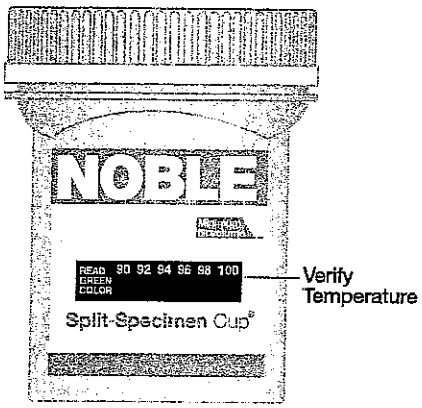
If a parent tests **positive** for alcohol and/or drugs **and** has a child in his/her care, the Recovery Specialist is required to notify the DCF Hotline if the situation meets the criteria for a mandated report, otherwise the RS should contact the DCF SW as soon as possible, but not later than 24 hours. If the RS is unable the reach the DCF SW, the RS will contact the DCF SW Supervisor and relay the information to her/him. If the DCF Supervisor is not available, the RS will leave the information of the test results on the Supervisor's voice mail.

Advanced Behavioral Health, Inc

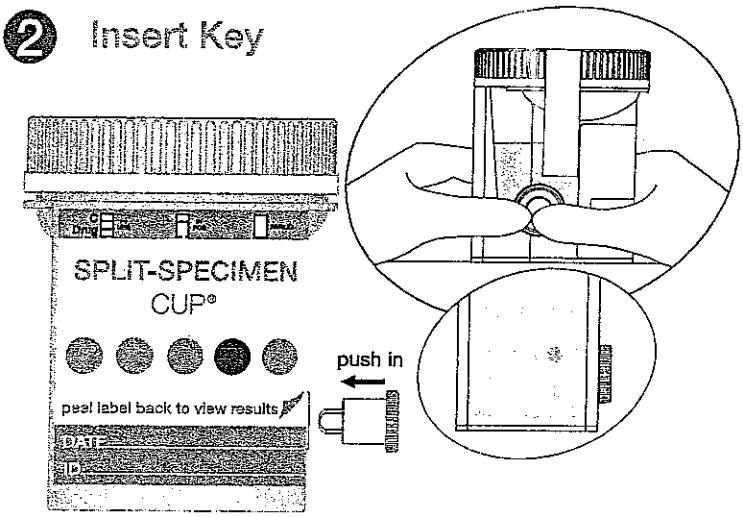
NOBLE

Split-Specimen Cup®

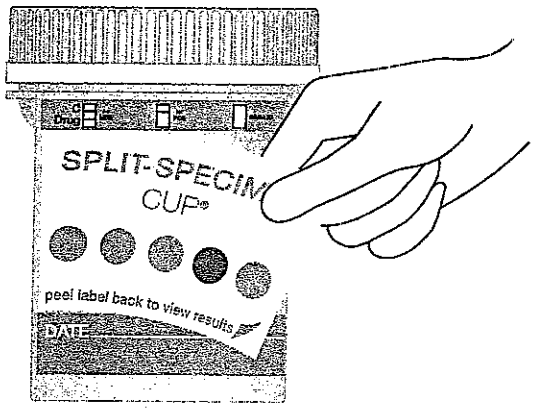
1 Collect Specimen



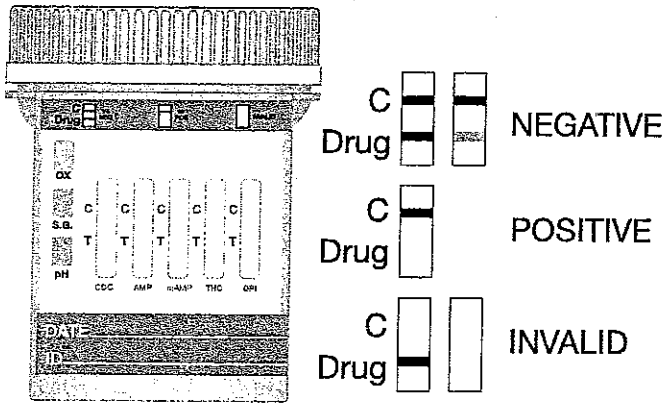
2 Insert Key



3 Peel Back Label

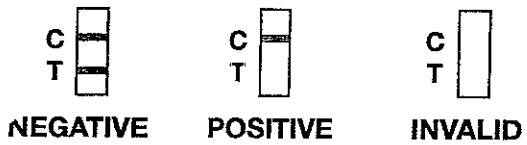


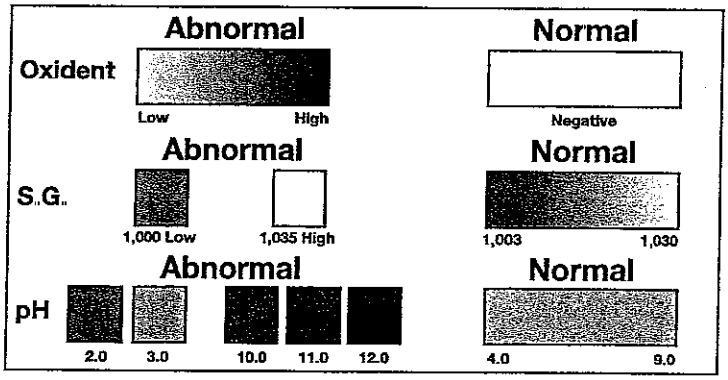
4 Read the Results



All positive results are presumptive and should be confirmed by an alternate method. (e.g. GC/MS)

Read results at (5) minutes.
Results stable up to (60) minutes.





SAMPLE ONLY - Color chart NOT exact.

Substance Abuse Information

NIDA InfoFacts: Understanding Drug Abuse and Addiction

PDF Version [N/A] Printer-friendly Version En Español

Many people view drug abuse and addiction as strictly a social problem. Parents, teens, older adults, and other members of the community tend to characterize people who take drugs as morally weak or as having criminal tendencies. They believe that drug abusers and addicts should be able to stop taking drugs if they are willing to change their behavior.

These myths have not only stereotyped those with drug-related problems, but also their families, their communities, and the health care professionals who work with them. Drug abuse and addiction comprise a public health problem that affects many people and has wide-ranging social consequences. It is NIDA's goal to help the public replace its myths and long-held mistaken beliefs about drug abuse and addiction with scientific evidence that addiction is a chronic, relapsing, and treatable disease.

Addiction does begin with drug abuse when an individual makes a conscious choice to use drugs, but addiction is not just "a lot of drug use." Recent scientific research provides overwhelming evidence that not only do drugs interfere with normal brain functioning creating powerful feelings of pleasure, but they also have long-term effects on brain metabolism and activity. At some point, changes occur in the brain that can turn drug abuse into addiction, a chronic, relapsing illness. Those addicted to drugs suffer from a compulsive drug craving and usage and cannot quit by themselves. Treatment is necessary to end this compulsive behavior.

A variety of approaches are used in treatment programs to help patients deal with these cravings and possibly avoid drug relapse. NIDA research shows that addiction is clearly treatable. Through treatment that is tailored to individual needs, patients can learn to control their condition and live relatively normal lives.

Treatment can have a profound effect not only on drug abusers, but on society as a whole by significantly improving social and psychological functioning, decreasing related criminality and violence, and reducing the spread of AIDS. It can also dramatically reduce the costs to society of drug abuse.

Understanding drug abuse also helps in understanding how to prevent use in the first place. Results from NIDA-funded prevention research have shown that

NIDA INFO

Recommend

- InfoFacts: Dr AIDS
- Commonly Al
- Drug Abuse a Addiction: Or America's Mo Challenging F Problems

Other NIDA

- smoking.druc
- hiv.drugabus
- marijuana-int
- clubdrugs.orc
- steroidabuse.
- teens.drugab
- inhalants.dru

comprehensive prevention programs that involve the family, schools, communities, and the media are effective in reducing drug abuse. It is necessary to keep sending the message that it is better to not start at all than to enter rehabilitation if addiction occurs.

A tremendous opportunity exists to effectively change the ways in which the public understands drug abuse and addiction because of the wealth of scientific data NIDA has amassed. Overcoming misconceptions and replacing ideology with scientific knowledge is the best hope for bridging the "great disconnect" - the gap between the public perception of drug abuse and addiction and the scientific facts.

[InfoFacts Index]

NIDA Home | Site Map | Search | FAQs | Accessibility | Help | Privacy | FOIA (NIH) | Employment | Print

The National Institute on Drug Abuse (NIDA) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. Questions? See our **Contact Information**. *Last updated on Thursday, February 8, 2007.*

COMMONLY ABUSED DRUGS

Visit NIDA at www.drugabuse.gov

Advanced Behavioral Health, Inc.

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety, panic attacks; tolerance, addiction
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration*/fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	*Also, for barbiturates—sedation, drowsiness*/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax:* candy, downers, sleeping pills, tranks	IV/swallowed, injected	*for benzodiazepines—sedation, drowsiness*/dizziness
flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	*for flunitrazepam*—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects
GHB***	*gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy	I/swallowed	*for GHB—drowsiness, nausea*/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death
methaqualone	*Quaalude, Sopor, Parest:* ludes, mandrex, quad, quav	I/injected, swallowed	*for methaqualone—euphoria*/depression, poor reflexes, slurred speech, coma
Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function*/memory loss; numbness; nausea/vomiting
ketamine	*Ketalar SV:* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	*Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest*
PCP and analogs	*phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	*for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence*/loss of appetite, depression
Hallucinogens			*altered states of perception and feeling; nausea;* persisting perception disorder (flashbacks)
LSD	*lysergic acid diethylamide:* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	*Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors*
mescaline	buttons, cactus, mesc, pevote	I/swallowed, smoked	*for LSD—persistent mental disorders*
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	*for psilocybin—nervousness, paranoia*
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness*/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV, V/injected, swallowed	*Also, for codeine—less analgesia, sedation, and respiratory depression than morphine*
fentanyl and fentanyl analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II/injected, smoked, snorted	*for heroin—staggering gait*
heroin	*diacetylmorphine:* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	*laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
oxycodone HCL	*OxyContin:* Oxy, O.C., killer	II/swallowed, snorted, injected	
hydrocodone bitartrate, acetaminophen	*Vicodin:* vike, Watson-387	II/swallowed	
Stimulants			*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia
amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*Also, for amphetamine—rapid breathing*/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis
cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	*for cocaine—increased temperature*/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

***Associated with sexual assaults.

5/03

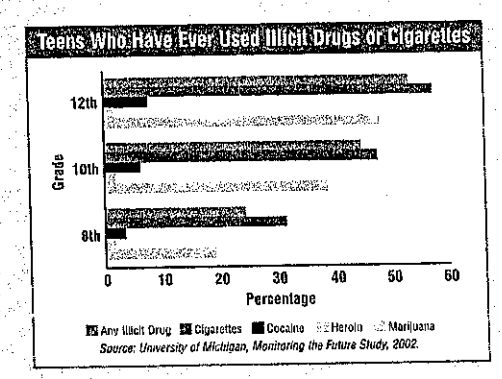
Advanced Behavioral Health, Inc.

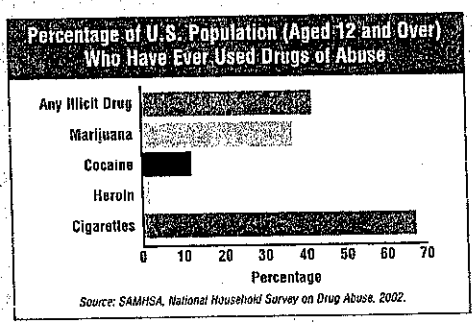
Substances. Category and Name	Examples of *Commercial* and Street Names	Dr[illegible]edule*/ Ho[illegible]ministered**	*Intoxication Effects*/Potential Health Consequences
Stimulants (continued)			
MDMA (methyl-enedioxymeth-amphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	*for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
methamphetamine	*Desoxyn:* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	*for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction
methylphenidate (safe and effective for treatment of ADHD)	*Ritalin:* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	*for nicotine*—additional effects attributable to tobacco exposure: adverse pregnancy outcomes; chronic lung disease, cardiovascular disease, stroke, cancer; tolerance, addiction
nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	not scheduled/smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice	III/injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	*stimulation, loss of inhibition; headache: nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

Principles of Drug Addiction Treatment

Nearly three decades of scientific research have yielded 13 fundamental principles that characterize effective drug abuse treatment. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide.*

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine, methadone, and levo-alpha-acetylmethodol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.





Order NIDA publications from NCADI:
1-800-729-6686
or TDD: 1-800-487-4889

Handout
Physical and Psychological Effects of Substance Use

SUBSTANCE	PHYSICAL/PSYCHOLOGICAL EFFECTS
Alcohol *Alcohol abuse* is a pattern of problem drinking that results in health consequences, social, problems, or both. However, *alcohol dependence,* or *alcoholism,* refers to a disease that is characterized by abnormal alcohol-seeking behavior that leads to impaired control over drinking	**Short-term effects of alcohol use include:** • distorted vision, hearing, and coordination • impaired judgment • altered perceptions and emotions • bad breath; hangovers **Long-term effects of heavy alcohol use include:** • loss of appetite, vitamin deficiencies; stomach ailments • skin problems • sexual impotence • liver damage • heart and central nervous system damage; memory loss
Methamphetamine Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Street names for the drug include "speed," "meth," and "crank." Methamphetamine is used in pill form, or in powdered form by snorting or injecting. Crystallized methamphetamine known as "ice," "crystal," or "glass," is a smokable and more powerful form of the drug.	**The effects of methamphetamine use include:** • euphoria • increased heart rate and blood pressure • increased wakefulness; insomnia • increased physical activity • decreased appetite; extreme anorexia • respiratory problems • hypothermia, convulsions, and cardiovascular problems, which can lead to death • irritability, confusion, tremors • anxiety, paranoia, or violent behavior • can cause irreversible damage to blood vessels in the brain, producing strokes Methamphetamine users who inject the drug and share needles are at risk for acquiring HIV/AIDS
Cocaine Cocaine is a white powder that comes from the leaves of the South American coca plant. Cocaine is either "snorted" through the nasal passages or injected intravenously Cocaine belongs to a class of drugs known as stimulants, which tend to give a temporary illusion of limitless power and energy that leave the user feeling depressed, edgy, and craving more. Crack is a smokable form of cocaine that has been chemically altered Cocaine and crack are highly addictive. This addiction can erode physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life.	**Physical risks associated with using any amount of cocaine and crack:** • increases in blood pressure, heart rate, breathing rate, and body temperature • heart attacks, strokes, and respiratory failure • hepatitis or AIDS through shared needles • brain seizures • reduction of the body's ability to resist and combat infection **Psychological risks:** • violent, erratic, or paranoid behavior • hallucinations and "coke bugs"--a sensation of imaginary insects crawling over the skin • confusion, anxiety and depression, loss of interest in food or sex • "cocaine psychosis"--losing touch with reality, loss of interest in friends, family, sports, hobbies, and other activities Some users spend hundred or thousands of dollars on cocaine and crack each week and will do anything to support their habit. Many

	turn to drug selling, prostitution, or other crimes. Cocaine and crack use has been a contributing factor in a number of drownings, car crashes, falls, burns, and suicides. Cocaine and crack addicts often become unable to function sexually Even first time users may experience seizures or heart attacks, which can be fatal
Hallucinogens Hallucinogenic drugs are substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, otherwise known as PCP, angel dust, or loveboat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin, or "magic" mushrooms Under the influence of hallucinogens, the senses of direction, distance, and time become disoriented These drugs can produce unpredictable, erratic, and violent behavior in users that sometimes leads to serious injuries and death The effect of hallucinogens can last for 12 hours. LSD produces tolerance, so that users who take the drug repeatedly must take higher and higher doses in order to achieve the same state of intoxication. This is extremely dangerous, given the unpredictability of the drug, and can result in increased risk of convulsions, coma, heart and lung failure, and even death.	**Physical risks associated with using hallucinogens:** • increased heart rate and blood pressure • sleeplessness and tremors • lack of muscular coordination • sparse, mangled, and incoherent speech • decreased awareness of touch and pain that can result in self-inflicted injuries convulsions • coma; heart and lung failure **Psychological risks associated with using hallucinogens:** • a sense of distance and estrangement • depression, anxiety, and paranoia • violent behavior • confusion, suspicion, and loss of control • flashbacks • behavior similar to schizophrenic psychosis • catatonic syndrome whereby the user becomes mute, lethargic, disoriented, and makes meaningless repetitive movements Everyone reacts differently to hallucinogens--there's no way to predict if you can avoid a "bad trip "
Inhalants Inhalants refer to substances that are sniffed or huffed to give the user an immediate head rush or high. They include a diverse group of chemicals that are found in consumer products such as aerosols and cleaning solvents Inhalant use can cause a number of physical and emotional problems, and even one-time use can result in death.	**Using inhalants even one time cause:** • sudden death • suffocation • visual hallucinations and severe mood swings • numbness and tingling of the hands and feet **Prolonged use can result in:** • headache, muscle weakness, abdominal pain • decrease or loss of sense of smell • nausea and nosebleeds • hepatitis • violent behaviors • irregular heartbeat • liver, lung, and kidney impairment • irreversible brain damage

	• nervous system damage • dangerous chemical imbalances in the body • involuntary passing of urine and feces **Short-term effects of inhalants include:** • heart palpitations • breathing difficulty • dizziness • headaches **According to medical experts, death can occur in at least five ways:** • asphyxia--solvent gases can significantly limit available oxygen in the air, causing breathing to stop; • suffocation--typically seen with inhalant users who use bags; • choking on vomit; • careless behaviors in potentially dangerous settings; and • sudden sniffing death syndrome, presumably from cardiac arrest
Marijuana Marijuana is the most widely used illicit drug in the United States and tends to be the first illegal drug teens use. It can be either smoked or swallowed.	**Short-term effects of using marijuana:** • sleepiness • difficulty keeping track of time, impaired or reduced short-term memory • reduced ability to perform tasks requiring concentration and coordination, such as driving a car • increased heart rate • potential cardiac dangers for those with preexisting heart disease • bloodshot eyes • dry mouth and throat • decreased social inhibitions • paranoia, hallucinations **Long-term effects of using marijuana:** • enhanced cancer risk decrease in • testosterone levels for men; also lower sperm counts and difficulty having children • increase in testosterone levels for women; also increased risk of infertility • diminished or extinguished sexual pleasure • psychological dependence requiring more of the drug to get the same effect The physical effects of marijuana use, particularly on developing adolescents, can be acute. Marijuana blocks the messages going to your brain and alters your perceptions and emotions, vision, hearing, and coordination.
Source: National Institute on Drug Abuse, 2004	

Home

Clinical Issues
Background
Special Populations
Group Approaches

The Library
Abstracts
Bibliography
Reprints
MINUET Newsletter
Links

Training
Upcoming Training
MINT Trainers
Training Videos

motivational interviewing
[resources for clinicians researchers and trainers]

What is MI?

Stephen Rollnick, Ph.D., & William R. Miller, Ph.D.

Reprinted with permission from Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*, 325-334.

Introduction

The concept of motivational interviewing evolved from experience in the treatment of problem drinkers, and was first described by Miller (1983) in an article published in Behavioural Psychotherapy. These fundamental concepts and approaches were later elaborated by Miller and Rollnick (1991) in a more detailed description of clinical procedures. A noteworthy omission from both of these documents, however, was a clear definition of motivational interviewing.

We thought it timely to describe our own conceptions of the essential nature of motivational interviewing. Any innovation tends to be diluted and changed with diffusion (Rogers, 1994). Furthermore, some approaches being delivered under the name of motivational interviewing (e.g., Kuchipudi, Hobein, Fleckinger and Iber, 1990) bear little resemblance to our understanding of its essence, and indeed in some cases directly violate what we regard to be central characteristics. For these reasons, we have prepared this description of: (1) a definition of motivational interviewing, (2) a terse account of what we regard to be the essential *spirit* of the approach; (3) differentiation of motivational interviewing from related methods with which it tends to be confused; (4) a brief update on outcome research evaluating its efficacy; and (5) a discussion of new applications that are emerging.

Definition

Our best current definition is this: *Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.* Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal.

responsive to the client's motivational signs. Resistance and "denial" are seen not as client traits, but as feedback regarding therapist behaviour. Client resistance is often a signal that the counsellor is assuming greater readiness to change than is the case, and it is a cue that the therapist needs to modify motivational strategies.

7. *The therapeutic relationship is more like a partnership or companionship than expert/recipient roles*. The therapist respects the client's autonomy and freedom of choice (and consequences) regarding his or her own behaviour.

Viewed in this way, it is inappropriate to think of motivational interviewing as a technique or set of techniques that are applied to or (worse) "used on" people. Rather, it is an interpersonal style, not at all restricted to formal counselling settings. It is a subtle balance of directive and client-centred components, shaped by a guiding philosophy and understanding of what triggers change. If it becomes a trick or a manipulative technique, its essence has been lost (Miller, 1994).

There are, nevertheless, specific and trainable therapist behaviours that are characteristic of a motivational interviewing style. Foremost among these are:

- Seeking to understand the person's frame of reference, particularly via reflective listening
- Expressing acceptance and affirmation
- Eliciting and selectively reinforcing the client's own self motivational statements expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitoring the client's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client.
- Affirming the client's freedom of choice and self-direction

The point is that it is the *spirit* of motivational interviewing that gives rise to these and other specific strategies, and informs their use. A more complete description of the clinical style has been provided by Miller and Rollnick (1991).

Differences From Related Methods

The check-up

A number of specific intervention methods have been derived from motivational interviewing. The Drinker's Check-up (Miller and Sovereign, 1989; Schippers, Brokken and Otten, 1994) is an assessment-based strategy developed as a brief contact intervention with problem drinkers. It involves a comprehensive assessment of the client's drinking and related behaviours, followed by systematic feedback to the client of findings. (The check-up strategy can be and has been adapted to other problem areas as well. The key is to provide meaningful personal feedback that can be compared with some normative reference.) Motivational interviewing is the *style* with which this feedback is delivered. It is quite possible, however, to offer motivational interviewing without formal assessment of any kind. It is also possible to provide assessment feedback without any interpersonal interaction such as motivational interviewing (e.g., by mail), and there is evidence that even such feedback can itself trigger behaviour change (Agostinelli, Brown

has been paid to the definition and characteristic spirit described above. Put simply, if direct persuasion, appeals to professional authority, and directive advice-giving are part of the (brief) intervention, a description of the approach as "motivational interviewing" is inappropriate. We are concerned to prevent an ever-widening variety of methods from being erroneously presented (and tested) as motivational interviewing. It should also be useful to distinguish between explanations of the mechanisms by which brief interventions work (which might or might not involve motivational processes) and specific methods, derived from motivational interviewing, which are designed to encourage behaviour change.

Differences From More Confrontational Approaches

Although motivational interviewing does, in one sense, seek to "confront" clients with reality, this method differs substantially from more aggressive styles of confrontation. More specifically, we would regard motivational interviewing as not being offered when a therapist;

- argues that the person has a problem and needs to change
- offers direct advice or prescribes solutions to the problem without the person's permission or without actively encouraging the person to make his or her own choices
- uses an authoritative/expert stance leaving the client in a passive role
- does most of the talking, or functions as a unidirectional information delivery system
- imposes a diagnostic label
- behaves in a punitive or coercive manner

Such techniques violate the essential spirit of motivational interviewing.

The **Motivational Interviewing** Page

Home
Introduction
[overview - special populations - group approaches]
The Library
[abstracts - bibliography - reprints - ongoing work - minuet newsletter - links]
Training
[upcoming training - mint trainers - training videos]

Created and maintained by:
Chris Wagner, Ph.D. and Wayne Conners, M.Ed.
Mid-Atlantic Addiction Technology Transfer Center
A CSAT Project
mid-attc@mindspring.com
http://www.mid-attc.org

attc addiction technology transfer centers
FUNDED BY CENTER FOR SUBSTANCE ABUSE TREATMENT

In cooperation with the Motivational Interviewing Network of Trainers (MINT), William R. Miller, Ph.D., and Stephen Rollnick, Ph.D.

What Makes It Motivational Interviewing?

Bill Miller and Steve Rollnick

ICMI Stockholm, June 2010

In 2008 we delineated "10 things that MI is not"

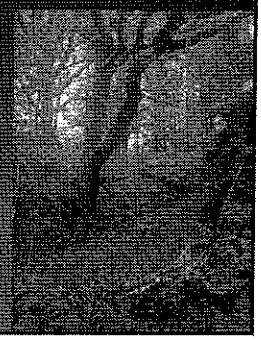
In *Behavioural and Cognitive Psychotherapy*, 2009, 37: 129-140

What makes it MI?

A ramble in the forest

This presentation represents an evolution in our thinking, well past MI 2, anticipating MI 3

It presents *our* thinking, and is meant as what Carl Rogers called a "discussion paper"



Ten Essential Characteristics of Motivational Interviewing

1. We propose that these are *necessary* and *defining* components of MI
2. None of them is *sufficient* to make it MI
3. Most are not *unique* to MI. It is their confluence that defines MI

What Makes it MI?

1. MI is a conversation ABOUT CHANGE

Usually but not necessarily about behavior change

Change can be broadly defined

What Makes it MI?

2. MI has a particular PURPOSE

The purpose of MI is to evoke and strengthen personal motivation for change

What Makes it MI?

3. MI is COLLABORATIVE

Person-centered partnership

What Makes it MI?

4. MI HONORS AUTONOMY and self-determination

People make their own choices

What Makes it MI?

5. MI is EVOCATIVE

MI evokes the person's own motivations for change

What Makes it MI?

6. MI uses SPECIFIC SKILLS

MI applies specific helping skills in particular prescribed ways e.g., differential use of OARS

What Makes it MI?

7. MI is GOAL-ORIENTED

MI moves toward a particular change goal

Not merely *exploring* ambivalence

MI seeks to resolve ambivalence in the direction of change

Sometimes MI involves *creating* ambivalence

What Makes it MI?

8. MI attends to specific forms of SPEECH

MI is attuned to and guided by particular aspects of client language

Elicits and strengthens client change talk

This is rather unique to MI

DARN-CAT and beyond

What Makes it MI?

9. MI RESPONDS TO CHANGE TALK in specific ways

Elaboration
Affirmation
Reflection
Summary

What Makes it MI?

10. MI RESPONDS TO RESISTANCE and sustain talk in specific ways

Nonconfrontational – avoids argument
Does not resist resistance

4 Fundamental Processes in MI

1. Engaging – The Relational Foundation
   - Person-centered style
   - Listen – understand dilemma and values
   - OARS core skills
   - Learn this first

Is it MI yet?

4 Fundamental Processes in MI

1. Engaging – The Relational Foundation
2. Guiding – The Strategic Focus
   - Agenda setting
   - Finding a focus
   - Information and advice

Is it MI yet?

4 Fundamental Processes in MI

1. Engaging – The Relational Foundation
2. Guiding – The Strategic Focus
3. Evoking – The Transition to MI
   - Selective eliciting
   - Selective responding
   - Selective summaries

Is it MI yet?

4 Fundamental Processes in MI

1. Engaging – The Relational Foundation
2. Guiding – The Strategic Focus
3. Evoking – The Transition to MI
4. Planning – The Bridge to Change
   - Replacing prior Phase I and Phase II
   - Negotiating a change plan
   - Consolidating commitment

Can it be MI without . . .

Engaging ?	No
Guiding ?	No
Evoking ?	No
Planning ?	Yes

So it's MI when . .

1. The communication style and spirit involve person-centered, empathic listening (Engage)

AND

2. There is a particular identified target for change that is the topic of conversation (Guide)

AND

3. The interviewer is evoking the person's own motivations for change (Evoke)

Three Essential Elements in any Definition of MI

1. MI is a particular kind of conversation about change (counseling, therapy, consultation, method of communication)
2. MI is collaborative (person-centered, partnership, honors autonomy, not expert-recipient)
3. MI is evocative, seeks to call forth the person's own motivation and commitment

2010: Toward MI-3

Three *levels* of definition (of increasing specificity)

1. A layperson's definition
   (What's it for?)
2. A pragmatic practitioner's definition
   (Why would I use it?)
3. A technical therapeutic definition
   (How does it work?)

1. A layperson's definition

(What's it for?)

Motivational interviewing is a collaborative conversation to strengthen a person's own motivation for and commitment to change

2. A pragmatic practitioner's definition (Why would I use it?)

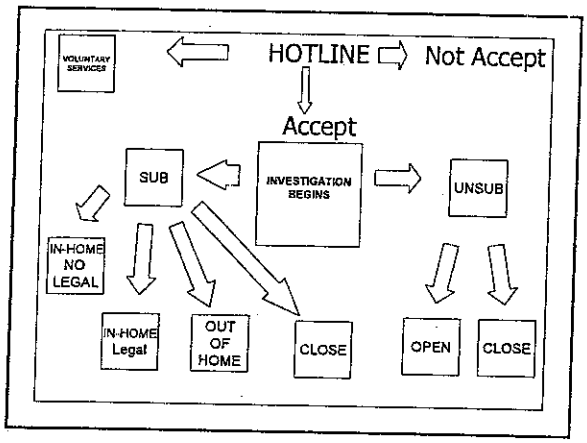
Motivational interviewing is a person-centered counseling method for addressing the common problem of ambivalence about behavior change

3. A technical therapeutic definition (How does it work?)

Motivational interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is intended to strengthen personal motivation for and commitment to a target behavior change by eliciting and exploring an individual's own arguments for change

Understanding DCF

Life of a Case



HOTLINE

- In 2006 the DCF Hotline received 91,000 calls.
- Approximately 43,000 of those calls were reports of neglect or abuse.
- DCF accepted 27,000 for referrals to be investigated.

Hotline Process

- When a call comes into the Hotline it is answered by an Intake Worker/Screener
- The Screener either accepts or does not accept the report (Screener utilizes SDM tools, case history and Supervisor consultation to help with decision)
- If the report is accepted it is forwarded to the Area Office.

Investigation Process

- The case is assigned to an Investigator and is responded in either 2, 24 or 72 hours depending on the safety concerns
- The Investigator responds and meets with the guardians, children, other family members, providers, school, etc.
- After 45 days a decision to substantiate or unsubstantiate the allegations has to be made
- The case is either transferred to an ongoing worker or closed

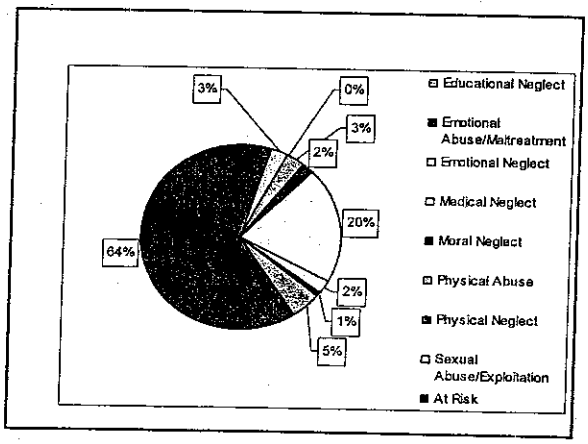
Substantiation Process

- If a parent/guardian receives notice that an allegation has been substantiated, he/she can appeal the decision
- If an appeal is requested, an internal review of the case is conducted
- If the substantiation is upheld by the internal review, a hearing can be requested.
- A hearing is then conducted with an independent arbiter present, DCF and the parent.

CENTRAL REGISTRY

- The primary purpose of the Central Registry is child protection through prevention and identification of abuse and/or neglect of children. The Central Registry consists of two components.
- 1.) **Perpetrator registry** consists of the names of those persons who have been substantiated as perpetrators of child abuse and or neglect.
- DCF has discretion over what names appear on the registry

- SUBSTANTIATION BREAKDOWN FOR 2006.....



Legal Process

- This is the "external process" that is not always linked to the substantiation or "internal process".
- This includes filing petitions in The Superior Court for Juvenile Matters.
- DCF/Parent must respond to the Court/Judge's decision on the matter.

Removal of a Child from Home

- ***CT General Statutes statute allows for DCF the right to remove a child from the custody of parent(s)/guardian(s) for up to 96 hours IF....***
- ***-DCF has PROBABLE CAUSE to believe the child is at IMMINENT RISK of physical harm.....AND.....***
- ***-immediate removal of the child is necessary to ensure the child's safety.***
- ***•96 Hour Holds must be signed and authorized by a DCF Program Supervisor or another DCF manager of equal or higher grade (Program Director, Area Director).***

Order of Temporary Custody (OTC)

- **The Court MAY issue an OTC vesting in DCF or some suitable person for purposes of the child's care and custody if it appears on the basis of the petitions and supporting affidavits that there is REASONABLE CAUSE to believe that....**

  ...the child is suffering serious illness or serious physical harm OR the child is in immediate physical danger from his/her surroundings AND

  ...as a result of the said condition, the child's safety is endangered and immediate removal is necessary to ensure his/her safety.....

Committed Children

- When a child becomes Committed to DCF:
- Reunification is always the first Permanency goal
- When Reunification is not possible or appropriate, DCF assumes the role of Statutory parent of the child. DCF might seek to Transfer Guardianship or Adoption for the child.
- If Transfer of Guardianship or Adoption is not an option ..DCF provides for the child's present needs and future planning for education, vocational, housing, etc.

Acronyms

ACR - Administrative Case Review
AAG - Assistant Attorney General
ABH - Advanced Behavioral Health, Inc.
ACF - Administration for Children and Families (Federal)
AD - Area Director
AO - Area Office
APHSA - American Public Human Services Association
APPLA - Another Planned Permanent Living Arrangement
ASO - Administrative Service Organization
BHP - Behavioral Health Partnership
BSF - Building Stronger Families
CAN - Connecticut Association of Non-profits
CARES - Child and Adolescent Rapid Emergency System
CASAC - Connecticut State Adolescent Substance Abuse Treatment Coordination Project
CBHAC - Children's Behavioral Health Advisory Council
CBT - Cognitive Behavioral Therapy
CCP - Connecticut Children's Place
CCPA - Connecticut Community Providers Association
CFSR - Child and Family Service Review
CHAP - Community Housing Assistance Program
CHEER - Community, Housing, Educational and Enrichment Resources Program
CJR - Connecticut Junior Republic
CJTS - Connecticut Juvenile Training School
CLOC - Children's League of Connecticut
CO - Central Office
CPA - Child Placing Agency
CPS - Child Protective Services
CSSD - Court Support Services Division (Judicial Branch)
CTJJA - Connecticut Juvenile Justice Alliance
CWLA - Child Welfare League of America
CYSA - Connecticut Youth Services Association
CYSPI - CT Youth Suicide Prevention Initiative
DBT - Dialectical Behavioral Therapy
DDS - Department of Developmental Services
DMHAS - Department of Mental Health and Addition Services
DOC - Department of Correction
DPH - Department of Public Health
DRS - Differential Response System
DSS - Department of Social Services
ECCP - Early Childhood Consultation Partnership
ED - Emergency Departments
EDT - Extended Day Treatment
EMPS - Emergency Mobile Psychiatric Services
EPSDT - Early Periodic Screening Diagnosis and Treatment
FAVOR - Family Advocacy for Children's Behavioral Health
FBR - Family-Based Recovery
FFT - Functional Family Therapy
FSAIS - Family Substance Abuse Treatment Services
FST - Family support teams

FWSN - Family With Service Needs
GAIN - Global Appraisal for Individual Needs
GAL - Guardian Ad Litem
HHS - Department of Health and Human Services (Federal)
HYP - Hartford Youth Project
ICFSS - Intensive Community Family Support Service Programs
IEP - Individualized Education Program
IICAPS - Intensive In-home Psychiatric Services
IV-E - Title IV-E of the Federal Social Security Act
JJ - Juvenile Justice
JJPOC - Juvenile Jurisdiction Policy and Operations Coordinating Council
JJPIC - Juvenile Jurisdiction Planning and Implementation Committee
MAWGY - Multi Agency Working Group on Youth
MDFT - Multi-Dimensional Family Therapy
MEPA - Multi Ethnic Placement Act
MET - Motivation Enhancement Therapy
MSS - Managed Service System
MST - Multi-Systemic Therapy
MST- FIT - Multi-Systemic Therapy - Family Intensive Therapy
MST-PSB - Multi-systemic Therapy – Problem Sexual Behavior
MYI - Manson Youth Institution
NAMI-CT - National Alliance for the Mentally Ill of Connecticut
OCA - Office of the Child Advocate
OFAS - Office of Foster and Adoption Services
OOS - Out of State
OPP - Our Piece of Pie Program.
OTC - Order of Temporary Custody
PARK Project - Partnership For Kids Project (Bridgeport)
PASS - Preparing Adolescents for Self-Sufficiency Group Home
PD - Program Director
PDCs - Permanency Diagnostic Centers
PEAS - Parent Education and Assessment Child Services
PFC - Professional Foster Care
PIP - Program Improvement Plans
PRTFs - Private Residential Treatment Facilities
PS - Program Supervisor
PWCL - Parents With Cognitive Limitations
PYDI - Positive Youth Development Initiative
RFP - Request for Proposal
RBA - Results Based Accountability
RBT - Reinforcement Based Therapy
RRG - Regional Resource Group
RTA CT - Raise the Age Connecticut
RTC - Residential Treatment Center
SAC - State Advisory Council
SACWIS - Statewide Automated Child Welfare Information Systems
SAFAR - Substance-Abusing Families at Risk
SCJM - Superior Court for Juvenile Matters
SDE - State Department of Education
SED - Serious Emotional Disturbance
STAR Home - Short-Term Assessment and Respite Home

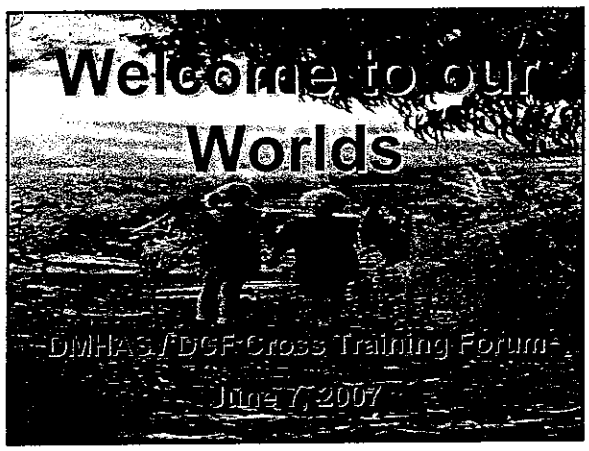
STEP - Support Team for Educational Progress
SW - Social Worker
SWCA - Social Work Case Aide
SWEAT - Supportive Work, Education and Transition Program;
SWS - Social Work Supervisor
TF-CBT - Trauma-Focused Cognitive Behavior Therapy
TGH - Therapeutic Group Home
TPR - Termination of Parental Rights
USD II - Unified School District # II
YCI - York Correctional Institution
YIC - Youth In Crisis
YSAB - Youth Suicide Advisory Board
YSB - Youth Service Bureau

Legal

Emily J. - Lawsuit which challenged the conditions of confinement in the Juvenile Detention Centers operated by the defendant officials of the State of Connecticut and the state's treatment of those children confined in those facilities.

Juan F. - Consent decree which resulted from a federal class action suit filed against the Department of Children and Youth Services, now the Department of Children and Families (DCF). The suit broadly challenged the department's management, policies, practices, operations, funding, and protocols concerning abused and neglected children in its custody and those who might come into its custody.

W.R. - Lawsuit that was filed by several plaintiffs (youths in DCF's care and/or their parents) who claimed that the DCF discriminated against them on the basis of their mental illness and that they were harmed by DCF's failure to put into place policies and procedures to make sure that mentally ill youth in the care of DCF had placements available to them which would help them to live in the community.



DCF Bridgeport Area Office
Serving the towns of: Bridgeport, Easton, Fairfield, Monroe, Stratford and Trumbull.

DCF Norwalk/Stamford Area Offices
Serving the towns of: Norwalk, Weston, Westport, Wilton, Darien, Greenwich, New Canaan, and Stamford.

Statewide Area Offices
Bridgeport, Norwalk/Stamford, New Haven, Waterbury, Norwich, Danbury, Middletown, Manchester, Torrington, Hartford, Willimantic, Meriden, New Britain.

The Department of Children and Families is the State of Connecticut Agency that is responsible for Child Protection

- Our Focus is the "Best Interest" of the child.
- Our clients are Parents, Guardians, or Persons entrusted with the care of children.
- We serve both Involuntary and Voluntary clients.

Mission

The mission of the Connecticut Department of Children and Families is to protect children, strengthen families and help young people reach their fullest potential.

DCF Mandates

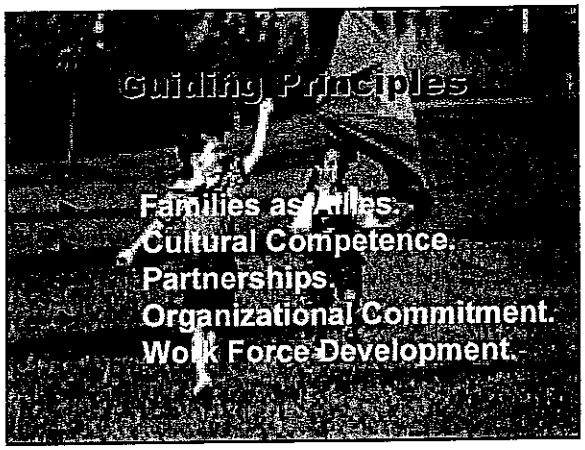
Child Welfare | Juvenile Justice | Mental Health | Substance Abuse

Child Welfare Mandates

- We intervene to protect children and youth who are reported to be abused by adults responsible for their care.
- We work to strengthen and preserve families so children can be safe and nurtured at home.
- We help foster parents and other substitute caregivers provide temporary care when children cannot reside at home.

Child Welfare Mandates

- We help children become adopted when their parents cannot provide permanent care and safety.
- We provide services to help young people develop to their fullest potential.
- We work as partners with children, youth, birth parents, and communities bringing quality services to Connecticut's young people.



Bridgeport DCF--211 staff members

GPS	FASU	Clinical	Parole
Social Workers: 107	Social Workers: 11	Mental Health: 2 Substance Ab: 1 Education: 1 Nurse: 2	Parole Workers: 10
Social Work Supervisors: 25	Social Work Supervisors 2	Supervising Clinician: 1	Parole Supervisor: 1

Managerial Staff:
Area Director: Maria Brereton
Program Directors: Janice Currier-Ezepchick
Malcolm Blue
Program Supervisors: Alexandra Molina, Albert Cagganello, Brian Behmke, Gayle Hoffman, Jayne Guckert, Yolanda Chapman Smith

The Life Span of a DCF Case

Reporter

Hotline

Regional Office Investigations Unit

Regional Office On-Going Services

Permanency Planning

Closure

...Once a Report is Made to the Hotline

- The Department will investigate cases where the abuse or neglect has been inflicted by or caused by a person responsible or entrusted for such child's health, welfare or care or by a person given such access to such child by such person responsible.
- All other reports will be referred to the appropriate local law enforcement authority.

"Person Responsible"

- Parent
- Guardian
- Foster Parent
- School Employees
- Staff personnel of child center based, family or group day care settings
- Staff employees of residential child care settings and that individual responsible for a child's health, welfare or care and is allegedly responsible for causing or allowing the infliction of physical injury or injuries or imminent risk

"Person Entrusted"

- Anyone given access to child or youth by a person who is responsible for the health, welfare or care of a child or youth.
- For the purpose of providing education, child care, counseling, spiritual guidance, coaching, training, instruction, tutoring or mentoring of such child or youth.

Who Must Report

Connecticut General Statutes identifies professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect.

Mandated Reporters

- Battered Women's Counselors
- Chiropractors
- Dental Hygienists
- Dentists
- Department of Children and Families Employees
- Licensed or Certified Alcohol and Drug Counselors
- Licensed or Certified Emergency Medical Service Providers
- Licensed Marital and Family Therapists
- Licensed or Unlicensed Resident Interns
- Licensed or Unlicensed Resident Physicians
- Licensed Physicians
- Licensed Practical Nurses
- Licensed Professional Counselors
- Licensed Surgeons
- Medical Examiners
- Members of the Clergy
- Mental Health Professionals
- Optometrists
- Parole Officers (Juvenile or Adult)
- Pharmacists
- Physical Therapists
- Physician Assistant
- Pediatricians
- Police Officers
- Probation Officers (Juvenile or Adult)
- Psychologists
- Registered Nurses
- School coach or coach of intramural or interscholastic athletics
- School Guidance Counselors
- School Paraprofessionals
- School Principals
- School Teachers
- Sexual Assault Counselors
- Social Workers
- Any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home licensed by the state
- Department of Public Health employees responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps
- Child Fatality Review employees of the Office of the Child Advocate

What Must Be Reported?

Mandated Reporters are required to report or cause a report to be made when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm (CGS 17a-101a).

A Mandated Reporter must report any suspicion to DCF or law enforcement regardless of the identity of the alleged perpetrator.

Reasonable Cause to Suspect

- Observed
- What is Told or Said
- Knowledge from Professional Training and Experience

CERTAINTY IS NOT REQUIRED

DCF has the authority to issue a 96 hour hold and assume immediate temporary custody of a child upon a determination that the child is at imminent risk of physical harm and that the immediate removal is necessary to ensure the child's safety.

DCF must then file in Superior Court, Juvenile Matters for an Order of Temporary Custody within 96 hours – or the child must be returned.

The Superior Court, Juvenile Matters becomes involved in all cases when a child is not returned home within 96 hours of removal by DCF.

The Authority of Superior Court, Juvenile Matters

The court has authority over all proceedings concerning the following:

- Abused, uncared-for, neglected or dependent children and youth
- Orders of Temporary Custody
- Neglect Petitions
- Termination of Parental Rights

The Joint Role

- The Superior Court, Juvenile Matters and the Department share the responsibility for the protection of children when their parents are unwilling and/or unable to provide for the children's well being.
- The ultimate goal of both the court and the Department is the welfare and best interests of the child.

The Court's Role

The court's role is to:

- Determine the merits of the case.
- Protect the rights of the parties.

According to Connecticut Law...

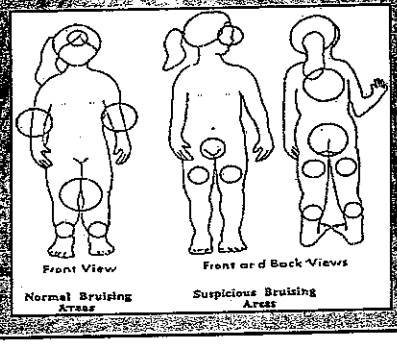
What is an "Abused" child?

Abuse – (CGS 46b-120)

A child under the age of 18:

- Who has had a physical injury inflicted upon him/her by other than accidental means, or which is at variance with the history given, or
- Who is in a condition which is the result of maltreatment such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment.

Normal / Suspicious Bruising Areas



According to Connecticut Law ...

What is a "Neglected" child?

Neglect - (CGS 46b-120)

A child under the age of 18 who has been:

- Abandoned;
- Denied proper care and attention, physically, educationally, emotionally or morally; or,
- Been permitted to live under conditions, circumstances, or associations injurious to his/her well-being.

According to Connecticut Law ...

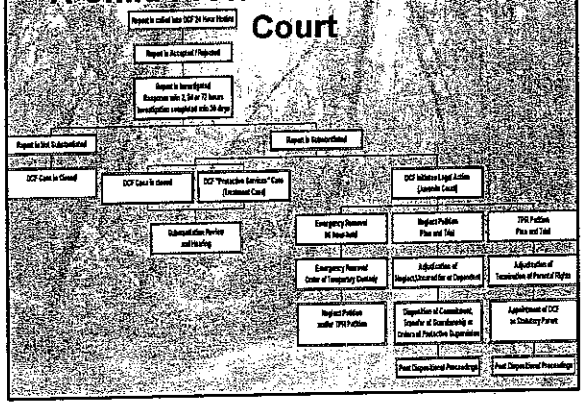
What is an "Uncared For" child?

Uncared For - (CGS 46b-120)

A child under the age of 18:

- Who is homeless, or
- Whose home cannot provide the specialized care which the physical, emotional or mental condition of the child requires.

A Child Protection Case and the Court



Structured Decision Making:

System Goals:

- Reduce the rate of subsequent abuse/neglect reports and substantiations.
- Reduce the severity of subsequent abuse/neglect complaints or allegations.
- Reduce the rate of foster care placement.
- Reduce the length of stay for children in foster care.

Structured Decision Making:

Process Goals:

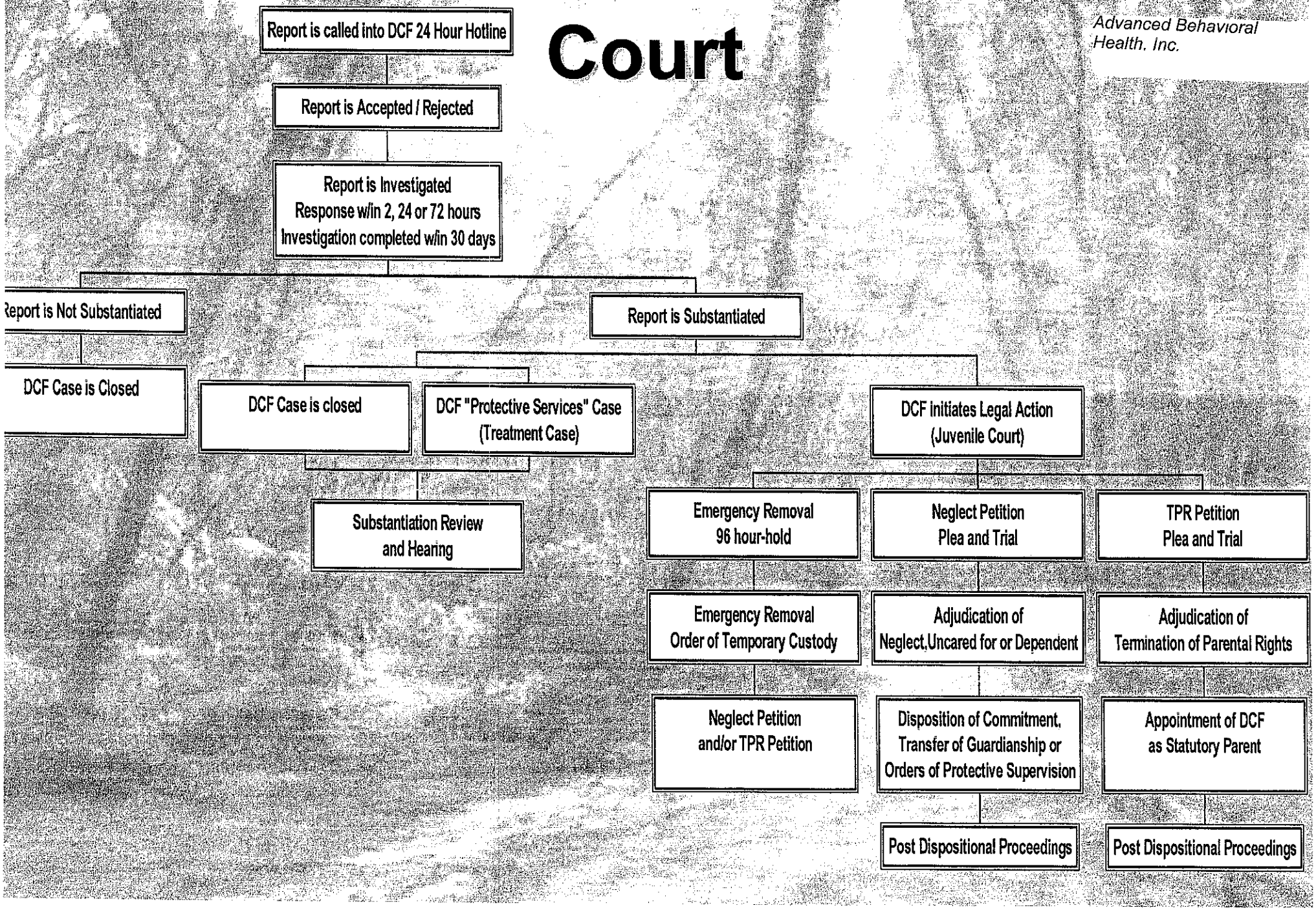
- Improve assessments of family situations to better ascertain the protection needs of children.
- Increase consistency and accuracy in case assessment and case management among child abuse/neglect staff.
- Increase the efficiency of child protection operations by making the best use of available resources.

Structured Decision Making: Key Points

- SDM is a set of assessment tools, not forms...the assessments help guide decisions.
- SDM guides decisions. Workers make decisions.
- Working together with social work staff, SDM can achieve reduced harm to children.
- SDM is part of a larger strength-based, family centered, and culturally appropriate practice framework of decision-making.

A Child Protection Case and the Court

Advanced Behavioral Health, Inc.



Advanced Behavioral Health, Inc.

What kind of help can DCF give my family?

The Department of Children and Families provides and funds a wide range of community-based services. Your social worker will explain these and other services available in your community. They may include:

- Information and Referral
- Individual and Family Therapy
- Intensive Family Preservation Services
- Parent Education and Support Centers
- Family Support Centers
- Parent Aide
- Parenting Classes
- Parent Support Groups
- Sexual Abuse Treatment
- Substance Abuse Services
- Children's Mental Health Services
- Voluntary Services For Children With Mental Health Needs

If you do not agree with the treatment plan or the services provided to your family, you can:

- Participate in treatment planning conferences. These reviews are held within 45 days of your case being opened for services or your child(ren) going into placement.
- Participate in administrative case reviews of the treatment plan. These reviews are held every six months. Your social worker will notify you when an administrative case review is scheduled, or, you may request one at any time.
- Request a treatment plan hearing to contest the Department's plan and/or provision of services. A hearing officer will hear both sides and issue a written decision on the appropriateness of the treatment plan in meeting the needs of the child(ren). You may choose to be represented by an attorney at your own expense. A treatment plan hearing may be requested by writing to the Commissioner of Children and Families at 505 Hudson Street, Hartford, CT 06106. Your written request must state the specific issues with which you disagree.
- If you are not satisfied after all administrative remedies are provided by the Department, you may have the right to bring an appeal to the Superior Court.

What other rights do I have as a parent?

- You have the right to be treated with respect and dignity.
- You have the right to have an interpreter present to assist you to understand all of the proceedings of your case.
- You have the right to request all of the documents related to your case translated into your primary language.
- You have the right to request and receive thorough and understandable answers to any questions you may have about the Department's involvement with your family.
- You have the right to have any person of your choosing (such as friend, relative, or clergy person) present during meetings with DCF social workers, unless a court restraining or protective order forbids the involvement of that person.
- You have the right to request and receive information contained in the Department's records about the investigation and findings concerning you and your child(ren). Access to the identity of the person(s) who reported suspected abuse or neglect may be restricted.
- You have the right to a written notification of and reasons for any action regarding the placement of your child(ren), if removal is determined to be necessary.
- You have the right to privacy. Records regarding you and your family will not be publicly released by the Department without your permission unless authorized by law. However, information may be disclosed to other agencies for investigation, treatment, or other purposes as permitted by law.
- You have the right to have an attorney with you at any time. If DCF files a court petition for temporary custody of your child, you should consult an attorney. If you are unable to pay for an attorney, you may ask the court to appoint one for you. A separate attorney will be appointed to represent your child(ren) in the proceedings.
- You have the right **not** to work or talk with us.
- You have the right to have information about your case expunged under certain circumstances.
- You have the right to contact the DCF Ombudsman's Office. In the best interest of children, the purpose of this office is to resolve disputes between clients, foster and adoptive parents, providers, citizens, and the Department. The Ombudsman can be reached from 8:00 A.M. to 5:00 P.M. Monday thru Friday at (860) 550-6301.

How can I contact the Department of Children and Families?

The Hotline is a centralized referral system. All calls concerning allegations of abuse or neglect or calls requesting information go through the Hotline. The Hotline can also respond to emergency situations when the DCF area offices are closed. Our area offices are open from 8:00 A.M. to 5:00 P.M. weekdays. After 5:00 P.M. and on weekends and holidays, you may call the **DCF HOTLINE** at **1-800-842-2288**, especially if you feel your child(ren) may be at risk. You can find area office telephone numbers and other information on our website www.state.ct.us/dcf.

Other Sources of Help...

INFOLINE - a free, telephone information and referral service that can put parents in touch with all kinds of helpful programs and services in the community. INFOLINE can often help in a crisis, whether it is domestic violence, a runaway teenager, mental health emergency, or another problem.
Call INFOLINE at 211

PARENTS ANONYMOUS - a self help group for parents who feel they may take their anger out on their children. Parents Anonymous groups meet regularly in many Connecticut communities to give parents support and help in handling problems. Meetings are confidential and members may remain anonymous. Most parents exchange first names and phone numbers to help them reach out for support. To locate a Parents Anonymous group near you, Call INFOLINE at 211

COMMUNITY COUNSELING SERVICES - many Connecticut communities have child guidance clinics, youth service bureaus, and child and family services. These programs provide individual, group and family counseling, and related services to help parents and children. Most programs have a sliding fee scale according to family income. Religious institutions in your community may also offer counseling and family services. Your local school system is another good source of information and assistance.

Published by the
Connecticut Department of Children and Families, 2004

M. Jodi Rell
Governor

Darlene Dunbar, MSW
Commissioner

A Parent's RIGHT to KNOW

Child Protective Services and Your Family

CONNECTICUT DEPARTMENT *of* CHILDREN *and* FAMILIES (DCF)
DCF Hotline: 1-800-842-2288
DCF Website: www.state.ct.us/dcf

The Department of Children and Families

(DCF) is a state agency that provides many services to help Connecticut's young people and their parents. The mission of the Department of Children and Families is to protect children, improve child and family well-being, and support and preserve families. These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with others.

The most critical part of our mission is to protect children and youth up to age 18 from abuse and neglect. This pamphlet is intended to help parents understand how protective services work. It will give you an introduction to the role and responsibilities of the Department, and your rights and the rights of your children.

It is important to know, first of all, that state law requires DCF to investigate all reports that meet statutory criteria of suspected child abuse and neglect. DCF's legal responsibility is to determine if a child has been abused or neglected. An investigation is the first step. It is also important to know that an investigation in itself does not necessarily mean abuse or neglect has taken place. Often, DCF's involvement becomes an opportunity to provide support services that can help a family.

DCF's primary goal in any investigation is to identify any safety concerns that present a risk factor to the minor children in the household. The Risk Assessment will determine the level of intervention needed, if any, and target services to assist the family.

Q & A for Parents about Protective Services

Why is a DCF Social Worker contacting me?

A social worker is contacting you because the Department received a report that your child may have been abused or neglected, or may be at risk of being abused. State law (Connecticut General Statutes Sec. 17a-101) requires DCF to investigate all reports of suspected child abuse or neglect. The social worker will want to talk to you about the report and your child's well-being.

Who reported my child as abused or neglected?

Anyone - a friend, neighbor, family member, or stranger - can make a report of suspected abuse or neglect. Any reporter may remain anonymous. However, the reporter's identity may be disclosed under certain limited circumstances. Some professionals are required by law to report suspected abuse or neglect and are called "mandated reporters." Mandated reporters include teachers, physicians, nurses, social workers, police officers, mental health counselors, clergy, daycare workers, and other professionals.

Why would a report be made?

Children are reported for a variety of reasons. Mandated reporters, for example, must contact the Department if they suspect a child:

- has been neglected, which means the child has been abandoned, is being denied proper care and attention, or is being permitted to live under circumstances which harm his or her well-being;
- has non-accidental physical injuries;
- has physical injuries that are inconsistent with an explanation of the injuries;
- has a condition resulting from maltreatment, such as malnutrition, sexual abuse, sexual exploitation, deprivation of necessities like food, clothing, shelter, and emotional maltreatment or cruel punishment; and
- is placed at imminent risk of serious harm.

Children have a right to be safe from these conditions.

What happens when DCF receives a report regarding my child?

Each accepted report of suspected abuse or neglect is assigned to a social worker who is responsible for conducting an investigation. It is the social worker's responsibility to investigate the report and determine if ongoing DCF involvement is required.

Who will the social worker talk to?

First and foremost, the social worker will talk to you, your child(ren), and other family members. It is important to hear from you so the Department can offer help, if needed, to your family. The social worker will contact physicians, teachers, daycare staff, baby-sitters, neighbors, relatives, or other people who have first-hand knowledge of you and your child(ren). You may also suggest others who you feel have information concerning your child. In certain situations, the worker may contact people without the parent's consent. The police must be contacted if the report indicates sexual abuse or serious physical abuse or neglect.

Does the social worker have to talk to my child?

Yes. The social worker must see and talk with your child, and will need to see and talk with other children in the home. In certain circumstances, the social worker may talk with your child before contacting you. He or she may talk with your child at school or at daycare.

What if I don't want to talk to the social worker?

DCF encourages parents to cooperate with an investigation. This provides parents with the opportunity to tell their story. You can choose not to speak with the social worker, but the Department is still required by law to investigate the report. If DCF believes your child is in immediate danger of serious harm, we will contact the police and, if necessary, file a petition with the court to see your child.

Will my children be taken away from me?

The great majority of children served by DCF remain at home with their parents. DCF's goal is to keep families together whenever possible. When support services are needed, your social worker will help arrange them.

There are times when it is determined that the risk to a child's safety requires out-of-home placement. DCF may authorize a child's removal if there is probable cause to believe that the child is at imminent risk of physical harm and that immediate removal is necessary to ensure the child's safety. An emergency administrative removal is called a 96-hour hold. The parent should receive in writing the reason for the Department's actions and the legal basis for the removal. Within 96 hours after such removal, the Department must seek an Order of Temporary Custody (OTC) from the Court if it is necessary to maintain the child in out-of-home placement. If that is the case, you will be entitled to a Court hearing within 10 days and have the right to an attorney. If you cannot afford an attorney, the court will appoint one for you. Your child(ren) will be represented by an attorney as well.

When a child must be placed in out-of-home care, DCF's goal is his or her safe return as soon as the family situation is determined to be stable and safe.

What happens after an investigation?

If DCF finds that your child has not been abused or neglected, the report is "unsubstantiated." This means that no further involvement is necessary unless you request services voluntarily.

If DCF finds that your child has been abused or neglected, the report is "substantiated," and your case will most likely remain open with DCF for services. Your social worker will then work with you to develop what's called a *treatment plan.* The social worker will discuss the services you can receive and how DCF will work with you to improve your family's situation.

If a child has been seriously abused or neglected, or sexually abused, DCF is required to refer the case to the police. At times, DCF's involvement begins after a call from a police department to help investigate a situation involving children.

Can I disagree with the Department's finding?

Yes. If at any time you disagree with a finding of substantiated abuse or neglect, you may:

- Request in writing a review of the finding addressed to the area director. If you disagree with the results of the review, you can request an administrative hearing.
- You are not required by law to talk to the social worker during the investigation. But if you choose not to say anything, the hearing officer may not be able to consider your side of the story at the administrative hearing.
- You can also send a written statement with the facts you feel are important and ask that your statement be added to your file.

Substance Abuse Managed Service System* (SAMSS) Meeting ~ Suggested Guidelines

* For open DCF cases in which parental/caregiver substance abuse is a concern. Cases can be added to the agenda by DCF, Recovery Case Manager/Recovery Specialist, SA Treatment Provider, and/or other service provider.

Purpose of SAMSS meeting:

The SAMSS meeting exists to provide a forum for case collaboration and networking between the child welfare system, adult SA treatment providers, and other related community providers. It is also an opportunity to share information on new and existing resources and to clarify questions with regard to the child welfare case and/or client's current status in or recommendations for treatment.

Organization/Structure:

- DCF facilitator(s) at each SAMSS meeting – this could be the AD, BH PD, CPS PD, PS, and/or SAS
- DCF contact person to organize the weekly agenda, coordinate the scheduling with DCF SWs, and serve as a contact person for outside agencies wanting to place a person on the agenda for discussion/update In New Britain, the Substance Abuse Specialist (SAS) has performed this role. 1:1 contact initiated by the SAS with the specific DCF SW early on was very helpful in both promoting the SAMSS meeting and in working with DCF SWs schedules to arrange the agenda
- DCF SW introduces the case providing a brief overview of DCF involvement and concerns regarding parent/caregiver's Substance Abuse using a set written format (i.e. case presentation form sample attached).
- Having a written agenda for participants is helpful to follow the flow of the meeting.
- Meetings occur regularly on a weekly or biweekly basis
- Each Area Office SAMSS meeting has a unique culture, and procedure. It is important to attend to the unique features of each.

Data Collection/Documentation:

- Include participant link # if plan to cross reference with DCF Information Systems.
- DCF SW should document SAMSS discussion/plan/outcome in LINK.

Initial Presentation: *(one or more of the following)*

- Parental/Caregiver's substance use is determined to be a significant risk factor in the safety and well being of the child(ren)/family.
- Additional community services are needed to support the parent/caregiver in obtaining or maintaining her/his recovery.
- Close coordination between the service providers is needed to support the parent/caregiver in his/her recovery
- Parent(s) have accepted a referral to the Recovery Specialist Voluntary Program (RSVP) following an OTC on the child(ren)

Updates: *(i.e., when to schedule)*

- As scheduled at initial presentation or last update.
- When significant change(s) occurs in the case status, e.g.:
  - Change in child status (e.g., removal or reunification)
  - Parent/Caregiver does not engage with recommended services
  - Parent/Caregiver disengages from SA services
  - Parental/caregiver relapse with substances
  - Case is stagnant, i.e., no progress noted by services providers, DCF, or individual
  - Change in level of care (LOC) – higher or lower – is made or recommended
  - Other need, concern, or significant progress to report

RSVP/RCM Participation in SAMSS:

- Recovery Specialists/Recovery Case Managers will attend each SAMSS meeting and be prepared to provide a brief, objective update that includes information provided on the RSVP monthly or RCM biweekly update,
- RSVP/RCM staff will begin their update with a preface such as:
  - *"In RSVP, the client is current fully compliant which means s/he is attending {LOC} treatment at {provider}; complying with RSVP random drug testing and testing negative; providing verification of attendance at self-help groups; and meeting regularly with the RS"*; or
  - *"In RSVP, client is currently non-compliant. While s/he is doing {X, Y, Z}, s/he is not yet providing verification of attendance at self help groups as required to be fully compliant with RSVP"*; or
  - *"In Recovery Case Management, I have met with the client X times and the current focus is on [X, Y, Z]. Progress has been noted in [A,B]; current needs include . . ."*
- Additional information that can be included in the update includes:
  - Current LOC for client and their attendance at tx
  - Current goals that are being addressed and the client's progress with regard to them
  - Any barriers to the client attending tx or complying with the program or overall needs (e.g. housing, employment, etc.)
  - Outreach efforts to engage/reengage the client
  - Description of Recovery Coaching goals and efforts (e.g. client is being encouraged to locate a sponsor through 12-step meetings; client is identifying challenges with upcoming holidays and is encouraged to work on this in treatment)

Documentation of SAMSS Discussion in RSVP/RCM Database

- Each time an open RSVP/RCM case is discussed or updated at a SAMSS meeting, the RS/RCM will document this in an activity note under "DCF Contact." In the progress note section, the RS/RCM will summarize the discussion and recommendations from this beginning the progress note with *"SAMSS Update . . ."*

CT Department of Children and Families

Mission and Guiding Principles

"The mission of the Department of Children and Families is to protect children, improve child and family well-being and support and preserve families. These efforts are accomplished by respecting and working within individual cultures and communities in Connecticut, and in partnership with others.

Guiding Principles

- **Overarching Principle - Safety/Permanency/Well-Being:** The Department of Children and Families (DCF) is committed to the support and care of all children, including those in need of protection, who require mental health or substance abuse services, and who come to the attention of the juvenile services system.

  In this context, DCF asserts that all children have a basic right to grow up in safe and nurturing environments and to live free from abuse and neglect. All children are entitled to enduring relationships that create a sense of family, stability and belonging.

- **Principle One - Families as Allies:** The integrity of families and each individual family member is respected, and the importance of the attachments between family members is accepted as critical. All families have strengths and the goal is to build on these strengths. Family involvement and self-determination in the planning and service delivery process is essential.

- **Principle Two – Cultural Competence:** The diversity of all people is recognized and appreciated and children and families are to be understood in the context of their own family rules, traditions, history and culture.

- **Principle Three – Partnerships:** Children and families are best served when they are part of and supported by their community. The Department is part of this community, works in association with community members, and is committed to its services being localized, accessible and individualized to meet the variety of children and families needs.

- **Principle Four – Organizational Commitment:** A successful organizational structure promotes effective communication, establishes clear directions, defines roles and responsibilities, values the input and professionalism of staff, creates a supportive, respectful and positive environment, and endorses continuous quality improvement and best practice.

- **Principle Five – Work Force Development:** The work force is highly qualified, well trained and competent, and is provided with the skills necessary to engage, assess, and intervene to assist children and families achieve safety, permanence and well-being."

OVERVIEW OF STRUCTURED DECISION MAKING® POLICY AND PROCEDURES

ASSESSMENT TOOL/ DECISION GUIDELINE	WHICH CASES	BY WHOM	WHEN	DECISIONS
Screening Criteria	All reports of child abuse and neglect.	Hotline worker	No later than end of worker's shift.	Determines whether reports meet criteria for CPS investigation.
Response Priority	All CPS reports accepted for investigation, including new referrals on existing cases.	Hotline worker	Upon completion of the screening tool.	Determines how quickly an investigation must be initiated.
Safety Assessment Investigation	All CA/N investigations of parent(s), guardian(s), and other adult household member(s) including new investigations on existing cases.	Investigation worker	For investigations during the initial home visit – documented within five working days.	Identifies safety factors, interventions, and/or plans that guide the decision to remove or return a child.
Existing Cases	All existing CPS cases.	Treatment worker	For existing cases whenever safety factors are identified, documented within five working days.	Identifies safety factors, interventions, and/or plans that guide the decision to remove or return a child.
Risk Assessment	All CPS investigations of parent(s), guardian(s), and/or other adult household member(s) including new investigations on existing cases.	Investigation worker	At end of investigation.	Estimates the likelihood of future maltreatment and informs the transfer/close decision.
Case Decision Matrix	All initial CA/N investigations of parent(s), guardian(s), and/or other adult household member(s).	Investigation worker	At the completion of the risk assessment.	Guides the case open or close decision.
	All in-home CPS treatment cases.	Treatment worker	At the completion of risk reassessment.	Guides the case open or close decision.
Family Strengths and Needs Assessment Child Strengths and Needs Assessment	All CPS treatment cases.	Treatment worker	• Prior to the development of the initial treatment plan, which is within 45 days of investigation disposition for in-home cases. • Within 45 days following placement.	Guides treatment plan objectives and services.
Risk Reassessment	All CPS treatment cases where all children remain in or have been returned to the home.	Treatment worker	90 days following the initial treatment plan and every 90 days thereafter.	Guides the decision to close case or continue to serve.
Family Reunification Assessment Packet (i.e., risk, visitation, and safety assessment/reassessment)	All CPS treatment cases where any child is in out-of-home placement with a goal of "reunification."	Treatment worker	• 90 days following the initial treatment plan and every 90 days thereafter. • Whenever a child is being considered for reunification.	Guides the decision to reunify, maintain reunification services, or change the permanency plan goal.
Family Strengths and Needs Reassessment Child Strengths and Needs Reassessment	All CPS treatment cases.	Treatment worker	In conjunction with every risk reassessment or reunification assessment.	Assesses progress and informs further treatment planning decisions.

STRUCTURED DECISION MAKING® SYSTEM GOALS

Structured Decision Making® Goals

1. **Reduce subsequent maltreatment to children and families.**

   a. Reduce subsequent referrals
   b. Reduce subsequent substantiations
   c. Reduce subsequent injuries
   d Reduce subsequent foster placements

2. **Expedite permanency for children.**

Structured Decision Making® Objectives

1. Identify **critical decision points.**

2. Increase **reliability** of decisions.

3. Increase **validity** of decisions.

4. **Target resources** to families at **highest risk.**

5. **Use case level data** to inform decisions throughout the agency.

Critical Characteristics of the Structured Decision Making® System

Reliability: Structured assessment tools and protocols systematically focus on the critical decision points in the life of a case, increasing worker consistency in assessment and case planning. Families are assessed more objectively, and decision making is guided by facts of the case, rather than by individual judgment.

Validity: Research repeatedly demonstrates the model's effectiveness at reducing subsequent abuse/neglect, as evidenced by reduced rates of subsequent referrals, substantiations, injuries to children, and placements in foster care. The cornerstone of the model is the actuarial research-based risk assessment that accurately classifies families according to the likelihood of subsequent maltreatment, enabling agencies to target services to families at highest risk.

Equity: Structured Decision Making® (SDM) assessment tools ensure that critical case characteristics, safety factors, and domains of family functioning are assessed for every family, every time, regardless of social differences. Detailed definitions for assessment items increase the likelihood that workers assess all families using a similar framework. Research demonstrates racial equity of the risk assessment tool in classifying families across risk levels. The reunification assessment tool has demonstrated expedited permanency for children, regardless of race

Utility: The model and its tools are easy to use and understand. Assessment tools are designed to focus on critical characteristics that are necessary and relevant to a specific decision point in the life of a case. Use of the tools provides workers with a means to focus the information gathering and assessment process. By focusing on critical characteristics, workers are able to organize case narrative in a meaningful way. Additionally, the tools facilitate communication between worker and supervisor, and unit to unit, about each family and the status of the case. Aggregate data facilitates communication among community partners and stakeholders.

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES r: 1/07
SDM® SAFETY ASSESSMENT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker:** _____ **Assessment Date:** ____/____/____

Assessment Type: ❑ Initial ❑ Subsequent

SECTION I: SAFETY FACTORS

The following factors are behaviors or conditions that may be associated with a child being in immediate danger of serious harm. Identify the presence or absence of each factor by checking either "yes" or "no." **Note: The vulnerability of each child needs to be considered throughout the assessment. Children ages zero through six cannot protect themselves. For older children, inability to protect themselves could result from diminished mental or physical capacity or repeated victimization.**

Yes	No		
❑	❑	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation indicated by: ❑ Serious injury or abuse to the child other than accidental. ❑ Caregiver fears he/she will maltreat the child ❑ Threat to cause harm or retaliate against the child ❑ Excessive discipline or physical force. ❑ Drug-exposed infant. ❑ Death of a child due to abuse/neglect
❑	❑	2.	Child sexual abuse is suspected and circumstances suggest that the child's safety may be of immediate concern
❑	❑	3.	Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect
❑	❑	4	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
❑	❑	5	The family refuses access to the child, or there is reason to believe that the family is about to flee
❑	❑	6	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care
❑	❑	7	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
❑	❑	8	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child
❑	❑	9.	Domestic violence exists in the home and poses a risk of serious physical and/or emotional harm to the child.
❑	❑	10.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal
❑	❑	11	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
❑	❑	12	There is a pattern of prior investigations or behavior AND current circumstances are near the threshold for any other safety factor.
❑	❑	13.	Other (specify): _____

IF NO SAFETY FACTORS ARE OBSERVED, PROCEED TO SECTION 3.

SECTION 2: SAFETY INTERVENTIONS

If no safety factors are present, go to Section 3. If one or more safety factors are present, consider whether safety interventions 1-8 will allow the child to remain in the home for the present time. Check the item number for all safety interventions that will be implemented. If there are no available safety interventions that would **allow the child to remain in the home,** indicate by checking item nine if the caregiver arranges for the care of the child outside of the home or intervention 10 if the child will be taken into protective custody.

Check all that apply:

Interventions that will enable the children to remain in the home for the present time:

- ☐ 1. Intervention or direct services by worker as part of a safety plan.
- ☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.
- ☐ 3 Use of community agencies or services as safety resources
- ☐ 4. Have the non-offending caregiver appropriately protect the victim from the alleged perpetrator
- ☐ 5 Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.
- ☐ 6 Have the non-offending caregiver move to a safe environment with the child
- ☐ 7 Legal action planned or initiated—child remains in the home.
  - ☐ The family has initiated a legal action (e g., restraining/protective orders, change in custody/visitation, mental health commitments) that mitigates identified safety factors
  - ☐ The Department may have or will be filing neglect petitions in Juvenile Court based on identified safety factors The decision to file petitions in and of itself is not an appropriate intervention to ensure the child's safety in the home.
- ☐ 8. Other (specify): _____

Intervention caregiver makes for the child to be cared for outside of the home:

- ☐ 9. Caregiver arranges for care of the child outside the home

Intervention to remove a child from the home:

- ☐ 10 Child placed in protective custody because no interventions are available to adequately ensure the child's safety

SECTION 3: SAFETY DECISION

Identify the safety decision by checking the appropriate box below. This decision should be based on the assessment of all safety factors, safety interventions, and any other information known about the case. Check one box only.

- ☐ 1. **Safe**. No safety factors were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm
- ☐ 2. **Conditionally Safe**. It has been determined that this child is at imminent risk of removal from the home and that reasonable efforts are being made to prevent the removal and that absent effective pre-placement preventive services, the plan is to place the child in foster care. One or more safety factors are present, and protecting safety interventions have been planned or taken. Based on protecting interventions, the child will remain in the home at this time or the caregiver has arranged for care of the child outside of his/her home as a protective intervention
- ☐ 3. **Unsafe**. One or more safety factors are present, and placement is the only protecting intervention possible for one or more children. Without placement one or more children will likely be in immediate danger of serious harm
  - ☐ All children placed.
  - ☐ One or more children will be placed in protective custody, but others remain in the home

Worker: _____ **Date:** ____/____/____

Supervisor: _____ **Date:** ____/____/____

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker :** _____ **Assessment Date:** ___/___/___

NEGLECT		Score
N1	Current Complaint Is for Neglect	
	a. No	0
	b. Yes	1 _____
N2	Prior Investigations (assign highest score that applies)	
	a. None	0
	b. One or more, abuse only	1
	c. One or two for neglect	2
	d. Three or more for neglect	3 _____
N3	Household Has Previously Received CPS (voluntary/court-ordered)	
	a. No	0
	b. Yes	1 _____
N4	Number of Children Involved in the CA/N Incident	
	a. One, two, or three	0
	b. Four or more	1 _____
N5	Age of Youngest Child in Household	
	a. Two or older	0
	b. Under two	1 _____
N6	Primary Caregiver Provides Physical Care Inconsistent with Child Needs	
	a. No	0
	b. Yes	1 _____
N7	Primary Caregiver Has a Past or Current Mental Health Problem	
	a. No	0
	b. Yes, check if applicable	1
	☐ during the last 12 months	
	☐ prior to the last 12 months	_____
N8	Primary Caregiver Has Historic or Current Alcohol or Drug Problem (check applicable items and add for score)	
	a. Not applicable	0
	b. Alcohol	1
	☐ during the last 12 months ☐ prior to the last 12 months	
	c. Drug	1
	☐ during the last 12 months ☐ prior to the last 12 months	_____
N9	Characteristics of Children in Household (check applicable items and add for score)	
	a. Not applicable	0
	b. ☐ Medically fragile/failure to thrive	1
	c. ☐ Developmental or physical disability	1
	d. ☐ Positive toxicology screen at birth	1 _____
N10	Housing (check applicable items and add for score)	
	a. Not applicable	0
	b. ☐ Current housing is physically unsafe	1
	c. ☐ Homeless at time of investigation	2 _____

ABUSE		Score
A1	Current Complaint Is for Abuse	
	a. No	0
	b. Yes	1 _____
A2	Number of Prior Abuse Investigations (number: _____)	
	a. None	0
	b. One or more	1 _____
A3	Household Has Previously Received CPS (voluntary/court-ordered)	
	a. No	0
	b. Yes	1 _____
A4	Prior Injury to a Child Resulting from CA/N	
	a. No	0
	b. Yes	1 _____
A5	Primary Caregiver's Assessment of Incident (check applicable items and add for score)	
	a. Not applicable	0
	b. ☐ Blames child	1
	c. ☐ Justifies maltreatment of a child	2 _____
A6	Two or More Domestic Violence Incidents in the Household in the Past Year	
	a. No	0
	b. Yes	2 _____
A7	Primary Caregiver Characteristics (check applicable items and add for score)	
	a. Not applicable	0
	b. ☐ Provides insufficient emotional/psychological support	1
	c. ☐ Employs excessive/inappropriate discipline	1
	d. ☐ Domineering caregiver	1 _____
A8	Primary Caregiver Has a History of Abuse or Neglect as a Child	
	a. No	0
	b. Yes	1 _____
A9	Secondary Caregiver Has Historic or Current Alcohol or Drug Problem	
	a. No	0
	b. Yes, alcohol and/or drug (check all applicable)	1 _____
	☐ Alcohol	
	☐ during the last 12 months ☐ prior to the last 12 months	
	☐ Drug	
	☐ during the last 12 months ☐ prior to the last 12 months	
A10	Characteristics of Children in Household (check appropriate items and add for score)	
	a. Not applicable	0
	b. ☐ Delinquency history	1
	c. ☐ Developmental disability	1
	d. ☐ Mental health/behavioral problem	1 _____

TOTAL NEGLECT RISK SCORE _____ **TOTAL ABUSE RISK SCORE** _____

INITIAL RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
☐ 0 – 1	☐ 0 – 1	☐ Very Low
☐ 2 – 4	☐ 2 – 4	☐ Low
☐ 5 – 8	☐ 5 – 7	☐ Moderate
☐ 9 +	☐ 8 +	☐ High

POLICY OVERRIDES. Check box if a condition shown below is applicable in this case. If any condition is applicable override final risk level to high.

- ☐ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim.
- ☐ 2. Cases with non-accidental physical injury to a child under age six
- ☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
- ☐ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
- ☐ 5. Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current)
- ☐ 6. Household member had prior Termination of Parental Rights.

DISCRETIONARY OVERRIDE. If a discretionary override is used, check box, mark override risk level, and indicate reason. Risk level may be overridden one level higher

☐ 7. If yes, override risk level (check one): ☐ Low ☐ Moderate ☐ High

Discretionary Override Reason: _____

FINAL RISK LEVEL (check final level assigned): ☐ Very Low ☐ Low ☐ Moderate ☐ High

Supervisor Approval: _____ **Date:** ___/___/___

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES
SDM® FAMILY REUNIFICATION ASSESSMENT/REASSESSMENT

r: 12/06

Case Name: _____ **LINK #:** _____ **Household Assessed:** _____

Area Office: _____ **Worker:** _____ **Assessment/Reassessment Date:** ___/___/___

Assessment/Reassessment #: 1 2 3 4 ___ **Removal Household (circle one)?** Yes No

A. FAMILY REUNIFICATION RISK ASSESSMENT/REASSESSMENT

R1. Risk Level from Most Recent Investigation (after overrides) — **Score**

a.	Very Low	0
b.	Low	3
c.	Moderate	4
d.	High	5
e.	No initial SDM risk level	4

R2. Household's Progress Toward Treatment Goals

a.	Successfully met all current treatment plan objectives	-2
b.	Pursuing all objectives detailed in treatment plan	-1
c.	Pursuing the majority of the objectives in treatment plan	0
d.	Pursuing less than the majority of the objectives in treatment plan	2
e.	Refuses involvement in programs, or fails to participate	4

R3. Has There Been a New Substantiation (in this household) since the Last Assessment/Reassessment?

a.	No	0
b.	Yes	6

Total Score: _____

SCORED RISK LEVEL:
Assign the family's risk level based on the following chart.

Score	Risk Level
☐ -2 – 1	☐ Very Low
☐ 2 – 3	☐ Low
☐ 4 – 5	☐ Moderate
☐ 6 +	☐ High

POLICY OVERRIDES TO HIGH. Check box if condition in 1, 2, 3, or 4 is applicable in the current review period. If condition 5 exists, the risk level will always remain high. If <u>any</u> condition is applicable, override final risk level to high.

☐ 1. Sexual abuse cases AND the perpetrator is likely to have access to the child victim
☐ 2. Cases with non-accidental physical injury to a child under age six.
☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
☐ 4. Positive toxicology screen (alcohol or drugs) of mother or newborn at time of birth.
☐ 5 Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. Override up or down one level
☐ 6. Reason: _____

FINAL RISK LEVEL: ☐ Very Low ☐ Low ☐ Moderate ☐ High

Juvenile Court

"In Court Review"

Overview of the Juvenile Court

Presented to the RSVP Pilot Program
February 24, 2009

Superior Court for Juvenile Matters Jurisdiction

- Jurisdiction = authority to hear certain cases;
- Juvenile Matters consist of:
  - Orders of Temporary Custody (OTC);
  - Neglect and Uncared of Petition;
  - Permanency Plan Review;
  - Termination of Parental Rights

Definitions

- **OTC – A court order that may be requested by DCF and signed by the judge *ex parte (without a formal hearing)* if there is a reason to believe that a child or youth is:**
  - Suffering from a serious physical illness or serious physical injury or is in immediate danger from his/her surroundings,
  - Is in immediate removal of the child or youth from their home is necessary to their safety

Definitions

- Neglect:
  - Has been abandoned;
  - Is being denied proper care and attention (physically, educationally, emotionally or morally);
  - Is being permitted to live under conditions, circumstances or associations harmful to the child or youth's well being;
  - Has been abused.

Definitions

- Uncared for:
  - Is homeless;
  - Whose home cannot provide the specialized care that the child or youth requires.

Who Is Everyone:

- **Parties** are: Parents, sometimes referred to as the "respondent parents", guardians and the child;
- **Assistant Attorney General** (AAG)- The lawyer who represents DCF in court;
- **DCF Social Worker** – the DCF employee assigned to the family and child and who represents the DCF position in court. He or she may make recommendations for placement of the child and services needed by the child and family

Who Is Everyone:

- **Attorney for the Child** – Every child or youth involved in the Superior Court for Juvenile Matters is represented by a court-appointed attorney. The lawyer is required to advocate for the child;
- **Attorney for the Parent** – a lawyer for the parent is required to counsel and advocate for the parent in court. If a parent is unable to pay for a lawyer the court will appoint an attorney to represent the parent. The Chief Child Protection Attorney assigns the attorney
- **Guardian ad Litem** – If there is a conflict between what the child or youth wants and what the attorney believe may be in their best interest the court will appoint a separate Guardian at Litem, who may be an attorney or from a program such as Court Appointed Special Advocates (CASA)

Who Is Everyone:

- **Court Services Officer** – A court employee assigned to child protection cases. Service as a liaison between the court, DCF attorneys and agencies, coordinates scheduling of cases for court hearings, services as a facilitator/mediator to encourage non- adversarial resolution of cases, monitors and oversees case activities to ensure timely permanency planning and review
- **Deputy Chief Clerk for Juvenile Matters** - A court employee who is responsible for the operation of the Juvenile Matters Clerks Office and supervision of al the staff in a specific court location. The Clerk's Office processes and maintain all court records

Filing a Neglect Petition

- Only certain people may file a neglect or uncared for petition;
- Most are filed by DCF;
- The petition states the reasons for DCF seeking the court's help with a particular child/family;
- Petitions are filed at the Superior Court for Juvenile Matters;
- The petition states certain facts called allegations, that support the petition;

+ summary of facts on what has transpired in a case

Orders of Temporary Custody

- Many neglect petitions are accompanied by a request by DCF to take immediate custody of a child;
- Sometimes the child has already been removed – called a 96 hour hold;
- DCF believes there is an emergency situation in which the child is in danger;
- Ex parte request-without a hearing

Orders of Temporary Custody

- A judge reviews the paperwork submitted by DCF and must determine certain things:
  - Whether a child is suffering from serious physical illness or injury or,
  - Is immediate danger from his/her surroundings

Probable cause = lowest level of evidence

Orders of Temporary Custody

- If the judge grants the ex-parte order a hearing must be held within 10 days
- Called the OTC Preliminary Hearing;
- A Case Management Conference is scheduled immediately prior to the preliminary hearing

Case Management Conference (CMC)

- Takes place just prior to the Preliminary Hearing;
- Managed and facilitated by the Court Services Officer (CSO);
- The CSO is trained in child protection matters and in conflict resolution approaches;

Case Management Conference

- CMC is an informal meeting;
- Who attends: The Assistant Attorney General(AAG) – the lawyer who represents DCF; the DCF Social Worker(s); the parents' lawyers, the child's lawyer, sometimes the parents;

Case Management Conference

- What is the meeting for:
  - To discuss the circumstances that resulted in the judge granting the OTC;
  - To discuss whether the parents are contesting the removal of the child from the home;
  - Placement of the child;
  - Services (Preliminary Specific Steps) needed by the child and the family
  - Schedule future court events;

What the parent will do

" DCF will do

Preliminary Hearings

- Hearing in from of the Judge:
  - Determine if all the parties have been notified of the hearing and are present (Confirm service);
  - Advise the parties f their rights;
  - Take steps to determine the identity of the child's father if unknown;
  - Make interim orders; — review specific steps
  - Either continue(sustain) the OTC or if the parents are contesting schedule a separate hearing

INQUIRE ABOUT Relatives (collateral)

Contested OTC Hearing

- Held either at the local court or at the Child Protection Session (CPS);
- DCF presents evidence to try to convince the judge that the child must stay in temporary custody;
- At the end of the hearing the judge can:
  - Sustain the OTC;
  - Return the child to the parents;
  - Place the child in the custody of another person, usually a relative (OTC VACATED) ↓ maybe

Neglect Hearings

- Plea Hearing – must be held 45 days after the petition is filed;
- At the hearing the Judge:
  - Advises the parents of their rights;
  - Appoints an attorney if one has not already been appointed;
  - Schedules a Case Status Conference(CSC).

Plea Hearing may be waived
" " = 5" "denial" OR no lo"
Can be done a same day as OTC
(like an "arraign" - guilty)

Case Status Conference

- Conducted by the CSO using facilitation and mediation techniques
- Who attends: The AAG, the DCF Social Worker(s), the attorney for the parents' and child;
- The purpose of the CSC:
  - To discuss settlement of the case
  - Any request for court ordered assessment of testing
  - Set trial dates if the case is contested.
  - Share case information.

  Prepare final specific steps if there is an agreement about how to resolve the neglect cases

"Settlement of the case" = agreement re: what happens to OTC /child/family

"Full Agreement"

or

"Partial Agreement"

Other Neglect Hearings

- Adjudication and Disposition
  - Before the court can decide the custody and guardianship of a child it has to make an adjudication – a finding of fact the child is neglected or uncared for;
  - Parent can either admit to the allegations or choose not to contest the allegations (plea of nolo contendere); or
  - Based on evidence presented, the judge decides whether the child is neglected or uncared for

Other Neglect Hearings

- If the judge determines that the child is neglected or uncared for, the court will than address *disposition* of the case or what to do with the child to prevent further neglect to the child
- The judge determines what type of placement will best serve the childs best interest

Other Neglect Hearings

- The judge has 4 dispositional options:
  - **Dismissal** – if the child's circumstances have greatly improved since the petition was filed the judge may decide that there is no need for additional involvement by either the court or DCF.
  - **Protective Supervision** - the child is returned to the custody of his/her parent(s) and will continue to live with them under court ordered supervision by DCF.

Other Neglect Hearings

- **Transfer of Guardianship** – As an alternative , the court can give custody and guardianship of the child to another person, usually a relative
- **Commitment** – When the judge orders the child to be committed, the custody and guardianship of the child is removed form the parent(s) and given to DCF – the commitment must be reviewed every 12 months

Permanency Review Hearings

- With in 12 months of the placement of the child in out of home care the judge must hold a hearing to review the ongoing *permanency plan* for the child
  - DCF is required to file the plan **9 months** after the child is removed from the home.
  - A hearing is held at which the judge reviews the permanency plan and decides whether or not to approve the plan

→ 11 month review in Willimantic

Permanency Plans

- Permanency Plans may include:
  - Ending the commitment and placement of the child and returning the child to the parent(s);
  - Transferring Guardianship of the child with another person, usually relatives;
  - Continuing the foster care placement
  - Termination of parental rights followed by adoption;
  - Some other planned permanent living arrangement, such as independent living

APPHB

with or w/out PS

cust. committed

Termination of Parental Rights (TPR)

- A proceeding that is held to permanently end the legal relationship between parent(s) and their child. If TPR is granted the child can be placed for adoption by another family.
- There are different allegations that must be proven for the judge to terminateparental rights, these allegations are for very serious circumstances

TPR severs legal rel. between parent & child

- abandon child
- parent & able to rehab

Most TPRs are contested

Adoptions happen in probate court

Roles and Responsibilities of People You will Encounter in the Court

JUDGE: **The Judge seeks input** from all of the parties and their attorneys by hearing testimony and reviewing written materials, including DCF reports, regarding the child's situation. **The Judge makes findings and rulings** according to law.

CLERK'S OFFICE: Each Juvenile Court has a Clerk's Office. The **Clerk's Office is responsible for case processing** and for maintaining official court records. There are a number of people who staff the Clerk's Office. The **Deputy Chief Clerk for Juvenile Matters** is in charge of the office. Other staff includes the CSO, **Deputy Juvenile Matters Clerk, Courtroom Clerk** and various administrative/clerical staff. If you contact the Clerk's Office you may speak to the Deputy Chief Clerk or one of the other staff. In the courtroom, you will encounter a Courtroom Clerk who is responsible for assisting the Judge in the courtroom and will produce written documents related to each court hearing including scheduling continuances.

The **Court Services Officer (CSO): assists the court and the parties** by providing case management, and convenes and **facilitates/mediates** conferences held at various stages in a case.

ATTORNEYS:

Child's Attorney: Each child is appointed an attorney, who is also likely to serve as the child's guardian ad litem, regardless

of the child's age or how long the child has been in foster care. If the child is adopted, there is a transfer of guardianship or the child returns home, the case is then closed and the attorney's involvement usually ends. **The child's attorney** is required by Connecticut law to see the child and **report the child's wishes to the court.**

To find the name of your foster child's attorney, **contact the DCF social worker** or supervisor or your CAFAP liaison. If you are still unable to get the information, you can contact the court. Be sure to identify yourself as a foster parent and provide your name, the child's name and date of birth. The clerk's office can then give you the name of the child's attorney.

Guardian ad Litem (GAL): If there is an identified conflict between what the child's wishes are and what may be in the child's best interest, the Judge may appoint a person as GAL to speak in court as to the **best interests of the child.** In Connecticut, the GAL is not required to be an attorney.

Parent's Attorney: Parents are entitled to have **an attorney represent them in their case.** If the parent is unable to afford an attorney, the court will arrange for state paid representation through the Chief Child Protection Attorney. The parent's attorney is responsible for **representing the parent's legal rights and interests in the case.**

Assistant Attorney General (AAG): The AAG is the attorney who represents the interest of the DCF in Juvenile Court cases. The **AAG will speak on behalf of the DCF social worker** in court hearings and conferences.

What Kind of Proceedings Take Place?

ORDER OF TEMPORARY CUSTODY (OTC) PRELIMINARY HEARING: Children are sometimes removed from their parents' care because DCF has sought and been granted an **Ex-parte (without a hearing) OTC**. A preliminary hearing must be held **not later than 10 days** after a Judge grants such an order. A **case management conference** is conducted, usually by the CSO, on the day of the preliminary hearing. At the case management conference the attorneys, and, if appropriate, their clients, the AAG and the DCF social worker will discuss the circumstances of the case. Their goal is to discuss possible settlement options and to set court case management dates. If no agreement is reached at the conference, a contested hearing is held before the Judge. The contested hearing can occur either that day or not later than 10 days after the preliminary hearing. At this hearing the Judge hears the evidence about why a child should remain in the temporary custody of DCF while the child protection case is resolved.

PLEA HEARING: At this hearing the **parents are advised of their rights and may deny or admit the facts on the petition** against them. If an OTC has been granted, the plea is usually entered on the day of the OTC preliminary hearing.

ADJUDICATION: In this phase of a case, the Judge will determine **the validity of the facts presented in the petition** against the parent(s). The Judge makes findings related to the case and determines whether the child has been neglected and/or abused.

DISPOSITION: At this hearing the Judge may hear testimony and read reports and evaluations. The Judge will determine what course of

action will be best for the child. The **disposition may in[illegible]e commitment to DCF, with DCF becoming the child's legal guardian** and placement in the home of a foster parent or relative. The Judge will **order specific steps** that serve as a road map for parents and DCF to resolve the issues which brought the case into court. Usually, the **specific steps** include **visitation and services**, such as parenting classes, therapy or substance abuse treatment.

PERMANENCY REVIEW HEARINGS: A Permanency Review hearing must be held **12 months after the child has entered care.** At this hearing, the Judge reviews DCF's proposed permanency plan for the child, including placement. The Judge will also receive information about the parent(s) progress with regard to the plan. The Judge **makes findings and rules on whether there have been "reasonable efforts" to achieve a permanency plan.**

REVOCATION HEARING: A revocation hearing takes place when either DCF or a party to the case believes that the child's stay in DCF care should end. At the hearing the **Judge determines whether the current placement of the child can be changed.** This may include returning the child to the parent(s) or transferring care and custody to a relative.

MOTIONS: Motions are filed and scheduled for a hearing when a **request is made by a party asking the Judge to hold a hearing on a particular matter.** This might include hearings regarding requests for evaluations or some type of relief that cannot be obtained through an administrative process at DCF.

CHILD PROTECTION MEDIATION: Mediation is a form of alternative dispute resolution. The court-connected program is voluntary and confidential. Mediators who are neutral and impartial are available to assist the participants in a mediation session.

Roles and Responsibilities of People You will Encounter in the Court

JUDGE: **The Judge seeks input** from all of the parties and their attorneys by hearing testimony and reviewing written materials, including DCF reports, regarding the child's situation. **The Judge makes findings and rulings** according to law.

CLERK'S OFFICE: Each Juvenile Court has a Clerk's Office. The **Clerk's Office is responsible for case processing** and for maintaining official court records. There are a number of people who staff the Clerk's Office. The **Deputy Chief Clerk for Juvenile Matters** is in charge of the office. Other staff includes the CSO, **Deputy Juvenile Matters Clerk, Courtroom Clerk** and various administrative/clerical staff. If you contact the Clerk's Office you may speak to the Deputy Chief Clerk or one of the other staff. In the courtroom, you will encounter a Courtroom Clerk who is responsible for assisting the Judge in the courtroom and will produce written documents related to each court hearing including scheduling continuances.

The **Court Services Officer (CSO): assists the court and the parties** by providing case management, and convenes and **facilitates/mediates** conferences held at various stages in a case.

ATTORNEYS:
Child's Attorney: Each child is appointed an attorney, who is also likely to serve as the child's guardian ad litem, regardless

of the child's age or how long the child has been in foster care. If the child is adopted, there is a transfer of guardianship or the child returns home, the case is then closed and the attorney's involvement usually ends. **The child's attorney** is required by Connecticut law to see the child and **report the child's wishes to the court.**

To find the name of your foster child's attorney, **contact the DCF social worker** or supervisor or your CAFAP liaison. If you are still unable to get the information, you can contact the court. Be sure to identify yourself as a foster parent and provide your name, the child's name and date of birth. The clerk's office can then give you the name of the child's attorney.

Guardian ad Litem (GAL): If there is an identified conflict between what the child's wishes are and what may be in the child's best interest, the Judge may appoint a person as GAL to speak in court as to the **best interests of the child.** In Connecticut, the GAL is not required to be an attorney.

Parent's Attorney: Parents are entitled to have **an attorney represent them in their case.** If the parent is unable to afford an attorney, the court will arrange for state paid representation through the Chief Child Protection Attorney. The parent's attorney is responsible for **representing the parent's legal rights and interests in the case.**

Assistant Attorney General (AAG): The AAG is the attorney who represents the interest of the DCF in Juvenile Court cases. The **AAG will speak on behalf of the DCF social worker** in court hearings and conferences.

ROLES

Assistant Attorney General (AAG)

The AAG is the lawyer who represents the legal position of the Department of Children and Families in court. The AAG is required to help develop and advocate for the state's interests in the case.

Attorney for the child

Every child involved with the Superior Court for Juvenile Matters is represented by counsel. The court is required to notify the Chief Child Protection Attorney (CCPA) who will assign an attorney to represent the child. This lawyer is required to advocate for what the child wants. If a conflict arises between the child's wishes or position, the court appoints a separate Guardian ad Litem (see **Guardian ad Litem**)

Attorney for the parent

A lawyer for a parent is required to counsel the parent about their legal rights and obligations. The lawyer must then advocate for the parent's wishes or position in at all court proceedings. If a parent needs a lawyer and the court finds that the parent is unable to financially pay for their own lawyer, the court will ensure that the Chief Child Protection Attorney (CCPA) assigns an attorney to represent the parent at no cost to the parent.

Court Services Officer

A Court Services Officer is assigned to Child Protection cases. The role of the Court Services Officer is to:

1. Act as a liaison between the court, DCF, attorneys, and agencies in child protection proceedings.
2. Coordinate the scheduling of cases for court hearings and case reviews.
3. Serve as a facilitator/mediator diverting matters from formal litigation.
4. Monitor and oversee case activity to insure speedy permanency planning and review.

Deputy Chief Clerk for Juvenile Matters

The Deputy Chief Clerk (DCC) for Juvenile Matters is responsible for the operation of and supervision of all staff in a specific Juvenile Matters court location. The DCC responsibilities include overseeing the Juvenile Matters Clerk's Office where all cases and court records are processed and maintained

Department of Children and Families Social Worker

The Social worker from the Department of Children and Families is their representative and is responsible for advocating for the services that the state believes are

needed. This can include the need for an out of home placement of a child. The social worker has the unique responsibility of working with the family before, during and after the court is involved with a case

Guardian ad Litem for the Child or Youth

The Guardian ad Litem for a child or youth may be a lawyer or a lay person who has received specific training from a program such as CIP (see heading titled Children in Placement). It is the responsibility of the GAL to conduct an independent investigation and report to the court on behalf of the "best interests of the child".

Guardian ad Litem for a Parent

When a respondent parent is a minor (under the age of eighteen [18]), or when a parent is considered to be unable to act on their own or assist their lawyer because of some disability, the court appoints a GAL to make an independent assessment and report to the court on what is in the parent's best interest.

Respondent Parent

The "parent" is usually the child's or youth's biological parent, but could also be an adoptive parent or some other individual who has been legally designated as the child's or youth's guardian. The Parent is a "respondent" (defendant) in a child protection case

GLOSSARY OF TERMS

Abused: Physical injury inflicted upon a child or youth which is not the result of an accident, conflicts with the explanations of the injury, or is the result of maltreatment such as sexual molestation, deprivation of necessities, emotional maltreatment, or cruel punishment

Adjudication: A finding made by a judge

Adjudicatory hearing: Juvenile court proceeding to determine whether the allegations made in a petition are true and whether the child/youth or parent should be subject to orders of the court.

Admission: Plea entered by the **respondent** in juvenile court agreeing that the charge in a **petition** is true. (similar to a guilty plea in Adult Court)

Adoption and Safe Families Act (ASFA): The federal law which sets timelines for certain DCF and court activities including holding a **Permanency Hearing**.

Allegation: The assertion, declaration, or statement of a party in a case, made in a pleading.

Appeal: Asking a higher court to review the decision of a trial because the lower court made an error.

Beyond a reasonable doubt: The degree of certainty required for a finding of delinquency; proof must be so conclusive and complete that all reasonable doubts are removed from the mind. This is the highest standard of proof.

Case Management Conference: A conference conducted at the beginning of an Order of Temporary Custody or Termination of Parental Rights case to assist the parties in indentifying preliminary issues that might be resolved immediately and develop a strategy for proceeding with unresolved issues.

Case Status Conference: A conference at which all the attorneys and pro se parties in a case are prepared to discuss settlement, unresolved issues, services needed by the child/family, future court proceedings and scheduling

CCPA: The **Chief Child Protection Attorney** oversees the assignment of attorneys and guardians ad litem to represent children and indigent parents in child protection cases before the Superior Court for Juvenile Matters.

Child: In child protection cases, any person under the age of sixteen (16) years.

Child Protection Session: CSO; The CSO assists the court and the parties by providing case management, and facilitating conferences at various stages in a case to mediate the resolution of issues.

Clear and convincing evidence: The degree of certainty required for a finding the termination of parental rights; proof must establish a firm belief in the facts alleged in the **petition**.

Commitment: Placement of a child/youth in the **custody** and guardianship (neglected, dependent, uncared for children/youth) of the **Department of Children and Families** by an order of the court.

Concurrent Planning: Allows DCF to adopt an alternative plan for permanency which may include placing the child in another permanent setting while still providing reasonable efforts to reunify the child with his/her family.

Contested OTC Hearing: A hearing on an ex parte order of temporary custody to an order to appear which is held not later that ten(10) days for the day of the preliminary OTC hearing.

Coterminous Petition: A petition alleging that a child/youth is neglected, uncared for or dependent and also that there are statutory grounds to terminate parental rights.

Court Appointed Attorney: State paid representation appointed by the court for a respondent who cannot afford to pay for a private attorney.

Custody: A court order deciding where a child will live and how decisions about the child will be made. Parents may ask for any custody arrangement that they believe is in the best interest of their child

Denial: Plea entered by a **respondent** in Juvenile Court disagreeing with the allegations in a **petition**. (similar to a not guilty plea in Adult Court)

Department of Children and Families (DCF): State agency responsible investigating child abuse and neglect and for the care and treatment of children and youth placed in their temporary custody or committed to the agency by the court..

Dependent minor: Child or youth living in a home that is suitable except for the financial inability of the parents, guardian, or other person maintaining the home to provide for the specialized care his/her condition requires.

Disposition: The manner in which a case is settled or resolved.

Dispositional phase: Court proceedings following **adjudication** which provides the court with information necessary to determine the best possible type of care and treatment to be provided to the child/youth or his/her family.

Ex parte: When a judicial order is granted for the benefit of one part only, and without notice to or contestation by any party adversely affected.

Finding: The court's or jury's decision on issues of fact

Foster Parent: A person licensed or certified by DCF or approved by a licensed child-placing agency to care for a child or youth.

Guardian Ad Litem: GAL; An individual, usually an attorney, appointed by the court to represent the best interests of a child versus the child's attorney who represents what the child wants.

Hearsay evidence: Evidence based on reports of second or third hand information, rather than on a witness's own personal knowledge.

Juvenile Court: Also called **Superior Court for Juvenile Matters** A special division of the Superior Court designated to hear all cases concerning uncared for, dependent children, youth, and delinquents. All Juvenile Court proceedings and case records are confidential and are not public information.

Mediation: A voluntary, confidential dispute resolution process available in child protection cases in which an impartial third party assists the parties to reach a mutually acceptable agreement.

Minor: Any person who is not of legal age. In Connecticut, any person under eighteen (18) years of age

Miranda rights: The requirement that a person receive certain warnings relating to his/her privilege against self-incrimination (right to remain silent) and the right to have the presence and advice of an attorney before being questioned by law enforcement authorities.

Multiple petitions: Two or more petitions filed in Juvenile Court against the same person.

Neglected child or youth: A child or youth who has a) been abandoned, b) is being denied proper care and attention, physically, emotionally, educationally, or morally, c) is being permitted to live under conditions, circumstances, or associations injurious to his/her well-being, or d) has been abused

Orders of temporary custody: Also called an **OTC** Court order placing a child or youth in the short-term legal custody of an individual or agency, usually DCF, authorized to care for children.

Permanency Hearing: A hearing that must be held within 12 months of a child's placement in out of home care At the hearing the court is required to make certain findings and act on the proposed **permanency plan**.

Permanency Plan: A plan developed by DCF which states a goal for the permanent placement who has been in the care of DCF for not more than 12 months. A permanency plan can include: returning a child to their parent(s), giving guardianship to a relative, adoption or another planned permanent living arrangement

Preponderance of evidence: General standard of proof in civil cases; where the evidence and the facts are more convincing than not. Used in neglect proceedings.

Protective Supervision: A disposition following an adjudication in neglected, uncared for or dependent cases created by an order of the court requesting a supervision agency, usually DCF, oversee the safety and welfare of the child while the child remains in their home.

Reasonable Efforts: A finding by the court concerning whether DCF and the parents made progress with finalizing a permanency plan.

Reasonable cause: The level of certainty required for the issuance of an arrest or search warrant or the grounds for detention or ex parte Orders of Temporary Custody; facts that would enable a reasonable person to form a conclusion. Also called probable cause.

Respondent: Another word for defendant; the person responding to a lawsuit. In Juvenile Court, the word refers to the person or persons named in a petition

Reunification: One option available once a child is removed form the home that allows for the child to return to the home and be reunified with his/her family

Specific Steps: Judicially determined actions, usually related to services, the parent or guardian and DCF should take in order for the parent or guardian to retain or regain custody of a child or youth

Standing Order: An administrative order that is issued by the Chief Administrative Judge or Presiding Judge that applies to a uniformly to specific proceedings within the court

Subpoena: A written notice issued by the court, the police, or a lawyer commanding a person to appear in court to testify as a witness

Summons: A written notice issued by the court commanding a person to appear in court at a given date and time. A summons is issued to an individual charged or other party on a petition or complaint.

Temporary custody: Court-approved placement of a child or youth outside of his/her home for a short period of time before an **adjudicatory** or **dispositional** hearing is held.

GLOSSARY: JUVENILE MATTERS CLERK'S MANUAL

A

AAG — An Assistant Attorney General who represents the Department of Children and Families in juvenile matters proceedings.

Abused — Physical injury inflicted upon a juvenile or youth which is not the result of an accident, conflicts with the explanations of the injury, or is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

Action — A judicial proceeding whereby one party demands protection or enforcement or right.

Adjournment — Postponement of a court session until another time or place.

Adjudicate — To hear or try and determine judicially

Adjudication — The entry of a judgment, decree, or order by a Judge or other decision-maker based on the evidence submitted by the parties.

Adjudicatory Hearing — A juvenile court proceeding to determine whether the allegations on a petition are true and whether the child/youth should be adjudicated and subject to orders of the court.

Admission — A plea entered by the respondent in juvenile court agreeing that the charge in a petition is true. This is similar to a guilty plea in the criminal court.

Adoption — A court order which establishes the legal relationship of parent and child between persons who are not so related

Adoption Agreement — An agreement to give and receive a child in adoption.

Affidavit — A written statement declaring certain facts to be true and confirmed by the oath of the person making the statement (which oath is taken before an officer having authority to administer it).

Affidavit of Service — An affirmed statement made in writing and signed, stating how, when and on whom service of process was made.

Affirmation — An act of declaring something to be true under the penalty of perjury by a person who conscientiously declines to take an oath for religious or other pertinent reasons.

Termination of Parental Rights: **TPR**; A court order which completely severs the legal relationship, including all rights and responsibilities, between a child and his/her parent(s) so that the child is free for adoption.

Uncared for: **Legal** description of a child or youth who is homeless or whose home cannot provide the specialized care which his/her physical, emotional, or mental condition requires.

Youth: **In child protection cases,** any person who is sixteen (16) or seventeen (17) years old.

AKA	Abbreviation for "also known as " Another name or spelling derivative used by an individual
Allegation	The assertion, declaration or statement of a party to an action, made in a pleading, setting out what the party expects to prove
Appeal	A proceeding by which a case is brought from a lower court to a higher court for the purpose of reviewing claimed errors of law.
Appeal Bond	The bond required upon filing an appeal.
Appearance	Coming into the case as a party by either representing oneself or through an attorney.
Appellant	The party who takes an appeal to a higher court.
Appellee	The party against whom an appeal is taken.
Argument	A reason given in proof or rebuttal.
ASFA	**Adoption and Safe Families Act**; A federal law setting forth specific guidelines that states must comply with in the court process for children in foster care.
Attorney of Record	Attorney whose name appears in the permanent records or files of a case.

B

Bench OTC	When the adult court orders from the bench that DCF take temporary custody of a child/youth in the context of an existing criminal or family case.
Beyond a Reasonable Doubt	The highest standard of proof requiring a degree of certainty so conclusive and complete that all reasonable doubts are removed from the mind.
Biological Parent	The biological mother or father of a person
Birth Certificate	An official certificate issued by a Public Health Department documenting the birth of a person.
Brief	A written or printed document prepared by the lawyers or pro se parties on each side of a dispute and submitted to the court in support of their arguments. A brief includes the points of law which the lawyer or pro se party wishes to establish, the arguments used, and the legal authorities on which the conclusions are based

Burden of Proof	The duty of a party to produce the greater weight of evidence on a point at issue.
Business Day	The clerk's office is open as scheduled but no judge is present

C

Calendar	A written schedule of cases to be heard in court.
Capias	A writ or order by the court directing an officer to take into custody the person named in the order (Civil arrest warrant.)
Case File	The court file containing the papers, forms, briefs, documents, etc. in a case
Case Law	Laws that develop through case decisions by judges. Not enacted by legislative bodies. Also referred to as "Common Law".
Case Management Conference	A conference conducted at the inception of an Order of Temporary Custody or Termination of Parental Rights case to assist the parties in identifying preliminary issues that might be resolved immediately and develop a strategy for proceeding with unresolved issues.
Case Status Conference	A conference at which all attorneys and pro se parties in a case are prepared to discuss settlement, unresolved issues, amendments to the pleadings, trial dates, preliminary witness lists, other necessary trial arrangements and such other actions that may aid in the disposition of the case.
Cause of Action	The ground on which an action may be sustained.
CCPA	The **Chief Child Protection Attorney** oversees the assignment of attorneys and guardians ad litem to represent children and indigent legal parties before the Superior Court for Juvenile Matters.
Certified Copy	A copy of a document with a certificate attesting that the copy is a true, authenticated copy of a document on file
Certify	To testify in writing; to make known or establish as a fact
C.G.S.	Abbreviation for Connecticut General Statutes.
Change of Venue	The transfer of an action begun in one district to another district for trial
Child	Any person under the age of sixteen (16) years of age.

Child in Placement	**CIP**; A voluntary program in Juvenile Court, which monitors child protection cases.
Child Placing Agency	Any agency within or outside the state of Connecticut licensed or approved by the Commissioner of Children and Families in accordance with Connecticut law, and with such standards which shall be established by regulations of the Department of Children and Families.
Clear and Convincing	A lesser standard of proof; the degree of certainty required to establish a firm belief in the facts alleged in the petition.
COLP	Commission on Official Legal Publications
Commitment	An order of the court whereby custody and/or guardianship of a child/youth are transferred to DCF.
Concurrent Planning	Allows DCF to adopt an alternative plan for permanency which may include placing the child in another permanent setting while still providing reasonable efforts to reunify the child with his/her family
Confidentiality	Records of the Superior Court for Juvenile Matters cannot be disclosed to any person other than the legal parties to the case without a court order or statutory exception. Information deemed confidential by statute includes, but is not limited to, the petition, reports, and any written or oral records of the court proceedings.
Contested OTC Hearing	A hearing on an ex parte order of temporary custody or an order to appear which is held not later than ten (10) days from the day of the preliminary hearing on such orders.
Continuance	The adjournment of postponement of an action pending in a court to a subsequent date and/or time
Consolidation	A judicial authority may resolve matters involving the same child or children of the same parent or parents into one hearing or trial.
Coterminous Petition	A petition alleging that a child/youth as neglected, uncared for or dependent and also that statutory grounds exist to terminate parental rights.
Count	The different part of a declaration, each of which, if stood alone, would constitute a ground for action.
Court Appointed Attorney	State paid representation appointed by the court for a respondent who cannot afford to retain private counsel.
Court Day	The clerk's office is open as scheduled and a judge is present

Court Monitor	The person who prepares a written record of the court hearing for a fee, if requested, from audiotapes made during the hearing
Court Reporter	The person who records everything said during the court hearing on a stenograph machine and prepares a written record for a fee, if requested.
Court Services Officer	**CSO**; The CSO assists the court and the parties by providing case management, and facilitating conferences at various stages in a case to mediate the resolution of issues.
Child Protection Session	**CPS**; A specialized court designed to hear complicated child protection cases
CSSD	The Court Support Services Division.
Cross-Examination	Questioning by a party or a party's attorney of an adverse party or a witness called by an adverse party.
Custody	See "Legal Custody".
Custody Order	Legally binding determination that establishes with whom a child shall live
Custodial Party	The person who has the primary care, custody and control of minor child(ren).

D

Date-stamp	The stamping on a document of the date it is received by the court.
DCF	The Department of Children and Families.
Decision	The determination reached by a court in any judicial proceeding, which is the basis of the judgment.
Declaration	An unsworn statement or narrative of facts made by a party to the transaction, or by one who has an interest in the existence of the facts recounted
Default	Occurs when a party fails to appear in the case or at the trial.
Default Judgment	A judgment rendered in favor of one party based on the failure of the other party to enter an appearance
Defendant	In civil cases, the person who is given court papers, also called a respondent. In criminal cases, the person who is arrested and charged with a crime.

Denial	A plea entered by a respondent in juvenile court disagreeing with the allegations in a petition, which is similar to a not guilty plea in criminal court
Dependent	A finding made when a child/youth is from a home which is suitable, save for the financial inability of his/her parent(s), guardian(s) or other person(s) maintaining such home, to provide the specialized care his/her condition requires.
Direct Examination	The first interrogation of a witness by the party on whose behalf the witness is called
Discovery	The pretrial procedure by which one party gains information held by another party.
Dismissal	The termination of a proceeding for a procedurally prescribed reason
Dismissal Without Prejudice	Permits the complainant to bring a new suit on the same cause of action while dismissal with prejudice bars the right to bring or maintain an action on the same claim or cause.
Dispose	The act of terminating a judicial proceeding
Disposition	An order of the court after a juvenile has been adjudicated as abused, neglected or uncared for based on the allegations in the petition which then terminates the case. Similar to a sentencing in adult criminal court.
Docket Number	A unique number assigned to the court case by the clerk

E

Emancipation	The release of a youth from legal authority and control of his/her parents and the corresponding release of the parents from their obligations to the youth.
Et Al	An abbreviation of et alii, meaning "and others".
Evidence	Any proof, or probative matter legally presented at the trial of an issue, by the act of the parties and through the medium of witnesses, records, documents, concrete objects, etc. for the purpose of inducing belief in the minds of the court or jury as to their contention.
Exhibit	A paper, document or object presented to a court during a trial or

	hearing, which on being accepted, is marked for identification or admitted into evidence
Ex Parte	When a judicial proceeding, order, injunction, etc., is taken or granted for the benefit of one part only, and without notice to, or contestation by, any person adversely affected.
Expert Witness	A person examined as a witness who has special knowledge of the subject about which he or she is to testify.
Extension	A court order lengthening the period of protective supervision or a child's commitment to DCF. DCF must show why it is in the child's/youth's best interest for the extension

F

Fee	A fixed charge.
Finding	The court's decision on issue of fact
Foster Parent	A person licensed or certified by DCF or approved by a licensed child-placing agency for the health, welfare or care of a child or youth.
FTA	**Failure to appear** for a court event

G

G.A.	The Geographical Area Superior Court. The court location where motor vehicle and most criminal cases are heard. There are 22 GA courts in Connecticut
GAL	See **Guardian Ad Litem**.
Genetic Testing	Analysis of inherited factors to determine legal fatherhood or paternity
Guardian	A person who has a judicially created relationship with a child or youth which is intended to be permanent and self sustaining as evidenced by transfer to the caretaker of the following parental rights with respect to the child or youth: protection, education, care and control of the person, custody of the person and decision making
Guardian Ad Litem	An individual, usually an attorney, appointed by the court to represent the best interests of the child versus child's attorney who acts on child's behalf

Guardianship of a Minor — Refers to the obligation of care and control, the right to custody and the duty and authority to make major decisions affecting such minor's welfare, including, but not limited to, consent determinations regarding marriage, enlistment in the armed forces and any major medical, psychiatric or surgical treatment.

H

Habeas Corpus — A court order used to bring a person physically before a court in order to test the legality of the person's detention. Usually, it is directed to the official or person detaining another, commanding him to bring the person to court for the judge to determine if that person has been denied liberty without due process of law.

Hearing — A proceeding where evidence is taken for the purpose of determining an issue of fact and reaching a decision on the basis of that evidence.

Hearsay — Evidence which does not proceeding from the personal knowledge of the witness, but from the mere repetition of what he or she has heard others say

I

Income — Any periodic form of payment to an individual, regardless of source, including wages, salaries, commissions, bonuses, worker's compensation, disability, pension, or retirement program payments and interest

Incompetency — Lack of legal qualification or fitness (physical, intellectual or moral fitness) to discharge a legally required duty

Indian Child Welfare Act — **ICWA**; A federal law which requires states to comply with

Indigent — A person who is found by the court to be unable to pay court costs and fees.

Interpreter — A person sworn at a trial to interpret the evidence of a non-English speaking or hearing-impaired person

Interstate Compact on the Placement of Children — **ICPC**; A uniform law enacted by all 50 states and the District of Columbia to ensure protection and services to children who are placed across state lines for foster care or adoption. This Compact establishes orderly procedures for the interstate placement of children and fixes responsibility for those involved in placing the child.

Intervening Party — Any person whose interest in the matter before the judicial authority is not of such a nature and kind as to entitle legal service or notice as a prerequisite to the judicial authority's jurisdiction to adjudicate the matter pending before it but whose participation therein, at the discretion of the judicial authority, may promote the interests of justice.

J

J.D. — The Judicial District Superior Court. The court where most civil and family matters are heard in a certain area of the state. There are thirteen judicial districts in Connecticut

Judge Trial Referee — A retired Superior Court Judge who is appointed by the Chief Justice and to whom any juvenile matter may be referred for hearing and decision

Judgment — The final determination of the rights of the parties in an action or proceeding. Also called a decree or order.

Judgment File — A document in which the entry of a judgment is recorded and preserved as a permanent court record. A certified copy of the judgment file is evidence of the actions of the court for legal purposes.

Judicial Branch — The Branch of Connecticut government charged with resolving disputes that are filed in state court.

Judicial Marshal — A Judicial Branch employee responsible for court security and prisoner transport

Jurisdiction — Power and authority of a court to hear and make a judgment in a case.

Juris Number — An identification number assigned to each attorney licensed to practice in Connecticut.

Juvenile — Any child under the age of 16 years-old alleged to have committed a crime or status offense

Juvenile Court — Also called Superior Court for Juvenile Matters. A special division of the Superior Court designated to hear all cases concerning uncared for, dependent children and youth and delinquents. All juvenile court proceedings and case records are confidential and are not public information.

K

L

Legal Custody Relationship with a child created by court order which gives a person legal responsibility for the physical possession of a minor and the duty to protect, care for and discipline the child.

Legal Guardian See "Guardian".

LKA Last known address

M

Mandated Reporters Those persons who are specifically required under Connecticut law to make a report when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of eighteen (18) years has been abused or neglected; has had non-accidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child; or is placed at imminent risk of serious harm.

Mediation A voluntary, confidential dispute resolution process available in child protection cases in which an impartial third party assists the parties to reach a mutually acceptable settlement.

Minor A person under the age of legal competency as defined by statute. In Connecticut, any person under eighteen (18) years of age.

Mittimus A warrant of commitment to jail or prison

Modification An order of the court that changes the terms of a prior order.

MOH **Memorandum of Hearing**; Documentation of what happens in a court hearing including orders entered, next court dates and factual findings; Clerks generate a MOH for each court hearing that the judges signs for the court file.

Motion A written or oral request to the court for a ruing of law during the course of legal proceedings.

Movant The party who initiates the motion.

N

Neglected — An allegation that a child has been abused, abandoned, denied proper care and attention either physically, educationally, emotionally or morally, or has been permitted to live under conditions, circumstances or associations injurious to his/her well-being

Nolo Contendere — Means "no contest"; A plea entered by a respondent in a case that allows the court to adjudicate a child as neglected, uncared for or dependent without the respondent admitting to the allegations in a petition.

Non-Custodial Parent — The parent who does not have primary care, custody, or control of the child, and has an obligation to pay child support.

Notarize — To formally complete a document by acknowledgement or oath

Notice — Such notice as is legally deemed reasonable to apprise the person to whom it is addressed of the initiation of a legal proceeding against him or her

O

Oath — A swearing to the truth if a statement which, if made by one who knows it to be false, may subject one to a prosecution of perjury or other legal proceedings.

Order — The judgment or conclusion of a court on any motion or proceeding

Order of Notice — An order designating dates and method of service either by publication or certified mail. Used when a respondent resides out-of-state or whose whereabouts are unknown.

OTC — **Order of Temporary Custody**; An ex parte Court order placing a child or youth in the short-term legal custody of an individual or agency authorized to care for juveniles.

P

Party — One of the litigants in a judicial proceeding.

Paternity — A legal determination of fatherhood.

Perjury — Knowingly making a false statement under oath during the course of a judicial proceeding

Permanency	A planned, permanent living arrangement for a child
Permanency Plan	A plan developed by DCF for the permanent placement of a child or youth in DCF's care. Permanency plans shall be reviewed by the judicial authority as required under Connecticut law
Petition	A legal document which specifies the complaint against the child/youth and/or family; it includes the name, age, and address of the minor and his/her guardian, as well as the statutory grounds and factual allegations upon which the request for court intervention is based. Neglect
Petitioner	Another word for plaintiff, the person starting the lawsuit.
Placement	When a child/youth is removed from his/her home and placed in a foster home, adoptive home, group home, temporary shelter, or residential treatment facility under DCF responsibility.
Plaintiff	The party who brings a court action. See also "**Petitioner**".
Plea	An admission or denial by a respondent of the allegations in a petition once that party has been advised of his/her legal rights.
Pleadings	Statements or allegations, presented in logical and legal form, which constitute a party's cause of action or grounds for defense.
Postjudgment	After judgment (disposition).
Preponderance of Evidence	A general standard of proof where the evidence and facts are more convincing than not.
Pretrial	Any scheduled discussion with the court prior to trial to narrow or settle the issues in dispute.
Proceeding	The form and manner of conducting judicial business which may include all possible steps in an action from its commencement to the executive of judgment.
Process	The legal means, such as a summons, used to subject a defendant in a lawsuit to the jurisdiction of the court.
Pro se	Appearing for oneself in court, as in the case of one who does not retain an attorney
Protective Supervision	A disposition following adjudication in neglected, uncared for or dependent cases created by an order of the court requesting a supervising agency other than the court to assume the responsibility of furthering the welfare of the family and best interests of the child/youth when the child's/youth's place of abode remains with the

parent or any suitable or worthy person, subject to the continuing jurisdiction of the court

Public Assistance Benefits granted from a state or federal program to aid eligible recipients.

Purpose A mandatory hearing type code associated with a court event that displays on the docket to designate the primary reason for the hearing

Putative Father The person alleged to be the father of the child who has not yet been medically or legally declared to be the father

Q

R

Reason Option hearing type code associated with a hearing's purpose to provide further clarification regarding the scope of the hearing.

Reasonable Efforts A finding by the court concerning whether DCF and the parents made progress with finalizing a permanency plan. The court's determination rests on whether DCF has or has not made progress ("reasonable efforts") to preserve or reunify the family.

Record The court file, exhibits and verbatim transcript made by the court reporter of all proceedings in a court hearing.

Remand The act of a higher court, after an appeal, in sending a case back to a lower court for action consistent with the decision and order of the higher court.

Removal If the Commissioner of DCF, or his/her designee, has probable cause to believe that a child or children in a household are in imminent risk of physical harm from his/her/their surroundings and that immediate removal from such surroundings is necessary to ensure the child's/children's safety, the Commissioner/designee shall authorize the removal of the child(ren) without the consent of the child's/children's parent(s) or guardian(s)

Respondent Another word for defendant; the person responding to a lawsuit. In Juvenile court, the word refers to the person or persons named in a petition

Reunification One option available once a child is removed from the home that allows for the child to return to the home and be reunified with his/her family. A court would order reunification when there is

evidence that a parent and child have a strong bond and the parent has made significant progress to address the issues which resulted in the child's removal.

Revocation — A judicial determination that the cause for commitment of a child/youth to DCF no longer exists and it is in the best interests of the child/youth for the commitment to end.

S

SCJM — **Superior Court for Juvenile Matters**; See "Juvenile Court".

Sealed File — A case that is held confidential either by law or court order. Sealed files generally may not be disclosed to the public.

Service — The delivery of a writ, notice or other document officially notifying a person of some action or proceeding in which the party is concerned.

Short Calendar — A list of motions in which a hearing is requested or required.

Show Cause — An order requiring a party to appear in court as directed and present to the court reasons why a certain action should or should not be permitted

Specific Steps — Judicially determined actions or "steps" the parent or guardian and DCF should take in order for the parent or guardian to retain custody of a child or youth.

State Marshal — A state employee who is responsible for service of process The State Marshals are overseen by a state commission and not employed by the Judicial Branch

Statute — A law enacted by a legislative body.

Statutory Parent — The Commissioner of the Department of Children and Families or the child-placing agency appointed by the court for the purpose of giving a minor child(ren) in adoption.

Stay — A statute, rule or court order whereby some action is held in abeyance until the occurrence of some event or further order of the court.

Stipulation — An agreement, typically written, by attorneys or pro se parties on opposite side of a case as to any matter pertaining to the proceedings or trial

Subpoena — A command to appear in court to testify as a witness.

Subpoena Duces Tecum	A legal paper requiring someone to produce documents or records for a trial.
Summons	A written notice issued by the court commanding a person to appear in a court at a given date and time. A summons is issued to an individual charged or other party on a petition or complaint.

T

Temporary Custody	*See* "**Order of Temporary Custody**".
Termination of Parental Rights	**TPR**; A court order which completely severs the legal relationship, including all rights and responsibilities, between a child and his/her parent(s) so that the child is free for adoption.
Testimony	Statements made by a witness or party under oath.
Transcript	The official written record of proceedings in a trial or hearing
Transfer	The court-ordered removal of an action from the jurisdiction of one court to the jurisdiction of another court.
Trial	A process by which a judicial determination of the issues between the parties to an action is accomplished.
Trust Account	The bank account containing all funds ordered by the court to be held by the clerk

U

Uncared For	A finding that a child or youth is homeless or whose home cannot provide the specialized care that the physical, emotional or mental condition of the child requires

V

Vacate	To set aside a previous decision of the court.
Venue	The particular Superior Court for Juvenile Matters which has jurisdiction to hear and determine a case.
Visitation	A court order deciding the amount of time a non-custodial parent may spend with his or her child, also called parenting time or access.

W

Waiver — An intentional or voluntary relinquishment of some known right

Waiver of Fees — A finding by the court of the inability to pay fees/costs due to indigence.

Witness — One who testifies to what was seen, heard, or otherwise observed.

Y

Youth — Any person sixteen (16) to eighteen (18) years of age

Recovery Specialist Voluntary Program (RSVP) Court Related Processes

I. Eligibility Criteria:

Eligibility for entry into the RSVP program, the following criteria must be met:

- Parent(s) must have had their child(ren) removed by the court issuing an Order of Temporary Custody;
- Substance Abuse must be a primary reason for the removal of the child(ren);
- The case must originate in one of the pilot locations as defined by the DCF Office nexus (cities and towns) and the juvenile court location nexus. Cases that are heard in the pilot court location but are not assigned to a social worker within the pilot DCF office location are not eligible for the program.
- The OTC is sustained either by agreement or following a contested hearing[1].
- Potential for reunification exists. *(Note: If DCF is not seeking reunification however the parent(s) is doing so the parent(s) is/are eligible for inclusion in RSVP.)*

II. Case Referral Process:

Eligible parents/legal guardians may be referred to RSVP with the consent of their attorney.

Prior to the OTC Case Management Conference/Preliminary Hearing, the Court Services Officer reviews the cases scheduled for the OTC docket for that week.

- The Recovery Specialist contacts the CSO via e-mail or phone to inquire if are any OTC cases scheduled for the docket there are no cases that meet the initial eligibility criteria. If there are no eligible cases, the Recovery Specialist need not attend court that day.

III. Step by Step Process:

If based on the review of the cases or early discussion in the OTC case management conference, it appears that there may be an eligible case:

- The CSO, attorney for the parent or child, the DCF social worker assigned to the case or AAG may suggest referral to RSVP at the beginning OTC case management conference (OTC CMC);

[1] See section on Contested OTCs

- The Attorney for the parent speaks with their client about the program and the client agrees to consider the program, the parent and their attorney than meet with the Recovery Specialist to learn about the program;

- If the parent declines, the Recovery Specialist is not invited into the OTC CMC.

- If the parent agrees to participate in the program and will not contest the OTC, the Recovery Specialist is invited to join the OTC CMC in progress. The Recovery Specialist may also review the court file. The Recovery Specialist is responsible for obtaining the signature of the parent and their attorney on the "Agreement to Participate". They will do so either during the initial interview with the parent or following the OTC CMC.

- The original "Agreement to Participate" is returned to the court and placed on the left side of the court file. Copies are provided to the parent participating in RSVP, to all attorneys, the DCF social worker, Assistant Attorney General, and to the Recovery Specialist as is customary in the local court.

- During the OTC CMC, the specific steps are discussed and cooperation with RSVP is added to the steps;

- A Case Status Conference is scheduled for approximately 2 weeks following the OTC CMC and another for approximately 6 weeks from the OTC CMC *(Note: Specific information about each of the conferences is found in the section entitled Case Status Conferences for RSVP cases).*;

- Upon conclusion, the case goes into court for the Preliminary Hearing and entry of the specific steps and acknowledgement of the "Agreement to Participate" and Standing Order associated with RSVP; The Recovery Specialist will attend this court hearing, if possible.

- Following the Preliminary Hearing, the Recovery Specialist and parent are provided with a copy of the Specific Steps as is customary in the local court.

IV: Case Status Conferences in RSVP cases:

A. CSC at 2 Weeks:

The purpose of the CSC scheduled two weeks from the OTC CMC is to provide all the parties and their attorneys an opportunity to receive an update on the parent(s) compliance in RSVP.

- The Recovery Specialist will provide the court, all counsel for whom the parent/client has signed a release, the DCF social worker and AAG with a copy of the RSVP report at specified intervals;

- The Recovery Specialist and the parent(s) participating in RSVP are invited into the conference;

- At the CSC, the Recovery Specialist will provide an update regarding the parent(s) compliance in RSVP;

- Any CP case related concerns/issues may also be discussed;

- Parties and their attorneys are reminded about the 4 week CSC.

B. CSC at 6 weeks:

The purpose of the CSC at six weeks is as describe in CT. Practice Book Sec. 35a-2(c):

"...all attorneys and pro se parties will be prepared to discuss the following:

(1) Settlement;
(2) Simplification and narrowing of the issues;
(3) Amendments to the pleadings;
(4) The setting of firm trial dates;
(5) Preliminary witness lists;
(6) Identification of necessary arrangements for trial including, but not limited to, application for writ of habeas corpus for incarcerated parties, transportation, interpreters, and special equipment;
(7) Such other actions as may aid in the disposition of the case."

- In addition, the Recovery Specialist will prepare and submit a report and be present at the CSC;

- The parent who is participating in RSVP is invited into the conference at the appropriate time so that their compliance with RSVP can be discussed with them.

C. Subsequent CSCs:

1. Ongoing conferences are scheduled as prescribed by the Practice Book, the same procedures as with the first six week CSC are followed.

Scheduling:

1. The CSC is to be scheduled within four weeks from the initial CSC(six weeks after the OTC CMC, whenever practicable given the court and attorneys' schedules.

2. Subsequent CSCs are scheduled every four weeks for within the first 90 days and every six weeks for within the next 90 days of the case regardless of adjudicatory or dispositional status or other case events scheduled in court unless they directly related to RSVP, i.e. filing of Motion to Terminate RSVP or In Court review related to RSVP, whenever practicable given the court and attorneys' schedules;

3. After the first 180 days, CSCs are scheduled every 8 weeks;

4. Any party may request a CSC at anytime to be scheduled at the discretion of the CSO.

5. If a JPT is set because the legal case did not resolve, the Recovery Specialist will file a report with the Clerk's Office and the Clerk's Office will distribute the report to all necessary parties, the Recovery Specialist does not attend the JPT. The parent's attorney will report on his/her compliance with RSVP at the JPT based on information provided in the report.

6. The Recovery Specialist will prepare and submit a report for each CSC.

V. Terminating RSVP:

The RSVP Pilot Standing Order articulates the reasons that a parent(s) participation in RSVP may be terminated. It may be for one or more of the following reasons:

- The parent has been reunified with his/her child(ren) for a period Protective Supervision with a timeframe to be determined by the Judge on a case by case basis;
- Reunification with either the parent participating in RSVP or the non custodial parent with no protective supervision ordered by the Judge and RSVP is recommending termination from the program
- The Judge approves a permanency plan that does not include the parent's reunification with his/her child(ren);
- Reunification with the children is no longer the goal for the parent and DCF;
- The parent requests the Judge to terminate his/her participation in the program;

- The parent revokes the releases signed pursuant to the Agreement to Participate in RSVP.
- The parent fails to demonstrate compliance with the Recovery Specialist or treatment as indicated by information submitted by the Recovery Specialist or treatment provider;
- The active case in court is ended;
- The parent has reached a point of stability in their recovery and no longer needs the RSVP program.

Administrative Discharge from RSVP are possible. The most common reasons for the discharge are:

- The parent is incarcerated after he/she has signed the Agreement to Participate;
- The parent in RSVP relocates out of state or out of the service area for RSVP;
- Following a substance abuse assessment, no substance abuse treatment is recommended.

The following procedures for termination are to be followed:

- In order to terminate RSVP a "Motion to End RSVP Program" must be filed by either the AAG or other counsel;
- The Motion is to be docketed in accordance with CT. PB Sec. 34a-1;
- The Recovery Specialist files a discharge summary;
- The RS is present at the Motion hearing but is not required to speak and must be called as a witness either by one of the party's attorneys or by the Judge. The Recovery Specialist may only testify as to what they personally know about the parent's participation, i.e. information provided in the RSVP report.

VI. Step by Step for Contested OTCs:

1. Contested OTCs not referred to CPS:

- If a case has been identified as eligible for RSVP but the parent(s) is/are contesting the OTC, the case is handled as is customary in the local court.
- If there is a settlement on the day of the contested OTC or the court sustains the OTC after a hearing and the parent(s) expresses interest in pursuing RSVP, the CSO handling the case contacts RS and request that s/he come to the court to meet with the parent(s)

- RS will again discuss the program with the parents and if the parent(s) and their attorney agrees to participate, arranges for the "Agreement to Participate" to be signed;

- RS will return the original to the court (CSO) and court staff will provide copies to the parent(s) participating in RSVP and all attorneys;

- The CSO will schedule the 2 week and 4 week CSC at the local court. The local Clerk's Office will enter the Recovery Specialist as an interested party, enter the court dates and will provide notices to the Recovery Specialist;

- Either at the conclusion of the contested hearing or when the case goes into court to enter the agreement, the Court enters the specific steps and acknowledgement of the Agreement to Participate and Standing order associated with RSVP on the record;

- Following the Hearing, the Recovery Specialist and parent are provided with a copy of the Specific Steps as is customary at the local court.

2. Contested OTCs referred to CPS:

- If a case is referred to CPS for a contested hearing, the CSO in the local court informs the CSOs at CPS either by phone or e-mail and in the Transfer Summary that the case may be a potential RSVP case;

- If there is a settlement on the day of the contested OTC or the court sustains the OTC after a hearing and the parent(s) expresses interest in pursuing RSVP, the CSO at CPS handling the case contacts RSVP Case Management Liaison (CML) at ABH and request that she come to the court to meet with the parent(s)

- RSVP CML will again discuss the program with the parents and if the parent(s) and their attorney agrees to participate, arranges for the "Agreement to Participate" to be signed;

- RSVP CML will return the original to the court (CSO) and court staff will provide copies to the parent(s) participating in RSVP and all attorneys;

- The CSOs at CPS will schedule the 2 week and 4 week CSC at the local court. The local Clerk's Office will enter the Recovery Specialist as an interested party, enter the court dates and will provide notices to the Recovery Specialist;

- Either at the conclusion of the contested hearing or when the case goes into court to enter the agreement, the Court enters the specific steps and acknowledgement of the Agreement to Participate and Standing order associated with RSVP on the record;

- Following the Hearing, the Recovery Specialist and parent are provided with a copy of the Specific Steps as is customary at CPS.

VII. General Process:

1. RSVP Progress reports and treatment of documents for Court Files:

- Information on the CSO's memorandum of case status conferences is limited to indicating the Recovery Specialist was present or not and that the RSVP report was received/not received; reviewed by the participant/not reviewed by the participants.

- The RS will either provide enough copies for distribution at court or will send copies directly to those who are to receive them.

- Copies of the RSVP Progress Reports are distributed as follows to those individuals for whom the parent has signed a release of information:

  - CSO
  - DCF Social Worker
  - Assistant Attorney General handling the case
  - Parent(s) Attorney
  - Child(ren)'s Attorney

- The court record is available for inspection by the RS only after the parent(s) and their attorney have signed the Agreement to Participate. The Recovery Specialist may only review documents as they pertain to the RSVP client.

- RSVP may not have copies of documents in the file with the exception of the signed "Specific Steps";

- The RSVP Agreement to Participate once signed by the parent(s) and their attorney is placed on the left side of the court file with other such documents.

- The RSVP Progress Reports are filed with the Clerk's Office, the original is placed in a sealed envelope marked RSVP Progress Reports – Confidential and placed in the court file

2. RSVP CP System:

- The Recovery Specialist is listed as an "Interested Party" as **RS – Recovery Specialist** to enable the Clerk's Office to provide them with notices of pertinent hearings;

- The Case Status Conferences associated with RSVP cases may be noted as **C** as the "Purpose" code and **SV** as the "Reason" code to identify them as CSC involving the RS and parent(s) in the program;

- When a Motion to Vacate the RSVP Program Participant Agreement is filed it is noted as **MTVRSVP** to identify it as such.

- When the parent(s) participated in RSVP is terminated the code for the **RS - Recovery Specialist** is removed from the CP system and they receive no further notices of court proceedings.

- Existing RSVP Progress reports are removed from the court file and destroyed (shredded).

Resources

Women & Children's Specialty Residential Programs

Treatment Services	ADRC, Coventry House	CPAS, New Life Center	Crossroads, Amethyst House	Liberations, FIRP	Morris Foundation, Women & Children's Program	The Connection, Hallie House	The Connection, Mother's Retreat
Child Care							
On-Site	X	X	X	X	X		
Off-Site	X_1		X		X	X	X
Developmental Assessment of Children							
On-Site	X		X	X	X	X	X
Off-Site	X	X	X	X	X	X	X
Health Care of Women Issues and Services							
On-Site	X	X	X	X	X	X	X
Off-Site	X	X	X	X	X	X	X
Parenting Skill Training/Information							
On-Site	X	X	X	X	X	X	X
Off-Site	X		X	X	X	X	X
Case Management Services							
On-Site	X	X	X	X	X	X	X
Off-Site	X	X_2	X	X	X	X	X
Family Counseling							
On-Site	X	X	X	X	X	X	X
Off-Site	X	X_2	X	X	X		
Medication Management							
On-Site	X		X	X		X	X
Off-Site		X_2	X	X	X		
Vocational Services							
On-Site					X	X	X
Off-Site	X	X_2	X	X	X	X	X
Educational Services							
On-Site						X	X
Off-Site	X	X_2	X	X	X	X	X
Trauma Services							
On-Site	X	X	X	X	X	X	X
Off-Site	X		X	X	X	X	X
Domestic Violence Services							
On-Site	X		X	X	X	X	X
Off-Site	X	X_2	X	X	X	X	X

1 = ADRC strongly utilizes TOPS (Time Out for Parents) regarding off-site childcare/placement for the clients in residential.
2 = CPAS permits women to participate once their DMHAS contractual requirements of 20 hours of on-site treatment is met.
Off-Site = refers to the program allowing the women and/or children to go off-site in order to receive the

Revised 11-07

PERINATAL DEPRESSION PROVIDER CONSULTATION LINE
Sponsored by the State of Connecticut Department of Public Health

What is the Perinatal Depression Provider Consultation Line?
United Way of Connecticut/2-1-1, in partnership with the Yale School of Medicine's Perinatal Depression Research Program (Psychiatrist Dr. Kimberly Yonkers and her staff); will staff a telephone line for healthcare providers with clinical inquiries about depression during and around the time of pregnancy ("perinatal depression"). The non-crisis service provides consultation, information and resources regarding symptoms of perinatal depression, treatment possibilities, and available community resources.

How Do I Access the Perinatal Depression Provider Consultation Line?
- Dial 2-1-1 and Press 2, then 4 off the menu tree or
- Call Child Development Infoline directly at 1-800-505-7000

Who Should Call?
Any physical or behavioral healthcare provider requesting clinical consultation about perinatal depression For example:
- What risks and benefits should I consider when prescribing medications to a pregnant depressed woman?
- I have a patient who is crying at every visit. Could she have depression?
- What questionnaires could help me screen my pregnant patients for depression?
- How might implementing a structured questionnaire impact my obstetrical practice?
- Where can I find treatment for a pregnant woman who has depression?

Is There a Fee for Using the Perinatal Depression Consultation Line?
No. Consultation services are generously funded by a grant from the State of Connecticut Department of Public Health.

What Can I Expect When I Call?
You will first speak with a Care Coordinator at 2-1-1 Child Development Infoline. Care Coordinators are trained to briefly assess and triage your questions. The Care Coordinator will ask you a series of questions that will be shared with a clinician at Yale Department of Psychiatry's Perinatal Depression Research Program. A Yale clinician will contact you to discuss your questions within 2 hours of your call to 2-1-1 or, depending on the time of day you contact Child Development Infoline, the morning of the next business day. You will also receive a follow-up call 2-3 weeks later to determine your satisfaction with the service and if you need any additional resources. All callers will be mailed a perinatal depression provider toolkit.

When Can I Call?
Staff at Child Development Infoline are available Monday-Friday, 8am-6pm. The grant is funded from March through October 2008. There is no limit to how often you can call.

Can I have My Client/Patient Call Herself?
The provider consultation line is a professional service for healthcare providers. However, depending on any additional needs of the woman (and her family) for whom you are seeking clinical assistance from the consultation line, a Care Coordinator may also encourage you to have your client/patient call 2-1-1 directly for assistance around basic needs and/or support services. 2-1-1 is available 365 days a year, 24 hours a day

For Further Information Log onto http://211infoline.org/ or call 2-1-1

In-patient Levels of Care

Detox:

- 3.7D – Regular Medical detox for clients without severe medical and/or psychiatric issues
- 4.2D = For clients with severe medical and/or psychiatric issues (i.e., suicidal, hx seizures, etc.)

Residential Treatment:

- Intensive – Up to 30 days
- Intermediate – 3 – 6 months
- Long Term Rehab – 6+ months

ABH SATEP Access Line
Region 4 Providers

	REGION 4 PROVIDERS			
SERVICE	**PROVIDER**	**LEVEL OF CARE**	**TOWN**	**PHONE #**
Detox	ADRC	3.7D	Hartford	860-714-3700
Detox	Alliance Treatment Center	3.7D	~~Avon~~ NB.	860-223-7707
Detox	Bristol Hospital	4.2D	Bristol	860-585-3000
Detox	St. Francis Hospital	4.2D	Hartford	860-714-2470
Detox	Blue Hills Hospital	3.7D/4.2D	Hartford	860-293-6400
Housing Support	Alternative Living Center	None	Hartford	860-714-3702
Housing support	Womens Alternative Living Ctr.	None	Hartford	860-545-7153
IOP	ADRC	2.5	Hartford	860-714-3704
IOP	CPAS Outpatient services	2.5	Manchester	860-645-0487
IOP	Institute for Hispanic Family	2.5	Hartford	860-527-1124
IOP/PHP	Teamworks	2.5	Manchester	860-649-0425
IOP/PHP	North Central Counseling	2.5	Enfield	860-253-5020
IOP/PHP	Institute of Living	2.5/3MH	Hartford	860-545-7200
IOP/PHP	Johnson Memorial Hospital	2.5/3MH	Stafford	860-684-4251
IOP/PHP	Manchester Memorial Hospital	2.5/3MH	Manchester	860-646-1222
IOP/PHP	New Britain General Hospital	2.5/3MH	New Britain	860-224-5804
IOP/PHP	Natchaug/River East	2.5/3MH	Vernon	806-870-0119
IOP/PHP	New Directions	2.5/3MH	Enfield	860-741-3001
IOP/PHP	Alliance Treatment Center	2.5	Avon	860-673-6115
IOP/PHP	UCONN Health Center	2.5/3MH	Farmington	860-679-3000
IOP/PHP	Wheeler Clinic	2.5	Plainville	800-793-3588
Meth Maint.	Comm. Subst. Abuse Center	1.3	Hartford	860-247-8300
Meth Maint.	Hartford Dispensary (Hartford)	1.3	Hartford	860-527-5100
Meth Maint.	Hartford Dispensary (New Britain)	1.3	New Britain	860-827-3313
Meth Maint.	Hartford Dispensary (Bristol)	1.3	Bristol	860-589-6433
Outpatient	ADRC	2.1	Hartford	860-714-3704
Outpatient	Bristol Hospital	2.1	Bristol	860-583-5858
Outpatient	Community Health Services	2.1	Hartford	860-249-9625
Outpatient	CPAS Outpatient Services	2.1	Manchester	860-645-0487
Outpatient	Hartford Behavioral Health	2.1	Hartford	860-727-8703
Outpatient	Institute of Living	2.1	Hartford	860-545-7200
Outpatient	Institute for Hispanic Family	2.1	Hartford	860-527-1124
Outpatient	Johnson Memorial Hospital	2.1	Stafford	860-684-4251
Outpatient	Manchester Memorial Hospital	2.1	Manchester	860-646-1222
Outpatient	New Britain General Hospital	2.1	New Britain	860-224-5804
Outpatient	New Directions	2.1	Enfield	860-741-3001
Outpatient	UCONN Health Center	2.1	Farmington	860-679-3000
Outpatient	Wheeler Clinic	2.1	Plainville	800-793-3588
Residential	Alternative Living Center	Recovery House	Hartford	860-714-3705
Residential	Blue Hills Hospital	Intensive	Hartford	860-297-0999
Residential	Farrell Treatment Ctr. (Men)	Intensive	New Britain	860-225-4641
Residential	ADRC	Intensive	Hartford	860-714-3739
Residential	Alliance Treatment Center	Intensive	Avon	860-673-6115
Residential	ADRC	Intermediate	Hartford	860-714-3739
Residential	Clayton House	Intermediate	Glastonbury	860-659-0309
Residential	Coventry House	Intermediate	Hartford	860-714-3703
	Pregnant Women & Children			
Residential	Alternative Living Center (Men)	Long Term Rehab.	Hartford	860-714-3702
Residential	Alternative Living Cennter (Women)	Long Term Rehab.	Hartford	860-545-7153
Residential	Hogar Crea	Long Term Rehab.	Hartford	860-527-7440
Residential	Open Hearth	Long Term Rehab.	Hartford	860-525-3447
Residential	Salvation Army	Long Term Rehab.	Hartford	860-527-8106
Residentail	Youth Challenge	Long Term Rehab.	Hartford	860-728-5199

ABH SATEP Access Line
OUT OF REGION PROVIDERS

	OUT OF REGION PROVIDERS (Regions 1, 2, 3, 5)			
SERVICE	**PROVIDER**	**LEVEL OF CARE**	**REGION**	**PHONE #**
Detox	Hall-Brooke Hospital	4.2D	1	203-227-1251
Detox	Southwest Mental Helath	4.2D	1	203-551-7429
Detox	Rushford	3.7D	2	860-346-0300
Detox	Connecticut Valley Hospital	3.7/4.2D	2	860-262-6321
Detox	Hill Health (SCRC)	3.7D	2	203-782-1106
Detox	St. Francis Care (Elmcrest)	4.2D	2	860-342-6270
Detox	Natchaug Hospital	4.2D	3	860-456-1311
Detox	Stonington Institute	3.7D	3	860-448-1111
Detox	SCADD	3.7D	3	860-447-1717
Detox	Pathways	3.7D	3	860-963-4971
Detox	MCCA	3.7D	5	203-792-4515
Residential	CASA	Intensive	1	203-339-4112
Residential	Horizons	Intensive	1	203-333-3518
Residential	Rushford	Intensive	2	860-346-0300
Residential	Connecticut Valley Hospital	Intensive	2	860-262-6321
	Men, Women, Pregnant Women			
Residential	Stonehaven	Intensive	2	860-346-0300
Residential	Lebanon Pines (Men)	Intensive	3	860-889-1717
Residential	Milestone	Intensive	3	860-928-1860
Residential	Stonington institute	PHP w/Off Camput	3	800-832-1022
Residential	Carnes Weeks	Intensive	5	860-496-2107
Residential	McDonough House	Intensive	5	860-354-4423
Residential	CASA	Intermediate	1	203-339-4112
Residential	Viewpoint Recovery (Men)	Intermediate	1	203-356-1053
Residential	Meridian House	Intermediate	1	203-356-1980
Residential	Families in Recovery	Intermediate	1	203-324-7511
	Preg/Parenting Women & Children			
Residential	Rushford	Intermediate	2	860-346-0300
Residential	Connection House	Intermediate	2	860-343-5512
Residential	Connection Women and Children	Intermediate	2	860-343-5512
	Pregnant Women's & Children			
Residential	Perception House	Intermediate	3	860-450-7130
Residential	Howard Street (Women)	Intermediate	3	860-442-1017
Residential	Altruism House (Women)	Intermediate	3	860-447-8021
Residential	Altruism House (Men)	Intermediate	3	860-889-3414
Residential	Mothers Retreat	Intermediate	3	860-405-2107
	Pregnant Women & Children			
Residential	Thomas Murphy Center	Intermediate	3	860-456-1769
Residential	Morris/Kendall House	Intermediate	5	203-574-3986
Residential	McDonough House	Intermediate	5	860-354-4423
Residential	McCall House	Intermediate	5	860-496-2105
Residential	Morris Foundation	Intermediate	5	203-574-3311
Residential	CT Renaissance	Intermediate	5	203-753-2341
Residential	Helping Hand	Long-Term Rehab	1	203-336-4745
Residential	Liberation House	Long-Term Rehab	1	203-356-1980
Residential	Daytop	Long-Term Rehab	1	203-426-3344
Residential	Crossroads (Men)	Long-Term Rehab	2	203-387-0094
Residential	Crossroads (Women)	Long-Term Rehab	2	203-387-0094
Residential	Crossroads	Long-Term Rehab	2	203-387-0094
	Pregnant Women & Children			
Residential	Amethyst House	Long-Term Rehab	2	203-821-3040
	Parenting Women & Children			

Recovery Coaching

Appendix B:
Tips for Engaging or reengaging challenging clients

(These also work with clients willing to go into treatment)

- Make the client feel comfortable
- Accept the client where he/she is; refrain from judging the client
- Establish a rapport with the client
- Listen
- Empathize
- Speak respectfully, honoring the client's worth and dignity
- Be honest with the client
- Be committed yourself to developing the relationship
- Use a caring tone of voice
- Talk with, not at, the client
- Be kind
- Be positive, focus on successes (big and little)
- Convey hope
- Explain the O & E program in language that is easy to understand; clarify the OEP role and relationship with DCF
- Be respectful of the client's right to self determination (freedom to make their own decisions and choices)
- Be aware of the client's temperament; know your own temperament
- Reach out to clients instead of waiting for them to ask for help
- Identify and assist in addressing client's immediate basic needs
- Recognize that clients make changes and enter treatment/recovery for different reasons
- Remind clients of the consequences of their choices; be mindful of the timeframes, e.g., appointments, court dates, CPS timeframes
- Use motivational interviewing techniques:
    - **Express empathy -** listen to the client's frustration, show them you hear them by rephrasing, reflect what they are saying, affirm that their frustration is warranted
    - **Develop discrepancy** - help point out the difference in where they say they are and where they want to be. Raise awareness of the consequences of their behavior, without making them feel guilty.
    - **Avoid arguments** - (the I'm right syndrome, trying to convince them that they need your help) just point out observations in a gentle manner.
    - **Roll with the resistance -** (accept that the client may not want you at that time) provide new ways of thinking about the problem, but accept that the client may think about the problem in a different way, provide information based on experience and knowledge.
    - **Support self efficacy** - (teach the client how to help themselves) believe that the client can make a change.
- Use humor, when appropriate. Be sensitive to the client's response(s); what is funny to one person may not be to another.
- Follow through – do what you say you will do. Actions speak louder than words.

A USER-FRIENDLY MODEL OF CHANGE

Robert Westermeyer, Ph.D.

James Prochaska and Carlo Diclemente (1982) developed a model of change which is unique in many ways. First, it is empirically driven. In other words it is based on the researchers' scientific investigation of change in humans. Second, the model conceptualizes change as entailing a number of stages which all require alterations in attitude in order to progress. Third, the model depicts change as a cycle--as opposed to an all or nothing step. The authors contend that it is quite normal for people to require several trips through the stages to make lasting change. So in this sense relapse is viewed as a normal part of the change process, as opposed to a complete failure. This does not mean that relapse is desirable or even invariably expected. It simply means that change is difficult, and it is unreasonable to expect everyone to be able to modify a habit perfectly with out any slips.

We enter the stages of change from a state of precontemplation-- during which the idea of change is not seriously considered. The cycle begins when we start to contemplate the need for change. Hopefully we will tip the scales in favor of change and become determined to take action. Then specific alterations in thinking and behaving will be initiated. It is hoped that the alterations become accepted and eventually ingrained or automatic. If we are able to maintain our accomplishments, we exit the cycle entirely.

However, sometimes we relapse or backslide. Relapses can vary in severity, as can our reactions to them. Some relapses can discourage so much that people return to a precontemplative stage for a long time before contemplating change again. Others get right back on track, considering the antecedents to relapse, where they need to put more effort, and swiftly move back into action again.

The reason the cycle model is so attractive, is that it views change as flexible to individual needs. Some people make lasting change quite rapidly, others require a few times through the stages. Just as some can master skiing on the first try, others require a couple of seasons to get to the intermediate level.

I will now briefly highlight each of Prochaska and Diclemente's stages of change.

PRECONTEMPLATION STAGE.

This is not so much a stage of change as a prelude to the formal stages. Precontemplation is when people with habit problems do not recognize, or are unconcerned, with the problem. A smoker may be so busy with his vocation that the constant hacking cough doesn't distract him enough to consider it a significant problem. A heavy weekend drinker may not have any obligations on Sunday, so the fact that he is throwing up all morning isn't an immediate concern. A cocaine abuser may have so many using friends and engage in so many "zany" antics while high, that the thought of relinquishing the behavior, despite nosebleeds and financial constraints simply has never been contemplated seriously.

Typically other people are quite aware of the problems and may even voice their concern. In this stage, however, people with strong addictive behavior problems are almost deaf to their voiced distress. It would be easy to call this "denial," but much more accurate would be to describe Precontemplation as a state when a person is "uninformed" in the sense that no personally convincing reason for change has been presented as of yet

CONTEMPLATIVE STAGE

Miller and Rollnick (1991) state that what frequently jars people into the next stage, that of contemplating the possibility of change, is convincing, personal and timely information--not coercion or even advice. People not yet contemplating change are not particularly open to advice, much less confrontation. We have all had experience with someone telling us that we must change some quality of ourselves, with which we are quite content, because they deem it unhealthy, unusual or annoying. Such advice which is deemed inappropriate can be met with responses like, "There is nothing wrong with that! That's your problem, not mine!"

However, learning more about what is problematic for you specifically, being afforded data which is very relevant and convincing,--very often forces you to at least consider the option of modifying your behavior.

This may seem doubtful, in that you have probably received loads of information about your habit--why it is hazardous to your health, family and so on. Perhaps you've read a great deal on the subject. Yet none of this information seems to have made any difference. The habit endures.

It is important to understand that I am not referring to generic information, but rather information specifically catered to you. The most powerful information is that which is intimately tied to your addictive behavior, runs contrary to established expectancies and has intimate ramifications for some or many aspects of your life.

This information might come to a smoker in the form of a comment by his 5-year old that she does not want him to die if lung cancer, "Please stop smoking, daddy. I don't want you to die." For a heavy drinker, the information may come from a General practitioner in the form of lab results. "The liver panel suggests that if you continue drinking the same amount of alcohol your liver will begin to show irreversible damage in 2 years." Keep in mind that most heavy drinkers hear about fatty liver and cirrhosis, and smokers hear about the risk of lung cancer all the time, but this information usually seems quite distant. The information provided to these people was important, individualized data from which they were unable to distance themselves.

The grand task for the early contemplator is to seize the moment. Contemplation can come and go quickly and you have to be ready to go with it in the heat of the moment. Often times we are afforded information by chance which serves to increase the desirability of change. It is very important not to miss out on the opportunity to use this information to shift gears. It is very easy to miss out on a brief window of opportunity, a moment in which you are saying to yourself, "I've had it! No more of this! I'm doing something about this right now!" You are very vulnerable to old influences at this time, both external pressures and convincing data from within. It is imperative to tip the scale of ambivalence in order to move from contemplation to determination and action.

As we shall see, there are a number of ways that you can facilitate this transition. First it is important for you to gain an accurate, unbiased picture of your addictive behavior problem. This can be done by thoroughly assessing all short and long term consequences and then constructing a "cost-benefit analysis.", i.e. chart the pros/cons of remaining the same and the pros/cons of changing. With this information in hand, you can begin to chip away at fixed expectancies which are preventing movement.

DETERMINATION STAGE

This is a transition period between shifting the balance in favor of change and getting things moving in

the that direction. Many people have fleeting moments of determination that swiftly vanish when all of the horrors involved come back into awareness. Determination will lead directly into action if you have thoroughly considered all aspects of your addictive problem realistically, if you have begun to modify expectancies and have established a goal what is conducive to your individual needs and values.

First of all, it is very important to know specifically what you need to modify in your lifestyle and what about your lifestyle is better left unchanged. Believe it or not, you rarely must "throw out the baby with the bath water" when it comes to habit change. Many people with good intentions for change believe that they must undergo drastic lifestyle and or identity change in order to alter a habit. For example, many recovering substance abusers believe that they must abstain not only from the substance they have abused, but all that is used to enhance pleasure and reduce pain and assume some stoic lifestyle. Rarely is this drastic a lifestyle change necessary, or even ideal for lasting change. What often happens is that in the process of major personality reconstruction people find that it is virtually impossible, or that they just hate it. They eventually become discouraged and stop the whole change process.

It is also important to establish a goal which works with you. A goal which is reasonable for me may be unreasonable or inadequate for you. Our goals must be consistent with our capabilities, our values, our needs. Sometimes, especially in the field of addiction treatment, an outcome is mandated by an expert as the only realistic goal. In fact, in the field of alcohol abuse treatment people who do not wish to conform to the goals mandated by the 12-step approach are often criticized, told that they are in denial and that it is not an option form them to aspire to anything but total abstinence. Not only is this tyranny, but it is completely inappropriate given what research has demonstrated about lasting change and problem drinkers.

In the last two decades science has confirmed that for non-severe problem drinkers, moderation is a viable and attainable goal (e.g. Sanchez-Craig, et al.,1984; Miller et al., 1980, 1981; Marlatt, 1989). In Mark and Linda Sobell's thorough treatment guide for working with non-physically dependent problem drinkers, the authors state that research suggests that people can benefit from very brief interventions, One study found that clients benifited equally, whether they took part in a group treatment program or merely read self-help material (Skutle and Berg, 1987). The Sobells contend that conventional treatment approaches for less than severely impaired alcohol abusers may be inappropriate. Furthermore, it has been found that self selection of treatment goals by non-physically dependent problem drinkers enhances motivation (Sobell et. al. 1992).

I agree that many people should not drink at all due to all the problems alcohol has caused them. Nonetheless, the vast majority of people with drinking problems are not seriously dependent and disabled by the habit (Sobell & Sobell, 1993). Most problem drinkers drink heavily in certain situations and are productive in other areas. Within this group, there are those who decide to change heavy drinking patterns. Many quit altogether, others change from a pattern of heavy drinking to one of moderate drinking. Does this mean that professionals should advocate moderation as a choice for all individuals with drinking problems. Absolutely not! Research supports the moderation alternative for the non-physically dependent problem drinker with a short heavy drinking history--not the severely impaired drinker who has consumed heavily for a long period of time.

Is moderation a legitimate outcome? Many would consider anything short of total abstinance as a goal for a heavy drinker to be a failure. "The person was a heavy drinker, now they are a moderate drinker. They are still drinking, which is unhealthy." I would argue that cutting down the amount of alcohol consumed is a tremendous success. It would certainly be nice if everyone engaged only in behaviors that were completely healthy. But in the real world, very few behaviors meet this criterion. Furthermore, goodness and badness occur along a vast continuum and are subject to individual interpretation. Any movement toward better health, no matter how small by outside standards, is a success, whether this

movement is part of a larger plan or an ultimate goal in and of itself.

This view is based on a model of change that is the foundation of addiction care in The Netherlands, Australia and some parts of the UK-- that of Harm Reduction. Simply, any movement toward bettering yourself, toward self-improvement, whether it is drastic or a minor modification is positive. Moving from heavy drinking, such that work, family and physical health was seriously impaired to two glasses of wine per evening, has turned a behavior which was seriously impairing many aspects of his life, to one that has reduced risk, or harm, many fold. Certainly quitting alcohol all together would be great! but this goal represents the most drastic of changes, one that many may not be able to attain. There are an infinite number of modifications which move progressively toward that ultimate goal, all of which are positive IN AND OF THEMSELVES.

Your goal for change does not have to be all or nothing. It is unfortunate that so many people believe that the only change worth making is complete personality overhaul. Without a doubt his mandate has led to a great deal of discouragement. Any change in the direction of health and happiness is wonderful. If you can completely eliminate every aspect of your addictive behavior problem, and if this goal suits you well, then FANTASTIC! If you decide that only partial movement would make your life infinitely better, in fact much better than complete elimination of the behavior, then that is FANTASTIC too! There are no models that accurately predict happiness for everyone. Only you can decide what will make you the most happy!

Consider another example: a smoker who goes through two packs a day who relapses invariably 2 or 3 weeks after quitting. Finally he decides that he really doesn't want to give up tobacco completely but he knows that cutting down never works. He ultimately makes the decision to quit smoking cigarettes and instead have one expensive cigar every other evening. He has reduced the amount of tar and nicotine and no longer takes smoke into his lungs. He is still engaging in a behavior which is hazardous, but he has reduced the hazard significantly. Further, he has made moderation passionate, by only smoking expensive cigars. Two years later he still hasn't returned to cigarettes; in fact, he reports that they smell "cheap,"compared to the smell of a "number 9" from the Dominican Republic.

It would be easy for us to claim that this man has substituted one addiction for another. Perhaps, but a much less pejorative (and much more accurate) explanation would be that he has reduced the harm a bit in his life. In order to make change possible you must establish a goal which works for your life! If it only works for others, your attempts will fail, or you will just end up miserable with your new lifestyle.

Once again, it is important to understand that I am not advocating that people sell themselves short on change. Quite the contrary, my aim is to help you discover all that you are capable of doing to make your life more vibrant and spontaneous. This is why following a path which is individualized is so important. If you follow someone else's path, it may interfere so much with other aspects of your lifestyle that it will seem unbearable. Altering a habit does not have to kill you. There is no reason to punish yourself.

ACTION STAGE

It is truly remarkable what people are capable of doing once sufficiently motivated and invested in a realistic goal. I have witnessed many people in awe over their inherent ability to change once they have removed barriers and have allowed themselves to tap into existing strengths.

Below are some techniques which, when added to your armory, can make lasting change more likely:

* Stimulus Control. What this means, simply, is to gain the ability to recognize "triggers" for addictive behavior, to predict outcomes before they occur and to intervene when needed to avoid relapse. As I have said, habitual behavior is by nature automatic. We go through the motions so often that the program drives itself. A person with an overeating problem may not even remember having eaten 3/4 of a bag of chips that afternoon. "I remember seeing the bag and opening it, after that I just don't know what happened."

Stimulus control techniques, as we will discuss emphasize predicting your environment, planning ahead and avoiding, what G. Alan Marlatt calls "Seemingly Irrelevant Decisions," learning to stop an automatic behavior early on as opposed to in the heat of the moment can prevent a relapse.

* Talking Back to Urges. In the throes of addictive behavior, strong, unswerving urges can plague you night and day. Learning to nip an urge early on, when it is just materializing makes it easier to control than later, when you have been immersed in the urge for an hour or so. Refer to the on-line document, "Coping With Urges" for specific techniques.

* Talking Back to Negative Thoughts. Negative emotions, like anxiety, anger and depression are triggers for many addictive behaviors. Research has supported cognitive therapy as the most effective therapeutic technique for combating various mood disorders. There are numerous resources already available which present the principles of cognitive therapy in detail

* Coping with Pressures from Others to Engage in Addictive Behavior. Many people who decide to change have not thoroughly informed friends and family of the decision, or the decision has been articulated but the seriousness has not been underscored. People can have a tremendous effect on our ability to remain true to our change efforts Furthermore, associates are sometimes not as invested in the change as we are. A drinker who decides to stop may not want to relinquish his friends, all of whom drink heavily. These people can have a tremendous influence on our decisions (often they are important to us) and can serve to spiral you into relapse, or at least make it extremely difficult to hold your ground

* Lifestyle Enhancement. A lifestyle without addictive behavior often leaves a lot of free time. What are you going to do with that free time? Many people find that because they have engaged in their habits for so long, they have not done or even thought about the other things that used to bring them pleasure. In fact these old activities may not even seem pleasurable any more.

Some people who are involved in A.A. find that they must attend a meeting or two every day, because they just don't know what to do with "dead time." Though I am not fond of the pejorative title "group addict" that is applied to these people, given that many of them find the groups to be invaluable, their lives so much more colorful and social than when they were abusing alcohol, I do believe that people can enhance their lives with activities other than , or in addition to, support groups.

When changing addictive behavior it is imperative to enhance your lifestyle with revived interests and new activities. Augmenting one's lifestyle can be hard however, especially if there are feelings of apathy or insecurity, and some guidance may prove helpful to you. Once you begin taking on new activities it can be an exciting time because you discover that the world offers so much when you are not running on addictive auto-pilot.

MAINTENANCE STAGE

To maintain changes, one must have practiced living a less harmful lifestyle until doing so becomes automatic. As I said, some people may need to go through the stages several times before lasting change

occurs. Not only is this is okay, it's customary. It would be unreasonable to expects a novice pianist to be able to play Beethoven's Moonlight Sonata perfectly after a month of lessons. Not being able to do so should not provoke such discouragement that you give up the piano (although some people certainly do). The same is true of addictive behavior. Allowing the possibility of a slip will take some of the pressure and self-loathing away from the change process.

RELAPSE

One of the most significant problems with the 12-step treatment model is the all-or-none manner in which relapses are construed. Regardless of the intensity, slips and relapses have always been viewed as failure, falling off the wagon, time to "start over."

I prefer to look at relapse in terms of degree. It is just so much more humane. To change addictive behavior is to learn how to behave differently in certain situations--in essence, no different than learning any other complex skill. How inappropriate it would be to have a no tolerance attitude during the toilet training of a two-year old. Imagine a "relapse", for example a wet bed after several weeks of dryness, being conceptualized as a failure. Slips and setbacks are a part of learning. In fact an integral part. It is through our mistakes that we learn where we need to put most of our efforts in the future.

Many people would consider a glass of champagne at a wedding reception, by someone who has vowed abstinence, as a relapse. Consider the implications of this. Here, a person who before initiating change was unable to control drinking at such occasions. At this wedding reception he did slip, and this is unfortunate; but he did something remarkable, he didn't have a second glass. A relapse or a momentary slip recovered and empowered? I choose the latter. Sure, he slipped, but he also kept himself from falling full throttle into a binge of wedding reception drunkenness. I mean really, consider all the cues he has successfully fought to avoid consuming even a second drink; other's drinking heavily, music, smoking, and so on--all strongly encoding into his previous drinking program. Though slipping momentarily, he has evidenced new control, that of keeping a lapse from becoming full blown. Success!

Many would disagree with my definition of a successful relapse. But consider what might occur if this individual was confronted by some well meaning alcoholism "expert" who was harsh with him, stating something to the effect of, "Well you've done it now Dan! You've fallen off the wagon! I warned you about coming to the wedding! You can't go to events like this. You didn't work your program! You've got to start all over tomorrow. I suggest that you get a sponsor to prevent this sort of thing reoccurring." How is this approach going to make poor Dan feel? Miserable, like a failure. Very often, these sorts of feelings are precipitants to drinking. So what is this "failure" likely to do when he gets home? Drink to medicate these feelings of hopelessness and helpless, of course!

Use the stages of change as a gauge or barometer for your motivation. Do you feel your drive for change waning? How can you get yourself back on track--from a state of contemplation to one of determination and action? How can you increase the desirability of change?

REFERENCES

DiClemenet, C.C., & Prochaska, J.O. (1982). Self change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. Addictive Behavior. &: 133-142.

Marlatt, G.A. (1985). Cognitive factors in the relapse process. In G. A. Marital & J.R. Gordon, Relapse Prevention. New York: Guilford Publications.

Marlatt, G.A. (1985). Lifestyle Modification. In G.A. Marlatt & J.R. Gordon, Relapse Prevention. New York: Guilford Publications.

Miller, W.R., Gribskov, C.J., & Mortell, R.L. (1981). Effectiveness of a self-control manual for problem drinkers with and without therapist contact. International journal of addictions, 16, 1247-1254.

Miller, W.R., Taylor, C.A., & West, J.C. (1980). Relative effectiveness of bibiotherapy, individual and group self-control training in the treatment of problem drinkers. Addictive Behaviors, 5, 13-24.

Miller, W.R., & Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: Guilford Publications.

Prochaska, J.O. & DiClemente, C.C. (1982) Transtheoretical therapy: Toward a more integrative model of change. Pscychotherapy: theory, research and practice, 19: 276-288.

Sanchez-Craig, M., Annis, H.M., Bornet, A.R., & MacDonald, K.R. (1984). Random assignment to abstinence and controlled drinking: Evaluation of a cognitive- behavioral program for problem drinkers. Journal of Consulting and Clinical Psychology, 52, 390-403.

Skutle, A., & Berg, G. (1987). Training in controlled drinking for early stage problem drinkers. British Journal of Addiction, 82, 493-501.

Sobell, M.B., & Sobell, L.C. (1993). Problem Drinkers: Guided Self-Change Treatment. New York: Guilford Publications.

Sobell, M.B., Sobell, L.C., Bogardis, J., Leo, G.I., & Skinner, W. (1992). Problem drinkers' perceptions of whether treatment goals should be self-selected or therapist selected. Behavior Therapy, 23, 43-52

---

964 Fifth Ave., Ste. 335, San Diego, CA 92101 (619) 544-1470

habtsmrt@cts.com

Recovery Coaching Question # 3 –

What does it take to be a "Kick A** RS/RCM?

A kick a** RS/RCM not only goes above and beyond but does the unexpected. Not only does the unexpected, but tries his/her best to make the impossible, possible.

A Kick A** RS/RCM keeps believing even when the client stops. I think you are all Kick A** RS/RCM's!!

A Recovery Coach referred to in that manner, has likely engaged the client in a very effective manner, and has advocated and collaborated with those programs and services that fulfilled the client's needs. Oftentimes when we begin working with clients, they are guarded, difficult and sometimes manipulative (for reasons that we all understand). A Recovery Coach's ability to gain trust, understand, and successfully guide a client is something that many client's recognize, and can lead to terms such as "Kick A**", this being a way for them to express that they realize they have been difficult but have met a positive, motivating force in the Recovery Case Manager. As I mentioned above, our ability to work with DCF and other community supports and programs for the benefit of the client, is also something that client's look favorably on. Clients are not always skilled in areas of communication, dealing with bureaucracies, and interpreting rules and policy. We do that for them, so we have what it takes to be referred to as "Kick A**.

A kick A** Recovery Specialist----is a helper that displays competent skills that are evident to the client and as a result provide the client with a sense of security. Through listening, collecting historical information and taking advantage of teachable moments, this helper strategizes with the client in mapping out what best works for that client. As a result, the client reaches goals/ exceeds expectations, impresses themselves and begins to have increased self-esteem which becomes their foundation in maintaining sobriety on their own. A hand up provides individuals with increased strength and self esteem where as a hand out will only pacify symptoms and will not provide a platform for the individual to perform on their own.

A kick a** RS supports when the going is good; and gets after a client when it's not.

A kick a** Recovery Specialist never quits despite the odds!!

A kick a** RS goes above and beyond supporting and encouraging the client all while using an open mind to think outside of the box!

A kick a** RS/RCM never gives up on his/her clients.

Recovery Coaching – Engagement

"All recovery-focused services hinge on effective engagement. The service ***RELATIONSHIP*** *is the foundation of recovery-oriented systems of care and all clinical and non clinical recovery support services.* ***Everything we are able to help each client achieve is contingent upon sustaining an empathic relationship.*** *Recovery-focused treatment is about* ***engagement, engagement, engagement.*** *The process of engaging and motivating each client is a continual one, as the strength of our service relationships and each client's motivation for recovery ebbs and flows.* ***At a practical level that means that every contact with a client is about re-engagement and re-motivation."***

~ From Bill White, et. al.

- I engage clients by meeting them wherever they are in their recovery, listening and being attentive to their needs, and being compassionate. I try to always be positive, offering encouragement and praise to my clients for any and all hurdles they've overcome, whether big or small. I know when I'm engaging a client when he/she is in contact with me consistently, even those who may be struggling and are not seeing me in person, but making frequent contact via telephone. What motivates me to keep outreaching to a "challenging" client is that client, him or herself. I always see that spark of motivation when a client agrees to participate in the program and it's up to me to try to keep that client motivated to keep moving forward in his or her recovery. – Beverly Chambers

- This is a good time to share with some of our newer team members my experience with attending a Bill White presentation several years ago in Hartford while with ABH: The room was filled with health care professionals of every type, and many individuals of high administrative positions eager to hear what this noted recovery expert had to share. Shortly into the presentation, Mr. White asked if there were any recovery managers or outreach workers in the group; I alone raised my hand. For the rest of the presentation, Mr. White made it known to everyone that I (we) perform one of the single most important jobs in the recovery process. The attention caught me off guard, but it felt good, and it was truly an honor to be recognized in this manner by such an important figure. Needless to say, the experience was more uplifting that I could ever describe in words and one that has motivated me through the years. I have a signed book with personal thanks that Mr. White gave me after presentation, which I am more than happy to share. ~ Omar Johnson

- I have a very indirect approach to engaging most of my clients, particularly the difficult ones. I find it effective to not jump right into the topic of recovery at most of my meetings. I usually (and quite deliberately) start by talking about something totally unrelated to the clients recovery, but nevertheless important to the client. If they like horses I talk about horses, if it's about their children, we talk about children, sports, etc, etc. I find that taking this route shows the client that I care about what's important to them them as a person first. Warms them up so to speak. Then I slowly work my way into recovery related matters. For me this can be time consuming, but it works for me. It builds rapport, trust and a stronger relationship. ~ Omar Johnson

- When I think about the meaning of engagement I think about going up and beyond to connect with each client individually. Like Omar, I believe in connecting to the person before I connect to the client. I try to understand their passions in an honest and caring manner. Once I feel I understand this, I try to build their recovery around their passion. I think that getting to know the person helps in not only the engagement but the re-engagement if a client falls off. I will call, stop by, meet up with them and discuss this passion before I talk about any expectations or recovery issues. I know that I have engaged a client because they see me as a person that can help instead of a program. This keeps many of my clients coming back for more and reconnecting with me when they fall off because they have a person that cares and is there for them and not just a program that they signed up for. This is very important to me so that I don't become part of the "System" in my client's eyes. I also believe in the saying "you catch more flies with honey then with vinegar" and I work from an caring and compassionate approach rather than a punitive approach.

  As for motivation to keep outreaching to clients that are challenging…I think of when I shadowed Rachel. She took me to visit a Client that she has worked with multiple times over many years. I always think about Rachel's determination and dedication to this Client despite having worked with her on the same issues for so many years. When I feel like "giving up" I channel Rachel and her diligence and determination to help improve this client's life circumstance. ~ Lisa DeWitt

- In order to engage a client I attempt to use Motivational Interviewing techniques to either plant the seed of change or to assist in motivating them through the Stages of Change. Using techniques such as Decisional Balance allows the opportunity for change talk. In the end, with that client who does not take steps toward change, I respect their individual autonomy and attribute their lack of motivation to them simply not being ready. I do not take a client's lack of motivation personal and hope the client will reflect on the experience and contemplate change one day in the future. ~ Rachel Voisine

- When I go for an intake, I schedule at least an hour and a half. I do this because I don't want to jump right in with the intake. This way I get the client to talk about some of the things that are important to them and possibly some of things they are having concerns about. This puts them at ease and lets them know that they're not "just" a client but a person that deserves to be listened to. When I meet a client and they act as if they don't want to be bothered and then, they call me for almost everything that happens in their life, then I know I've engaged them. To be engaging, you bring about trust and confidence by treating people with respect and integrity; when this happens, they will allow you in, to be able to help them. What motivates me to keep outreaching to engage a "challenging client is that I'm always thinking that this, may be the time that they see the light that leads them out of the fog. ~ Sonia Dupuy

- How do you engage/reengage clients? **I engage the client where they are at in Recovery and basic life-skills.**

- What does it mean to be engaging? **To be engaging is being consistent and inviting; sort of like a good Sales person.**

- How do you know that you are engaging a client? Or, not? **When the client is buying into what you are offering your sales-pitch is working. If you believe in your**

product and even if they aren't engaged continue to be the great sale person you are and they will see that your product works.

- What motivates you to keep outreaching to engage a 'challenging' client? **We all know I get these clients. Knowing the client has a chance to be successful. And that everyone deserves a chance no matter how rough the road to Recovery is!!! Believe in the Product; RSVP**. ~ Greg Johnson

As a Recovery Coach, how do you follow through? Why is it important to your work?

- As a Recovery Coach, it is important to follow through because besides the client, we are probably the only ones doing so, or the **only ones** if the client has been exhausted from getting nowhere on their own. Often times we are the client's only resource & if we are invested in our role, we are well aware of the daily injustices the clients face and are willing to go to bat to assist in creating change. I follow through on my cases by beginning or ending my week calling **all** my clients, clinicians and DCF workers because even a voicemail message will serve as a reminder to providers and prevent the case from falling between the cracks. – Rachel

- *By any means necessary within my role as an advocate for the client. Including the client before, after or during the process of follow through shows the client that they do have support. For some clients they have a hard time accepting/trusting support. Clients have said that they feel as though they are just told what to do, but no supports or assistance is given to them to follow through. So, one way of following though for a client could mean contacting or organizing with the client and their team of providers (or without the client) a meeting to problem solve where the problem is and come up with solutions on how to correct or improvement the situation for the client. Because at the end of the day it is the client that suffers, if follow through is not done collectively, as a collaborative team of providers working for the best interest of the client. As Rachel stated, clients who try on their own and get nowhere can and/or gets frustrated, if not overwhelmed and give up. We all know that gets them nowhere fast, if not in more trouble sometimes or in a deeper depression. Keva*

- For me, follow through is not only about getting the job done but it is about diligence and timeliness. I believe that by showing a client how to follow through with thoughtfulness and precision is as important, if not more, than doing it for them. I think of myself as a role model, not only for the Client but for other providers. I believe if you raise the bar and give high quality service, (which is often determined by the follow through) other providers will meet your level of service.

  The way in which I assure that I have good follow through is to make a list for myself each evening before I leave of tasks that need to be accomplished the next day. I prioritize them according to need and timeline. By prioritizing them, I can assure that if I end up with a crazy day, I know what needs to accomplished and by when so that the job is done. I also work on multi-tasking (making calls while I wait in court, taking notes about meetings so I can capture essential information for activity notes, etc). Lisa

- *I usually use my activity notes to document any requests or concerns that the client has agreed to. Before each client meeting I try to read over the last meeting note so the client knows and feels that I'm on top of things. I then inquire about the steps or actions that were taken by the client, and either intervene or offer further assistance if needed until the goal is met or progress is made. Follow through is important because it links together those things that need to be done to improve the quality of the lives of our clients, which in general terms is our goal. I might also add that follow through is important because it keeps our meetings client centered and goal oriented. Omar*

- My follow thru is like a gr8 baseball pitcher who uses all resources to get the ball over the plate. As a LRS my resources will assist with carrying my client thru Recovery and or Reunification. It is important because many of these clients rely on our resources to move forward from a place where they have been STUCK. Greg

  The thought of different pitch types (fastballs, sinkers, curves, sliders etc) made me think of one's skill in making the most of resources, which is what follow through mostly involves. I personally throw a lot of curve balls. My stuff doesn't always come directly but it ends up over the plate. Omar

- With Consistency!!!!!!!! Kathy

This Week's Topic on "Recovery Coaching"

What kinds of thing do you do to keep your "Emotional Bank" full so that you have the emotional resources necessary to continue to assist and support your clients?

My emotional bank tends to start to deplete when there are challenging circumstances in my personal life that are causing me to feel distressed, anxious and/or overwhelmed. I find that daily aerobic exercise, deep breathing, mindfulness and meditation, prayer , time off- whether its an extra hour or a whole day, and writing my thoughts on paper are some of the tools I can use keep my " Emotional Bank " from becoming too depleted while I am going thru the difficult circumstance.

Donna

~

All I can say to this one is coffee, soda & chocolate☺

Rachel

~

In addition to trying to eat properly and getting proper sleep (and some exercise as of late), I actually do a combination of things to help keep my emotional bank full:

(1) In the morning I have a routine. I must have some quiet time, usually about ten minutes, where I sit quietly in the same place to gather my thoughts. During this time I don't intentionally think about work or much of anything. I just listen to anything, including thoughts that just come to me (I guess you could say I'm easing into my day).
(2) Once I'm at work and rolling along, I try, and it is often difficult, to take a break after I've met with a challenging or draining client. I find that it is easy to carry over "attitude" to the next person which influences our decisions and quality of interaction, so I try to do something (lunch, sit quietly, talk to Holly) that soothes my mind.
(3) There is one last thing that I'd like to mention which I believe is very important. When dealing with difficult clients, I often remind myself that we can not fix everything. I think about the fact that we are merely humans ourselves, with limitations, weaknesses and flaws of our own. This thought alone, when I am doing all that I can, keeps me emotionally stable

Omar

~

Prayer
Exercise
Meditation
Travel
And More Prayer!!!

Greg

~

This is definitely not one of my strong points, as some of you may know. I am much better at taking care of others than I am myself. I appreciate reading all of your responses as it is giving me ideas on how to pay more attention to myself.

Beverly

~

When my emotional bank starts to deplete, I tend to spend time with just "me". Music, meditation and reading work for me. Another thing that works is organizing my surroundings. When things around me are not organized, my mind is constantly trying to put things in order and I can't focus on the situation at hand.

Sonia

~

When I find myself becoming overwhelmed I usually take the weekend to just loaf around and limit activity. During the course of the week I try to schedule things within each day according to my motivation level rather than take on such a high demand of activity all at once. I also take short breaks and brainstorm with co-workers (Greg) to get outside opinions on how to deal with certain client stressors. I almost always try to find a way to make myself smile even when I don't feel like smiling. If all else fails arrange to take a day off to regroup.

Henry

~

An "empty tank" seems to be my specialty right now!!
As a new mom and new to this position I find that my tank can run very empty at times. To refill, I enjoy taking walks with my family (dog included), reading a magazine, a cup of tea, and watching mindless reality shows on tv. (amazing race specifically) Sometimes the last three happen all at once! At work, I often check in with co-workers (Keva, Holly, you all), take lunch (I get to run home, which despite doing a load of laundry or a few dishes is relaxing) and listening to music (thanks Keva)!

Lisa

~

Eat and keep a full stomach, take vacations, spent time with family as well as communicate to my co worker, Lisa when my bank is full, so that she could help me empty it☺, thanks Lisa

Keva

RSVP/RCM Recovery Coaching - Listening

*Please take a few minutes to reflect on how you **actively listen** within your role as a RS/RCM. Here are a few questions to consider, I'm sure you will come up with more:*

- *How do you know when someone is actively listening to you?*
- *What is it like for you when someone is actively listening to you?*
- *What helps you to listen effectively?*
- *How do you know that you are listening?*
- *What does your body language 'say' to the person (client/co-worker/colleague, etc.) who is speaking?*
- *When you find yourself 'tuning out' and not listening well, what do you do to get back to a place of active listening?*
- *What is it like for you when you are actively listening to another?*
- *Why is active listening an important part of being a Recovery Coach?*

****

Rachel: Actively listening- I am sure to put my cell phone on vibrate, have a note book and pen in hand just in case the client needs phone numbers for resources or often times clients/RCM can benefit from having a visual of organizing thoughts and prioritize them. I also position my body toward the client in order to let the client know that I am paying attention purposely interrupt the client after every couple of statements and repeat what the client said in order to be sure that I understand the clients point. I attempt to re-frame the client's statements in order to help them organize their thoughts and use their words more effectively. Finally, I create a list of priorities and steps they can keep in order to keep them on track and take self initiative in making calls on their own between home-visits.

Sonia: When I meet with a client, I make sure to write and highlight the things that we discussed that are important to the client. Anything that I promised to research or have an answer for, I put an asterisk by it so that when I speak to the client again, it's done. This lets the client know that he/she is important and valued.

When someone is actively listening to me, I feel that what I say matters and is of importance. I know how good this feels to me so I try to do the same for others. As a Recovery Coach I want the person I'm listening to, to feel validated. I want them to know that what they are saying matters. I also like to make sure that what I'm hearing is what they're saying; so I repeat what they have told me to make sure I understand.

Omar: How do you know that you are listening? O: *I know I am listening when my responses (verbal) and posture (body language) flow and respond accurately with what is being said to me at that moment.....and the client and not I, is doing most of the talking.*

Teresa: What does your body language 'say' to the person (client/co-worker/colleague, etc.) who is speaking? Your body language speaks much louder than what actually comes out of your mouth. It is not verbal communication. By watching someone's gestures, movements and facial expression can reveal what someone is saying or not. Your body language can display many emotions..... attentiveness, not interested, happy, bored etc. I don't think you can have a genuine conversation (listening and responding) without some form of body language.

Greg: To engage a client I often use the old school method of answering a question with a question so the client or person I am interacting with have a clear and cut understanding that I hear them and I would also be clear that they hear me. The most prolific listener's always since

RSVP/RCM Recovery Coaching - Listening

the beginning of time, have been HONEST if I know I share the Wisdom and if I don't know I say "I DO NOT KNOW".

Lisa: I believe that active listening is a "learned skill" that can always be improved. When I know that I am actively listening to other, family, friends, co workers, clients, I am attentive (not distracted with objects or other tasks) responding with body language (head movements, facial expressions, body position is open and facing the person speaking), interjecting during pauses with summarization or explorative questions, and being present in the moment.
I feel that being present is the most important because if I am wondering in my mind or doing other tasks I am not give the person the respect and attention that they deserve.
When I find myself wondering in my mind I channel Omar and his ability to stay present with a client through his patience and genuineness. I think to myself "this topic is important to this person and they think that I am worthy to share this with." That always keeps me actively listening.

I think that it is important to actively listen with our clients because sometimes we are the only people that will listen. Many of our clients have burned a lot of bridges in the past and many people in their lives do not listen, so I feel that **we are their listeners**. Active listening can help move a client forward by reflecting back to them what they are saying and help them decipher what direction they want to go.

When someone is actively listening to me, I feel that the person respects and thinks I am worthy of their time and energy. Thanks to all of you for being active listeners.

Recovery Coaching Quotes

"All recovery-focused services hinge on effective engagement: The service ***RELATIONSHIP*** is the foundation of recovery-oriented systems of care and all clinical and non clinical recovery support services. ***Everything we are able to help each client achieve is contingent upon sustaining an empathic relationship.*** Recovery-focused treatment is about ***engagement, engagement, engagement.*** The process of engaging and motivating each client is a continual one, as the strength of our service relationships and each client's motivation for recovery ebbs and flows. ***At a practical level that means that every contact with a client is about re-engagement and re-motivation."*** ~ White, W., et. al.

Last week's recovery question revolved around the question of what role we perceived ourselves as playing in our client's recovery. Below are our responses, which reflect a rich mixture of our individual styles, approaches and experiences. Please be prepared to discuss at our staff meeting tomorrow, any responses that bring up points that you feel are particularly important.

Rachel : I perceive my role as a Recovery Coach the same way I do as a parent when my kids started to take their first steps and I followed closely behind them with my arms reaching out around their parameter, guiding & encouraging them to continue at the same time reassuring them that I was there as a safety net to catch them if they lost their balance & to redirect them when they strayed in a potentially dangerous direction ☺ Rachel

Sonia: After thinking of both the coach's role and the quarterback's role in football, I've decided that my coaching style is more like a quarterback. The quarterbacks role is one of the most visible and important roles on the team. The quarterback is responsible for calling the plays and making decisions during the play. Unlike the coach, quarterbacks are on the field for every offensive play, leaving only if injured or if the game is in the bag. We as RCMs/RS' are in the field and able to see first hand what is going on in our client's lives. We are there to call the plays when needed and stepping out when the outcome is no longer in doubt

Greg: RECOVERY COACH- mapping out a positive plan that is conducive to client where they are at during their time in trying to get back on track; or get back what was lost.

Lisa: Good Afternoon Everyone,
Hope everyone is doing well.
After giving this question some though I feel that as a recovery coach it is my job to be a positive force that highlights client's strengths, is a calming presence in all of the chaos and encourages with words and actions all while being a listening, non judgmental ear.
Have a great Wednesday!!
Lisa

Donna: Recovery Coach- a role that includes teaching, listening, learning, inspiring, cheerleading, assisting and believing. ~D

Henry: Recovery coaching to me is building up drive and motivation within a person. It is showing them that the possibilities are endless once they've taken the first step. It is building a bond of trust and mutual respect for one another and showing that individual that they are not alone with whatever endeavors they face. It is supporting an individual thru the good and the bad times. It is building a persons moral into becoming a better person for themselves. For they are the brick in the road that paves the foundation for those that will need to walk the road to recovery in the future. Those we coach in some way, shape or form will soon become recovery coaches as well for the next struggling individual.

Keva: I see my role of a recovery coach to be as if I am part of a journey, providing encouragement and positive validation for my client's efforts. To also be there to identify and provide them with the necessary tools and perspectives for where or when they take accountability for their actions.

Beverly: I perceive my role as a Recovery Coach as being encouraging, supportive, empathetic and to help a client to see his/her self-worth.

Kathy: Listening to the clients concerns and addressing the barriers they face. Helping the client to steer away from negative behaviors and once their behaviors has turned around tell them how good they are doing. Then encourage them to continue on the right path Kathy

Omar: I perceive my Recovery Coach role as being one of an enlightener. By developing a caring relationship, I am able to assist the client with seeing the whole picture of their situation more clearly. As a result, the client becomes more confident and utilizes strengths and available resources

courant.com/news/opinion/hc-op-casey-1229-20101229,0,5976274.story

Courant.com

The Joy Of Not Drinking

By MAURA J. CASEY

The Hartford Courant

December 29, 2010

Even after all this time, I can still sense the occasional awkwardness when people discover I don't drink, particularly around the holidays. I can see it in their eyes as they start to discuss with me the wine list at a restaurant, only to stop, or when they laugh while relating a boozy escapade and then cut the story short.

I understand their discomfort. They believe this: Maura cannot drink. The statement is correct, but, 25 years after the December night when I last had one too many, the emphasis is all wrong.

It's true that when anyone decides to quit, he or she starts by saying, "I cannot drink." But year after sober year, the statement changes to a living affirmation: I *can* not drink. There's no deprivation involved, and certainly no sympathy necessary.

Indeed, the personal growth needed for sobriety, as opposed to the white-knuckled and resentful abstention of alcohol, is neither negative nor the equivalent of a closed door. Instead, it is a series of yeses.

Yes to savoring a sunset without reaching for anything to enhance its beauty.

Yes to lifting raising a glass of sparkling cider during the wedding toast — or when the clock strikes midnight on New Year's Eve.

Yes to greeting the arrival of a baby or celebrating a graduation without needing or even wanting anything more to accompany unvarnished joy.

It sounds Pollyannaish, I suppose, to those who haven't lived it, but it is possible to enjoy not drinking as much as drinking. Of course, that takes a certain maturity, a quality sorely lacking in media portrayal of alcohol. Instead, that portrayal has a comic-strip feel, as a recent article in The New York Times pointed out; on television, alcohol is either a rollicking good time or "a life destroying scourge." Neither deals with either the complexities or contradictions involved.

What rarely is shown is the simple joy of sobriety. Yet it is as real and as rich as all the well-publicized

extremes.

Few can quit entirely alone, and recovery is famous for relying upon support of others in words and meetings. But overlooked is the silent power of personal example. While still a committed drinker, I became friends with an accomplished journalist. Joanna had it all: a big job at a major daily, a Pulitzer prize and, to my surprise, a refusal to imbibe. "I like life to move at its own pace," is the most she would say, smiling, and I envied her sense of balance. Her example, more powerful than words, helped me stop later on. A year after I stopped, my sister Ellen did, too.

Not drinking has provided unexpected humor, like the time I asked someone to drink for me. At a whiskey taste at Ireland's Shannon Airport, I asked a stranger to sample and evaluate some morning shots so I could buy a bottle for my husband. He gallantly agreed.

Sobriety has given me a season of gratitude. It has made me a better wife, mother and writer. And, yes, it entails doing without sometimes. Fine wines at restaurants never held much attraction, and now I don't have to pay for them. I miss the occasional cold beer, but I am grateful in the knowledge I need never play beer pong, a pointless amusement not yet invented when I finished my last brew. And the airport whiskey? I have to admit, when the bottles were opened and I got a whiff of that still-familiar scent, I salivated

It's OK. By now, I, too, like life to move at its own pace.

Maura Casey is a former New York Times editorial writer who is a free-lance member of the Courant's editorial board. She lives in Franklin.

On becoming a better therapist

BARRY DUNCAN

Most therapists aspire to become better at what they do. However, research has shown that personal therapy has nothing to do with outcome; there are no therapeutic approaches, strategies or interventions shown to be better than any other; professional training and discipline do not matter much to outcome; there is no evidence to show that continuing professional education will improve effectiveness; and, although it defies common sense, experience does not improve outcomes either. So what does 'professional development' mean and how do we accomplish it? In this edited extract from his recent book, *On Becoming a Better Therapist*, BARRY DUNCAN explores how we can remember our original aspirations, continue to develop as therapists, and achieve better results more often with a wider variety of clients.

As unsophisticated as it sounds, most of us got into this business because we wanted to help people, and most of us carry an inextinguishable passion to become better at what we do. Despite our good intentions, unfruitful encounters with clients, combined with the confusing cacophony of 'latest' developments, can weigh on us and steer us into ruts, making us forget why we became therapists in the first place. How can we remember our original aspirations, continue to develop as therapists, and achieve better results more often with a wider variety of clients?

Call me cynical, but the field is not really sure what professional development means or how we can accomplish it. We are often told that to develop ourselves as psychotherapists requires us to become more self-aware through personal therapy. This makes a lot of intuitive sense and to gain an appreciation of what it is like to sit in the client's chair seems invaluable. But a look at probably the best source, *The Psychotherapist's Own Psychotherapy* (Geller, Norcross & Orlinsky, 2005), reveals that the cold hard truth is that while therapists rave about its benefits, personal therapy has nothing to do with outcome.

Our quest for the 'Holy Grail' does not help us either—our search for that special model or technique that will, once and for all, defeat the psychic dragons that terrorize our clients. The 'right approach', be it crafted by 'masters' of the field, or a meticulously researched evidence-based treatment, or the everyday garden variety, doesn't matter much to outcome. Not one approach has ever shown it is better than any other (Duncan, Miller, Wampold & Hubble, 2010).

The famous dodo bird verdict, *"All have won and all must have prizes"*, invoked by Saul Rosenzweig in 1936 to illustrate the equivalence of outcome among approaches, is the most replicated finding in the psychological literature. A recent example is provided by treatments for the diagnosis *du jour*, Post Traumatic Stress Disorder (PTSD). Cognitive Behavioural Therapy (CBT) has been demonstrated to be effective and is widely believed to be the treatment of choice. Benish, Imel and Wampold (2007) have shown via meta-analysis that several approaches with diverse rationales and methods are also effective—eye-movement desensitization and reprocessing, cognitive therapy without exposure, hypnotherapy, psychodynamic therapy, and present-centered therapy. What is remarkable here is the diversity of methods that achieve about the same results. Two of the treatments, cognitive therapy without exposure and present-centered therapy, were designed to exclude any therapeutic actions that might involve exposure (clients were not allowed to discuss their traumas because that invoked imaginal exposure). Despite the presumed extraordinary benefits of exposure for PTSD, the two treatments without it, or in which it was incidental (psychodynamic), were just as effective. This study only confirms that the competition among the more than 250 therapeutic schools remains little more than the competition among aspirin, Advil and Tylenol. All of them relieve pain and work better than no treatment at all.

Although the need and value of training seems obvious, it has long been known that professional training and discipline do not matter much to outcome (Beutler et al., 2004). A

just published study confirms this conclusion. Nyman, Nafziger and Smith (2010) reported that it did not matter to outcome if the client was seen by a licensed doctoral-level counsellor, a pre-doctoral intern, or a practicum student. As for continuing professional education, there is not one solitary study to support that it improves effectiveness in any way.

What about experience? Surely, years of clinical encounters make a difference. But are we getting better, or are we having the same experience year after year? More bad news here—experience just doesn't seem to matter much (Beutler et al., 2004). In large measure, experienced and inexperienced therapists achieve about the same outcomes. Although it defies commonsense, experience does not improve outcomes either.

Finally, regardless of our methods of getting better, we are quite self-delusional about our effectiveness. Consider a study reported by Sapyta, Riemer and Bickman (2005). One hundred and forty-three clinicians were asked to rate their job performance from A+ to F. Two-thirds considered themselves A or better, and 90% considered themselves in the top 25%! Not one therapist rated him or herself as below average. If you know anything about the Bell Curve, you know this cannot be true!

Does this mean that you should forget the whole thing? No. Contrary to my cynical portrayal of the state of the field's efforts to help you get better, an empirically-based method has arisen from the most extensive investigation of therapist development ever conducted.

How psychotherapists develop

In a remarkable study, David Orlinsky and Helge Rønnestad took an in-depth look at therapists' experience of their professional growth (reported in their 2005 book, *How Psychotherapists Develop*). Over a 15-year period, they collected richly detailed reports from 5000 psychotherapists of all career levels, professions, and theoretical orientations from over a dozen countries. From this extensive analysis, *Healing Involvement*, the pinnacle of therapist development was identified.

How can we remember our original aspirations, continue to develop as therapists and achieve better results more often with a wider variety of clients?

Healing Involvement reflects a mode of participation in which therapists experience themselves as personally committed and affirming to patients, engaging at a high level of basic empathic and communication skills, conscious of flow-type feelings during sessions, having a sense of efficacy in general, and dealing constructively with difficulties if problems in treatment arise.

Healing Involvement represents us at our best—those times when our immersion into our client's story is so complete, our attunement so sharp, and the path required for change eminently accessible. So, what causes this and, more importantly, how can we make it happen more often?

Orlinsky and Rønnestad identified three sources of *Healing Involvement*. The first is the therapist's sense of *cumulative career development*—improvement in clinical skills,

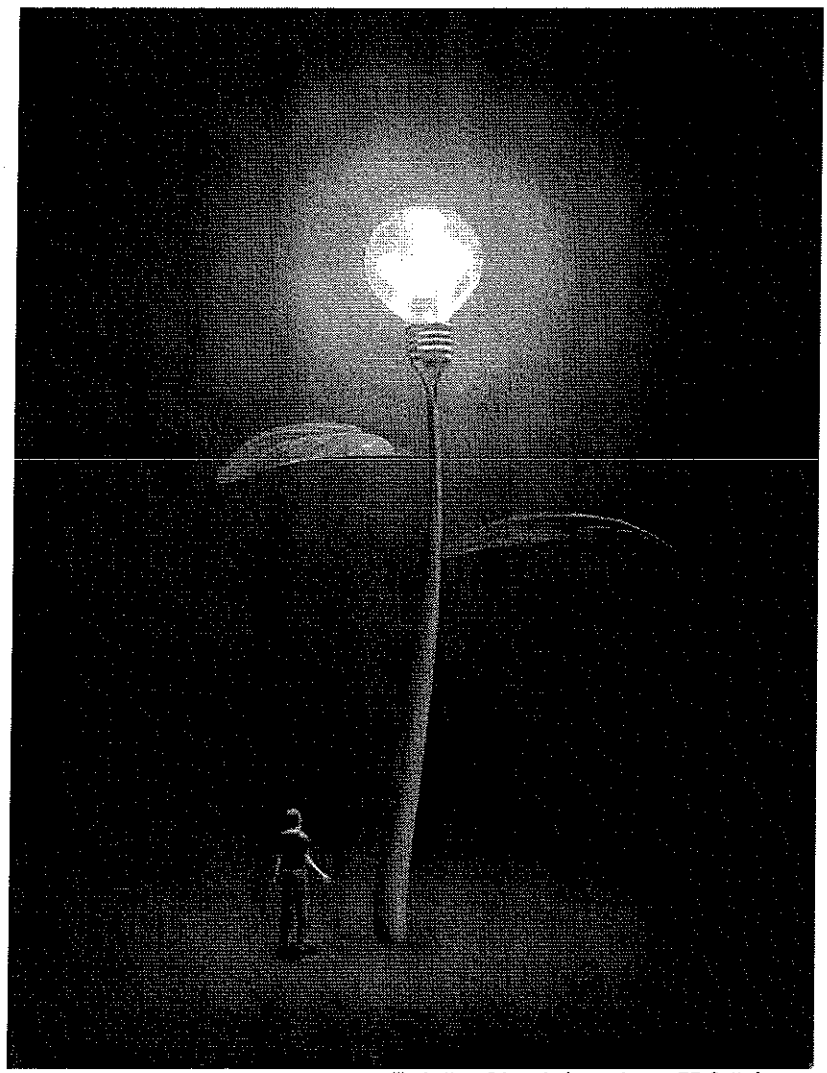


Illustration: © i-works/amanaimagesRF, Getty Images

increased mastery, and gradual surpassing of past limitations. Therapists like to think of themselves as getting better, over time, at what they do. Eighty-six per cent of the therapists, regardless of career level, reported that they were 'highly motivated' to pursue professional development. There is no other profession more committed to getting better at what they do. At a personal level, it is important for the development of each therapist to know they have this commitment.

The second influence is the therapist's sense of *theoretical breadth*. The capacity to understand clients from a variety of conceptual contexts enhances the therapist's flexibility in responding to the challenges of clinical work. Possessing a range of understandings of client problems allows therapists to experience *Healing Involvement* more often with more clients.

The third, and by far most powerful, influence of *Healing Involvement* is the therapist's sense of *currently experienced growth*. Therapists like to think of themselves as developing *now*. Your ongoing experience of professional development is therefore critical to becoming a better therapist. Therapists with the highest levels of current growth showed the highest levels of *Healing Involvement*. The experience of current growth translates to positive work morale and energizes you to continue professional reflection—so that you keep the 'pedal down' on the developmental process. Your sense of current growth keeps you vitally involved in the work itself.

Now the astute reader might be thinking: *"Wait a minute... Isn't Healing Involvement just more therapist self-delusions about how effective they are?"* Yes, it would be if it wwere not for the other person who is critical to psychotherapy outcome—the client. We need their help to ensure our *Healing Involvement* translates to their benefit.

We need our client's help

While I often don't remember where I leave my glasses, I still vividly recall my first client, Tina. I was in my initial clinical placement in graduate school at the Dayton Mental Health and Developmental Center, a euphemism for the state hospital. Tina was like a lot of the clients—young, poor, disenfranchised, heavily medicated, and on the merry-go-round of hospitalizations—and, at the ripe old age of 22, a 'chronic schizophrenic'.

I gathered up the battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long-past-its-prime, barrack-style building that reeked of cleaning fluids over-used to cover up some other worse smell, the 'institutional stench'. On the way, I couldn't help but notice the looks I was getting—a smirk from an orderly, a wink from a nurse, and funny-looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist, a kindly old guy, put his hand on my shoulder and said, *"Barry, you might want to leave the door open"*. And I did.

I greeted Tina, a young, extremely pale woman with short brown, cropped hair, who might have looked a bit like Mia Farrow in the *Rosemary's Baby* era had Tina lived in friendlier circumstances. To begin, I introduced myself in my most professional voice. Before I could sit down and open up my test kit, Tina started to take off her clothes, mumbling something indiscernible. I just stared in disbelief. Tina was undaunted by my dismay and quickly was down to her bra and underwear when I finally broke my silence and said, *"Tina, what are you doing?"*. Tina responded not with words but actions, and removed her bra as if it had suddenly become made of wool and very uncomfortable. So there we were, a graduate student, speechless, in his first professional encounter, and a client sitting nearly naked. Tina was mumbling loudly and incoherently, contemplating whether to stand up to take her underwear off or simply continue her mission while sitting.

In desperation I pleaded, *"Tina, would you please do me a big favor?"*. She looked at me for the first time, and said, *"What?"*. I replied, *"I would really be grateful if you could put your clothes back on and help me get through this assessment. I've done them before, but never with a client, and I am kinda freaked out about it."* Tina whispered, *"Sure,"* and put her clothes back on. Although Tina struggled with the testing and clearly was not enjoying herself, she completed it. I was so appreciative of Tina's help that I told her she really pulled me through my first real assessment. She smiled proudly, and from then on smiled every time she saw me.

Tina started my psychotherapy journey and offered up my first lessons for consideration—authenticity matters and when in doubt or in need of help, ask the client. Asking clients for help, soliciting their feedback about the benefit of therapy allows you to use the empirical evidence about therapist growth without falling prey to the pitfalls of a therapist-centric view of outcome.

Feedback can, by itself, improve your outcomes substantially. Consider a recent investigation of client feedback I conducted with colleagues in Norway (Anker, Duncan & Sparks, 2009). This study, the largest randomized clinical trial (RCT) of couple therapy, found that clients who gave their therapists feedback about the benefit and 'fit' of services on two brief, four item forms, the *Outcome Rating Scale* (ORS) and the *Session Rating Scale* (SRS), reached clinically significant change nearly four times more than non-feedback couples (both measures available free for individual use at www.heartandsoulofchange.com). Moreover, the feedback condition maintained its advantage at the six-month follow-up and achieved a 46% lower separation/divorce rate, leading to the national adoption of the ORS and SRS in Norway.

And this study is not a fluke! The findings with the ORS and SRS have been replicated in two independent RCTs (Reese, Norsworthy & Rowlands, 2009; Reese, Toland, Slone & Norsworthy, in press). Moreover, our feedback system builds on the extensive pioneering research of Michael Lambert who has conducted five RCTs using the Outcome Questionnaire 45.2 (OQ) as the feedback tool. Lambert and colleagues, time and time again, have shown that systematic feedback significantly improves outcomes, and doubles treatment effectiveness for

clients who would otherwise be headed for treatment disaster (Lambert, 2010).

Continuous feedback individualizes psychotherapy based on treatment response, and provides an early warning system to identify 'at-risk' clients thereby preventing drop-outs and negative outcomes. Systematic client feedback also provides the means to accelerate your development.

Track your cumulative career development—getting better all the time?

Therapists like to think of themselves as getting better over time, but the only way to know is to collect outcome data. Routine collection of client feedback about the benefits of therapy that they experience allows you to plot your cumulative career development, so you know about your effectiveness, and importantly, so you can implement and evaluate strategies designed to improve your outcomes

Finding out how effective, or not, you really are can be risky business. You might learn something you might not want to learn. But the only way to get better is through feedback about where you are now versus where you would like to be—to aspire for the best results, and proactively get them. It does take courage, but so did walking into a room for the first time with someone in distress—and so does doing it day in and day out.

Need some encouragement to consider this? In our Norway Feedback Study (Anker et al., 2009), we found that tailoring therapy based on client feedback improved the outcomes of nine of the ten therapists. Feedback seems to act as a 'leveler' among therapists, raising the effectiveness of lower or average therapists to that of their more successful colleagues. In fact, a therapist in the low effectiveness group without feedback became the therapist with the best results with feedback. This heartening finding suggests that regardless of where you start in terms of your effectiveness, you too can be among the most successful therapists if you take charge of your development.

Tracking your career development need not be complicated or expensive You can begin by simply entering scores from the *Outcome Rating Scale* (or any other reliable and valid measure) into an Excel file. Then, track outcome over time with calculations available in Excel: average intake and final session scores; number of sessions; dropout rates; average change score (the difference between average intake and final session scores); and, ultimately, the percent of your clients who reach a reliable or clinically significant change—a statistical metric defined by your chosen measure (on the ORS, a reliable change is 5 points and a clinically significant change is a 5 point change that also crosses the clinical cutoff of 25). The percent of your clients who benefit is your benchmark—the number you are trying to increase by taking action about your development.

Simply plot your effectiveness by each block of 30 or more clients. These calculations provide a detailed snapshot of your growth over time. You will see whether your efforts are paying off, and if your chosen methods to increase your benefit to clients needs to be tweaked or changed outright. Excel does most of the calculations for you and there is also software (ASIST; visit http://www clientvoiceinnovations. com/) and web options (http://www. MyOutcomes.com) available that make it easy. They do involve some cost (and ethically I am bound to inform you that I benefit financially from both of these options)

Once you know your baseline effectiveness level, you are 'ready to rock'. It is fine to put time into learning models and techniques, but it may make sense to invest your efforts in areas that will bring you the biggest return. What are those areas? One way to understand this is to look at the variation among therapists—we all know that some therapists are better than others. Who the therapist is exerts a powerful influence on outcome, second only to client factors—therapist effects account for six to nine times more impact on therapeutic change than model and technique. A recent investigation of the therapists in the famous *Treatment of Depression Collaborative Research Program* highlights this point (Kim, Wampold & Bolt, 2006) Clients who received sugar pills from the top third most effective psychiatrists achieved better outcomes than clients prescribed antidepressants from the bottom third, least effective psychiatrists. Who delivered the treatment mattered more than what they were delivering, even with drugs!

... therapist effects account for six to nine times more impact on therapeutic change than model and technique.

What accounts for the variability among therapists? There is one good possibility and one no-brainer that separate the best from the rest. In a clever investigation that conducted minute-by-minute analysis of therapist-client interactions, Gassman and Grawe (2006) found that unsuccessful therapists focused on problems and neglected client strengths, while successful therapists focused on their clients' resources from the start. As for the no-brainer, research consistently shows that the alliance accounts for the lion share of therapist variability Therapists who form better alliances across clients, not just the 'easy ones', have better outcomes. These two areas, what Gassman and Grawe called *'resource activation'*, and securing strong alliances with more clients represent the best ways to accelerate your development. Remember, though, whatever recipe you chose to improve your outcomes, 'the proof of the pudding is in the eating'

Heroic stories

Resource activation does not mean ignoring pain, being a cheerleader, or glossing over tough issues. Rather, it requires that you listen to the whole story—what I like to call the 'heroic' story. Human beings are complex and have multiple sides, depending on who is recounting them and what sides are emphasized The folklore of our field has drawn us toward the more

pathological account as the only or best version. It is neither.

Consider these comments from Sam, a very distressed young man:

"I've been in a lot more physical pain lately... No one wants to be around me because of my mental illness... My desire to self injure has been higher... My financial situation is out of control. ..My dreams have been increasingly violent toward my stepfather, his mental torture is constant, telling me that I am never going to amount to anything. .and that I am worthless and do everything wrong. It's hard to argue with him because here I am, I amounted to nothing, he's right ..And I fantasize about it every day, different ways of just crushing him And I feel just hopeless. .and half the time I am fighting to survive and half the time I am wondering if I should just stop fighting... Part of me hopes that the whole system will collapse, that society itself will just fold. I am depressed now and the rest of the world is normal. Take an event that would depress anyone And then being depressed would be normal so in a way the whole world would come to my level of depression so I wouldn't be abnormal."

There are stories of self harm and suicidal ideation, of homicidal ideation, and apocalyptic fantasies. Are these accounts the only or truest ones of Sam's identity as a human being? As you read the excerpts below, consider the following questions:

- what are the obvious and hidden strengths, resources and resiliencies?
- what are the competing stories of Sam's identity?
- what is present that can be recruited to solve the problems?

Sam: *"I am one of those leeches on society I am a negative person. I take away. I think that is one of the reasons why I want to see it all come apart."*

Barry: *"Well, no wonder. It would be like a new beginning if everything came apart—you would have a fighting chance to have a different kind of life. Right now you don't see any hope for a different kind of life to be possible."*

Sam: *"Right, I feel I could contribute to a society that had decayed to the point where it would need my contribution. I just feel I would be really good in a situation like that. I could lead a small rag tag band of warriors to lead attacks on the machines or bad guys."*

Barry: *"So it's like there is this inner warrior that wants to come out, you'd be able to take charge of that situation, to contribute in that situation."*

Sam: *"I feel like I would be a good leader."*

Barry: *"What keeps you from killing your stepfather?"*

Sam: *"The only things keeping him alive are my fear of getting caught and my own personal realization that I am not sure killing him would make me feel any better. I am so full of rage when it comes to him. He screwed up all our lives Everything he touches is destroyed. I almost feel like it's my responsibility to take him out of the world so he can't do any more harm. But then I would have to do harm to do that and I can't do that because it's against my religion."*

Barry: *"A couple of things occur to me. One is that it's really not surprising that you are struggling now, there are a lot of low spots in your life, a lot of shit has happened in the past, a lot of animosity directed at your stepfather, a lot of bad things have happened to you, to wake up every day and feel like you are a leech on society, your identity, this inner warrior never able to be expressed, all this stigma that goes along with the mental disability, the physical pain, being in a financial hole, there is a lot of stuff conspiring to make you feel very bad about yourself. On the other hand, while I believe that's true, simultaneously not only do you have this inner warrior aspect of you, that leadership, knowing that there is a lot more to you that this society at this time allows you to express, there are also all these other things about you that are very impressive. You are really a savvy guy, you're smart, you have a dry sense of humor, we didn't laugh much but you said a lot of things that were funny. And you have a little bit of a twisted way of looking at things and that's very funny and I think that's a real strength you have. You know a lot of stuff about a lot of things—you're bringing a lot to the table, not the least of which is your insight about your stepfather and your ability to control yourself."*

Many stories have emerged. While the story of Sam's problems—suicidal/homicidal ideation, depression and self-loathing—was real, this story was not the only one and not the most representative of his identity. There was another tale of a remarkably reflective man who wants to contribute to society, a leader, an inner warrior who controls his impulses. Clients' heroic stories pave the way for change by showcasing abilities and making them available for use.

Consider Sam's concluding statements:

Sam: *"Somehow I'll find a way to give back to society It may not be today or tomorrow but someday, because I am pretty young and have a lot of time to figure out how I can make society better and it doesn't have to be the end of the world."*

Several therapies that focus on resource activation or are 'strength based' offer a plethora of ways to inquire about, recruit, harvest and enlist client competencies; solution focused, narrative, client-directed, positive psychology, to mention a few. Find ways that fit your own therapeutic style to help you 'activate' client resources. For example, a question that comes from a narrative tradition and is a good fit for me is, *"Who in your life wouldn't be surprised to see you overcome the problem before you now?"*.

Consider Yolanda, a young woman I saw the day after child protective services (CPS) removed her children because Yolanda started using 'crack' again. CPS was not the bad guy here—there was a contract and Yolanda violated it when she started using again. One story about Yolanda was that she was the crack-addicted mother who had her kids removed by CPS. A strength-based approach suggests this is not the only story that can be told, and is not the one that best reflects who Yolanda really is and what she brings to the table

At our first meeting, Yolanda was devastated—teary, lethargic and she had an understandable 'edge'. Far worse was that she barely said anything and didn't even look at me. Here were two people who couldn't have been more different from one another—Yolanda was an impoverished 21 year-old African American woman whose world was just split wide open, and me, an old middle class white guy without a care in the world, relatively speaking. So I asked a question to see if I could get to Yolanda's resources.

Barry: *"Yolanda, who in your life wouldn't be surprised to see you stand up to this situation, stop using crack and do*

what CPS wants so you can get visitation of your kids back?"
Yolanda: (Long pause) *"Well, my Uncle Charlie wouldn't be surprised."*
Barry: *"If Uncle Charlie was here, what story would he tell that would inspire in me the same confidence he has in you?"*
Yolanda: *"Uncle Charlie liked to tell the story of when I used to visit him over the summer with all my other cousins. One summer when I was six or seven, my cousins and I ran further into the forest than we had ever gone before. We were running full blast over a ravine and I stepped in quicksand and pretty quickly sank to my waist and was slowly sinking. We were way out in the woods and my cousins ran all the way back to get my uncle who rushed to get me, which seemed to me to be about forever later. Thinking that I would already be dead, Uncle Charlie was so relieved to see me that he cried for joy—by that time I had sunk up to my neck. He never stopped talking about when he found me. I was calm and collected and just as still as I could be—somehow I instinctively knew not to struggle or make a move. He always told me and everybody else what a trooper I was. Uncle Charlie would not be surprised by my ability to deal with this stuff. He always told me if I could deal with that situation as a kid, I would be able to deal with anything in my life."*

Uncle Charlie was right. There were many other stories about Yolanda that could better capture her humanity and showcase her resources. For instance, when she stood up, under great peril, to her crack-dealing, abusive partner, and left him and the crack house behind. Despite his continued stalking and threat of violence, Yolanda acted to protect her children. In addition, under all this duress, she chose to quit crack—and did so for 17 months until a combination of events persuaded Yolanda to relapse. So there was a crack-addicted mother who lost her kids, and there was the heroic mother who stood up to abuse to protect her children, and had made good choices for 17 months regarding her crack use. With these resources and resiliencies to work with, and Yolanda now engaged in the beautiful thing we call therapy, my job was easy. Yolanda started going to NA again, worked with CPS and me to complete their requirements, and started supervised visitation that ultimately led to regained custody of her children.

Reliance on the alliance

Although much ignored, it is a fact that the alliance is our most powerful ally and represents the most influence we can have over outcome—and is also the quickest way to accelerate our development. Do not give the alliance short shrift! I know this is challenging—the alliance is not sexy in comparison to 'the miracle cure'. But the alliance is not the anesthesia before surgery—it's not the stuff you do until you get to the real therapy. We do not offer Rogerian reflections to lull clients into complacency so we can stick the real intervention to them!

...your client's perception of empathy is more powerful than any technique you can ever wield.

The alliance is probably best conceptualized as an all-encompassing framework for psychotherapy—it transcends any specific therapist behaviour and is a property of all aspects of providing services (Hatcher & Barends, 2006). The alliance is evident in anything and everything you do to engage the client in purposive work, from offering an explanation or technique to scheduling the next appointment.

You have to *earn* the alliance—it's not given to you, you have to put yourself out there with every person, every interaction, and every session. It is a daunting task—don't underestimate it.

Let's put the alliance in perspective. The alliance accounts for five to seven times the amount of variance of outcome attributed to model and technique. Although there is a lot of talk about what distinguishes therapists, the most definitive thing we know about what makes some therapists better than others is their ability to secure a good alliance across a variety of client presentations and personalities (Baldwin, Wampold & Imel, 2009). There are over 1000 process-outcome findings that support the association between a strong alliance and positive outcome (Orlinsky, Rønnestad & Willutzki, 2004). Despite this, however, naysayers will dismiss the alliance by saying the research is only correlational. Even more damning, they say we don't know which comes first, client experience of a strong alliance or client report of change or benefit—the classic chicken or the egg question. Our recent alliance study of 500 clients (Anker, Owen, Duncan & Sparks, 2010) directly addressed this question. The alliance significantly predicted outcome over and above early benefit, demonstrating that the alliance is not merely an artifact of client improvement, but rather a force for change in itself.

Embrace it and put it high on your developmental priority list. Monitor your alliance with clients, expand your repertoire of relational skills, and track your cumulative career development to see if it matters. I think it will. The alliance is your craft. Practice well the skills of your craft. At some point, your craftsmanship elevates to art. Investigate multiple ways to practice your alliance skills and consider your growth as a therapist to be parallel to the development of your relational repertoire.

There are many ways to understand alliance skills as well as many available systems to improve your relational abilities, from classic Rogerian to addressing alliance ruptures, to specific models that are attentive to relational aspects, such as motivational interviewing. One way to think of your relational responses, as an overall backdrop, is the concept of *validation*. Validation reflects a genuine acceptance of the client at 'face value' and includes an empathic search for justification of the client's experience in the context of trying circumstances—that they have good reason to feel, think and behave the way they do. Validation helps them breathe a sigh of relief and know that blame is not a part of our game—we are on their team.

Validation combines two robustly empirically demonstrated aspects of the relationship—empathy and unconditional positive regard. A review of the research (Norcross, 2010) in the second edition of *The Heart and Soul of Change* (Duncan et al , 2010) confirms what you already know. Regarding empathy, a meta-analysis of 47 studies found an effect size (ES) of .32. To put this in perspective, the ES of model and technique differences is only .20. So your client's perception of empathy is more powerful than any technique you can ever wield. With respect to positive regard, when clients rate outcome, 88% of studies find a significant relationship between client experience of positive regard and a successful conclusion of therapy. Carl Rogers was on to something!

Consider Sam again. After hearing all the things troubling him and his desire to see the end of world, these were my first comments:

"Makes a lot of sense. Another way of saying that would be that anyone experiencing what you are—if they were in pain, just came out of surgery, were in a financial hole they couldn't get out of, and didn't have anything going socially, anybody on the planet would be depressed, anybody walking in your shoes would be depressed, and anybody would be struggling with whether or not they wanted to live." That's a long way to say, *"No wonder you are depressed"*.

These comments replaced the self-invalidations (*"I'm a leech, a negative person, etc"*), and the invalidations of others (bizarre thinking, etc). When clients feel validation, different conclusions can be reached and alternative actions can emerge. Sam sighed and relaxed, knowing I was in his corner and the next exchange further clarified why he wanted an apocalypse as well as his recognition of his leadership ability.

Securing a good alliance also entails agreement about the goals and the tasks of therapy—what you are going to work on and how you are going to do it. In an important way, the alliance is dependent on the delivery of some particular treatment—a framework for understanding and solving the problem. There can be no alliance without treatment. On the other hand, technique is only as effective as its delivery system—the client-therapist relationship. If technique fails to engage the client in purposive work, it is not working properly and a change is needed.

Here is where the variety of models and techniques pays off. While there is no differential efficacy among approaches in general, there is differential efficacy among approaches with the client in your office *now*. The question is: does the approach resonate or not? Does its application help or hinder the alliance? Is it something that both you and the client can get behind?

Your alliance skills are truly at play here—your interpersonal ability to explore the client's ideas, discuss options, collaboratively form a plan, and negotiate any changes when benefit to the client is not forthcoming. Technique, its selection and application, in other words, are instances of the alliance in action. This process of exploration can also help you expand your theoretical breadth.

Theoretical breadth—what the eclectic/integrationists have been telling us all along

Another important influence on *Healing Involvement* is your *theoretical breadth*. Therapist allegiance to any particular theoretical content involves a trade-off that enables and restricts options. Theoretical loyalty provides a clear direction but is inherently limiting—'cookie cutter therapy' is safer to do, but is only useful for a portion of the people you see.

We probably, at most, can hold only two or three systems of therapy in our heads at one time. However, we can use far more successfully if we open ourselves to Jerome Frank's classic observation that what is important about a model is not their inherent truth across clients, but rather a rationale for the client's problem and a ritual to solve it. Knowing all models can be 'boiled down to' an explanation and remedy makes them easier to get a handle on and try out. This is in contrast to the arduous requirement of two years of intensive supervision often portrayed as necessary in order to understand or implement an 'approach' (but you might want to keep that to yourself)

So how do we broaden our theoretical horizons? First, pay attention to those theories that make sense to you—that fit your own views of human nature, problems and solutions. Expand what you already know. Add explanations and methods from approaches that are similar to the one you already practice e.g., if you are solution-focused then it is likely narrative ideas would be an easy stretch of your skills

Next, listen to your client's ideas and throw your self-consciousness to the side—let the client's theory be your theory with *that* client (Duncan, Solovey & Rusk, 1992). Tailoring your approach to your client's ideas provides opportunities to expand your theoretical breadth. This may not be easy to do if the client's ideas rub you up the wrong way. For example, at one time, I was biased against any historical expedition into client's lives. I was rigid in my thinking and, while I didn't know it, I'm sure I lost plenty of clients as a result. Until one day a young woman, Claire, told me that she had been sexually abused as a child and that she wanted to pursue therapy based on a *Courage to Heal* framework, a popular approach back in the eighties. I bristled immediately and offered to refer her to therapists who I knew did 'that kind of work'.

But Claire didn't take my refusal. She told me that a close friend of hers had seen me, and she was convinced I was the person for the job. Claire asked, *"Couldn't you at least look at the book and give it a try?"*. Essentially, she shamed me into stepping outside of my comfort zone, and it was incredibly rewarding. We followed the workbook, I shared my concerns along the way, and Claire benefited greatly from the work—her own idea of how she could be helped. Her toughest task was to get me on board. The *'Courage to Heal'* approach provided a rationale for Claire's experience of problems, and a remedy to address them. Claire helped me to learn that theory only has value in the particular assumptive world of the participants—the client and therapist—and that theory need not be 'true' across clients; rather, any theory needs only to be valid with *this* client in my office *now*.

Finally, be proactive in adding theoretical dimensions to your work. Become familiar with many ways of understanding problems and solutions Play 'on the other hand' games with your colleagues in supervision and client conferences. When someone presents an explanation about a client difficulty, encourage everyone to present alternative myths and rituals. You can then turn the discussion toward the description that represents the better fit with the client. Talking with your colleagues about varied rationales and remedies will benefit everyone's work. It is also fun and allows an appreciation that models offer only metaphorical accounts of how people can change, not the truth with a capital 'T' or what clients must do to change.

Currently experienced growth—what have you done for me lately?

Critical to therapists' perceptions of their development is their currently experienced growth. Therapists like to think of themselves as developing now, but where does this sense of growth come from? According to Orlinsky and Rønnestad, the most widely endorsed influence was practical learning through therapists' experiences with clients. Not workshops and books trumpeting the latest and greatest Rather, almost 97% of therapists reported that learning from clients was a significant influence on their development. In truth, beyond cliché, therapists do believe that clients are the best teachers.

How do we put those hard earned lessons to work for us and our outcomes? It starts with separating your current clients into two piles—those who are benefiting and those who are not. Reflect on your clients who are changing and how you are contributing; also consider your clients who are not improving and how you are therapeutically handling these tough circumstances—we can do our best work in these challenging situations. The idea is to proactively consider the lessons clients are teaching us, and to reflect on their importance to our development as well as our identity as therapists. Your reflections and discussions with colleagues and supervisors, as well as clients, will permit you to squeeze all the learning out of each situation.

Note any changes or new behaviours with clients, then put a magnifying glass on them, and strive to understand how you were able to 'pull it off'. Recognize that these instances depict a new chapter in your development as a therapist. Perhaps you did something for the first time with a client, or a light went on and you now understand something in a different way. When you articulate what is different about your work, you make it more real, and are more likely to continue it in the future and have it impact your outcomes. The Norwegian therapist who became the most effective in our study noted several things that feedback brought to her work, as well as what she had learned from her experiences with clients—the value of clarity and focus, of shared responsibility, purpose and true collaboration, and importantly, she gained a sense of security and the courage to take risks.

Don't take it lightly when you do something different. Talk to your colleagues and reflect upon your actions in terms of your development and identity.

You do what?

I used to avoid the question of what I did for a living like the plague. I didn't like saying I was a psychologist or a therapist and hearing remarks like, *"Are you going to psychoanalyse me?"*, or other harmless looks or comments people give or say 'off the cuff'. I didn't like it because I didn't have an authentic way to describe what I did that captured what being a therapist meant to me. I knew the medical model didn't do it for me—I never saw clients as patients with illnesses who require treatment from an expert administering powerful interventions. I wasn't sure until I tried to articulate answers to these questions: What is your identity as a therapist? How do you describe what you do? At your very best, what role do you play with your clients? What recent work with a client represents the essence of your identity, illustrating what you embrace most about what you do (Duncan & Sparks, 2010)?

As we develop as therapists, it is useful to contemplate both our identity and how we describe what we do—to define, edit, refine, expand, or outright change it altogether. This helps to keep our growth clearly in focus and enables us to compare our current descriptions to earlier accounts. Our belief in what we do, or what researchers call our *'allegiance'* to our chosen ideas and practices, is a powerful mediator of positive outcome. Given the impact of our expectations and beliefs, it makes sense to describe our work in ways we can believe in and that do not restrict our flexibility. Anything that keeps our development on the front burner will help us stay vitally involved in the work—which is what it takes to get better.

The treasure chest

The *'Treasure Chest'* started out as a file into which I put clients' unsolicited communications about the work I did with them—their feedback, usually well after therapy had ended. Over time, the Treasure Chest offered a way to buffer burn out, a momentary sanctuary from the downsides of the work, when the requirements of the system bring you down, or when you see several clients in a row that aren't benefiting much, or when a client story hits home in a particularly painful way. It's the place to escape tough times and reconnect to the work, to why you became a therapist in the first place.

Consider Adam, a young man who spent his eighteenth birthday in prison for gang violence, but was released soon after as part of an early parole program. He was mandated to therapy and I saw him as a favour to the probation officer who had been a student of mine. Adam was a long time member of the skinheads. I wasn't sure I could work with Adam, not because of his record or gang status or because he was a scary looking dude, but rather because he was openly racist and regularly spewed hate-filled comments. In amazing ways I had never heard, Adam strung together obscenities and slurs with an alarming passion—about me (I was a lackey for the other side), the probation officer (an African American woman), and about everyone else who wasn't dedicated to white supremacy. But somehow,

therapy worked its magic with Adam and me. Over time, Adam's intellect and compassion pulled him out of the indoctrination of hate that had dominated his life. He became curious about my attitudes about African Americans, Jews and Hispanics when he learned that I grew up not far from where he did—a serendipitous shot in the arm for our work. Our conversations deepened and ultimately challenged the lies embedded in hate and prejudice. Adam, an introspective man, took these discussions to heart, and began to let go of his racist background and understand how poverty and despair set the context for his beliefs. He moved out of the neighborhood where the spectre of gang life was inescapable, and moved on in other ways as well.

About six months after I had written a letter in support of Adam's enlistment in the Army, I received this:

"Hi Barry,

I wanted to write you and let you know what was happening and to say thanks. As you know I fulfilled the obligations of my parole and joined the Army (Thanks for the letter!). I just made corporal and things are going well for me. I am told that I am sergeant material and I intend to take college courses when I get stationed after infantry training. But what I really wanted to tell you about was my barracks.

The Army has lots of different kinds of people. In fact, I am the minority here. Most of the guys in my unit are black or Hispanic. And that's the thing I wanted to tell you. I see their uniform first before I notice whether they are white or not. I see them as my team and I will watch their backs like I know they will watch mine. My best friend in my unit is a Mexican-American guy from Texas. We have had some great discussions about racism and he came from a real poor background, probably even worse than me. He has gone through some real hard times with white people.

So, thanks Barry. Thanks for not giving up on me, for putting up with my bullshit, and for seeing that I was capable of something different."

These unsolicited notes, letters, and cards have sustained me in tough moments as a therapist. Over the years, I added another dimension to my Treasure Chest file, my reflections about the clients who taught me the most about being a psychotherapist, a narrative account of my development as a therapist told through my experiences with clients. Tina was one of those stories. Some have appeared in previous issues of *Psychotherapy in Australia*.

The pre-requisite to accelerating your development is your understanding that you are a primary figure in each client's ultimate outcome—the client is certainly central, but as the old saying goes, 'it takes two to tango' Your view of your growth impacts your ability to be involved deeply in the therapeutic process. The first step is to track your cumulative career development and take it on as a project. Proactively monitor your effectiveness in service of implementing strategies to improve your outcomes. Practice the skills of your craft and monitor your results. Next, deliberately expand your theoretical repertoire and loosen your grip on the inherent truth value of any given approach. Plurality of perspective serves you and your clients. Most importantly, pay close attention to your currently experienced growth. Take a step back, review your current clients and consider the lessons you are learning. Empower yourself, like you would your clients, to enable the lessons to take hold and add meaning to your development as a therapist. Articulate how client lessons have changed you and your work, and what it means both to your identity as a helper and to how you describe what it is that you do. Continuing that theme, reflect on your identity and construct a story of your work that captures what you do as a helper. Continue to edit and refine your identity and accounts of what constitutes the essence of your work—evolve a description you can have allegiance to but that doesn't lead to dead ends. Finally, to keep your development in the viewfinder, collect client notes, cards, and letters about your work with them as well as client stories that mark significant events in your growth as a psychotherapist—the *Treasure Chest*. Helping you re-remember why you became a therapist, opening this file enables an escape from the pressures and disappointments of the daily grind of being a therapist. Chronicle your development as a therapist through narrative accounts of the clients who taught you the most.

If you got into this business, like me and the majority of therapists I meet, because you wanted to help people, you already have what it takes to become a better therapist. It boils down to two things. The first is your commitment to forming partnerships with clients to monitor the outcome of the services you provide. The second is your investment in yourself, your own growth and development. Systematic client feedback provides the method for both. Your love of the work provides the rest.

References

Anker, M., Duncan, B., & Sparks, J. (2009). Using client feedback to improve couples therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*(4), 693–704.

Anker, M., Owen, J., Duncan, B., & Sparks, J. (in press). The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. *Journal of Consulting and Clinical Psychology.*

Benish, S., Imel, Z. E. & Wampold, B. E. (2007). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*, 746–759.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., et al. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). New York: Wiley.

Clement, P. W. (1994). Quantitative evaluation of more than 26 years of private practice. *Professional Psychology: Research and Practice, 25*(2), 173–176.

Duncan, B. L. (2010). *On becoming a better therapist*. Washington, DC: American Psychological Association.

Duncan, B., Miller, S., & Wampold, B., & Hubble, M. (Eds.) (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington DC: American Psychological Association.

Duncan, B., Solovey, A., & Rusk, G. (1992). *Changing the rules: A client-directed approach*. New York, NY: Guilford.

Duncan, B., & Sparks, J. (2010). *Heroic clients, heroic agencies: Partners for change* (2nd ed.). Ft. Lauderdale, FL: HSCP Press. www.heartandsoulofchange.com

Gassman, D. & Grawe, K. (2006). General change mechanisms: The relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. *Clinical Psychology and Psychotherapy, 13* 1–11.

Geller, J., Norcross, J. & Orlinksky D. (Eds.). (2005). *The psychotherapist's own psychotherapy: client and clinician perspectives*. New York, NY: Oxford University Press.

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43,* 292–299.

Kim, D. M., Wampold, B. E. & Bolt, D. M (2006). Therapist effects in psychotherapy: A random effects modeling of the NIMH TDCRP data. *Psychotherapy Research, 16,* 161–172

Lambert, M (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York, NY: Wiley.

Lambert, M. (2010). Yes, it is time for clinicians to routinely monitor treatment outcome. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A Hubble (Eds.), *The heart and soul of change. Delivering what works* (2nd ed., pp. 239–268). Washington, DC: American Psychological Association.

Norcross, J. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E Wampold, & M. A Hubble (Eds.), *The heart and soul of change. Delivering what works* (2nd ed., pp. 113–142). Washington, DC: American Psychological Association.

Nyman, S., Nafziger, M., & Smith, T. (2010). Client outcomes across counselor training level within a multitiered supervision model. *Journal of Counseling and Development, 88*(2), 204–209.

Orlinsky, D. E., Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of process -outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 307–390). New York, NY: Wiley.

Reese, R., Norsworthy, L. & Rowlands, S. (2009). Does a continuous feedback model improve psychotherapy outcomes? *Psychotherapy: Theory, Research, Practice, Training, 46,* 418–431.

Reese, R. J., Toland, M T., Slone, N. C., & Norsworthy, L. A. (in press). Effect of client feedback on couple psychotherapy outcomes. *Psychotherapy: Theory, Research, Practice, Training*

Sapyta, J., Riemer, M., & Bickman, L. (2005). Feedback to clinicians: Theory, research, and practice. *Journal of Clinical Psychology, 61*(2), 145–153.

Acknowledgments

AUTHOR NOTES

BARRY DUNCAN PsyD, is a therapist, trainer and researcher with over 17,000 hours of clinical experience. He is the director of the Heart and Soul of Change Project, a practice-driven training and research initiative that focuses on what works in therapy, and more important, on how to deliver it on the front lines via client-based outcome feedback. Dr. Duncan has over 100 publications as well as 15 books to his credit, including *The Heroic Client, Brief Intervention for School Problems,* and the second edition of *The Heart and Soul of Change*. He is the co-developer of the *Outcome Rating Scale* (ORS), *Session Rating Scale* (SRS), Child ORS, and Child SRS, measures designed to give clients the voice they deserve, as well as provide clients, clinicians, administrators, and payers with feedback about the client's response to services, thus enabling more effective care tailored to client preferences.

Comments: barrylduncan@comcast.net

Working with Victims of Domestic Violence

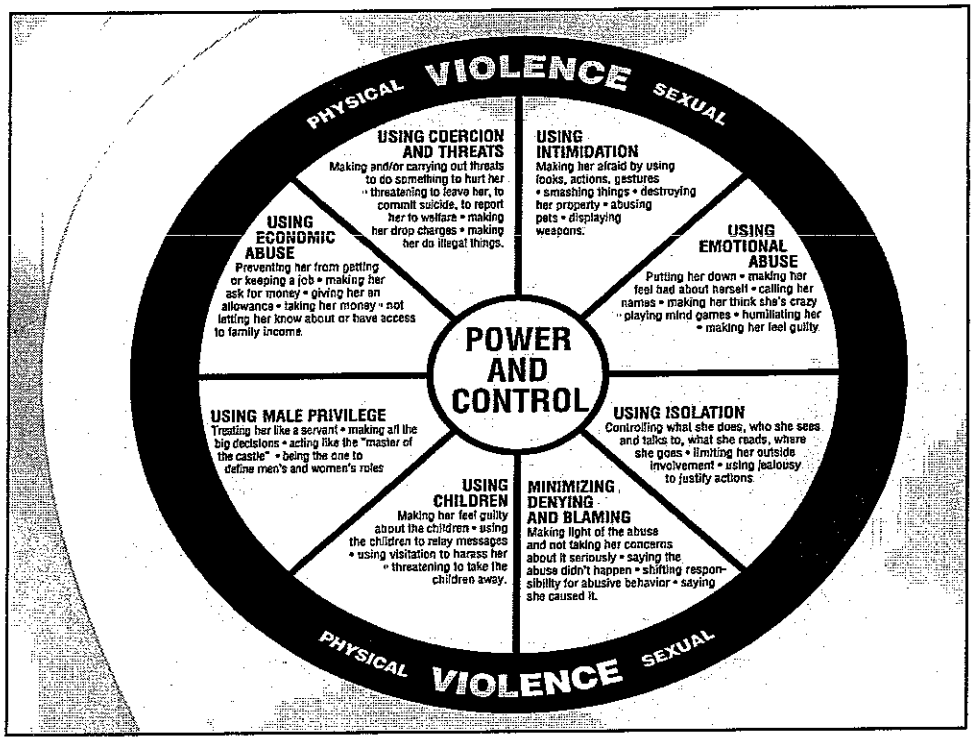
Victoria Nitcher-Sherman, LMFT
Advanced Behavioral Health, Inc.
November 6, 2007

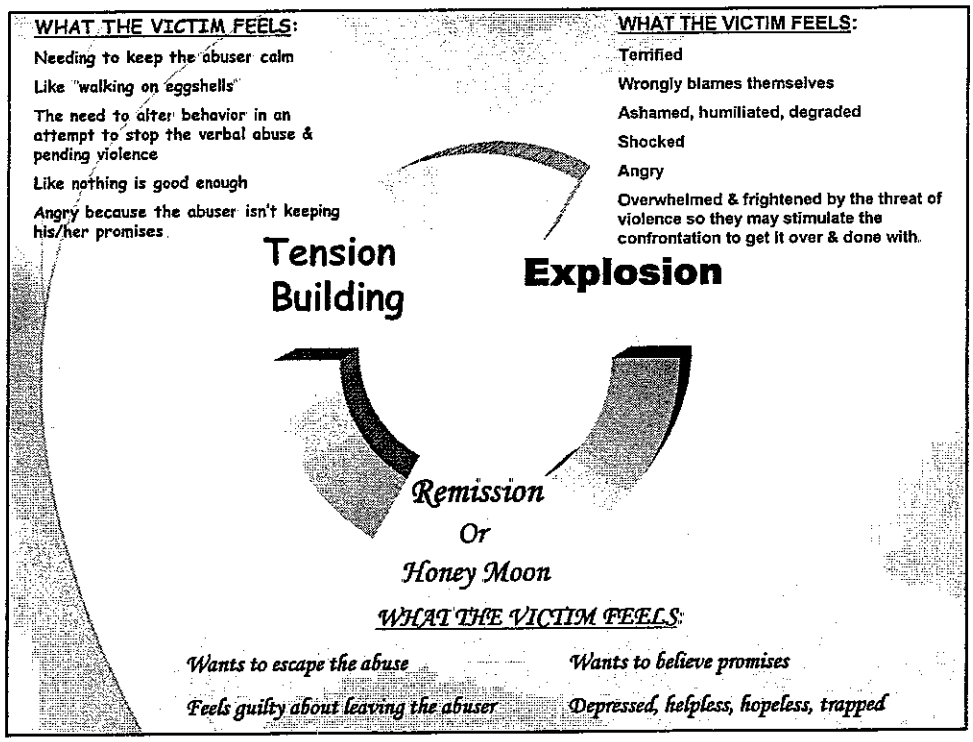
Domestic Violence is. . .

Domestic violence is defined as *a pattern* of behaviors involving physical, sexual, economic and emotional abuse, alone or in combination, by an intimate partner often for *the purpose of establishing and maintaining power and control* over the other partner

Statistics

- Domestic Violence affects 1 in 4 women in their lifetime
- Repeat victimization occurs at a rate of 44% (Dodd et al, July 2004)
- Reported Domestic Violence Cases: (1)
  - Females attacked by male perpetrators - 81%
  - Males attacked by female perpetrators - 8%
  - Males attacked by male perpetrators - 7%
  - Females attacked by female perpetrators - 4%
- 2001/02 - 46% of all female homicide victims were killed by current or former partners, which equates to over 2 women a week. 2
- Women are at greatest risk of homicide at the point of separation or after leaving a violent partner. (Lees, 2000)





Effects on Children

- ☹Anxiety
- ☹Depression
- ☹Difficulty Sleeping
- ☹Nightmares or flashbacks
- ☹Easily Startled
- ☹Psychosomatic Symptoms
- ☹Act out the role of
  - ☹Victim or Victimizer
- ☹Low Self-Esteem
- ☹Truancy
- ☹Regression
  - ☹Begin wetting bed
  - ☹Temper Tantrums
  - ☹Acting much younger
- ☹Problems at School
- ☹Use of ETOH or Drugs
- ☹Eating Disorders
- ☹Ambivalent feelings for
  - ☹ Abusing Parent
  - ☹ Non-abusing Parent

The Connection between Substance Abuse and Family Violence

- Members of families where one or both parents abuse substances are at high risk for physically abusing and neglecting their children.
- Persons who have experienced family violence are at greater risk for alcohol and drug use as a coping mechanism than those who have not.
- Adults who were abused as children may use substances to deaden the pain of past memories.
- Men who assault their partners often use alcohol or other drugs prior to the assault.

Continued

- Perpetrators may abuse substances to diminish their feelings of guilt or shame or to assist in denial of their acts.
- Women abused in the past, or currently living with an abusive partner, may use alcohol or other drugs to deal with the pain, anxiety and fear of the situation.
- Research suggests that adolescents who run away from violent homes are at risk of further victimization and substance abuse.
- Adolescents who have been abused or who have witnessed abuse may resort to alcohol or other drug use as a coping mechanism

Colin Campbell and Julie Devon Dodd

"Why Doesn't She Leave"

- ✓ Still cares for the partner
- ✓ Hopes he will change
- ✓ Feeling ashamed and believes it is her fault
- ✓ Low Self-Esteem
- ✓ Too Exhausted
- ✓ Lack of Supports
- ✓ Economic Reasons
- ✓ Isolation from friends and family

"Why Doesn't He Stop"

- Not only are women at their highest risk of death when they leave, but leaving doesn't guarantee the violence will stop, especially if there are children.
- In a recent study, 76% of separated women reported post-separation violence (Humphreys & Thiara, 2002)
  - 76% subjected to continued verbal & emotional abuse
  - 41% subjected to serious threats toward self & children
  - 23% subjected to physical violence
  - 6% subjected to sexual violence
  - 36% stated violence was ongoing

Ways Helping Professionals Revictimize those Battered

- We don't believe them
- We don't recognize their strengths
- We fail to recognize manipulative tendencies as survival skills
- We question why they stay or return
- We fault their parenting
- We take control

Ways we fail to Support

- We uphold unrealistic expectations
- We question their need for protection when they have contact with their partner
- We buy into such labeling as: co-dependency, enabler, addicted to love
- We fail to validate and/or understand the positive, even loving feelings toward the partner
- We assume that leaving an abusive partner will set her free without recognizing the social abuse & stigma that low income, single women who are head of households have

Implications for Service Providers

- Safety Planning must always be the first priority
  - Outreach workers can enhance effective safety planning when the impact of substance abuse as a risk factor is considered.
- Develop strategies to address both substance abuse and family violence as the impact of these problems on *ALL* family members should be considered.

Implications for Service Providers Continued

- Victims of family violence who have substance problems may require additional support. Dealing with both may make it more difficult for the victim to leave and/or to stop abusing substances.
- Attempting to address one problem without addressing the other may lead to a false sense of security.

Resources

1: Stanko, Prof E (2000). The Day to Count: A Snapshot of the Impact of Domestic Violence

2: Flood-Page, Claire and Joanna Taylor (eds) (2003) Crime in England and Wales 2001/2002

DCF Domestic Violence Consultants – Most areas offices have Domestic Violence Consultants available to provide assistance, training and direct support to the social workers.

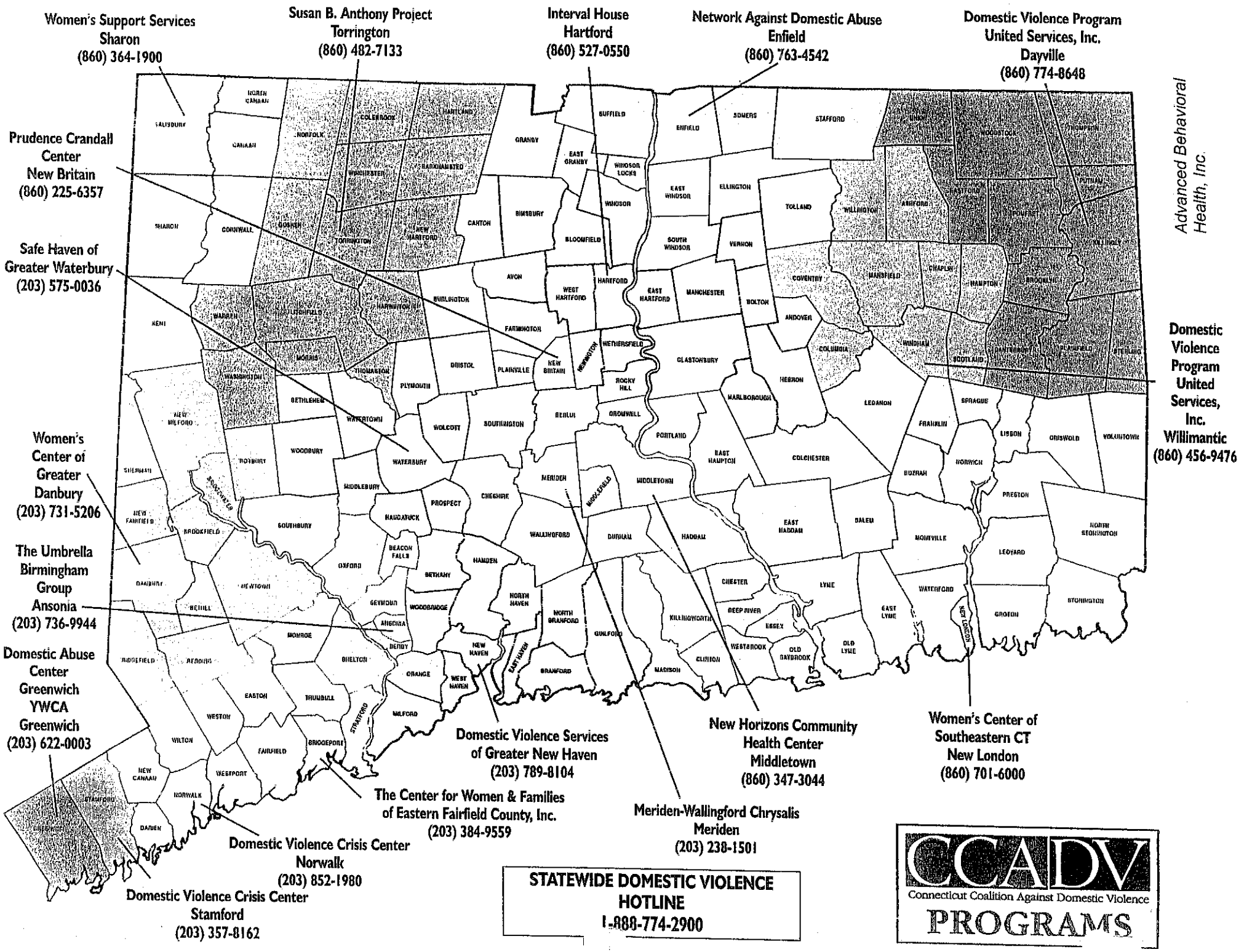
WWW.womenshealth.gov

www.snbw.org (Support Network for Battered Women)

www.rlc.org (Legal Issues)

Court Support Services – Local Court Houses
- Assistance with Protection From Abuse Orders
- Assistance with Temporary Restraining Orders

CCADV – CT Coalition Against Domestic Violence
- Local DV Agencies


Women's Support Services
Sharon
(860) 364-1900
Susan B. Anthony Project
Torrington
(860) 482-7133
Interval House
Hartford
(860) 527-0550
Network Against Domestic Abuse
Enfield
(860) 763-4542
Domestic Violence Program
United Services, Inc.
Dayville
(860) 774-8648
Advanced Behavioral Health, Inc.
Prudence Crandall Center
New Britain
(860) 225-6357
Safe Haven of Greater Waterbury
(203) 575-0036
Domestic Violence Program
United Services, Inc.
Willimantic
(860) 456-9476
Women's Center of Greater Danbury
(203) 731-5206
The Umbrella
Birmingham Group
Ansonia
(203) 736-9944
Domestic Abuse Center
Greenwich YWCA
Greenwich
(203) 622-0003
Domestic Violence Services of Greater New Haven
(203) 789-8104
New Horizons Community Health Center
Middletown
(860) 347-3044
Women's Center of Southeastern CT
New London
(860) 701-6000
The Center for Women & Families of Eastern Fairfield County, Inc.
(203) 384-9559
Meriden-Wallingford Chrysalis
Meriden
(203) 238-1501
Domestic Violence Crisis Center
Norwalk
(203) 852-1980
Domestic Violence Crisis Center
Stamford
(203) 357-8162
STATEWIDE DOMESTIC VIOLENCE HOTLINE
1-888-774-2900
CCADV
Connecticut Coalition Against Domestic Violence
PROGRAMS

womenshealth.gov
1-800-994-9662
TDD: 1-888-220-5446

Safety Planning List

Here are some helpful items to get together when you are planning on leaving an abusive situation. Keep these items in a safe place until you are ready to leave, or if you need to leave suddenly. If you have children, take them. And take your pets, too (if you can).

Identification for yourself and your children

- ❑ birth certificates
- ❑ social security cards (or numbers written on paper if you can't find the cards)
- ❑ driver's license
- ❑ photo identification or passports
- ❑ welfare identification
- ❑ green card

Important personal papers

- ❑ marriage certificate
- ❑ divorce papers
- ❑ custody orders
- ❑ legal protection or restraining orders
- ❑ health insurance papers and medical cards
- ❑ medical records for all family members
- ❑ children's school records
- ❑ investment papers/records and account numbers
- ❑ work permits
- ❑ immigration papers
- ❑ rental agreement/lease or house deed
- ❑ car title, registration, and insurance information

Funds

- ❑ cash
- ❑ credit cards
- ❑ ATM card
- ❑ checkbook and bankbook (with deposit slips)

Keys

- ❑ house
- ❑ car
- ❑ safety deposit box or post office box

A way to communicate

- ❑ phone calling card
- ❑ cell phone
- ❑ address book

Medications

- ❑ at least 1 month's supply for all medicines you and your children are taking, as well as a copy of the prescriptions

A way to get by

- ❑ jewelry or small objects you can sell if you run out of money or stop having access to your accounts

Things to help you cope

- ❑ pictures
- ❑ keepsakes
- ❑ children's small toys or books

Current as of January 2006

Staff Development

4/11/07

Recovery Coaching

Techniques for helping clients
begin recovery

Recovery

- to regain a normal or usual state, as of health
- hope, optimism, courage, confidence in the future, and belief in the capacity of the individual to triumph, even against all odds
- a continuing, deeply personal, individual effort that leads to growth, discovery, and the change of attitudes, values, goals, and perhaps roles

Stages of Recovery

- Early Recovery
  - Sober and abstinent
  - Create awareness of habits, behaviors
- Middle Recovery
  - Fog lifts
  - Focus on others instead of self
- Later Recovery
  - Rebuilding underway
  - Understanding meaning

How can we coach recovery?

- Identify recovery goals
- Identifying strengths
- Develop a recovery plan
- Develop ways to measure success
- Advocate
- Celebrate success
- See setbacks as opportunities for growth
- Coordinate communication about recovery

DE STAFF Mtg 5.23.07

Training

Depression and Pregnancy:
Perinatal and Post-Partum

Introduction

- Depression / Mood Disorders
- Occurrences during and after pregnancy
- How we can help

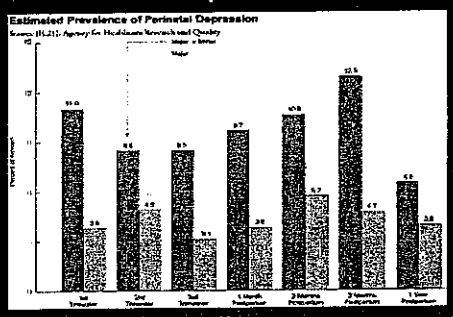
Overview

- Depression is common in general population
- Pregnancy and post-partum are at risk times

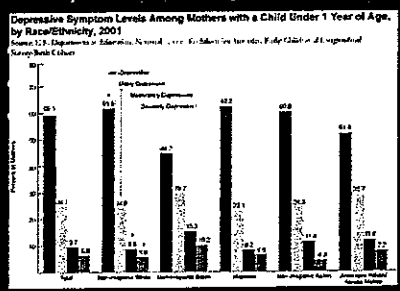
Vocabulary

- Depression
  - Sleep
  - Appetite
  - Energy
  - Mood
- Perinatal
- Postpartum

Perinatal Depression



Postpartum Depression



Postpartum Psychosis

- Small number of women (one or two in 1000)
- Women who have a bipolar disorder or other psychiatric problem may have a higher risk for developing this form of Perinatal Depression.

- Extreme confusion
- Hopelessness
- Cannot sleep (even when exhausted)
- Refusing to eat
- Distrusting other people
- Seeing things or hearing voices that are not there
- Thoughts of hurting yourself, your baby, or others

Common Symptoms

- Sad feelings
- Feeling very anxious or worrying too much
- Being irritable or cranky
- Trouble sleeping (even when tired) or sleeping too much
- Trouble concentrating or remembering things
- Trouble making decisions
- Loss of interest in caring for yourself (for example, dressing, bathing, fixing hair)
- Loss of interest in food, or overeating
- Not feeling up to doing everyday tasks
- Frequent crying, even about little things
- Showing too much (or not enough) concern for the baby
- Loss of pleasure or interest in things you used to enjoy (including sex)

What Can we Do?

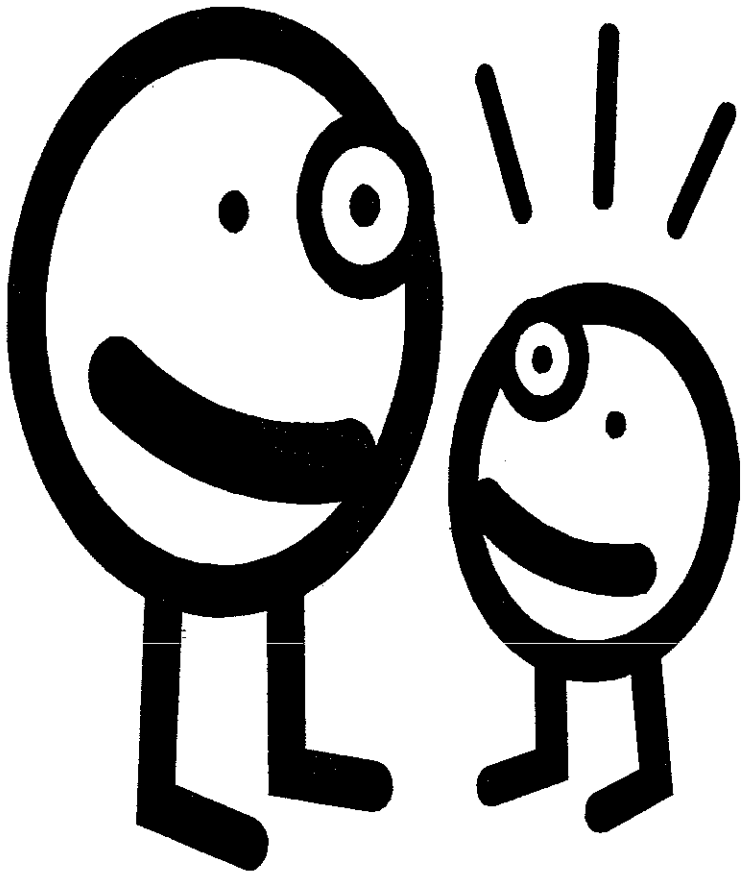
- Help clients look at symptoms more objectively
- Help clients engage in both perinatal and postpartum health care
- Help clients to discuss symptoms with behavioral health professionals

Where to Get More Information

- http://www.hrsa.gov

3/12/08

Strategies for Engaging Clients in Services



Richard Fisher, LCSW

DMHAS Education and Training Division

DMHAS Definition of Recovery

- ***The Department endorses a broad vision of recovery that involves a process of restoring or developing a positive sense of identity and meaningful sense of belonging apart from one's condition and then rebuilding a life despite or within the limitations imposed by that condition.***
- **A recovery-oriented system of care identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive sense of membership in the broader community.**

'A little over half of the beneficial effects of psychotherapy are linked to the quality of the alliance'

- Horvath, 2001

The therapeutic relationship contributes 5 to 10 times more to the outcome than the particular model of approach employed (Bachelor and Horvath, 1999; Duncan, Miller and Sparks, 2004; Wampold, 2001)

What makes for a welcoming environment?

Wrong Door vs. No Wrong Door

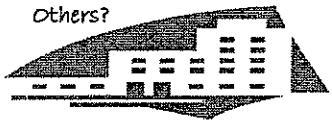
Drab and Dirty vs. Bright and Clean

Cold Staff vs. Warm Staff

Ignoring vs. Welcoming

Waiting a long time vs. Being seen on Time

Others?



Maslow's Hierarchy of Needs

- Physiological Needs
- Safety Needs
- Needs of Love, Affection and Belongingness
- Needs for Esteem
- Needs for Self-Actualization

Forming a Therapeutic Alliance

Demonstrate an understanding and acceptance of the client

Help the client clarify the nature of his difficulty

Indicate that you and the client will be working together

Communicate to the client that you will be helping her to help herself.

Express empathy and a willingness to listen to the client's formulation of the problem.

Assist the client to solve some external problems directly and immediately.

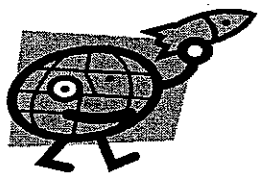
Stages of Recovery

- 1. Overwhelmed by
- 2. Struggling with
- 3. Living with
- 4. Living beyond

Boston University Center for Psychiatric Rehabilitation

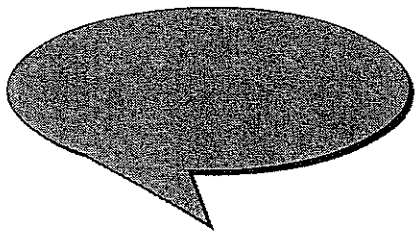
Starting Where the Client Is: Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance



Relationship/Trust versus Compliance and Control

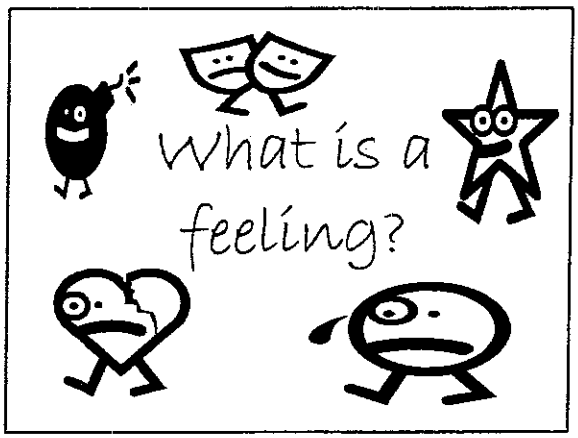
Active Listening



"We were given two ears but only one mouth, because listening is twice as hard as talking."

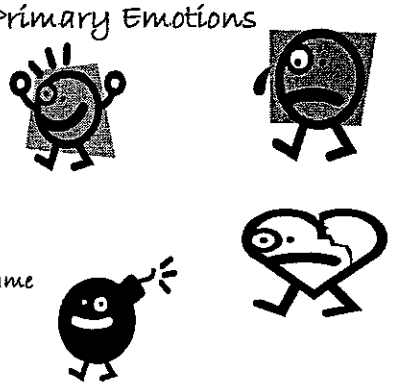
Express Empathy

- Sympathy vs. Empathy
- Judgment vs. Understanding
- Feeling Vs. Situation



Primary Emotions

- Anger
- Sorrow
- Joy
- Surprise
- Fear
- Disgust
- Guilt/Shame
- Interest



Reflective Listening

- Reflect back what the person said, identifying the feeling they are expressing
- "Sounds like you were really **hurt** when Marsha put you down"
- "It must have been **frustrating** to try to get your psychiatrist to understand what you are going through and not be given enough time"
- "You were Pretty **angry** at being talked down to by your uncle"
- "Your really **angry** at Steve for breaking up with you, it really **hurts**, I know you really **loved** him"

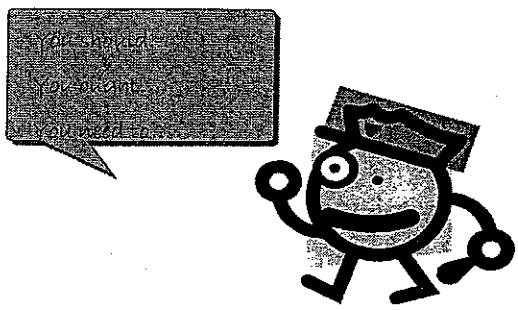
Levels of Empathic Response

- Level 1: Detracting: Using judgments, giving advise, minimizing, us ing sympathy, criticizing. As king questions
- Level 2: Reflecting: Reflecting back the situation, paraphrasing what was said, reflecting surfa ce feeling
- Level 3: Insightful: Reflecting back the situation or trigger with the underlying deeper feeling

Sounds like you feel (insert feeling), when (insert situation that resulted in feeling)
"Sounds like you feel angry, when you get ignored by Bill."

When (insert situation), you felt (insert feeling)
"When you got lost and didn't know where you were, you felt pretty scared."

Avoid Command Language



Punctuating Strengths, Instilling Hope

Discouragement is a basic condition the prevents people from functioning

Encouragement builds self-confidence and stimulates courage

What are people's strengths and positive attributes

Pointing them out reminds people of their existing and latent competencies-

---

I got to say, you really gave Michael good advise about how to deal with his landlord

Living on the streets takes a lot of survival skills, how do you do it?

I like the way you dealt with your roommate, you were really kind.

You know everything about the Red Sox, you have an amazing memory!

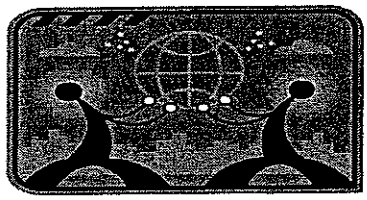
Getting Started

What are your clients goals?
(listen to clients formulation of the problem)

"DCF is making me come or they will take away my kids"

"They told me the only way they would let me out of the hospital is if I came here"

Your job is to assist clients to find answers that are congruent with their own values



Be aware of your own values

- You are not value neutral, how do your values influence your intervention? (People should work, feminism, cleanliness, exercise, duty to family and friends)

Cultural Competence

Attempt to understand the world through your clients vantage point

Do not judge as pathological behavior, beliefs, experiences that are normal for your clients culture or environment

Who is the person I am meeting with and how do they understand the service relationship? (Get their perspective on why they are there and how they feel about it. What precipitated their coming for services?) What would they like? What are their goals? How do they understand their own experience?
How does their family/support system understand their problem/condition and what type of help do they want/think will help? Are there any stresses in their life?

Forming a Therapeutic Alliance

- Demonstrate an understanding and acceptance of the client.
- Help the client clarify the nature of his difficulty.
- Indicate that you and the client will be working together.
- Communicate to the client that you will be helping her to help herself.
- Express empathy and a willingness to listen to the client's formulation of the problem.
- Assist the client to solve some external problems directly and immediately

From TIP 42
Substance Abuse Treatment for Persons with Co-occurring Disorders
U.S. Dept. of Health and Human Services
Substance Abuse and Mental Health Services Administration

Reflective Listening
Feeling List

abandoned, abused, accepted, accused, admired, adventurous, affectionate, affirmed, afraid, aggressive, aggravated, agitated, alarmed, alienated, alive, alone, ambivalent, angry, annoyed, antagonistic, anticipated, anxious, apathetic, appreciated, apprehensive, approved, arrogant, ashamed, assertive, attacked, attractive, awed, awkward,
balanced, beaten, belligerent, betrayed, bewildered, bitter, blamed, bored, bothered, bugged, burned up
capable, cared for, castrated, caustic, chagrined, challenged, cheated, closed, comfortable, comforted, compassionate, competent, complacent, compromised, concerned,confident, confused, congruent, connected, consumed, contaminated, controlled, out of control, creative, cross, cruel, crushed, curious, cut off,
dead, deceived, defeated, defensive, defiant, degraded, dejected, delighted,deserving, desired, desperate, destroyed, devastated, dirty, disappointed, discontented, disgusted, disillusioned, disjointed, dismayed, distant, distorted, distracted, distressed, disturbed, dominated,domineering, drained, dread, drowning, drugged, dumb, dying,
eager, edgy, egotistic, elated, embarrassed, embraced, empty, endangered, enraged, enthused, envious, evasive, exasperated, exhausted, exhilarated, exploited, explosive, exposed,
failed, failure, fat, fatigued, fearful, fighting mad, floundering, fooled, forgiven, forgotten, fouled, free, friendless, friendly, frightened, frustrated, furious,
galled, generous, genuine, gifted, gracious, grateful, gratified, greedy, grumpy, guilty,
hate, hated, hatred, healed, heavy, helpless, hopeful, hopeless, hostile, hurt, hyperactive, hypocritical,
ignored, immobilized, impatient, impotent, inadequate, indifferent, incompetent, inconsistent, in control, indecisive, independent, indignant, inferior, infuriated, inhibited, injured, insecure, irked, irritated, isolated, intense, integrated, intimate, intimidated, irrational, irritable,
jealous, joyful, judged, judgmental,
liberated, light, limited, lonely, like a loser, lost, lovable, loved, loyal,
mad, manipulated, marked, masked, masochistic, melancholic, miffed, misinformed, misunderstood,
naked, needy, neglected, noxious,
obligated, offended, optimistic, outraged, overlooked, oversized, over sexed, overwhelmed,
pain, panic, paranoid, passionate, peaceful, persecuted, perturbed, pessimistic, phony, pissed-off, playful, pleased, pleasured, possessed, possessive, powerful, powerless, precious, preoccupied, pressured, private, protective, proud, provoked, punished, purposeful, put down, put out, puzzled,
rageful, rambunctious, reassured, rejected, resentful, responsible, responsive, restrained, resurrected, revengeful, reverence, rewarded, rigid,
sacred, sad, sadistic, scapegoated, scared, secretive, secure, seductive, seething, selfish, sensual, shaky, shamed, shocked, shy, sick, sincere, sinful, smothered, soiled, sorrowful, spontaneous, spiteful, stressed, strong, stubborn, stupid, subservient, superior, supported, suspicious, sympathetic,
teed off, tender, terrified, threatened, ticked off, tired, tolerant, tolerated, traumatized, tranquil, triumphant, trusted, trusting, turned off,
ugly, unable, unappreciated, unbalanced, uncertain, understood, unfulfilled, unhappy, unique, unloved, unprepared, upset, unresponsive, unlikable, uptight, used, useful, useless,
vain, valuable, vengeful, vicious, vindicated, vindictive, violent, vulnerable,
warm, weak, weary, whole, withdrawn, wonderful, worn out, worthless, worthy
youthful, yearning, zany, zealous

Engagement
Avoiding Command Language

Re-write the statements below in a way to avoid the use of "command language". Try to re-frame the statement in a way to be more effective and get your point across without "telling the person what to do".

1. "Don't call me Mr. Jones, just call me Leon."

2. " If you don't like going to the hospital all the time you should take your medications like the doctor says".

3. "You shouldn't isolate yourself all the time. It doesn't make you happy".

4. "You better stop yelling at everyone all the time, it's completely inappropriate."

5. "You ought to think about getting a job instead of staying home smoking reefer and watching T.V."

6. "You ought to get yourself on a budget, them you wouldn't be in this situation".

DMHAS Education and Training Division
Engaging Clients in Services
Giving Feedback on Behaviors

Giving positive feedback

When we give clients positive feedback it makes it more likely that the positive behavior will occur again. It also helps to improve and solidify your relationship with the client. Recovery is often a slow process and may involve setbacks. It is important to be on the lookout for positive actions and recognize them when they occur.

"Your apartment looks great, you did a wonderful job"
"I like the way you dealt with your roommate, you kept your cool but still told him how you feel".
"You have a great sense of humor".
"I like the way you are kind to other people"

Giving feedback on ineffective or inappropriate behavior:

It is very difficult for people to change attitudes, personalities, beliefs or feelings. It is more likely that people will change behavior. People will be more open to change if you focus your feedback on effective behaviors, rather than criticism of their personality or attitude.

Focusing on behavior:

Avoid: "You're acting really lazy, and now you missed your appointment"
Try: "You're staying in bed yesterday and missing your appointment is going to make things more difficult for you now".

Focusing on behavior and ways to improve

Avoid: "You always lose important paperwork"
Try: Getting that application filled out is important. Let's discuss setting up one place to put all of your important papers"

Reminding client of positive skill you observed, and using it to be more effective

Example: "Last week you were so supportive of Tom when he told you about the problems he was having on his job. I saw how much he appreciated you. Everyone recognized your common sense advice and the understanding that you showed. I wish you could apply that common sense and understanding in dealing with Bill, I thought you two were going to get into a fight."

Example: You were so well organized about the paperwork for the club house project; I wish you could use some of your organizational skill and self-discipline in getting your Section 8 application going"

No one likes to be told what to do. You can avoid telling people what to do and still give them information in a way that they are more likely to be responsive to.

Avoid: You should take your medication.
Try: I notice that when you take your medications that you are less confused and seem calmer.

Avoid: You should be going to AA meetings everyday.
Try: I have found that when people try out AA meetings they get something out of it, even if they are reluctant to go at first.

Strength Assessment

- Daily Routine: living situation, typical day, hobbies, chores, work, leisure time
- Educational and Work Activities
- Creative Outlets: Sports, hobbies, reading, writing, music, TV and movies, art, drama
- Relationships: Family, friends, significant others, who are your supporters
- Spiritual Supports/Self Help
- Health and wellness

Case Management Liaison

Project SAFE'sRSVP and RCM Services
Case Management Liaison Procedures

The Case Management Liaison (CML) oversees various technical and administrative activities supporting the guidelines of Project SAFE's RSVP and RCM Services These responsibilities include:

I. Assigning Clients

The CML will monitor all referrals and case assignments to RSVP and RCM in the Project SAFE database using the following process:

- All new referrals to RSVP and RCM appear in the "New Cases" list in the Project SAFE database. A Release of Information (ROI), which the client has signed giving ABH permission to communicate with DCF, must be received in order to assign the case to RCM Services. RSVP referrals will already have had a ROI signed by the client at the court
- The CML will make weekly reminder calls to the DCF workers who have not yet sent a ROI. The CML will log a progress note in the appropriate client field for each of those calls and log any communication with the DCF worker. The weekly census list also includes information on ROIs still needed
- When the CML receives the ROI from the DCF worker, the CML checks the box next to the client's name indicating that the ROI has been received.
- Clients for whom the ROI has been received are assigned to a RCM on a "first come, first served" basis from the date the referral was received
- The CML assigns the client to an RCM by right clicking on the client name, left clicking on "assign" and double clicking on the appropriate RS/RCM. The RS/RCM is deemed appropriate based on the region and the number of clients the RS/RCM currently has (RS/RCM max 15, LRS max 10). Spouses or significant others are assigned to the same RS/RCM unless contraindicated, e.g., concern regarding domestic violence.
- If the client is a rereferral to RSVP or RCM, the CML would normally assign the client to the RCM that had previously worked with the client unless this would incur a long wait period for the client or was contraindicated
- Once the case has been assigned in the O & E database, the CML will fax a copy of the referral and the ROI to the RCM/RS and email the RS/RCM and the LRS that a new client has been assigned.
- The CML will keep on file the hard copies of the ROI and Referral by Region.

II. Unassigned Clients/Waiting List

When RSVP/RCM program site is at full capacity, subsequent referrals for which a release of information has been received will remain on the unassigned list. When a slot becomes available, if there has been a delay in assigning the case/delay of more than three weeks, the Case Management Liaison (CML), will telephone the DCF Social Worker to confirm that services are still needed and obtain the following information:

- Verify client's current address/phone #
- Did the client attend the evaluation?

- If yes, was treatment recommended?
  - If yes, LOC? Has client started treatment?
    - If yes, are Case Management services available at that provider?

- Are RCM services still needed? If yes, and client is engaged in treatment, what assistance is currently needed?

- Review when Project SAFE referral date ends and, if needed, request that DCF worker call Project SAFE to make a new referral.

- Inquire if there are any potential safety concerns in conducting outreach to the client's home.

- Provide DCF SW with the Recovery Case manager's (RCM) name and phone number. Tell DCF SW that s/he can expect a call within the next few days from the RCM.

  The CML will use the following guidelines to contact DCF when an RCMslot becomes available:

  - On Day 1 – The CML will initiate contact with the DCF SW.
  - On Day 2 – If no return call from the DCF SW, the CML will follow up with DCF Supervisor.
  - On Day 3 - If the CML does not get a response back from DCF SW within 3 business days, we will assume that RCM services are not needed at this time and move to the next client on the list.

III. Archiving Cases

Unassigned cases are archived when a ROI is not received within 45 days of the referral and/or when the DCF Worker rescinds the referral toRCM

- The CML is alerted to the cases that are archiving through a report summary that is emailed daily
- Cases are automatically archived after 45 days on the unassigned list. If no ROI was received in this timeframe, the case will remain on the archived list. If the ROI was received and the case was awaiting assignment when it archived, the CML will need to reactivate the case to the unassigned list. The CML will reactivate the client by going into the Archived list and right clicking the client's name and then left clicking on "reactivate-un-archive".
- If a DCF SW rescinds a RCM referral prior to the case being assigned, the CML will manually archive the referral by right clicking on the client name, left clicking on" yes", left clicking on "Roll off- Archive and adding a text reason.

IV. Auditing Case Files

The CML will audit all client files once a month to ensure that documentation in the case files is complete and up to date.

- The CML will send out an email in advance to the RSVP/RCM Teams informing them of the date of the Audit.
- The CML will review each case file including the Intake info, Service Plan, Screening, Activity, case review notes -noting corrections/clarification needed by each RS/RCM
- The CML will list the corrections that need to be made in the O&E Dept Drive in the appropriate RS/RCM/LRS file (see Dept Drive/SAFE/O&E/Audits/Region)
- The CML will then email the Teams letting them know the audits are finished and a date for completion of any corrections
- Once the RS/RCM/LRS completes the corrections and advises the CML, the CML will review the case again and approve as 'appropriate' in the O&E Dept Drive
- The CML will also make any corrections in the Database that the RS/RCM/LRS are unable to make due to editing limitation time frames.

V. Discharging Clients

- When the Team Leader informs the CML that there is a discharge, the CML will do the third review of the client file (the first done by the RS/RCM/LRS, the second done by the LRS or APD) and inform the LRS/RS/RCM if there are any corrections to be made or if any information is missing.
- Once the case file is in order, the CML will discharge the file by reviewing the recommendation summary and if in order, completing the Discharge field in the electronic client file
- The CML will then run the DCF Discharge Report and give it to the Program Manager to review and sign
- Once approved by the Program Manager, the CML will fax a copy of the DCF Discharge Report to the LRS/RS/RCM and will mail the original with the discharge cover letter to the appropriate DCF worker. *(see O&E Dept. Drive: Form Letters)*
- The CML will also save (by region) a hard copy of the DCF Discharge Report in a file drawer.

VI. Follow Ups/Surveys

A. DCF Surveys

The CML will conduct DCF by phone on those clients who have successfully discharged from RCM.

1. The CML will be alerted to the clients who need to be followed up on by the "Discharge Follow Up Alert "report, which is received daily in email.
2. The surveys will be conducted at 30, 60, 90, and 120 day intervals (see Survey forms in the Dept drive)
3. Once gathered in hard copy, the second page of info on the DCF survey and all of the information on the Provider survey will be inputted into the ACCESS database in the respective formats (see Dept Drive/SAFE/O&E/CPS data/Provider Surveys revised 3-15-07 and CPS Data Modified Main).
4. The first page of the DCF survey will be inputted into the EXCEL sheet and the DCF comments will be inputted into the WORD format collection of DCF comments (see Dept Drive/SAFE/O&E/Surveys).
5. All hard Copies will be archived after the 120 day collection and input of information.

B. Client Surveys
The CML will input all client responses on completed surveys received into EXCEL and ACCESS formats and note comments received in the Word Document (see Dept Drive/O&E/Surveys)

V. Reports

As part of their ongoing responsibilities, the CML will create, update, and/or run the following reports:

Weekly Census Report:
The *Weekly Census Report* provides a snapshot for DCF and DMHAS on referral activity. The CML will update the *Weekly Census* in the O&E Dept. Drive by reviewing the number of unassigned clients on the Unassigned list, the number of clients assigned that week on the active client list and the number of discharged clients for that week. The CML will email the *Weekly Census Report* to DCF and DMHAS staff on the identified "distribution list ".

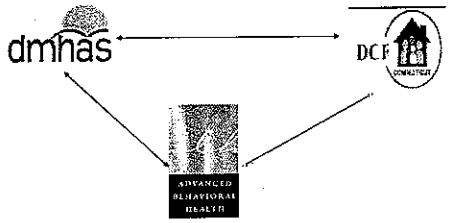
Referral Activity Summary Report:
The CML will run the *Referral Activity Summary Report* on the 1st of each month for the previous month and will enter the correct numerical information into the ongoing monthly *Productivity Report* which is reviewed by the Program Manager.

Quarterly/Annual/Other Reports:
The CML will gather, input into EXCEL and chart information for the Quarterly and Annual Reports as well as information for supervision purposes including but not limited to:

- RS/RCM/LRS threshold information based on type and duration of O&E activity
- Waitlist information
- Referral information - #s, Type of referral, gender, ethnicity
- CPS data
- Types of Services Provided
- Archive case information
- Other reports as needed

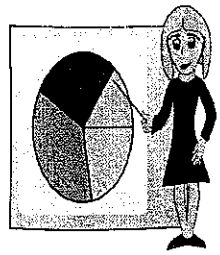
Project SAFE

Project S.A.F.E.



Overview of Presentation

- Project SAFE in general
- Drug Testing
- Associated Programs
- Questions



What is Project S.A.F.E.?

A program designed to:

- Provide priority access to evaluations for parents and caregivers involved in child welfare cases, and
- Outpatient Substance Abuse (SA) Treatment when recommended.

Historical Overview

- Established in 1995 by DCF
- To coordinate central intake to drug screening, evaluation and treatment for substance abuse.
- 1999 collaboration with DCF and DMHAS

Project S.A.F.E.
1-800-272-0097

- 24 hours 1-800 line to process referrals
- Centralized administrative services
- Quality management activities

Payor of Last Resort

- Reimbursement based on the payment difference between Primary Insurer Rate (if applicable) and Project SAFE
- Does not cover co-pays or spend-downs
- Claims received by ABH® for all outpatient services

Program Facts

As of 2010:

- Over 89,000 clients referred
- Over 55,000 received substance abuse evaluations
- Over 30,000 referred for AOD treatment
- Over 16,500 received AOD treatment

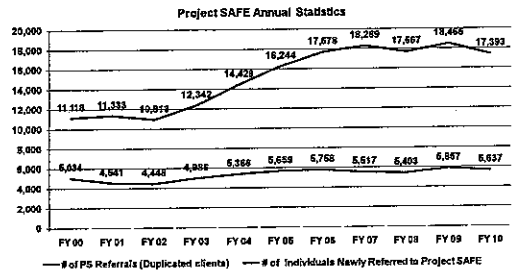
Advanced Behavioral Health, Inc.

Demographics – FY 10

- Approximately 10,000 unduplicated individuals per year
- 51% Women; 49% Men (new PS referrals)
- 67% Women; 33% Men (re-referrals)
- 41% Caucasian; Mixed/Other – 22%; 19% African-American; 18% Hispanic

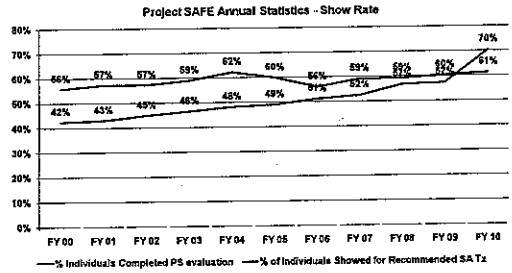
Advanced Behavioral Health, Inc.

PS Referrals



Advanced Behavioral Health, Inc.

PS – Show Rates



Advanced Behavioral Health, Inc.

Program Facts

FY 2010 (statewide)

- 61% Completed PS Evaluation
  - 44% Recommended for Treatment
    - 70% Received Treatment

Advanced Behavioral Health, Inc.

Who is eligible?

- DCF involved adults
- Parents or Primary Caregiver of child identified in child protective service case
- There is a suspected substance abuse problem that may be effecting the ability to parent effectively
- Client is in need of evaluation, outpatient treatment services, and/or drug testing

Advanced Behavioral Health, Inc.

Outpatient Services Covered by Project S.A.F.E.

- Evaluation
- Individual counseling
- Group counseling
- Family counseling
- IOP
- PHP
- Urine Drug Screen
- Hair Test

Advanced Behavioral Health, Inc.

How Do I Make A Referral?

Advanced Behavioral Health, Inc.

Referral Information

- Demographic Information
- Reason for Referral
- Gain SS

Advanced Behavioral Health, Inc.

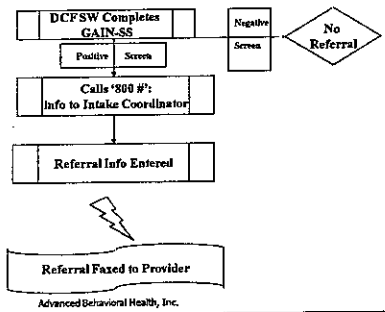
Referral Information

GAIN – SS

- Global Assessment of Individual Need – Short Screen
- Four Domains
  - Internal Disorders
  - Behavioral Disorders
  - Substance Use Disorders
  - Crime/violence

Advanced Behavioral Health, Inc.

Flow of Referral



Advanced Behavioral Health, Inc.

Important Things to Remember

- DCF SW must Call-in Referral
- Random Drug Screens after Evaluation
- Keep Treatment Guidelines in Mind
- ROI needed prior to Referral
- DCF SW faxes ROI to Provider

Advanced Behavioral Health, Inc.

DCF Social Worker Responsibility

- Demographic Info
- Reason for Referral
- Release of Information (ROI) - Fax to Provider
- Communication

Advanced Behavioral Health, Inc.

After the Referral is Complete

- The Provider will schedule an appointment
- The Provider will call the DCF SW with the results and treatment recommendations
- A written report of the evaluation will follow

Advanced Behavioral Health, Inc.

Provider Responsibility

- 3-5 Business Days*
- Insurance Verification
- Communication

* 3-5 Business days when available

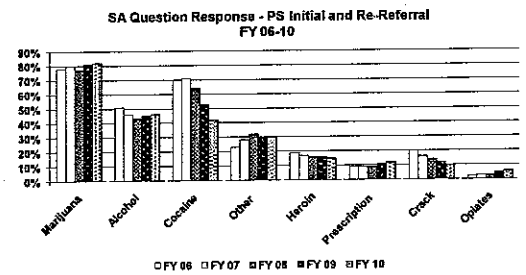
Advanced Behavioral Health, Inc.

Drug Testing as a Tool

- Urine Drug Tests
- Hair Tests

Advanced Behavioral Health, Inc.

Substances Reported



Advanced Behavioral Health, Inc.

Urine Drug Testing

"Test results that are quickly confirmed are far more useful in drug treatment than are test results that are available after two or more days."

- Robert Dupont et.al. Drug Testing in Treatment Settings 2005

Advanced Behavioral Health, Inc.

Urine Drug Testing

- Instant Drug Tests used in PS screen for:
  - Amphetamines
  - Cocaine
  - Marijuana (THC)
  - Opiates
  - PCP

Advanced Behavioral Health, Inc.

Drug Screen Confirmation

- GS/MS Confirmation(s) for the following:
  - Instant Drug Screen is positive for one or more substances and the client denies use, the specimen should be sent to the lab for confirmation; *or*
  - Instant Drug Screen is positive for opiates and client provides a recent prescription for a medication that explains this result; *or*
  - Client reports or DCF suspects synthetic opiate use.
  - ***Note:*** The Instant Drug Screen results are considered presumptive and the GC/MS confirmation are considered the final results.

Advanced Behavioral Health, Inc.

Hair Testing

- Hair testing is utilized to determine a three-month history of substance use/abuse history prior to the hair test.
- Positive hair test results can be further analyzed to determine if the client's use/abuse of substances occurred within 30/60/90 days prior to collection. This multi-sectional testing can be performed on a positive sample per request of the referring DCF Social Worker.
- ***Note:*** Project SAFE Referral requires approval of DCF SAS, BH PD, or designee.

Advanced Behavioral Health, Inc.

Limitations of Drug Testing

- A positive level does not:
  - Indicate level or intoxication
  - Administration route
  - Distinguish between drugs of abuse and certain medications (Requires confirmation)

Advanced Behavioral Health, Inc.

Limitations of Drug Testing

- A negative result may not necessarily indicate the person is drug-free.
- Negative results can be obtained when the drug is present below the cut-off level of the test.
- Drug Detection Windows vary by substances and frequency of use.

Advanced Behavioral Health, Inc.

Associated Programs

RSVP & RCM

Advanced Behavioral Health, Inc.

Recovery Case Management (RCM)

Middletown, Norwich
Bridgeport*,
New Britain*, Norwalk*, Willimantic*

Advanced Behavioral Health, Inc.

What is RCM?

- Case management services targeted at helping clients engage in substance abuse services and supporting them in increasing their recovery capital
- Monthly documentation to DCF
- SAMSS meetings in each area
- Discuss potential referral with AO designee

Advanced Behavioral Health, Inc.

Recovery Specialist Voluntary Program (RSVP)

Bridgeport/Norwalk,
New Britain, Willimantic

Advanced Behavioral Health, Inc.

RSVP

- IDTA grant to CT from NASACW – planning process by DCF, DMHAS, and Courts
- Pilot sites in New Britain, Bridgeport, and Willimantic
- Voluntary Program for parents with SA who have had a child removed on an Order of Temporary Custody (OTC)
- SAMSS Meetings in each area

Advanced Behavioral Health, Inc.

Role of the Recovery Specialist

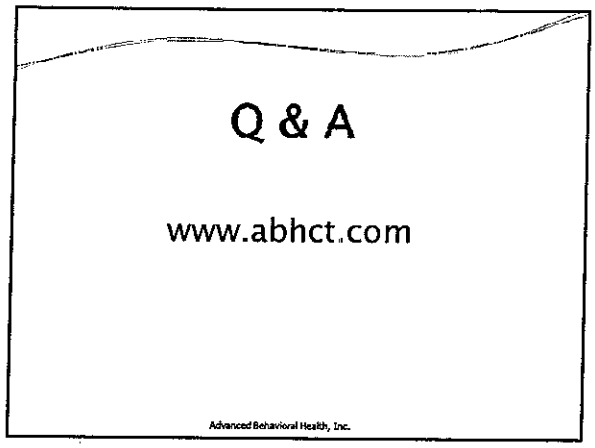
- Support clients in engaging in SA treatment and community supports
- Random drug screens
- Support clients in increasing their recovery capital
- Provide monthly documentation to DCF, the court, and attorneys

Advanced Behavioral Health, Inc.

RSVP – Additional Info for DCF SWs

- Request copy of FAQ on RSVP for DCF SWs
  - Documentation
  - Communication
  - Referrals
  - Role of Recovery Specialist

Advanced Behavioral Health, Inc.


Q & A
www.abhct.com
Advanced Behavioral Health, Inc.

Advanced Behavioral Health, Inc.
Middlesex Corporate Center
213 Court Street, 10th Floor
Middletown, Connecticut 06457

Client Referral

Client ID . . .
Name . . . . . .

Substance Abuse Screening / Information Form Data

1. Client appeared to be under the influence of drugs and/or alcohol.
2. Client showed physical symptoms of trembling, sweating, stomach cramps, nervousness.
3. Drug paraphernalia was present in the home, i.e., pipes, charred spoons, foils, blunts, etc.
4. Evidence of alcohol was present in the home, i.e., excessive number of visible bottles/cans whether empty or not.
5. There was a report of a positive drug screen at birth for: Mother Child
   list drugs detected:
6. There was an allegation of substance abuse in CPS Report.
7. The child(ren) reports substance abuse in the home. When?
8. The client has been in substance abuse treatment. When?
9. The client has used the following in the last twelve months: Marijuana/Hashish
   Heroin/Opiates Cocaine/Crack Other Drugs:
10. Client shared that s/he has experienced negative consequences from the misuse of alcohol, i.e.,
    DWI/DUI Domestic Fights Job Loss Arrests
    Other:
11. Client shared s/he has experienced trouble with the law due to the use of alcohol or other drugs, i.e.,
    DWI/DUI Domestic Violence Drug Possession Charg
    Other:
12. There are adults who may be using drugs and/or misusing alcohol who have regular contact with the client's child(ren).
13. The client acknowledged medical complications due to the use of substances.
14. Other Comments

Advanced Behavioral Health, Inc.
Middlesex Corporate Center
213 Court Street, 10th Floor
Middletown, Connecticut 06457

Date: 3/29/2010
Time: 4:59 PM

Client Referral

Client ID . . .
Name . . . . . .

GAIN Short Screen Data

Date of Screening

		Past Month 3	2-12 Mos. Ago 2	1+ Years Ago 1	Never 0	Don't Know -8	Refused -7
IDScr	**1. When was the last time you had significant problems...**						
	a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future ?	○	○	○	○	○	○
	b. with sleeping, such as bad dreams, sleeping restlessly or falling asleep during the day ?	○	○	○	○	○	○
	c. with feeling very anxious, nervous, tense, fearful, scared, panicked, or like something bad was going to happen ?	○	○	○	○	○	○
	d. when something reminded you of the past, and you became very distressed and upset ?	○	○	○	○	○	○
	e. with thinking about ending your life or committing suicide ?	○	○	○	○	○	○
EDScr	**2. When was the last time you did the following things 2 or more times ?**						
	a. Lied or conned to get things you wanted or to avoid having to do something ?	○	○	○	○	○	○
	b. Had a hard time paying attention at school, work, or home ?	○	○	○	○	○	○
	c. Had a hard time listening to instructions at school, work, or home ?	○	○	○	○	○	○
	d. Were a bully or threatened other people ?	○	○	○	○	○	○
	e. Started fights with other people ?	○	○	○	○	○	○
SDScr	**3. When was the last time...**						
	a. you used alcohol or drugs weekly ?	○	○	○	○	○	○
	b. you spent a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick) ?	○	○	○	○	○	○
	c. you kept using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people ?	○	○	○	○	○	○
	d. your use of alcohol or drugs caused you to give up, reduce or have problems at important activities at work, school, or social events ?	○	○	○	○	○	○
	e. you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems ?	○	○	○	○	○	○
CVScr	**4. When was the last time you...**						
	a. had a disagreement in which you pushed, grabbed, or shoved someone ?	○	○	○	○	○	○
	b. took something from a store without paying for it ?	○	○	○	○	○	○
	c. sold, distributed or helped make illegal drugs ?	○	○	○	○	○	○
	d. drove a vehicle while under the influence of alcohol or illegal drugs ?	○	○	○	○	○	○
	e. purposely damaged or destroyed property that did not belong to you ?	○	○	○	○	○	○

5. Do you have other significant psychological, behavorial or personal problems you want treatment for or help with ?

6. What is your gender ?

Advanced Behavioral Health, Inc.
Middlesex Corporate Center
213 Court Street, 10th Floor
Middletown, Connecticut 06457

Client Referral

Client ID . . .
Name . . . . . .

GAIN Short Screen Data (continued)

DCF Link #:

11. Mode:

12. Number of 2 & 3's: *IDScr:* *EDScr:* *SDScr:* *CVScr:* *TDScr:*

13. Referral Type:

15. Referral Comments:

Project S.A.F.E Covered Services

There are eight basic treatment services that are reimbursable within Project S.A.F.E.

- Evaluation
- Individual Therapy (SA I.1)
- Group Therapy (SA I.1)
- Family Therapy (SA I.1)
- Intensive Outpatient Therapy (IOP) (SA II.1)
- Partial Hospitalization Program (PHP) (SA II.5)
- Urine Drug Screens
- Hair Testing

The following section contains a description of these services.

Evaluation:
Clients are referred for a Project S.A.F.E evaluation because the DCF Social Worker has completed the DCF substance abuse screen (DCF form 2110) and found reason to believe that the individual's ability to parent effectively is impaired as a result of his/her use. The evaluation is conducted by an approved Project S.A.F.E Provider and consists of a bio-psycho-social assessment focusing on the following areas:

- Demographic Information
- Family composition and history
- Substance abuse history
- Trauma history
- Medical history and current medical status
- DSM IV TR Diagnostic formulation
- Drug screen results
- Summary and recommendations

Each evaluation should contain a written narrative in the aforementioned areas.

Once the evaluation is completed by the provider, the results of the evaluation should be **verbally** communicated to the DCF Social Worker within **twenty-four (24) hours (one business day)** of its completion. A written clinical summary will be forwarded to both the Social Worker and the DCF Substance Abuse Specialist within **five (5) business days** of the evaluation.

Adolescent Evaluation:
Project S.A.F.E. also has capacity to conduct adolescent specific evaluations. The Project S.A.F.E. Adolescent Evaluation Project was initiated in (the then) Region IV to provide Substance Abuse Evaluations to adolescents who are suspected of substance abuse, but do not meet the basic Project S.A.F.E. criteria. **DCF Region IV** Social Workers who believe that an adolescent would benefit from a Project S.A.F.E.

evaluation should complete the following forms prior to contacting the North Central Region ARG:

- Adolescent Screening Form
- Project SAFE Referral Form

These two forms are then reviewed by the ARG, and approved if clinically appropriate. Once approved, the ARG or designee will call the ABH Intake Coordinator at 1-800-272-0097, and make the referral.

Individual Therapy:
Individual therapy consists of one to one therapy in duration of up to one hour, with a frequency of no more than once weekly and no less than once per month. Treatment focuses on reducing symptoms, improving function, maintaining abstinence and relapse prevention.

Group Therapy:
Group therapy consists of therapy in duration up to one and a half hours, with a frequency of once weekly. Treatment focuses on reducing symptoms, providing psycho-education, improving functioning, relapse prevention and maintenance of abstinence. Groups should be limited to no more than twelve (12) clients per group session.

Family Therapy:
Family therapy consists of therapy sessions with a client and one or more individual(s) identified by the client as family, with duration of up to one hour, a frequency of no more than once weekly. Treatment focuses on building and maintaining supports for recovery, repairing relationships, reducing symptoms, providing psycho-education and maintenance of abstinence.

Intensive Outpatient Therapy (IOP):
A non-residential service provided in a general hospital, private freestanding psychiatric hospital, state operated facility or in a facility licensed by the Department of Public Health as a "Psychiatric Outpatient Clinic for Adults". IOP services provides each client with **three to four (3-4) hours per day, three to five (3-5) days per week** of clinically intensive programming based on an individualized treatment plan. Treatment focuses on reducing symptoms, improving functioning, maintaining community connection and relapse prevention. As a client is preparing for discharge, titration of IOP may occur, decreasing the frequency to less than three (3) times per week. IOP must include one therapy session per day, inclusive of (at least) one individual therapy session per week. Random drug screens can be completed on the same day that a patient attends and are reimbursed separately.

Partial Hospitalization Program (PHP):
A non-residential service provided in a general hospital, private freestanding psychiatric hospital, state operated facility or by a provider that is a non-profit entity that involves ambulatory intensive psychiatric and/or substance abuse treatment services. PHP services are designed to serve individuals with significant impairment resulting from substance abuse as well as co-occurring psychiatric disorders. These services target adults who have recently been discharged from inpatient facilities, or whose admission to inpatient care may be prevented by treatment in PHP program. PHP consists of therapeutic programming of **a minimum of four (4) hours per day, at least four (4) days per week**, based on a comprehensive and coordinated individualized treatment plan involving the use of multiple concurrent treatment services and modalities. Treatment focuses on reducing symptoms, improving functioning, maintaining community connection, and relapse prevention. As a client is preparing for discharge, titration of PHP may occur, decreasing the frequency to less than four (4) times per week. PHP must include one therapy session per day, inclusive of (at least) one individual therapy session per week. Random drug screens can be completed on the same day that a patient attends and are reimbursed separately.

Urine Drug Screens:
Urine drug screens are used to determine the recent use/abuse of substances. Random urine drug screens are defined as two (2) urine drug screens per week for a period of six (6) weeks. Random screens should not occur on the same day and time each week. In order for the screens to be random, the client may be contacted by the treatment provider and asked to come in within the next twenty- four (24) hours for a drug screen, provided it is not on a day when treatment services are provided. Random drug screens can also be requested for a client who is not in active treatment under the following circumstances:

- In response to a court ordered request or;
- Has had an evaluation within the past six (6) months.

Hair Testing:
Hair testing is utilized to determine a three-month history of substance use/abuse history prior to the hair test. Careful collection of samples by authorized treatment providers following collection guidelines is necessary to ensure effective use of hair testing. **Positive** hair test results can be further analyzed to determine if the client's use/abuse of substances occurred within 30/60/90 days prior to collection. This multi-sectional testing can be performed on a positive sample per request of the referring DCF Social Worker. A hair test may be requested for some of the following reasons:

- Family reunification planning is expected to occur in the immediate future.
- DCF or provider staff has reason to believe that client has attempted to alter the urine drug screens or failed to keep scheduled appointments.
- Central or Area Office has concerns about a particular high risk or high profile case.

- DCF staff identifies cases in which domestic violence is connected with substance abuse.
- The Court requires documentation of historical drug use during a 30/60/90 day period
- DCF staff identifies abuse/neglect cases in which the primary caregivers are said to be in recovery from substance abuse.

Treatment Levels of Care

In this section guidelines adapted from the ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised (ASAM PPC-2R), published by the American Society of Addiction Medicine ASAM in 2001 are used to define treatment levels of care. Each level of care has general characteristics and criteria. Project S.A.F.E provides reimbursement to providers for all of the outpatient levels of care:

- Outpatient Services – Level I SA1.1
  Individual Counseling, Family Counseling, Group Counseling, Urine Screens, and Hair test
- Intensive Outpatient Services – Level II, SA II.1
- Partial Hospitalization Program Services – Level II, SA II.5

In an effort to provide general guidelines, we have included a level of care (page 13-15) table in this Preferred Practices document. It is intended as a guide for clinical practice rather than a set of rules.

Service Limitations and Exclusions

A. The following limitations shall apply to substance abuse services performed under Project S.A.F.E
   a. Covered services and procedures are limited to those listed in the Project S.A.F.E. fee schedule
   b. At the time of initial referral from the DCF Social Worker the following types of visits can be authorized:
      i. One (1) evaluation
      ii. One (1) urine drug screen
      iii. Twelve (12) random drug screens
      iv. One (1) hair test
      v. Undisclosed number of outpatient SA I.1 levels of care
   c. Medication Management is not a reimbursable service under Project S.A.F.E.

B. Reimbursement for the following behavioral health services is excluded under Project S.A.F.E
   a. Psychiatric evaluation
   b. Medication Management
   c. Psychological Assessment
   d. Services that Project S.A.F.E., DCF and DMHAS determine are not directly related to the diagnosis and treatment of a behavioral health disorder or those that do not reduce symptoms and/or psychological distress.
   e. Services, consultation or information provided over the telephone
   f. Services that Project S.A.F.E., DCF and DMHAS determine are primarily for vocational or educational guidance or that is related solely to a specific employment opportunity, work skill work setting and/or the development of an academic skill.
   g. Breathalyzer
   h. Methadone Maintenance

C. Project S.A.F.E. shall not reimburse for inpatient or residential levels of care.
D. Project S.A.F.E. does not reimburse for psychiatric evaluation or medication management.
E. Project S.A.F.E. does not reimburse for any required spend-down funding, and/or co-payment requirements