

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD



CLINICAL SERVICES POLICY AND PROCEDURES MANUAL

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CLINICAL SERVICES POLICY AND PROCEDURE MANUAL

TABLE OF CONTENTS

OVERVIEW OF CLINICAL SERVICES	5
CRITERIA FOR ACCEPTANCE	6
CUSTOMER SERVICE	6
INTAKE PROCEDURES	6
Case Assignments.....	7
Waiting List Policy.....	8
Vocational Counseling.....	9
CULTURALLY COMPETENT SERVICE DELIVERY	10
EMERGENCY INTERVENTION.....	10
CONFIDENTIALITY	11
Procedure Regarding Response to Subpoena Duces Tecum:	12
Procedure Regarding Response to Subpoena for Witness (Court Appearance):	13
ORIENTATION TO SERVICES.....	15
Treatment Planning and Service Delivery.....	16
Evidence-Based Practices.....	19
CONTRABAND.....	20
EMERGENCY SERVICES.....	21
Mission.....	21
Goal.....	21
Target Population	21
Admission Criteria	22
Available Services	22
Special Populations.....	23
Discharge Criteria for ES and Child/Adolescent Crisis	24
Hospital Admission/Discharge and Case Management Coordination	25
MENTAL HEALTH OUTPATIENT SERVICES	26
Mission Statement.....	26
Goals	26
Target Population	26
Admission Criteria	27
Transition/Discharge Criteria	27
Available Services	27
Psychological Evaluations	27
Engagement	28
Peer Services.....	28
Adult Therapy.....	29
Family Therapy.....	29
Group Therapy.....	30
Medication Management	30
Special Populations.....	32
Exclusionary Criteria	33
Exclusionary Criteria	34
CHILD AND ADOLESCENT SUPPORT SERVICES.....	35
UTILIZATION REVIEW	35
Mission Statement.....	35
Goal.....	35
Target Population	35
Admission Criteria	36

Exclusionary Criteria	36
Continued Stay Criteria	36
Discharge Criteria	36
CHILD AND ADOLESCENT CASE MANAGEMENT SERVICES.....	37
Mission Statement.....	37
Goal.....	37
Admission Criteria	37
Available Services	38
Exclusionary Criteria	39
Continued Stay Criteria	39
Discharge Criteria	39
Transition to Adult Services	39
Expected Length of Service.....	39
Frequency of Service Plan Review	40
HIGH FIDELITY WRAP AROUND SERVICES.....	41
Mission Statement.....	41
Goal.....	41
Target Population.....	41
Special Population.....	41
Admission Criteria.....	41
Exclusionary Criteria.....	41
Available Services.....	41
4 Phases.....	42
MENTAL HEALTH CASE MANAGEMENT POLICIES.....	42
Mission.....	42
Goal.....	42
Target Population.....	42
Diagnosis.....	43
Duration of Illness.....	43
Exclusions and Terminations from Service.....	43
Available Services.....	44
Identification.....	44
Assessment.....	44
Engagement.....	44
Coordinate.....	44
Linking.....	44
Monitoring of Medical Care.....	45
Monitoring Services.....	45
Advocacy.....	45
Reasonable Accommodation.....	45
Staffing.....	45
Referrals.....	46
Checklist Criteria for Serious Mental Illness.....	46
Transitioning Individuals from Jail.....	47
Transitioning Individuals from Child & Adolescent Case Management.....	47
Treatment Team Meetings.....	48
Discharge and Case Closure.....	48
Criteria for Discharge.....	49
Adult Mental Health Case Management Levels.....	49
Level 1.....	49
Level 2.....	50
Level 3.....	52
GOVERNOR'S ACCESS PLAN (GAP).....	53
PROJECT FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH).....	55
SUBSTANCE USE DISORDERS SERVICES	55
Mission Statement.....	55

Goal.....	55
Target Population.....	56
Special Populations.....	56
Admission Criteria.....	57
Exclusionary Criteria.....	57
Available Services.....	58
Assessment.....	58
Individual Therapy.....	58
Treatment Groups.....	58
Intensive Outpatient Program (IOP).....	58
Drug Screening.....	58
Jail-based Services.....	59
Residential Treatment.....	59
Acupuncture.....	59
Support Groups.....	59
SUBSTANCE USE CASE MANAGEMENT SERVICES.....	61
Mission Statement.....	61
Program Goals.....	61
Target/Priority Population.....	61
Case Management Procedures.....	62
Exclusionary Criteria.....	64
ADMISSIONS TO WESTERN STATE HOSPITAL OF PERSONS WITH A PRIMARY SUBSTANCE ABUSE DIAGNOSIS.....	67
Discharge Planning and Follow-up Appointments.....	67
Medical Appointments.....	67
RAPPAHANNOCK REGIONAL JUVENILE DRUG TREATMENT COURTS.....	91
PROGRAM OVERVIEW.....	91
Mission Statement.....	91
Program Description.....	91
Participating Members of the Drug Court Team.....	92
Assessment Process.....	95
Mission Statement.....	96
Goal.....	96
Admission Criteria.....	97
Exclusionary Criteria.....	97
Continued Stay Criteria.....	97
Discharge Criteria.....	97
Expected Length of Services.....	97
Frequency of Review.....	97
ASSESSMENT AND DOCUMENTATION.....	97
Medical History.....	97
Progress Notes.....	98
Diagnostic Study.....	98
Individual Service Plan.....	99
Quarterly Progress Reports.....	101
DISCHARGE AND TRANSITION PLANNING.....	101

OVERVIEW OF CLINICAL SERVICES

The Clinical Services Division of the Rappahannock Area Community Services Board (RACSB) consists of programs dedicated to education, recovery treatment, and the wellness of Planning District 16 residents affected by mental health and substance abuse disorders.

The Clinical Division policies are built on the biopsychosocial model, which supports the fact that individuals are a complex combination of the biological, psychological, social, experiential, physical, and spiritual. In addition, RACSB understands that service delivery must be person centered and the individual sets his/her goals for treatment. These two concepts are intertwined by the fact that everyone does not experience the same event as traumatic; therefore, assessment and treatment planning must be person centered. RACSB is transitioning to a trauma informed system of care.

RACSB recognizes the value of delivering services based on evidence-based practices and person-centered service delivery. In addition, engagement is of the utmost importance if an individual is going to participate in services. These principles are the basis for the policies of the Clinical Division.

This manual is organized by the general policies that all programs follow, which are contained in the Overview of Clinical Services, then policies unique to each program can be found under the related title of each section.

Family and Community Involvement

Research shows that most individuals are successful in recovering from a mental health and/or substance use disorder when there are family supports, appropriate and effective friendships, and the individual is rooted in the community via support groups, work, their faith, or other positive connection. As a result, each program discussed in this manual encourages the family, as well as members of the individual's support system, to participate in treatment as agreed upon by the individual receiving services. Thus, it is encouraged to obtain a signed release of information for emergency contacts as well as other family members/members of support system. Frequently, the individuals receiving services have goals to strengthen communication skills or relationships with key family members.

The programs operated in the Clinical Division are listed below. Each service is provided at the clinic located in that locality unless otherwise indicated. Please note that if a service is provided at one specific site, an individual residing in Planning District 16 is served at that site.

- Outpatient therapy for individuals, groups, families, adolescents, children with substance use disorders, mental health needs, or intellectual disabilities
- Medical Psychiatric Services beginning at age two
- Adult Mental Health Case Management
- Child and Adolescent Mental Health Case Management, Intensive Care Coordination, Utilization Review

- Substance Abuse Case Management-Primarily at Fredericksburg Clinic
- Specialized Substance Abuse Services to Women-At Fredericksburg Clinic
- Substance Abuse and Mental Health Services are delivered to adults and adolescents based on unique service agreements between RACSB and community stakeholders
 - Adult and Juvenile Drug Treatment Court
 - Rappahannock Area Office On Youth-services provided onsite
 - District 21 Probation and Parole-services provided onsite
 - Safe Harbor Child Advocacy Center-services provided onsite
- Emergency Services
- Medication Assisted Treatment-Primarily at Fredericksburg Clinic
- Project LINK

CRITERIA FOR ACCEPTANCE

All services shall be offered in compliance with the Civil Rights Act of 1964 and all other applicable Federal and State Regulations. There shall be no discrimination based on gender in addition to the above-named regulations. (See admission criteria for each service program.)

RACSB does not provide outpatient therapy or medical services to RACSB employees or their family members. Any employee who requests therapy services will be referred to the RACSB Employee Assistance Program, which is a benefit available to all employees. Information about the Employee Assistance Program is available on the RACSB internal employee Intranet and through the Office of Human Resources. At the same time, RACSB acknowledges that there are mitigating circumstances where an employee or a member of their family may need to receive services at RACSB which will require approval from the Executive Director

CUSTOMER SERVICE

RACSB values the individuals receiving services and wants each person to feel welcome at RACSB. In an effort to transition to a trauma informed system of care, the administrative staff, who work at the front desk of the outpatient clinics will complete a course in Mental Health First Aid as well as trauma informed systems of care. The Clinic Coordinator and Office Manager/Office Associate shall monitor the waiting room to ensure it remains neat and clear of debris. Complaints are directed to the Office of Consumer Affairs.

INTAKE PROCEDURES

Referrals are accepted from the individual seeking services, either in person or via the telephone, as well as from all appropriate community agencies. Individuals seeking services who need immediate intervention are connected to Emergency Services. The Emergency Services number (540-373-6876) is directly connected to the Emergency Services staff, bypassing the front desk.

Same Day Access (SDA) is provided at each outpatient clinic primarily for adults and older adolescents. Individuals are directed to come to the clinic to initiate services instead of scheduling an appointment.

Individuals discharged from a psychiatric facility will receive a scheduled appointment. Specific policies regarding services to individuals discharged from a psychiatric facility are outlined later in this manual.

Minimum requirements for internal referrals:

- Ability to communicate (If the individual is hearing impaired or does not speak English, an interpreter shall be arranged. This should be noted on the referral form.);
- Ability to provide informed consent;
- Therapy is the appropriate service needed to support the individual in obtaining the goals identified.
- Individual will have identified treatment needs
- All assessments are to be presented to the Clinic Coordinator to ensure to ensure that the individual is linked to appropriate provider.

Case Assignments

Once a clinician completes an intake, the Adult Assessment or Child Assessment and the American Society of Addiction Medicine assessment shall be printed by the clinician and submitted to the Clinic Coordinator for case assignment the same day. Preferably, this discussion will occur prior to the individual leaving the appointment.

Case Assignment for Special Populations Enrolling in Substance Use Disorder Services

Individuals who are pregnant and injecting substances, pregnant and using Opioids, pregnant and using other substances, as well as those with a history of the same shall be offered an appointment within 48 hours. In addition, individuals injecting substances or using Opioids, or with a history of the same shall be offered an appointment within 48 hours of requesting services. All other individuals using substance will be served after individuals described above.

If RACSB has established a wait list, these individuals shall be served first. In the rare occurrence that these individuals cannot be seen for fourteen days, each will receive educational materials about the dangers of sharing needles, related health issues (TB, Hepatitis B and C, HIV, AIDS), support groups, RACSB's Emergency Services number, and other community providers who may be able to assist. The Substance Use Case Manager will also call the individual daily and/or the emergency contact.

If these individuals are placed on a wait list, they will receive the same information and phone calls but will also be linked to other community providers of Medication Assisted Treatment (MAT) and other substance use disorders treatment providers.

The Executive Director, or designee, shall notify the Women's Services Coordinator at the Department of Behavioral Health and Developmental Services of a waiting list.+ All other individuals using other substances and/or alcohol, shall be placed on the waiting list or referred to other providers. If they have insurance, they will be assisted in locating a provider in their network.

Juvenile and Adult Drug Treatment Court referrals will not be placed on a waiting list because RACSB is held to a Memorandum of Agreement with the Rappahannock Drug Treatment Courts.

WAITING LIST POLICY

RACSB attempts to avoid initiating a waiting list for Outpatient Services but there are times that a waiting list is not only necessary but appropriate. When RACSB is recruiting therapists or case managers, there may be a need to establish a waiting list. In addition, since RACSB is one of the few organizations in Planning District 16 that accepts Medicaid, it is feasible that a waiting list would be needed because of the limited number of providers who serve individuals with Medicaid. All individuals will be placed on the waiting list based severity of need, not on payer source.

In order to establish a waiting list, the Clinic Coordinator or Program Supervisor must recommend a waiting list be established, which, in most cases, will be due to vacancies in clinical positions which are not anticipated to be resolved quickly. This recommendation is submitted to the Clinical Services Director. The Clinical Services Director can either recommend to the Executive Director that a waiting list be established or recommend that the request be denied. The Executive Director must approve all waiting lists before one can be established.

Once a waiting list is approved and established, community stakeholders are notified via letter as well as at community meetings where RACSB is represented. Each Clinic Coordinator or Program Supervisor must maintain a list of people who have agreed to be placed on the waiting list on the Waiting list Form

Each person who calls to request services, if presenting with an urgent request or emergency, shall be connected to the Clinic Coordinator or a clinician for triage to determine the need for emergency assistance. Individuals who walk into the clinic to request services shall meet briefly with a clinical staff member to assess if the person needs emergency intervention. Urgent referrals should be seen without delay and referred to Emergency Services.

Each Clinic Coordinator or Program Supervisor conducts a minimum of a weekly review of the waiting list. This review shall include clinical staff, the Clinic Coordinator, or the Program Supervisor, contacting the person by phone to inquire about the status of their symptoms as well as their interest in remaining on the waiting list. The Clinic Coordinator or Program Supervisor shall provide an approximate time when the person can expect to be scheduled.

Those on the waiting list will be seen as soon as the appropriate therapist has time available on his/her schedule. When more than one therapist has time available to provide services, therapists may consider their treatment specialties in selecting persons for their caseload. However, referrals will be responded to without prejudice, with therapists adhering as much as possible to a chronological progression and with sensitivity to the priority status of the referral. When a waiting list is established, people who reside outside of Planning District 16 will not be served.

The Department of Medical Assistance Services (DMAS) requires that people who have Medicaid choose their provider, regardless of where the person may reside. Outside of the Medicaid requirement, when RACSB establishes a waiting list at a clinic, only people who reside within Planning District 16 shall be served to prioritize services to people who are in need and reside in

the communities RACSB serves. Individuals will be given the opportunity to be placed on the waiting list. However, they will be encouraged to access services in their locality.

Substance Use Disorder Services:

When RACSB has a wait list, individuals who are pregnant and injecting substances, pregnant and using other substances, and all other individuals injecting substances shall be offered an appointment within 48 hours despite the waiting list. Individuals who are not pregnant but are injecting substances or using opioids, shall also receive an appointment within 48 hours; however, if RACSB is running a wait list, these individuals will receive educational materials about the dangers of sharing needles, related health issues, support groups, RACSB's Emergency Services number, and other community providers who may be able to assist. In addition, with approval from the Executive Director, the Department of Behavioral Health and Developmental Services will be notified. All other individuals using other substances and/or alcohol, shall be placed on the waiting list or referred to other providers. If they have insurance, they will be assisted in locating a provider in their network.

Juvenile and Adult Drug Treatment Court referrals will not be placed on a waiting list because RACSB is held to a Memorandum of Agreement with the Rappahannock Drug Treatment Courts.

Staff Qualifications

Staff will be recruited and employed in keeping with the policies of RACSB as well as the required and preferred qualifications noted in the relative job descriptions. Staff will be assigned to programs based on the job duties and program requirements.

Supervision

Unlicensed staff with a Master's degree in Counseling or Social Work, shall be eligible to register a supervisor with the Virginia Board of Health Professions to receive clinical supervision toward licensure. The clinical supervision contract shall be signed in keeping with RACSB's policies as outlined in RACSB's supervision agreement. Supervision shall be documented on RACSB's supervision notes form.

Mental Health

Individual who are discharged from a state or private psychiatric facility will not be placed on the waiting list.

Priority will be given to the following populations in this order:
Children referred by the local Family Assessment and Planning Teams
Children referred by the Department of Social Services
Veterans and their families

Vocational Counseling

Individuals receiving services in the mental health or substance use disorder programs are strongly encouraged to take advantage of the vocational rehabilitation services offered at the local office of the Department of Aging and Rehabilitative Services (DARS). RACSB has a strong partnership with staff at DARS. The Rehabilitation Counselors come to all RACSB's outpatient clinics to educate groups on the services available via the DARS program, to meet with individuals on a one-to-one basis, and attend staff meetings to coordinate individual's needs. All these activities require an active, signed Confidential Release of Information, which can be generated by DARS or RACSB but must be contained in the electronic health records and meet 42.C.F.R. requirements.

Culturally Competent Service Delivery

Cultural competence is one of the six guiding principles of Trauma Informed Systems of Care. Staff members of RACSB have become increasingly aware of the needs to provide culturally competent services. RACSB is dedicated to responding effectively to the changing multicultural nature of Planning District 16.

RACSB strives to be culturally-competent service providers by fostering an appreciation for the unique family customs, perspectives and histories of the specific groups we serve. RACSB has an employee who has been trained to provide interpreter services in the health field for Spanish speaking individuals. Otherwise, RACSB uses Proprio Language Services for telephonic Interpreting.

In an effort to promote appreciation of cultural diversity, RACSB utilizes a workshop and in-service training approach to our personal and professional growth. Staff members are encouraged to share their experiences in consultation and discussion. All clinical staff members are encouraged to attend conferences and workshops which address culturally competent service delivery, and they participate in a minimum of one (1) in-service program each year that is intended to enhance cultural sensitivity. Whenever requested, individuals seeking services are connected with staff members from their own cultural group.

RACSB partners with the Virginia Department of Health and Catholic Charities in their efforts to support Refugees coming to the United States.

EMERGENCY INTERVENTION

The programs in the Clinical Services Division promote the belief that persons receiving services are entitled to be completely free from any unnecessary use of seclusion, restraint and time out. Staff in these programs shall not use seclusion or restraint. It is the policy of RACSB to use emergency interventions only when all other methods of intervention have failed.

Clinical Services staff may use emergency interventions in an emergency, but only to the extent necessary to stop the emergency and only if:

- Less restrictive measures have been exhausted; or
- The emergency is so sudden that no less restrictive measure is possible.

CONFIDENTIALITY

Information gained during service provision in Clinical Services programs is confidential and shall be made available only to those legally authorized to have access to that information under federal and state laws. Moreover, precautions are taken to prevent inadvertent disclosure of information by appropriately securing records and by maintaining vigilance over privacy during oral discussions with and about individuals receiving services. As part of the intake process, persons seeking services are provided information regarding confidentiality and limits thereof.

With the inception of the electronic health record (EHR) all employees who use The EHR to complete clinical documentation will have access to all clinical records of the people served at RACSB, regardless of which clinic or program the person is enrolled in. Only RACSB employees who have a legitimate, clinical or administrative cause to access the clinical record (quality assurance reviews, supervisory reviews, clinical documentation due to providing a service to this person, critical incident reports) are to access the record.

When needed, a block can be placed on a specific chart to prohibit a RACSB employee from accessing the record. Coordinators or Supervisors shall obtain the approval of the Clinical Services Director prior to contacting the IT Department to request an employee be blocked from accessing a clinical chart.

RACSB has the capacity to encrypt e-mails containing protected health information and meets the Health Insurance Portability and Accountability Act (HIPAA) requirements. All other policies which address information technology can be found in the *Information Technology Policies* on RACSB's internal employee Intranet under *Policy and Procedure Manuals*.

State and federal confidentiality laws bind information on services provided at RACSB. Information that needs to be shared in cases of emergency, court orders, search warrants, subpoenas, duty to warn requirements, and mandated reporting requirements are codified requirements through which information may be released without the prior consent of the person receiving services. Any employee served with a search warrant at a site operated by RACSB should immediately notify the program supervisor for direction. In most instances, an attempt will be made to seek a legal opinion; therefore, the Clinical Services Director shall be notified immediately in this instance. The Clinical Services Director shall immediately contact the Executive Director. Employees will, however, comply with law enforcement mandates in the event of emergency situations or when a law enforcement officer refuses the request of the employee to seek further direction.

When releasing clinical information that pertains to substance abuse services, RACSB employees shall inform the person that the records that will be released contain information regarding substance abuse services. The substance abuse section on RACSB's Release of Information form shall be checked and any other clarifying information shall be noted on the Release of Information Form. RACSB enforces the limits set by 42.C.F.R. on releasing substance abuse related clinical documentation or information.

Training on confidentiality, Human Rights, Code of Ethics, Corporate Compliance is provided at New Employee Orientation and annually. For more information, see RACSB Employee Handbook.

Advanced Directives

RACSB supports the Recovery Model in all its programs. A vital component of this model is the use of Advanced Directives. Advanced Directives are used to designate an agent the individual can trust to carry out the individual's wishes, to advocate for what the individual would want, and who will adhere to the individual's instructions and preferences. Advanced Directives can cover medical health care, mental health care, or end of life care. RACSB will access assistance in developing Advanced Directives through the Department of Behavioral Health and Developmental Services as well as RACSB employees who have been trained to develop an Advanced Directive.

Capacity Evaluations

In keeping with the Human Rights Regulations of the Department of Behavioral Health and Developmental Services, a capacity evaluation shall be completed by a clinician licensed by the Virginia Board of Health Professions when an individual is in need of or requests an authorized representative be designated.

Subpoena for Witness and Subpoena Duces Tecum

When employees are issued a Subpoena for Witness, they are to notify their supervisor immediately and have the subpoena reviewed by the Clinical Services Director or the Corporate Compliance Officer. The purpose of review is to assure that the subpoena meets all necessary legal requirements to disclose confidential information.

If the subpoena is complete, and staff attends a court hearing, it is recommended they call issuing Counsel prior to their attendance to review what is expected of them during the proceedings. In addition, it is recommended, to the extent possible, that staff inform the individual receiving services prior to the court appearance. Staff should inform their supervisor and document in the case notes when they received the subpoena, when they appear in court, and the outcome of that appearance. Staff should not take the entire medical record with them to court unless specifically requested to do so.

Procedure Regarding Response to Subpoena Duces Tecum:

1. When a subpoena duces tecum is delivered to Rappahannock Area Community Services Board, the staff member in receipt of the subpoena is responsible for forwarding the subpoena to the Clinical Services Director or the Corporate Compliance Office within one business day. The subpoena shall also be stamped with the date of receipt.
2. The Clinical Services Director or the Corporate Compliance Officer reviews the subpoena duces tecum to determine if it has been properly served.
3. If the subpoena has been improperly served, the Clinical Services Director or the Corporate Compliance Officer contacts the individual who initiated the subpoena and explains the corrections that are necessary.

4. If the subject of the subpoena did not receive treatment in a substance abuse program, the record is photocopied.
5. The Executive Director signs and has notarized a form (form found on RACSB's Intranet) certifying that the records being sent are true copies of all original records in the possession of Rappahannock Area Community Services Board, for that individual.
6. The Clinical Services Director shall receive a letter from the Council who issued the Subpoena Duces Tecum indicating whether or not a Motion to Quash was filed.
7. The photocopied record and the certificate are forwarded as requested in the subpoena.
8. If the person received services in a substance abuse program, the Clinical Services Director or the Corporate Compliance Officer contacts the individual initiating the subpoena and provides information regarding the Federal Substance Abuse Confidentiality Law (42 C.F.R.). The medical record cannot be released without a court order that adheres to the requirements of 42 C.F.R.

Procedure Regarding Response to Subpoena for Witness (Court Appearance):

1. When a subpoena is served to any staff member of Rappahannock Area Community Services Board, he/she consults with the Clinical Services Director or the Corporate Compliance Officer who determines if the subpoena has been properly served.
2. If the subpoena has been improperly served, the staff member will contact the Clerk of Court that served the subpoena and indicate that he/she will be unable to respond to the subpoena in its present form.
3. Employees must receive a Subpoena for Witness in order to testify in court.

PAYMENT FOR SERVICES

The Rappahannock Area Community Services Board does not deny services because of inability to pay. At the time the individual requests services, financial information is obtained from the caller. The Office Managers or Office Associates also verify benefits if the person has insurance of any type. If the person presents in person, the financial interview will be completed at that time. It is in this interview that a determination is made regarding the ability of the person seeking services to pay, whether third party billing can occur, and if the individual is eligible for financial assistance.

Outpatient and case management services provided at RACSB are supported by fees collected directly from individuals and from third-party payers. Outpatient therapy services have also been subsidized in part by funds provided by the localities served by the CSB. As a result of this subsidy, it is possible to provide some of the services to individuals at a reduced rate, based upon their ability to pay. Except for those persons for whom any payment would present an extreme financial hardship, some financial participation is expected, to defray costs as well as to demonstrate investment in the treatment process. The amount of the payment for self-payers is determined, in consultation with the individual, during the financial interview. Co-payments for insured persons are determined by the terms of their policy. All persons receiving services are expected to make the agreed payment in full at the time that the service is rendered. If an individual's financial situation changes during the course of treatment, the clinician should make a referral to Reimbursement, so that the financial agreement can be updated.

Should a person indicate an inability to meet the payment obligation, a Clinical Addendum or a Deferred Payment may be pursued. Policies related to these two options can be found in the ***Financial Policies and Procedure Manual*** on RACSB's Intranet.

Individuals who do not pay the co-pay shall receive the service he/she was scheduled to receive; however, the individual may not be scheduled for another service until the co-pay is paid in full. Exceptions to this requirement involves individuals diagnosed with a serious mental illness who refuse to make the agreed payment and for whom discontinuation of services would severely impair their ability to maintain a satisfactory adjustment in the community. In addition, women who are pregnant and injecting substances, women who are pregnant and using substances, and all individuals injecting substances are also excluded from this requirement. In such circumstances and after consultation with the supervisor, the clinician will discuss the reasons for seeking an exception to the fee requirement. Coordinators/Supervisors may wish to consult with the Clinical Services Director when making these decisions.

Certain Outpatient Services are not eligible for financial assistance, including: medications; Intensive Care Coordination; Clinical Mediation; Substance Abuse Evaluations, and Sex Offender Risk Assessments. Sex Offender Risk Assessments shall be conducted by clinicians who are Certified Sex Offender Therapists through the Virginia Board of Health Professions. In addition, services that are not ongoing in nature, such as psychological and substance abuse evaluations that have been ordered by the courts are not eligible for financial assistance. Court ordered marital mediation also is not eligible for the sliding fee scale. Exceptions may be granted for extenuating circumstances on an individual basis, in consultation with the Clinical Services Director. A full description of the agency's policies related to fee collection can be found in the ***Financial Policies and Procedures manual***.

Therapist/Case Manager Role in Payment for Services

Best practice and research supports that individuals who pay a fee for a service, regardless of the amount, increases in motivation and investment in treatment. Therapists shall be notified by the Office Manager/Office Associate each time an individual cannot pay the co-pay for the therapy service.

The Therapist shall adhere to the following procedure:

- Provide the scheduled service to the individual.
- Determine if the individual falls into the exceptions noted above.
- Problem solve around how to make a payment, barriers to payment.
- If the individual does not fall into the exceptions noted above, do not reschedule the individual.
- Discuss the individual with his/her supervisor to ensure there are no other options for payment and to make sure all clinical needs are addressed.
- Individuals who are presenting as a follow up to a psychiatric hospital admission or admission to a residential facility shall be seen for the entire session, regardless of ability to pay.
- Individuals who are pregnant and injecting substances, pregnant and using other substances, or all individuals who inject substances are to be seen regardless of ability to pay.

- All of the above actions shall be documented in the individual's electronic health record the same day.

No Show/Cancellation Policy

Therapy Appointments

A "no show" is defined as not attending the appointment without calling to cancel the appointment. A cancellation in less than 24 hours is defined as someone who calls to cancel an appointment but does not do so within 24 hours of the appointment. Both a "no show" and a cancellation in less than 24 hours results in a charge of twenty dollars. Please reference RACSB's financial policies for details on charges for these appointments.

Two cancellations and/or "no shows" may result in services being suspended until the individual can commit to participate in treatment. Two cancellations and/or "no shows" can be a combination of one "no show" and one cancellation. If an individual provides a 24-hour notice for the cancellation, while the individual will not be charged, the missed appointment will count toward the limit of two "no shows" and/or cancellation.

Therapists and case managers shall not close an individual to services without the approval of their immediate supervisor. The Clinic Coordinator and Supervisors have the option to have the individual sign a No Show/Cancellation Contract.

Medical Appointments

The no show/cancellation policy applies to the medical program as noted above to include payment for services as well as the population excluded from these policies. If an individual has not seen a RACSB prescriber in six months, he/she may be required to complete a clinical assessment with a therapist or case manager prior to seeing the prescriber. The prescriber can decide if he/she wishes to refill medications in the interim.

ORIENTATION TO SERVICES

General orientation to services at the Rappahannock Area Community Services Board will be provided at the initial intake completed by a therapist or case manager. Orientation provides the individual with the opportunity to understand the purposes, programs, and services of RACSB. Orientation information is given in a manner understandable to the person receiving services. All persons entering services are provided a copy of the **Consumer Handbook**, a pamphlet that provides an overview of the agency and gives some indication of what persons might expect as they enter services at RACSB. They sign the appropriate document to indicate that he or she has received the orientation information.

RACSB is transitioning to a trauma informed system of care. Therefore, RACSB acknowledges that the majority of the persons receiving services have events he/she may have experienced as traumatic. In addition, it is possible the individual may be experiencing an emotional crisis at the time of intake. With that reality in mind, RACSB acknowledges that the RACSB Orientation cannot be completed if the person presents with symptoms to the point that such discussion is

counter indicated. In this situation, the clinician or case manager shall document in the **Collaborative Note in AVATAR** that the Orientation could not be complete as well as the reason. The first session where the person's symptoms are stable, the RACSB Orientation shall be reviewed and documented.

During the orientation phase of the intake process, the following topics will be addressed:

- Services provided by RACSB;
- Availability of 24-hour emergency services;
- Services being goal focused;
- The need for participant involvement in every phase of services;
- Rights of person being served, including access to the advocate, grievance and appeal procedures;
- Staff member responsible for coordinating services and description of role of that individual;
- Financial interview, which includes financial responsibility to the agency;
- Confidentiality and the limits of confidentiality;
- Safety considerations; and Safety Plan developed if needed
- Definition of Therapy will be discussed so individual understands the therapeutic process
- No Show/Cancellation Policy for Medical and Outpatient Services
- Discussion of group therapy and types of groups offered
- Discussion of Discharge Planning and recommended number of individual sessions to complete individual therapy

Program specific topics will be covered upon admission to individual programs.

Treatment Planning and Service Delivery

All treatment at the Rappahannock Area Community Services Board is individualized and person-centered to meet the needs of the individual. Again, as RACSB transitions to a trauma informed system of care, the therapist or case manager will want to ask what happened to the individual, identify inherent strengths that the individual can use in recovery, and identify the idiosyncratic way in which diagnosis with broad, general descriptions are manifested in very personal, person centered, individualized ways because no two people are the same.

All problems, goals, and objectives shall be written using the individual's words and in a fashion that the individual can read and understand the Treatment Plan.

There are two types of treatment plans.

The Preliminary Treatment Plan is completed by the therapist or case manager the same day as the initial clinical assessment. The purpose of this Plan is to show that an initial discussion regarding treatment goals occurred during the first appointment. In response to the question regarding level of risk, behaviors such as ongoing use of heroin, cutting with a razor blade, reluctance to take psychotropic medications, and reluctance to take medications for physical health are examples of the type of risks that shall be addressed on this plan. These risks shall be reflected

in the assessment, initial treatment plan, and comprehensive progress notes. A **safety plan shall** be developed immediately when risk is identified. The safety plan shall be scanned into the chart under assessment.

A more **Comprehensive Treatment Plan**, which directs the service delivery, is developed in conjunction with the individual shall be completed by the **fourth appointment or within thirty days of the initial assessment**, whichever date comes first. Brief treatment approaches build on existing strengths and abilities possessed by the individual. This comprehensive treatment plan, shall delineate the anticipated outcomes, the strategies likely to be used to achieve these outcomes, and the expected date of accomplishing these outcomes. In addition, the treatment plan and/or activity notes will identify triggers, assess for risk and dangerous behaviors, and list current coping skills. Goals and objectives shall be measurable and time limited. The problems, goals, objectives of the treatment plan shall be supported by the information in the initial assessment or intake assessment.

Efforts are made to accommodate are made to address the needs of special populations. These include, but are not limited to, interpreters/translators and/or staff with specific training regarding culturally competent service delivery, offering services in a different geographical location (if hours of operation or physical accessibility is an issue), etc.

Safety Planning

A Safety Plan shall be developed at the first session, and anytime during treatment if needed, if the individual presents as a risk to self, others, or a severe safety risk such as running away. The safety plan form that can be found on RACSB's Intranet under Forms, "Safety Plan." This plan shall be scanned into the chart and a copy provided to the individual and family/support system, if applicable. The treatment plan shall be updated to include any necessary changes. If there is no change to the treatment plan, updating is not required. In addition, if the individual is new to RACSB, the risk shall be addressed in the Preliminary Treatment Plan to include a narrative specifying the risk. The Preliminary Treatment Plan shall be completed at assessment for outpatient services.

Medical History and Health

Individuals living with comorbid mental health and substance use disorders frequently are diagnosed with chronic health conditions. These individuals die, on average 25 years earlier than individuals who have the same chronic health issues but are not diagnosed with a mental health diagnosis or substance use disorder. Therefore, RACSB emphasizes the need to support individuals through education, linking to medical providers, teaching the role of an emergency department, coordinating with primary care physicians.

The Medical History Form in the electronic health record is completed at intake, updated when needed but at a minimum of once a year.

Medical History/Physical Harm Reduction: This section is referencing individuals with a substance use disorder, serious mental health disorder, and/or co-occurring disorders.

Individuals who use substances as well as those with a mental health diagnosis are at high risk to contract HIV, AIDS, Hepatitis B, Hepatitis C, Tuberculosis, other severe infections, and sexually transmitted diseases. In addition, they are more apt to use the emergency room for ongoing medical care than establish a relationship with a primary care physician. Upon request or if assessed need individuals are encouraged, linked, or referred to seek medical attention. For screening for TB individuals are referred to their local Health Department or private physician to obtain.

Individuals are educated on these issues while in group, guests from the Virginia Health Department make presentations on the above noted illnesses, how to contract the illnesses, symptoms, and treatment. They also provide education on prevention.

Individuals are encouraged to be tested for these illnesses since they can be life threatening easily passed to other individuals if one is not aware of the he/she has one of these illnesses, and can lead to death.

Therapists and case managers obtain signed release of information for primary care physicians and notify the physician in writing when someone is enrolled in services, terminates services, or is placed on medication. In addition, they encourage those without a primary care physician to choose one by educating them on physician's offices near their home. The psychiatric nurses provide health education as well as referrals to primary care physicians at each visit. RACSB is aware of the need to enhance the link between primary health care and individuals living with a mental health diagnosis.

All RACSB sites meet the Americans with Disabilities Act (ADA) requirements and are accessible to persons with physical disabilities.

Staff Training

Case reviews, staff meetings, clinical supervision, peer supervision, in-service training, workshops, and conferences all support professional and programmatic growth and address the needs of the individuals served.

On the second and third Wednesday of each month a mandatory clinical training is provided. The training begins at 8:30AM and ends at 10:30AM. More time can be scheduled if needed. Training topics have included the SOAP Note, DSM-V, Acceptance and Commitment Therapy (ACT), Substance Use Disorders curriculum, Risk Documentation, Columbia Suicide Severity Rating Scale, Trauma Informed CBT (TF-CBT), Combat PTSD, VA Benefits.

Employees where a license from the Virginia Board of Health Professions is required must at least be licensed eligible in Psychology, Social Work, or Counseling. A new employee has thirty days from the date of hire to submit all paperwork to be register a RACSB licensed clinical supervisor to provide clinical supervision. The Clinical Services Director and Executive Director shall indicate approval for the employee to receive clinical supervision for licensure by signing RACSB's Licensure Agreement. If an employee must reimburse RACSB for clinical supervision hours when separating employment, a payment plan is not allowed. The amount must be paid in full prior to the final day of employment.

All clinicians are responsible for ensuring that they do not have individuals, groups, or meetings scheduled when taking planned leave or attending trainings and/or meetings.

Evidence-Based Practices

Therapist will use the evidence-based practices for which they have been trained.

Moral Recognition Therapy (MRT) is used in substance abuse groups for adults and adolescents.

The American Society of Addictions Medicine (ASAM) Placement Criteria is used to determine if the individual may best be served in an inpatient residential treatment program while another individual may require an Intensive Outpatient Program. In addition, the six components of the ASAM is used to assess treatment needs to include withdrawal symptoms and co-occurring disorders.

Substance Abuse Subtle Screening Inventory (SASSI): This assessment is used when completing substance abuse evaluations to be presented to the Court and as indicated in the outpatient Substance Use Disorders outpatient program.

Stages of Change is a tool used to assess a person's readiness to make changes in his/her life. This tool is used at the time the assessment is completed and at discharge to assess progress toward goals. Stages of Change is appropriate for use with individuals who have mental health and substance use disorders.

Motivational Interviewing is used by all therapists.

Seeking Safety is used in treatment groups for individuals who have experienced trauma and/or are diagnosed with substance use disorder.

Assertive Community Treatment (ACT)

There are other evidence-based practices used by different therapists based upon received training. For example, there is a **Dialectical Behavioral Therapy** group provided at the Fredericksburg Clinic

Screening, Brief Intervention, and Referral to Treatment (SBIRT): This evidence-based technique is used primarily by the Mental Health Nurses.

Medication Assisted Treatment (MAT) Outcome Measures for Mental Health and Substance Use Disorders Programs. The Patient Health Questionnaire-9 (PHQ-9) **is used to assess the level of depression. The individual shall complete the questionnaire at the first visit. The questionnaire is designed so the individual can respond to the questions independently from the therapist. The responses shall be reviewed during the intake as well as at future sessions as needed. The score will be noted in the Comprehensive Progress Note. The therapist may administer this tool more frequently if clinically indicated. The individual can take the tool home and fill it out, bringing it to the next therapy session.**

Stages of Change: This evidence-based practice is contained in the electronic health record and assessed at the initial assessment as well as at discharge. However, the therapists and case managers use this tool frequently while providing ongoing treatment.

Adverse Childhood Experiences (ACE): Trauma informed systems of care use the ACE to assess the number of adverse childhood experiences. These experiences can be observed or experienced. If the individual experiences the event as traumatic, research shows the risk for substance use disorders, mental health disorders, suicide, increase substantially.

Interactive Journaling: Purposeful and goal-oriented journaling developed by Dr. David Me Lee's the Change Companies.

In addition, RACSB follows the outcome measures set forth and defined by the Department of Behavioral Health and Developmental Services (DBHDS).

CONTRABAND

The use of illicit drugs within the context of Clinical Services programs or their presence on any property operated by RACSB is prohibited. RACSB provides a smoke-free environment at all the five (5) outpatient clinics. Smoking, or the use of tobacco products, on RACSB property is prohibited to include vapors. Any person found to be selling, distributing, and/or using illicit drugs on the premises will be subject to disciplinary action, including possible discharge from services. Any drugs confiscated from a person receiving services will be treated as an "unknown" medication and will be given to the medical services staff for disposal, in accordance with procedures used for disposal of surplus or expired medications.

Over-the-counter or prescribed medications will be permitted only for the personal use of the individual for whom they are intended. It is the responsibility of this individual to make certain that such medications remain in their possession at all times and should be in the original container while in RACSB facilities, and any indication that such medications are being distributed to others will subject the owner to disciplinary action, including possible discharge from services.

In accordance with the policy outlined in the **Health and Safety Policy Manual**, weapons are not allowed in any RACSB facility. The term "weapon" includes but is not limited to knives and firearms. Objects which have no logical purpose other than to inflict injury will be considered weapons. RACSB considers a weapon to be any instrument capable of inflicting bodily harm and which is used or worn in a threatening manner, as deemed by staff.

Introduction of a weapon to any RACSB facility by anyone other than a law enforcement officer acting in an official capacity is against agency policy and must be reported on an incident report form. Unauthorized possession of a weapon by a person within a RACSB facility will be grounds for denial of services, in addition to any appropriate legal sanctions. The emotional stability of the individual bringing a weapon onto a RACSB property shall be assessed and action should be taken accordingly. If the individual presents as suicidal or homicidal, the weapon should be confiscated and secured until it can be relinquished to the appropriate legal authority. If there is no indication

that suicidal or homicidal behavior is a concern, the individual should be advised to leave the property immediately and not to return until contacted by program staff.

INCIDENT REPORTS

RACSB's Incident Report policy can be found in the Administration policies. This section is intended to outline RACSB's policy regarding a response to an incident that can provide learning opportunities.

The Critical Incident Review process allows the Executive Director, Quality Assurance Coordinator, Clinical Services Director, Director of Operations, Director of Community Support to convene a team to review an incident, identify lessons learned, write a summary and submit it, within two weeks of the incident, to the Executive Director, Quality Assurance Director, Clinical Services Director and any Director who may have requested the Team meeting. Members of the Team shall be the direct service providers to the individual, another clinician for objective input, and anyone else deemed to be appropriate.

EMERGENCY SERVICES

Mission

Emergency Services provides unscheduled assessments to individuals who are experiencing a crisis or need immediate assessment in order to further determine the level of care that is indicated. The individuals receiving services are present with a mental health issue, intellectual disability or substance use disorder. Emergency services are available 24-hours per day and seven (7) days per week.

Services include crisis intervention, stabilization, and referral assistance over the telephone or face-to-face. While respecting the right of persons to control their treatment to the extent to which they are capable, Emergency Services therapists seek to work collaboratively with the individual receiving services, their families and with other agencies involved in their care to pursue a satisfactory resolution to the crisis. Emergency Services may include walk-ins, home visits, jail interventions, pre-admission screenings, and other activities for the prevention of institutionalization or associated with the civil commitment process.

Goal

To assure the individual receives the safest and most appropriate treatment in the least restrictive setting suitable to their needs.

Target Population

Those residents of Planning District 16, or individuals experiencing a crisis within Planning District 16, who meet the DSM – V criteria for a mental illness, intellectual disability, or substance abuse disorder. Crisis intervention services are reserved for those persons requiring immediate care in order to insure their safety or the safety of others.

Admission Criteria

Emergency Services are available to individuals who, due to mental illness, intellectual disability or a substance use disorder, are experiencing significant and acute disruption in their ability to function in their daily lives. Referrals for crisis intervention services may be made by the persons themselves or by persons concerned that an individual's mental state may have a negative impact on the physical safety of the individual or another person. Referrals will be taken in person at the Fredericksburg Clinic or by telephone. Outside normal working hours, emergent referrals are coordinated by an answering service, which forwards telephone requests to the therapist who is on-call. In the event of the need for crisis intervention and stabilization, an on-site intervention will be arranged.

Available Services

Interventions are conducted face-to-face or by telephone. Emergency Services staff members meet the individual at an assigned location, and a law enforcement officer may accompany the therapist when there is concern regarding physical harm. Intervention by Emergency Services personnel is intended to meet the immediate need and is not intended to be a continuing therapeutic relationship.

All Emergency Services personnel are licensed or licensed eligible and experienced in the area of crisis intervention. All have completed the state-endorsed program for certification of emergency services therapist and have met orientation requirements set forth by DBHDS. (See ***Emergency Services Policy Manual*** for further details.) Staff meetings, clinical supervision, peer supervision, in-service training, workshops and conferences support continued individual and programmatic growth. The Emergency Services Coordinator works closely with the Institute of Law, Psychiatry and Public Policy, associated with the University of Virginia, and the Department of Behavioral Health and Developmental Services (DBHDS) in order to remain apprised of changes in the statutes which affect the practice of mental health in the Commonwealth of Virginia. A licensed supervisor is on call to the Emergency Services Therapists 24 hours/day, seven days/week.

Emergency Services serves as the designated agent for assessing the need for involuntary hospitalization for individuals in Planning District 16. As such, evaluation for involuntary commitment, processing of an Emergency Custody Order (ECO), and/or a Temporary Detention Order (TDO) are services provided by the RACSB Emergency Services Therapists. Emergency Services serves this function regardless of the primary disability or age of the individual. In the role of monitoring of admissions to state facilities, Emergency Services Therapists also assess all persons seeking admission to a state psychiatric facility, regardless of whether the admission is voluntary.

While voluntary and involuntary hospitalizations are a major responsibility of Emergency Services, the staff also provides information, screening and referral to appropriate services within RACSB or to other services in the community. Among these is the Crisis Stabilization Program at The Sunshine Lady House for Wellness and Recovery, for which Emergency Services staff determine appropriateness for admission. Emergency Services staff remains knowledgeable regarding community resources.

Emergency Services Therapists triage individuals who present with multiple challenges and service needs. As appropriate, they also consult with other qualified RACSB personnel, who may assist them in determining the most appropriate outcome. Emergency Services Therapists also have the discretion to schedule medical appointments in case of emergency.

While medical personnel are available during regular clinic hours, in case of medical emergencies, persons are referred to the Emergency Department. The RACSB Emergency Information form and Medical History form includes an emergency contact and medical history for individuals currently enrolled in services or who have received services. These forms are shared with Emergency Medical Service (EMS) First Responders.

Upon completion of an intervention, the Emergency Services Therapist will complete a prescreening form, or a clinical progress note that documents the encounter with the individual to include final disposition and the services the individual received.

Emergency Services staff receive “hot sheets” from other RACSB programs to alert them to any specific behavior or service plans for a particular individual. In addition, Emergency Services has an e-mail address, EmergencyServices@rappahannockareacsb.org, which alerts all full-time and after-hours Emergency Services staff to a person who may need their services. During business hours, the Emergency Services telephone number connects directly to the telephone located on the desk of each Emergency Services Therapist. Documentation must be completed by the end of the Emergency Services Therapist’s shift or, if there are mitigating circumstances, within 24 hours.

CIT Drop Off Center

RACSB operates a Crisis Assessment Center (CAC) at Mary Washington Hospital’s Emergency Department. The CAC is staffed with an Emergency Services Therapist and CIT Officer from 2pm-12am daily. Local law enforcement personnel can bring individuals on an ECO to the CAC and can transfer custody of the ECO to the CIT officer. The individual receives expedited care by personnel specifically trained in crisis de-escalation in a hospital room that has been modified to maximize safety. Please see the *Emergency Services Policy Manual* for operational details.

A Peer Specialist works in this program as scheduled to provide peer support services to individuals experiencing a crisis. This individual has lived experience and therefore can provide support and hope to individuals who are in the midst of a crisis. In addition, the intervention of the Peer Specialist will assist the individual in crisis to feel less vulnerable and better incorporate this experience into his/her life experiences overall. This service will increase the likelihood that an individual will engage in treatment after the crisis has ended, which is a time when individuals are vulnerable and may not see a need for treatment once the crisis is stabilized. There will be more detail provided on overall peer services within this policy manual under Mental Health Outpatient Services.

Special Populations

Emergency Services staff typically provide services to individuals in a state of crisis where there frequently is a concern about unpredictable behavior and the safety of the individual, community, and/or specific individuals identified by the individual. Therefore, interventions must be provided

in a context that guarantees the safety of all parties. Oftentimes, services can be provided within the clinic office under usual therapy circumstances. If a safety is a concern the individual will be seen in a setting, such as the hospital emergency department or the offices of law enforcement, and with appropriate security personnel to assure safety. Occasionally, it may be appropriate to provide services within a person's place of residence. Most often, this will be done only on the condition that police accompany the therapist.

Every effort is made to facilitate accurate communication between individuals being served and therapists. The agency employs a signing therapist for hearing-impaired persons, and this therapist will assist in interventions when available. At other times and in situations in which there is no staff to translate the person's language, contract interpreters or translators will be employed. RACSB uses Propio Language Services to access telephonic interpreters.

Child/Adolescent Emergency Services Program

Child and Adolescent Emergency Services staff work exclusively with children and adolescents. They provide direct response to crises and provide therapeutic crisis intervention services for up to thirty days. During this time, they work to stabilize the individual and family, provide support to the family and link the individual to ongoing resources/services. Please see the *Emergency Services Policy Manual* for additional details.

Discharge Criteria for ES and Child/Adolescent Crisis

In most instances, individuals are discharged from Emergency Services at the conclusion of the single intervention, the result of which is typically a referral to additional services. When a referral need cannot be met immediately, it may be necessary for Emergency Services staff to keep an open case with the person and to maintain contact until a referral can be affected or until the crisis situation has been otherwise resolved. In such instances, the person is discharged from the program as soon as responsibility for care has been transferred to another provider.

The extent to which Emergency Services achieves its mission is assessed through measuring how long it takes for Emergency Services Therapists to respond to a request to assess someone at a location other than RACSB. The goal is for the Emergency Services Therapist to arrive at the location to assess the individual within one (1) hour. In addition, Emergency Services Therapists will call the people who are scheduled for a hospital discharge appointment the night prior to the appointment. The number of kept appointments is another way to measure the ability to engage people in treatment post-hospital discharge.

Emergency Services Therapists attempt to work collaboratively with individuals in facilitating access to treatment. However, it is sometimes necessary to impose involuntary treatment interventions in order to reduce threats to the person's safety. Even under such conditions, it is the goal of Emergency Services to maximize the extent to which individuals ultimately express satisfaction with the service they received.

Hospital Admission/Discharge and Case Management Coordination

Continuity of Care Guidelines require that persons discharged from state psychiatric facilities should be evaluated by a physician in the community within seven days of their discharge from the hospital, or as soon as is practicable but no later than 7 days. Other supportive services, including appointments with a case manager or therapist, should be made available within seven days of discharge as well. The procedures for coordinating services at the time of admission and discharge are outlined below.

1. Western State Hospital

At the point of prescreening, Emergency Services Therapists will notify RACSB's Liaison to Western State Hospital (WSH) who will coordinate discharge planning from that point forward. The Adult Mental Health Case Manager Supervisor shall also be informed of all WSH admissions by the Emergency Services Therapist.

2. Snowden at Fredericksburg, Spotsylvania Regional Medical Center, all private psychiatric hospitals:

The hospital case manager will call the RACSB's front desk at the Fredericksburg Clinic to schedule a hospital discharge appointment. The RACSB receptionist will schedule an appointment with an Emergency Services Therapist within **seventy-two hours of discharge**. The Emergency Services Therapist will assess the individuals to ensure that psychiatric symptoms are stable, that they have medications and know who to contact should they need a refill prior to seeing a RACSB psychiatrist or psychiatric nurse practitioner. The Emergency Services Therapist will provide the individual with a medical appointment and therapy or case management appointment at the appropriate clinic. The medical appointment shall be scheduled within **thirty days** of the date the individual is assessed by the Emergency Services Therapist.

Should a person fail to keep the initial discharge appointment with Emergency Services Therapist, the Emergency Services Therapist will call to follow up with the individual the same day. The result of this contact will be documented in the Hospital Discharger Log.

3. RACSB cannot require an individual participate in a service to access medical services due to regulations from the Department of Medical Assistance Services (DMAS). However, when an individual is discharged from a psychiatric facility, the individual will be required to participate in some type of therapy and/or case management until the individual and RACSB staff agree that he/she is ready to step down to a lesser level of care or receive fewer services.
4. If the individual is currently engaged with a therapist or case manager, then the Front Desk staff will schedule the individual to see that provider within 14 calendar days. The Front Desk will obtain a medical appointment within 30 days of discharge and give this appointment to the provider who is scheduled to see the individual.
5. Individuals assessed and released from an Emergency Custody Order (ECO) or assessed by Emergency Services and determined to need other services than psychiatric hospitalization shall be scheduled to see a therapist or case manager within 14 calendar days.

Please note that the *Emergency Services Program* as a policy and procedure manual which provides specific policies for that program. The Emergency Services Policy and Procedure Manual can be found on the RACSB Intranet under Policy and Procedure Manuals.

MENTAL HEALTH OUTPATIENT SERVICES

Mission Statement

The Mental Health Outpatient Services program, to include medication management services, have been designed to provide appropriate levels of care to those experiencing significant and acute disruption in their ability to cope with their daily lives.

RACSB endorses the Recovery Model which is person centered and focused on empowering the individual to learn about his/her unique needs, strengthen their ability to manage their lives, symptoms, and services.

Goals

The goal of mental health outpatient services is adhere to interventions which are person centered, evidence based while promoting individual recovery and resilience, so the individual can be an active participant in his/her life and in the community. The Mental Health Outpatient Services is built on the trauma informed care paradigm that the question is “What happened to you?” instead of “What is wrong with you?”

In addition, therapy is most impactful when it is an intermittent and episodic intervention focused on empowering the individual to learn to be his/her own therapist. The individual will identify their unique symptoms, how to effectively manage or alleviate symptoms, and when to return to therapy as needed.

To that end, research shows that the positive benefits from outpatient therapy peaks by the twelfth visit with the fifteenth visit being the point where efficacy declines substantially. Therefore, RACSB promotes short-term, solution focused, trauma informed interventions which empower the individual to maintain his/her recovery as well as to know when to reach out for outpatient services when added support is needed.

Target Population

Those persons who meet the DSM – V criteria for any serious mental illness, serious emotional disturbance, at risk for emotional disturbance, or adjustment disorder. Mental Health Therapists provide individual, couples, family and group therapy. There is no age limit applied, but children are generally treated within the context of the family. Children under the age of 5 will not receive therapy unless the clinician has received specific training on how to treat that age group.

Admission Criteria

Outpatient mental health treatment services are available to all persons residing in Planning District 16 whose functioning has been compromised due to mental health issues and for whom the available treatment may be beneficial. Therapy services are intended to be brief and to address targeted areas of concern, as identified by the individual. Medication Management Services are provided to persons for whom the adjunctive use of medications is likely to facilitate improving and maintaining optimal adjustment. Medication Management Services may be continued for an extended period, at the discretion of medical staff. Please refer to the *Medication Management only Services* section contained under this heading.

Transition/Discharge Criteria

Discharge planning starts at the beginning of treatment

- If the individual meets goals
- Return to level of function
- Risk of harm to self or others

Available Services

Psychological Evaluations

RACSB does not provide psychological evaluations as a general outpatient service. However, there are four circumstances in which psychological evaluations are completed.

1. RACSB Intellectual Disability Support Coordinators may refer persons (adults and children) who need evaluation to qualify for ID waiver program services.
2. Adult and Juvenile alleged criminal offenders are referred by the courts for determinations pertaining to their competency to stand trial and mental status at the time of the offense, and to determine if the individual has been restored to competency.
3. The courts may also refer adults or for mental health and substance abuse assessment to assist the courts in decisions related to custody of children. The content of these assessments does not opine as to the individual's ultimate ability to parent or maintain custody. Rather, the assessments assist the court in identifying an individual's strengths and weaknesses which may affect parenting. These assessments are provided only for adults where the State of Virginia is the custodian of their children. These families are engaged with local Departments of Social Services. This service must be recommended and supported by the local Family Assessment and Planning Team (FAPT) as well as the local Community Policy and Management Team (CPMT).

Sex Offender Assessments

Sex Offender assessments shall be provided for adolescents and adults only when RACSB employs a Certified Sex Offender Treatment Provider (CSOTP) registered with the Virginia Board

of Counseling and in good standing. RACSB does not provide therapy service to this population.

All assessments will be scheduled in the early morning at a time when there are no children or vulnerable individuals in the clinic. The assessments will be scheduled only at the site where the CSOTP is located. These referrals shall not have access to Same Day Access. The CSOTP shall schedule all assessments personally to ensure that vulnerable individuals and children are not in the building. This service is provided to determine the suitability of treatment for adolescent and adult sexual offenders. The service is provided at a set fee and is not eligible for the sliding fee scale.

Engagement

It is accepted in the field of mental health and substance abuse that certain events, behaviors, or diagnosis place an individual at higher risk for self-harm, psychiatric hospital admissions, co-occurring mental health and substance use disorders, and co-morbid physical health problems. Again, when individuals have adverse childhood or adult experiences, the result is that engagement in services may be more challenging, which is another fact that supports RACSB transitioning to a trauma informed system of care. For the purpose of these policies, these risk factors will be grouped together to more readily express how the Clinical Division is going to address these individual's needs. Below is a description of practices and procedures that have been implemented with the goal of increasing the individuals who engage in services.

The *Columbia Suicide Severity Rating Scale, Short Version*, shall be administered at each initial appointment and at every appointment thereafter where an individual expresses suicidal ideation. **The *Columbia Suicide Severity Rating Scale, Short Version* can be located on RACSB's Intranet under Forms, "Suicide Risk Assessment/Columbia Suicide Severity Rating Scale".**

Peer Services

Peer support is one of the six guiding principles of Trauma Informed Care. (RACSB) recognizes the value of evidence-based practices including Peer Support Services.

Peer Specialists are identified as individuals in recovery, with life experience. Peer Support Services provide strength based, non-clinical, person centered, wellness focused support to others diagnosed with mental health and/or substance use disorders. These services are voluntary and consider the acuity of the individual receiving services.

Peer Specialists have a unique role in the field of Behavioral Health Care. They are the only RACSB professional position that requires the staff to utilize his/her personal recovery in supporting another individual. A Peer's lived experiences form the foundation of his/her professional knowledge as well as the Certified Peer Recovery Specialist training provided by the Department of Behavioral Health and Developmental Services (DBHDS).

The Clinical Division has Peer Specialists employed in the Emergency Services program as well as in the Medication Assisted Treatment Program. The Department of Medicaid Services (DMAS) in

Virginia has updated their policies related to substance use disorders to include reimbursement for Peer Specialists which serves to underscore the positive impact of peer services.

Peer Specialists will receive supervision from a licensed professional, participate in the monthly trainings referenced in this document, and ongoing continuing education to increase their knowledge base as well as to support them in their recovery as they support others.

Therapy Services

RACSB provides individual, group, family, and marital counseling. An overview of each service is provided below.

The goal is to restore an individual to the level of functioning and quality of life where he/she can manage symptoms, engage in natural supports, participate in group therapy, participate in psychiatric appointments, manage physical health, strengthen parenting, engage in employment, and effectively engage in relationships with others. In addition, the individual will have the ability to identify the behaviors, feelings, and circumstances whereby he/she will need to return for therapy services.

At the initial assessment, and in keeping with the Same Day Access model, the individual will receive a provisional diagnosis, a clear recommendation for the type of therapy (or therapies) that will be effective, number of sessions recommended, next appointment, and introduce the concept of developing a treatment plan. By having this conversation, discharge planning begins as the individual discusses goals, number of sessions, and next steps. Not every individual will need to attend a group; however, the concept of group therapy as well as the powerful impact will be discussed when appropriate. The therapist will work with family members and friends to develop natural supports prior to discharge.

NOTE: Clinic Coordinators or Immediate Supervisors can approve an extension of individual sessions past twelve if clinically indicated.

Adult Therapy

The purpose of the treatment is to seek solutions for targeted problems, and the goals and treatment methods are determined in cooperation with the individual. Brief interventions are emphasized. Sessions are scheduled according to the clinical need, although crisis counseling may be referred to the Emergency Services unit. Persons experiencing marital difficulties may be encouraged to seek treatment jointly with his or her partner as a means of facilitating progress. The cost of therapy services is based on the individual's ability to pay or upon agreements with third-party payers.

Family Therapy

Based on the assessment and as therapy progresses a family therapy approach may be recommended. The presenting problem may relate to the child's conduct or a concern about parenting style, and each member of the family may bring a different perspective to the issue, sometimes identifying dissimilar treatment goals. However, common themes often result in a greater combined effort for change and in a structure for supporting one another in resolving

concerns unique to individual family members. At times, it may be necessary to see members individually, but working jointly provides the greatest assurance that parties are moving together towards a common goal.

Child/Adolescent Therapy

There is no mandatory age of consent for children to receive care, so they may do so without family involvement; however, inclusion of the family in the treatment process is strongly encouraged. Age-appropriate treatment tools and accommodations are available within the treatment sites to the extent possible. The assessment of children additionally focuses on their developmental and school histories and their relationships within their families as well as with their peers. Regardless of whether the child's parents participate in the treatment, the effect on the child of the family's functioning, including any current or prenatal substance abuse, is weighed in the context of treatment planning. Accommodations are made, whenever possible, so that services are provided at a time that does not interfere with the child's educational experience. Perhaps more than with other populations, the child and adolescent therapist serves a case management function, making certain that treatment is coordinated with other professionals who are involved in the child's care and education.

Group Therapy

Certain presenting problems may best be addressed in the company of other persons who share that experience. Therefore, a variety of group treatments are offered by RACSB to address concerns frequently raised and found to be impacted by group approaches, which may include education, support, or confrontation. Groups vary in size depending on the nature of the topic and the population, but they tend to be small enough to encourage participation by all members. They may be time-limited or on-going and have at least one staff member as a facilitator. They are frequently held in the evening to accommodate the needs of the participants.

Therapists are expected to dedicate 65% of their time to providing direct service.

Treatment Planning and Service Delivery

Medication Management

Medication Management Services are offered to persons whose psychiatric condition may be improved using pharmacotherapy. The service includes an initial assessment of need and subsequent monitoring. The benefits of the medication(s) and side effects are reviewed with the individual when medication is prescribed, changed, or added. A psychiatrist or psychiatric nurse practitioner, who continues to have at least quarterly (usually monthly) contact with the individual after stabilization on the medication, performs the initial evaluation. For the purpose of these policies, psychiatrists and psychiatric nurse practitioners shall be referred to as prescribers.

Individuals who are age fourteen and older must complete an initial assessment with a RACSB therapist or case manager prior to seeing a prescriber. This assessment is needed to assess the individual's needs, determine if therapy should be attempted prior to a referral to medical services (best practice), and obtain necessary signatures to allow RACSB to coordinate care.

Individuals who are age thirteen and below shall see a Board Certified Child/Adolescent Psychiatrist. These individuals are not required to participate in an assessment prior to seeing the psychiatrist. The Psychiatrist will make referrals for therapy, case management, or other services as appropriate and needed.

Medication management services shall not routinely be recommended at the time of the assessment for ages fourteen and older.

Referral to Medical Services

The therapist or case manager will discuss referrals to the medical program with the Clinic Coordinator or his/her designee to ensure that the referral is clinically indicated and will enhance recovery. The Clinic Coordinator will approve, deny, or seek additional information. The therapist or case manager then coordinates with the Office Manager or Office Associate who will provide an appointment with a psychiatrist or psychiatric nurse practitioner. The therapist or case manager will notify the individual of the appointment time. The therapist must have the medical appointment scheduled and notify the individual within two business days of the Coordinator's approval.

Since the service is frequently offered in conjunction with other RACSB program involvement, it requires that the medical staff work closely with therapists and case managers to remain abreast of situational changes impacting the person's adjustment and response and to plan treatment in accordance with all aspects of the individual's service plan.

Office Managers and Office Associates contact all scheduled appointments three days before the appointment. Office Managers and Office Associates shall follow the appropriate Same Day Access script when calling individuals.

Individuals Who Participate in Medical Services Only

Individuals may participate in medication services without being enrolled in another RACSB service. However, the prescriber shall refer individuals for therapy or case management by contacting the Clinic Coordinator, Case Management Supervisor, or their designee. In addition, Mental Health Nurses will identify individuals in need of services and make appropriate referrals as well.

If an individual completes an initial assessment and is requesting to participate in medication services only, the Clinic Coordinator must approve this request following the criteria listed below:

- Individual has not been admitted to a psychiatric hospital in the previous two years.
- Individual can articulate symptoms, identify symptoms, and show ability to take the initiative to contact the prescriber when needed outside of regular appointments.
- Individual must be able to keep appointments as scheduled and call to cancel and reschedule prior to 48 hours if needed.
- Individual must have transportation to appointments.

- Release of Information is signed for an Emergency Contact

If someone is admitted to a psychiatric hospital, the policy noted under Psychiatric Hospital/Crisis Stabilization Admissions shall be followed.

Receive Medication Only Services While Engaged in Therapy Outside of RACSB

If an individual is approved to participate in medication only services while receiving therapy from a therapist who is not employed at RACSB, the individual shall sign a release of information form to grant permission for RACSB to provide brief monthly updates of the individual's participation in medical services.

For more information on the Medical Services of RACSB, please refer to the *Medical Policies* located on the RACSB employee Intranet under *Policies and Procedures*.

Special Populations

Communication: RACSB strives to be inclusive in its efforts to meet the needs of the communities it serves. Given the diversity of the population, it is not possible to have specialized services established to meet every need, but an effort is made to respond to recurrent requests and to anticipate likely trends in demand. In response to such requests, a decision was made to allocate resources to the provision of specialized services for deaf and hard-of-hearing persons. Communication devices are available, as are the services of a part-time signing therapist. In addition, sign language interpreters are routinely employed to assist persons with communication as they participate in agency programs other than outpatient therapy. The Fredericksburg Clinic has access to TTY. All other clinics have access to <http://www.varelay.org>.

As the Planning District becomes more diverse, meeting the needs of non-English speaking individuals becomes a greater challenge. A RACSB staff member, who is bilingual, has completed training on how to provide interpretive services. She is scheduled, as needed, to sit in on sessions where an interpreter is needed. Agency literature has been translated, and employees are sought who are fluent in Spanish. Isolated occasions of accommodating other languages have occurred, but these have not been sufficiently frequent to warrant any significant reallocation of resources.

Ages 17-25: Research shows that engaging individuals who experience their first symptoms of Schizophrenia or a Psychotic Disorder who are ages 17-25 is challenging. However, the research also supports the fact that decreasing the number of psychiatric inpatient admissions, medication compliance, peer support, will all decrease the impact of these illnesses on the brain as well as the individual. As a result, the Adult Mental Health Case Managers and Child/Adolescent Case Managers work diligently at communication, building a bridge when an individual moves from adolescents into adulthood, and providing person centered service delivery.

Veterans and their Families: RACSB is located near Quantico Marine Corp Base. Dahlgren Naval Base is located in Planning District 16. Therefore, specialized training is available for RACSB staff who work with this population. RACSB's electronic health record documents about an individual's veteran status as well as which branch of service the individual identifies with.

Co-occurring Disorders: Individuals who are challenged by co-occurring mental health and substance abuse diagnosis are expected to face more challenges. RACSB's therapists are trained to assess individuals for both mental health and substance use disorders. Both mental health and substance abuse needs must be documented in the assessment, treatment plan, quarterly progress reports, and collaborative notes. The Clinic Coordinator will decide if the individual needs SA or MH Case Management based upon the assessment. In addition, gender specific co-occurring group therapy is available.

Exclusionary Criteria

Persons who fail to comply with reasonable requirements intended to assure the safety of all program staff and participants may be excluded from further participation in services

Best practices include the following elements:

Integrated Services; Assertive Engagement (especially for ages 17-25); Shared Decision Making; Motivational Interviewing and Stages of Change; Harm Reduction; Substance Abuse Services

Integrated Services: Outpatient therapy services at RACSB are integrated in all staff are trained in the areas of mental health and substance abuse services.

Assertive Engagement: RACSB case management and outpatient staff (clinical staff) shall call the individual the day of the initial assessment to follow up and welcome the individual again to RACSB. The next appointment will be reiterated.

The clinical staff will call the individual within two days of the initial appointment to check in, see how they are feeling and encourage them to attend the next appointment.

Clinical staff shall obtain signed release of information for Primary Care Physicians, family, other service providers at the first session.

Individuals shall receive six to eight individual sessions while participating in an appropriate group when available. The smaller clinics may not have a group available in which case the individual will be seen weekly for six to eight sessions and scheduled using appropriate clinical judgement thereafter.

Shared Decision Making, Motivational Interviewing, Stages of Change: In an effort to engage in shared decision making, staff will use motivational interviewing techniques and identify in the chart the stage of change the individual is currently and set a goal of where the individual wants to go. Tools such as a timeline that outlines the history of all mental health, substance use, and physical health issues will be developed here so the individual can identify triggers and patterns that he can build on to move toward recovery.

Harm Reduction and Substance Abuse Treatment: The goal, especially for individuals with co-occurring disorders is to reduce the harmful effects of the substance use. This goal is achieved by meeting the individual where he/she is at the time of treatment.

Education about sharing needles, the harm of using Heroin, especially when someone has a period of sobriety, the impact of substances on mental health symptoms, the impact of substances and mental illness on the brain. The focus is on wellness and viewing recovery and wellness as an ongoing journey where the clinical staff facilitate the process based on everyone's needs.

History of Suicide Attempts and/or Self Harm (cutting): Individuals who have a history of suicide attempts shall be scheduled as indicated above for hospital and crisis stabilization discharges.

Exclusionary Criteria

Persons who fail to comply with reasonable requirements intended to assure the safety of all program staff and participants may be excluded from further participation in services.

Efficiency

To assure access to outpatient mental health services with limited personnel, it is important that services are provided as efficiently as possible, maximizing the amount of time they have available to provide direct services. The percentage of therapists' work hours spend providing direct service will be tracked monthly for all staff providing outpatient mental health treatment services.

In addition, data is obtained monthly on the number of individuals seeking services through the Same Day Access program, number who were seen on the same day and the number asked to return on a different day. Please note that no one is turned away without first speaking to a therapist or supervisor to ensure there is no need for emergency interventions.

Consumer Satisfaction

The degree of satisfaction with outpatient mental health treatment services will be measured using a Consumer Survey. This will be administered to persons by mail no later than three months following discharge. Further, a satisfaction survey is conducted by the Department of Behavioral Health and Developmental Services once each year, and the opinions of persons receiving services during the data collection time period are solicited. For parents of minors, DBHDS uses the Parent Perceptions Survey for this purpose.

RACSB conducts a point-in-time survey at each clinic once a year. Everyone scheduled to be seen during this one week period as well as people seen on a walk-in basis shall complete a survey. This survey obtains information about the individual's experience with services at RACSB to include returning phone calls, quality of services, and opinion about the facilities where services are provided. The results are compiled and shared with the Executive Director, Board of Directors, and all members of Management. A written corrective action plan is required to address what measures will be taken to improve areas of concern.

Accessibility

RACSB seeks to make its services readily available to the community, and the extent to which individuals believe services to be accessible is reviewed annually as part of the RACSB accessibility plan. This plan is reviewed by the RACSB Board of Directors. In addition, there are Walk-In Clinics at each clinic so individuals can walk in and complete

the initial assessment without an appointment. This program requires that individuals are seen on a first come, first served basis.

Same Day Access was launched at RACSB in October 2017.

Strategic Planning

In order to use resources wisely, it is necessary to anticipate community needs and to plan accordingly. To aid in this effort, input from persons receiving services as well as from potential referral agents is gathered from a variety of sources. Among these are the satisfaction surveys, which provide an indication of common perceptions of program strengths and needs. In addition, the Family Assessment and Planning Teams (FAPT), composed of representatives from five (5) public agencies in each locality, are polled annually, and their input is incorporated in program planning. Other sources of input include measures of the agency's ability to meet continuity of care agreements and information gathered in the context of focus groups, retreats and open houses conducted on an intermittent basis at various agency sites.

CHILD AND ADOLESCENT SUPPORT SERVICES

UTILIZATION REVIEW

Mission Statement

Utilization Review (UR) serves children and adolescents who are identified as seriously emotionally disturbed or at risk of developing a serious emotional disturbance. In addition, the child is at risk of entering a residential facility, at risk of being placed outside the home, or are currently placed in a residential setting. The purpose of this service is to safely and effectively maintain, transition, or return the child home or to a relative's home, family like setting, or community at the earliest appropriate time. This service also ensures that the child's environment is one that addresses the child's needs. This service provides a level of case management which is above and beyond the scope of targeted case management. In order to obtain this goal, the ICC services are provided primarily in the home, at residential facilities where a child may be placed, or in day/school placements.

Goal

Services are intended to preserve families, prevent out-of-home placements by building on the child and family's strengths as they define them. In addition, if a child is placed outside the home, UR will work to ensure the child returns home as soon as the child has met the treatment goals at the placement.

Target Population

Services are provided for families with children at risk of out-of-home placement or families with children returning home from such placement. The need for treatment is reviewed quarterly.

Admission Criteria

- Child displays psychological symptomatology consistent with DSM – V diagnosis and which require, and are likely to respond to, therapeutic intervention.
- The child is experiencing Serious Emotional Disturbance (SED), or is considered “at-risk” for such, which interferes with their ability to function in more than one life area, typically requiring intervention by more than one community agency.
- Children at risk of out-of-home placement or a more restrictive placement due to psychological, environmental and/or behavioral symptomatology.
- Children who experience difficulty meeting their basic needs in a family setting.
- Child and/or family require intensive case management services in addition to therapeutic services and 24-hour crisis availability.
- Child returning to home following an out-of-home placement.
- Child entering a foster home following a residential placement.
- Should the child exhibit suicidal or homicidal ideation, he or she is able to engage in a safety plan outside of a hospital environment.
- Parents/Caregiver willing to participate in treatment.
- Child is 21 years old or younger and/or is still in school under IEP services.
- Case load max of 12 UR cases due to intensity level and travel involved

Exclusionary Criteria

- A primary diagnosis of Substance Abuse, Developmental Disability, or of Delirium, Dementia, or other Cognitive Disorder.
- Presence of any condition requiring acute inpatient medical care.
- Child meets the criteria for admission to a higher level of psychiatric care.
- Child and Family can utilize and benefit from outpatient services.

Continued Stay Criteria

- Person continues to meet admission criteria.
- Family and child continue to respond to and benefit from treatment services.

Discharge Criteria

- Child or family no longer meets admission criteria or meets criteria for a more or less intensive level of care.
- Implementation of services at a higher or lower level of care.
- Child or family is not compliant with treatment requirements and expectations.

Expected Length of Service

- Expected length of stay is dependent upon the medical necessity of the individual.

CHILD AND ADOLESCENT CASE MANAGEMENT SERVICES

Mission Statement

Child and Adolescent Case Management Services of the Rappahannock Area Community Services Board provides comprehensive targeted case management services to children, adolescents, and their families in the Planning District 16 who have developed a Serious Emotional Disturbance (SED) or are at risk of developing a SED. Child and Adolescent Case Management services assist individual children/adolescents and their families with accessing needed medical, psychiatric, social, educational, vocational and other needed supports essential to meeting the basic needs of the youth and their families. Case management services are implemented to provide skill building and monitoring of service provided as well as the family's response; coordinate and facilitate linkage to appropriate community resources; assess needs and plan appropriate services; monitor service delivery with other providers; advocate for the child and family; develop a crisis plan that includes the individual's preferences regarding treatment; and assist the individual in accessing primary medical care, as needed.

The Child and Adolescent Case Management Services program is committed to providing unconditional support to families through flexible, timely and least intrusive services. Unconditional support is defined as a commitment to serve families until they no longer need or desire services. Least intrusive services are defined as planning and providing services based on family needs and using the appropriate quantity of services based on family request. Core principles in providing services are:

1. Services are built around family preferences, choices and values.
2. Families are the primary resource and decision makers for their child and family.
3. Services are built around the family and individual strengths.
4. Services are built around the natural support system of the family and community.
5. Services are appropriate based on culture and age appropriateness.
6. Services are aimed at maximizing interagency cooperation to maintain the youth in the family or community.

Goal

The primary goal of this program is to preserve the family unit, decrease the symptoms of a SED and maintain the youth in the least restrictive setting in the community. The expected outcome of services will be to reduce the time youth need inpatient hospitalizations/residential treatment and to reduce the number of days youth require educational services that are more restrictive than the public school setting.

Admission Criteria

Child and Adolescent case management services were designed to meet the needs of children and adolescents less than 18 years of age who are assessed to be seriously emotionally disturbed or at risk of serious emotional disturbance. Transitional Planning Case Management Service are also

provided for young adults age 18 to 22 who still have educational needs or are in the custody of Social Services.

Serious Emotional Disturbance (SED) is defined as a serious mental health problem that can be diagnosed under DSM – IV, and/or all of the following:

1. Problems in personality development and social functioning that have been exhibited over at least one year's time; and
2. Problems that are significantly disabling based on the social functioning of most similarly-aged children/adolescents; and
3. Problems have become more disabling over time; and
4. Service needs that require significant intervention by more than one (1) agency.

At-Risk of Serious Emotional Disturbance is defined as including children, ages 0 through 7, who meet one (1) or more of the following criteria:

1. Exhibits behavior or maturity that is significantly different from most children their age, and which is not the result of developmental or intellectual disabilities; or
2. Parents or caretakers having predisposing factors that could result in their children developing serious emotional or behavioral problems; or
3. Have experienced physical or psychological stressors that have put the children at risk for serious emotional or behavioral problems.

The majority of referrals to this program are from the family, Comprehensive Services Act Family Assessment and Planning Teams, Commonwealth Center for Children, and RACSB Emergency and Outpatient Services. Referrals also originate from the school systems, social services, and the Juvenile Court Services Unit.

The child and at least one (1) parent/guardian must participate in assessment, treatment planning and the delivery of services. Both biological parents and any current guardian/parent figure are crucial to the development and delivery of services. Treatment planning should include re-connection with distant or absent parents whenever possible. All other family members identified by the child and parent as immediate should be included when possible in the delivery of services. Consideration of the child's culture and living situation is part of the definition of immediate family members. The child and immediate family members are the primary decision makers in the delivery of services. The Case Manager works towards strengthening the family's connection to the community and assist the family in building resources and support to meet the child's needs within the community. Strong emphasis is to be placed on improving the family's connection/access to natural, non-professional support systems within the community.

Available Services

Case management services typically include:

1. On-going assessing and treatment planning to meet the individual's needs;
2. Developing crisis plans for families as needed;
3. Making collateral contacts with significant others;
4. Coordinating services and treatment planning with schools and other involved agencies;
5. Linking directly to services by making appropriate referrals;
6. Monitoring service delivery(including medication monitoring); and

7. Enhancing Opportunities.

Exclusionary Criteria

Child is receiving another service in which case management is a component.

Continued Stay Criteria

Child continues to meet admission criteria.

Discharge Criteria

1. Child no longer meets admission criteria or meets criteria for a less intensive level of care.
2. Child is not compliant with treatment requirements and expectations.
3. Child or parent/guardian requests termination of services.

Planning for discharge from case management services is to begin at the assessment. The child and adolescent case manager will work in collaboration with the family to plan for services after discharge from the case management program. The plans will include on-going crisis management plans, referral to other services, reports to the other involved agencies, and possible assignment of the family to another RACSB program for continued care. As parents are the primary decision makers for their children, part of the treatment planning is to include assisting the parent/guardian in meeting future needs of the identified child. Each case will be reviewed for discharge based on meeting the short-term goals, the parents' ability to meet the long-term needs of the child and successful linking with services identified to meet long-term needs. Children needing on-going psychotropic medications and medication monitoring will either be successfully linked to a psychiatrist in the community or maintained, as needed, on the case management caseload. As part of the discharge process, the case manager will facilitate the transfer to other providers, whether within or outside RACSB.

Transition to Adult Services

There are situations where the individual will require ongoing case management services upon reaching adulthood and/or graduation from a secondary education program, whichever comes first. The Supervisor for Supportive Services for Children and Adolescents will identify the children or adolescents who may require case management services as soon as is appropriate based upon the current level of functioning, DSM – V diagnosis, and ability to function without supports. Once an individual is identified, the Adult Mental Health Case Management Supervisor shall be alerted to the needs of the individual. The Supervisor for Supportive Services for Children and Adolescents shall provide updates every six (6) months (or more frequently if the adolescent is age 16 or older) to the Adult Mental Health Case Management Supervisor. The Adult Mental Health Case Management Supervisor shall contact the family and the individual, to discuss how to transition to adult services, when the adolescent is 17 years old or when the individual is anticipated to enroll in Adult Mental Health Case Management Services in the next year.

Expected Length of Service

The expected length of service is six (6) to twelve (12) months.

Frequency of Service Plan Review

The service plan is reviewed on a quarterly basis.

Effectiveness

Persons within the target population for child and adolescent case management are often at some risk for placement outside of the family home. While hospital and residential placements disrupt educational programming, family cohesion and community-based treatment and place an enormous financial burden on families and communities, disruptive behaviors or the expectation of specialized treatment interventions often lead parents to seek placement elsewhere. Case management is intended to strengthen the parents' ability to meet the child's needs within the home and to coordinate responsive services within the community.

Efficiency

The intensity of need varies greatly among the children receiving case management services. However, it is expected that each case manager will maintain an average monthly billable caseload of 28 cases. In addition, in keeping with the continuity of care expectations for persons discharged from the Commonwealth Center for Children, the case manager will insure that each child who is discharged will be seen within seven (7) days of discharge.

Satisfaction

The degree of satisfaction with case management services will be measured using a Consumer Survey. This will be administered via mail no later than three (3) months following discharge from the program. For parents of minors, DBHDS uses the Parent Perceptions Survey for this purpose.

Accessibility

RACSB seeks to make its services readily available to the community, and the extent to which persons believe services to be accessible is reviewed annually in the RACSB accessibility plan. The RACSB Board of Directors reviews this plan annually.

Strategic Planning

In order to use resources wisely, it is necessary to anticipate community needs and to plan accordingly. To aid in this effort, input from individuals receiving services as well as from potential referral agents is gathered from a variety of sources. Among these are the satisfaction surveys, which provide an indication of common perceptions of program strengths and needs. In addition, the Family Assessment and Planning Teams (FAPT), composed of representatives from five (5) public agencies in each locality, are polled annually, and their input is incorporated in program planning. Other sources of input include measures of the agency's ability to meet continuity of care agreements and information gathered in the context of focus groups, retreats and open houses conducted on an intermittent basis at various agency sites.

HIGH FIDELITY WRAP AROUND SERVICES

Mission

High Fidelity Wrap Around Services (HFW) is an evidence-based team-base, collaborative process for developing and implanting individualized care plans for children with mental health challenges and their families.

Goal

The goals of HFW are to meet the stated needs (not necessarily services) prioritized by the youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural support system over time, and integrate the work of all child serving systems and natural supports into one streamlined plan.

Target Population

Youth and families who are within 90 days of discharge from a residential facility. Youth and family experiencing a crisis who can benefit from a team made of their family and community supports

Special Populations

Children at risk of removal from the home or who experience repeated crisis that negatively impact their ability to live effectively in the community.

Admission Criteria

Referrals are received from Family Assessment and Planning Teams (FAPT) in Planning District 16 once the Community Policy and Management Team (CPMT) has approved funding for the service.

Exclusionary Criteria

Youth placed in a residential facility are not eligible for this service until he/she is within 90 days of discharge.

Available Services

HFW is divided into four Phases. It is the role of the “facilitator” who is the RACSB HFW Case Manager to guide the family and the team of people who are supporting the family through the four phases. While HFW does not use the same language such as “assessment”, there are components in each phase that correspond to different components such as assessment and treatment planning.

Four Phases:

- **Engagement and Team Preparation:** Facilitator begins developing rapport, building trust and identifying the shared vision of the youth and family. The focus is to be on strengths and needs as identified by the family and their support system.
- **Initial Plan Development:** During this phase, team trust and mutual respect are built while creating an initial plan of care using the HFW quality planning process.
- **Implementation:** During this phase the HFW plan of care is implemented engaging all members of the family and their identified support system.
- **Transition:** During this phase, plans are made for a purposeful transition out of formal JFW to a mix of formal and natural supports in the community-the equivalent to discharge planning.

MENTAL HEALTH – ADULT CASE MANAGEMENT POLICIES

Mission Statement

The mission of mental health case management is to assist adults with serious mental illness live full lives, integrated into their community, with a coordinated plan for formal and informal supports, focused on both their mental and physical wellness, which will optimize their functioning and empower them to be successful in pursuit of their goals and fulfilling their needs.

Goal

To provide effective and efficient coordination and linkage of services to adults with serious mental illness in a person-centered manner and to empower them to improve their quality of life.

Target Population

Adults, **18** years of age or older, who have severe and/ or persistent mental or emotional disorder that seriously impairs their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or intellectual disability are also included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness.

Diagnosis

There must be a major mental disorder diagnosable under DSM V (Diagnostic and

Statistical Manual of Mental Disorders, Fifth Edition), which is a schizophrenic, major affective, paranoid, organic or other psychotic disorder, personality disorder or other disorder that may lead to chronic disability. A diagnosis of adjustment disorder or a V code may not be used to satisfy these criteria. Case Managers who do not have a master's degree shall have the Adult Assessment co-signed by a RACSB clinical staff member who has a master's degree at the time the assessment is completed.

There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

1. Unemployed; employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills or has a poor employment history.
2. Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
3. Has difficulty establishing or maintaining a personal social support system.
4. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
5. Exhibits inappropriate behavior that often results in intervention by the mental health and/or judicial system.

Duration of Illness

Individuals are expected to require services of an extended duration or the treatment history meets at least one of the following criteria:

1. Has undergone psychiatric treatment more intensive than outpatient care more than once in their lifetime (e.g., crisis response services, alternative home care, partial hospitalization, inpatient hospitalization)
2. Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Exclusions and Terminations from Services

Exclusions:

1. Those persons who do not meet the adult serious mental illness criteria.
2. Those persons who may meet the criteria but refuse case management.

Terminations:

Persons are terminated from case management services for the following reasons:

1. The person refuses services.
2. The person requests to be terminated from services.
3. The person refuses to sign a plan for services.
4. The person perpetuates violence against his or her case manager.

In the case of exclusion or termination, each individual is given a list of alternative community services that may be of assistance to him/her. If the individual agrees, a formal letter may be sent to another service organization for contact and possible intervention.

Available Services

The case management role is to determine an individual's eligibility for services.

Identification

For each individual requesting case management services, it must first be determined that the individual meets the criteria for services.

Assessment

The case management role is to identify the specific needs for each person. The assessment process begins with the initial contact and is an on-going process. Information is gathered from an individual and/or his or her family. The information gathered should be regarding the areas of finances, health care, mental health, social and interpersonal relationships, recreation/leisure, activities of daily living, transportation, legal needs, and education.

Engagement

When an individual is first opened to Case Management Services, numerous meetings will be scheduled, and the involvement will be frequent and intense to allow for a beneficial working relationship to be established and to link the individual with necessary resources, early on. The intensity of engagement is defined and monitored by the Department of Behavioral Health and Developmental Services. Engagement is measured as the percentage of adults with serious mental illness admitted to the mental health services program area, who receive at least one hour of case management services within 30 days of admission and who receive at least 5 additional hours of case management services within 90 days of admission. After the first 90 days, service will be delivered as clinically appropriate, based on the individual's Level, but no less than one direct service each month and one face to face visit at least once every 90 days. Any missed appointments or lack of contact by the individual in response to outreach from the Case Manager will be documented.

Coordinate

The case management role is to use the information collected from the assessment process and to work in conjunction with the individual to develop an overall plan for each individual. These plans are based on the multidisciplinary or interdisciplinary team process and involve substantial input from persons, their families, human service providers and significant others from the person's social support network. These plans are person centered and focused on what is important to and important for, each individual.

Linking

The case management role is to link persons to resources that are available to meet their needs. The linking function is frequently referred to as brokering. The primary function of the linking/brokering function is to steer people toward the existing services that can be of benefit to them.

With the initiation of the Commonwealth Coordinated Care Plus project September 2017, case managers also coordinate with Care Coordinators at the Managed Care Organizations (MCO's) who have a contract with the Department of Medical Assistance Services (DMAS).

Monitoring of Medical Care

The case manager will assess everyone's medical needs when completing the Medical History Form at intake and annually at the ISP meeting. The case manager will link the individual with necessary medical providers, assist with coordination of care, follow up on any hospitalizations or treatment and encourage regular appointments with a Primary Care Provider. The case manager will meet with the individual face to face within 72 hours of discharge of a medical or psychiatric hospitalization. In order to assist with care coordination, the case manager will mail a letter to the individual's PCP. This letter will only be mailed out if the individual is in agreement and there is a Confidential Release of Information on file for the Primary Care Provider.

Monitoring Services

The case management role is to continuously monitor the services provided to the individuals. This requires on-going contact with individuals, their families, and the service providers to ensure that effective and appropriate services are being delivered and that these services continue to meet the current needs of the person. Regular face to face contact is the ideal way to monitor services. Monitoring also involves engaging with individuals in the community to monitor their housing stability, independent living skills as well as services and supports in the home.

Advocacy

The case management role is to ensure that the provider system and others continue to be responsive to the person's needs and wants. Case Managers may have to function as case advocates for individuals, especially those individuals who may be unable to speak for themselves.

Reasonable Accommodation

Reasonable accommodations are made to address the needs of special populations. These include, but are not limited to: interpreters, translators and/or staff with specific training regarding culturally competent service delivery, offering services in a different geographical locations (if hours of operation or accessibility are an issue), etc.

Staffing

Case managers have a minimum of a Bachelor's Degree in a related human service field and one year experience working with people with serious mental illness. Bi-weekly staff meetings, once monthly interdisciplinary staff meetings, supervision, in-service training, workshops, and conferences all support professional growth, programmatic growth, and address the needs of the individuals served. The once monthly interdisciplinary staff meetings will involve the coordinator's for both the Kenmore Club and the RACSB Residential Program. This interdisciplinary staff meeting will allow for discussion regarding programmatic changes,

individual participation as well as compliance of individuals who are in the community, Not Guilty for Reason of Insanity (NGRI) following a Conditional Release Plan (CRP).

Referrals

When a referral is made to Adult Case Management, an initial contact will be made within 10 business days of receiving the referral. The referral will be acknowledged and allow an opportunity to gather additional information. During the next seven calendar days or at the availability of the individual, an appointment will be made to meet with the individual face to face. During this meeting the Case Manager, if individual meets criteria, will establish a preliminary ISP and complete paperwork necessary to facilitate the eligibility process. The "Intake Packet for all Programs" and release forms are the primary documents used for this purpose. Within 45 days a final determination of eligibility for services will be established. If the individual meets eligibility criteria, has active case management needs and wishes to participate in active case management services, the individual is assigned a primary Case Manager. If all Case Managers are at capacity for services, then the individual is placed on a Waiting List for services.

If an individual needs services that **RACSB** cannot provide, the case manager will assume the responsibility for information and referral. Any linking that is appropriate to the individual's level of functioning, will be done by the case manager. If these services are to be concurrent with **RACSB** services, releases of confidentiality will be signed, such that the services can be co-coordinated. All relevant services, whether provided by **RACSB** or another agency, will be incorporated into the individual's service plan. The referral information will be documented in the record, including but not limited to: place, date, reason for referral, name of contact person, and any outcome of the referral. Information will be shared with other agencies only with authorization of consumer and based on need to know.

Checklist Criteria for Serious Mental Illness

The Checklist is used as the eligibility tool to determine if an individual meets the criteria for the population served by Mental Health Case Management. When an intra-agency referral is made, the Checklist is attached to the referral so the referring party can show that documentation exists that verifies the SMI Diagnosis. Once the diagnosis is determined then the standard Case Management Intake Process is followed.

When a referral is received from the community/hospital/social services, etc., the same form is used to help determine which service an individual needs to be referred to. If the individual determined to meet the admission criteria served by Mental Health Case Management, then an appointment is made, and the Intake Process is followed.

Checklist Criteria for Serious Mental Illness
(Adult Case Management Services)

A. Adult (18 or older)

AND

B. Major Mental Disorder per DSM-IV

- Schizophrenia

- Major Affective Disorder

- Paranoia

- Organic/other Psychotic Disorder
- Personality Disorder
- Other Disorder that may lead to chronic disability

AND

C. Level of Disability (At least 2 of the following criteria)

- Unemployed; limited employment skills; poor employment history
- Requires public financial assistance; may need help to access such
- Has difficulty establishing or maintaining personal support system
- Requires assistance in basic living skills (hygiene, food prep, \$ management)
- Exhibits inappropriate behavior often resulting in intervention by mental health and/or judicial system.

AND

D. Duration of Illness (At least one of the following criteria)

18

- Has undergone psychiatric treatment more intensive than outpatient care more than once (crisis intervention, partial hospitalization, inpatient hospital.)
- Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
- Is the client a codependent or collateral family member of someone with a substance abuse problem?

Transitioning Individuals from Jail

Identification & Referral

- Jail Services will identify adults who have a diagnosis of SMI who will need continuity of services after reentry.
- Jail Services will provide Adult MHCM Supervisor with information regarding these identified adults, as well as an official referral, approximately one month before anticipated reentry into the community.
- Adult MHCM Supervisor will communicate with Jail Services, once a month in order to assist with identification of adults needing continuity of services, upon reentry. An appointment for an intake for Adult MHCM Services will be scheduled, to occur within 10 days of an individual's release.
- Adult MHCM Supervisor will assign the identified adult to an Adult MHCM, in order to schedule an intake, upon discharge.

Transitioning Individuals from Child & Adolescent Case Management

- Child and Adolescent Support Services Supervisor will identify children who have a diagnosis of SMI who will need continuity of services as they enter adulthood and who will meet the criteria for Adult MHCM Services.
- C&A Supervisor will provide Adult MHCM Supervisor with information regarding these identified children, approximately one year before anticipated discharge from C&A CM Services.

- Approximately, six months before transfer to Adult MHCM services, the child will be assigned to their future Adult MHCM who can begin to track their services, familiarize themselves with their needs as well as attend any FAPT Meetings or other team meetings as deemed appropriate.
- Child and Adolescent Support Services Supervisor and Adult Mental Health Case Manager will communicate either via email, phone or in person at least once each month, in order to identify children who may need MHCM services as they enter into adulthood.
- C&A cases needing further discussion will be staffed at WIT or the Snowden Meeting to discuss plans for future services and to allow for collaboration of ideas regarding housing and/or support services.

Treatment Team Meetings

Whenever possible all those involved in the treatment plan need to participate in planning meetings. When attendance is not possible, appropriate communication with other individuals involved in the treatment plan are the responsibility of the individual responsible for the overall coordination and integration of the treatment plan. This communication is essential to insure effective and efficient delivery of services. When an interdisciplinary team is serving an individual, that individual benefits greatly from the support of the team. The team members benefit from the mutual support and expertise of each team member. The team promotes the philosophy of the program. There needs to be an Individual Plan specific to each service or program in which the individual is involved based on the needs and preferences of the person being served. The Individual Service Plan needs to focus, where appropriate, on the integration and inclusion of the individual, into community, family and/or support systems. A very reliable measure of improved level of functioning is increase in community involvement.

When additional services are needed which Rappahannock Area Community Services Board is unable to provide, the RACSB staff member responsible for coordinating the individual's services will assist the individual in obtaining and scheduling these services. Services with RACSB will be coordinated such that the individual will be able to participate in this full range of services. All services addressing the individual's presenting problems, whether offered by RACSB or other agencies, will be reflected in the Individual Treatment Plan. The case manager will coordinate team meetings prior to an individual enrolling in a service such as the Kenmore Club, Supervised Residential Services, Supported Living Services and/or PACT Services or moving from one service to another service, such as a move from Home Road Supervised Apartment Program to Liberty Street Apartments. The case manager is also responsible for coordinating any treatment team meetings when there is a concern regarding an individual's progress in a program, ability to follow the rules of the program or increased psychiatric symptoms.

Discharge and Case Closure

Discharge planning begins at orientation when the agency's policies regarding short term, solution focused approach are explained. During treatment, natural supports are strengthened and referrals for additional services in the community are made. At the time of admission, the person is asked to sign a document giving RACSB staff member's permission to conduct follow up following discharge. This makes individuals aware that RACSB staff members are concerned with their well-being following discharge. Discharge is planned with the full participation of the individual, all

staff involved in the services in which the consumer is participating and any other appropriate individuals.

Criteria for Discharge:

1. Discharge - evaluation, assessment - individuals referred for evaluation or assessment only - no ongoing services.
2. Discharged - treatment completed - mutual decision for the individual to terminate services because he/she satisfactorily completed treatment services.
3. Administratively discharge - moved out of the area, lost contact.
4. Individual died.
5. Discharged noncompliant - individual has consistently refused to work within the treatment plan, to keep appointments or follow recommendations.
6. Individual terminated no contact – at least 90 days from the last contact.

The discharge summary sheet shall contain:

1. Diagnosis or disability
2. Strengths, abilities, needs and preference of individual
3. Desired outcomes and expectations established
4. Admission date of client
5. Discharge date of client
6. Name of primary therapist/case coordinator
7. Medication information
8. Summary of services provided and client's progress towards
9. Treatment goals since admission
10. Reasons for discharge
11. Follow up referral plans and requirements to assist individual in maintaining and/or improving functioning and increasing independence.

Adult Mental Health Case Management Levels

Level 1 – Most Intensive

Description

This level of service is designed to meet the need needs of individuals with exceptionally high needs and/or high risks. Individuals receiving this level of service may have been recently discharged from a medical/psychiatric hospital, released from jail or not currently or consistently connected with community based psychiatric and/or medical services. They are also, most likely experiencing more intense/severe psychiatric symptoms, struggling more often with medication compliance and may also be using substances.

Admission Criteria

- Diagnosed SMI that significantly impairs her ability to maintain stability in the community
- Is actively participating in psychiatric services or is seeking to initiate services
- Requires assistance in accessing mental health, medical and other community-based services:
 - Employment/vocational services

- Housing
- Money management/payee services
- Transportation
- Education
- Legal assistance
- Application for Disability/Medicaid benefits

Must meet two of the following conditions

- Unable to be served by less intensive community-based services
- New to community-based treatment
- Experienced at least (3) emergency psychiatric interventions (ES and/or SLH)
- Regular contact with legal system
- Homelessness, risk of homelessness, extreme housing instability
- Patterns of high service needs
- Lack of consistent natural supports

Step-Down Criteria

- Actively participating in both mental health and medical services
- No hospitalizations for 90 days
- No involvement with legal system for 90 days
- Demonstrated progress in connecting with natural supports
- Demonstrated progress in accessing community-based services

Continuation Criteria

- Still meets admission criteria
- No marked progress toward goals
- Continues to require significant assistance from Case Manager
- Lack of consistent connection with community based mental health and/or medical services

Discharge Criteria

- Showing marked progress towards goals in ISP
- Mutual agreement of team to step down to next level of CM Services
- Refusal to actively participate in services, connect with Case Manager, attend appointments
- Lack of interest in working toward goals set in ISP

Level 2 – Moderate

Description

This level of service is designed to meet the needs of the individual who is engaging in services but continues to require a moderate level of supports through Case Management to maintain the current level of stability and connection with community-based services. This level of service may

also be for the individual who continues to struggle to engage in services but no longer meets criteria for Level 1.

Admission Criteria

- Diagnosed SMI that significantly impairs her ability to maintain stability in the community
- Is actively participating in psychiatric services or is seeking to initiate services
- Requires assistance in accessing mental health, medical and other community-based services:
 - Employment/vocational services
 - Housing
 - Money management/payee services
 - Transportation
 - Education
 - Legal assistance
 - Application for Disability/Medicaid benefits

Must meet two of the following conditions

- Extreme inconsistency or failure in scheduling/attending appointments, both mental health and/or medical within the last 6 months
- Extreme inconsistency in adhering to physician's orders in the form of medication and/or medical tests/care within the past 6 months
- Experienced a psychiatric hospitalization within the past 6 months
- Experienced at least (2) emergency psychiatric interventions (ES and/or SLH)
- Failure to receive assistance through natural supports in order to connect with community-based care or resources within the past 6 months
- Moderate contact with legal system within the past 6 months
- Difficulty maintaining employment due to mental illness in past 6 months
- Difficulty obtaining and/or maintaining housing in past 6 months
- Difficulty managing finances within past 6 months

Step-Down Criteria

(Progress seen in 6-month time frame)

- High percentage of goals met or progress made toward goals of ISP
- Increased number of appointments scheduled and kept
- Increased engagement in community-based services
- Increased participation in and compliance with recommended care (medications/treatment)
- Reduced psychiatric symptoms
- Reduced hospitalizations both psychiatric and medical
- Reduced need for crisis intervention from either Emergency Services or CM
- Reduced contact with legal system
- Improved stability in housing

- Increased identification of and use of transportation services
- Progress noted towards employment or volunteer work
- Has applied for Disability Benefits and/or Medicaid
- Progress noted toward better finance management, including payee services

Continuation Criteria

- Still meets admission criteria
- Short term goals not yet achieved
- Increased participation in mental health/medical services, but still requiring a higher level or supports to maintain participation
- Continues to experience hospitalizations and/or the need for crisis intervention

Discharge Criteria

- Marked progress toward goals set in ISP, 80%
- Little or no progress in meeting goals, despite attempts to engage individual in services
- Refusal to actively participate in services, connect with Case Manager, attend appointments
- Lack of interest in working toward goals set in ISP

Level 3 – Supportive

Description

This level of service is designed to be more supportive in nature. This individual is successfully connected with community-based services, but they may not always be consistent in following through. This individual is not deemed as high risk for hospitalization or incarceration, but continues to require assistance to improve and/or maintain their level of functioning. They have very little natural supports and require assistance in advocating for themselves and connecting with resources.

Admission Criteria

- Diagnosed SMI that significantly impairs her ability to maintain stability in the community
- Is actively participating in psychiatric services or is seeking to initiate services
- Requires assistance in accessing mental health, medical and other community-based services:
 - Employment/vocational services
 - Housing
 - Money management/payee services
 - Transportation
 - Education
 - Legal assistance
 - Application for Disability/Medicaid benefits

Must meet at least one of the following conditions

- Has not fully met all of treatment goals within the past 6 months
- Has demonstrated low to moderate difficulty in scheduling and attending mental health or medical appointments in the past 6 months
- Required assistance in linking with necessary resources in the past 6 months
- Required assistance in coordinating services in the past 6 months
- Required assistance communicating with or connecting with natural supports in the past 6 months
- May have experienced an increase in psychiatric symptoms in the past 6 months
- May have experienced a psychiatric hospitalization in the past 6 months
- Minimal contact with legal system in the past 6 months
- Experienced at least (1) emergency psychiatric interventions (ES and/or SLH) in the past 6 months
- Difficulty maintaining employment due to mental illness in past 6 months
- Difficulty obtaining and/or maintaining housing in past 6 months
- Difficulty managing finances within past 6 months

Continuation Criteria

- Still meets admission criteria
- Goals not yet achieved
- Slight decline in scheduling/attending appointments
- Medium to high inconsistency of involvement from natural supports
- Continues to require at least moderate level of assistance from Case Manager

Step Up Criteria

- Increased symptoms, hospitalizations, legal trouble, crisis interventions
- Current functioning is below baseline

Discharge Criteria

- Marked progress toward goals set in ISP, at least 90%
- Little or no progress in meeting goals, despite attempts to engage individual in services
- Refusal to actively participate in services, connect with Case Manager, attend appointments
- Lack of interest in working toward goals set in ISP

Governor's Access Plan (GAP)

GAP Case Management Services

The Governor's Access Plan is a program for adults ages 21-64, who are diagnosed with a Serious Mental Illness, designed to integrate behavioral health and medical health services and care coordination. All documentation and service delivery guidelines apply to individuals enrolled in GAP, however this service also requires that the individual's need for care coordination of their

medical health be outlined in their Treatment Plan along with any other goals that have been identified. Regular case coordination should occur between the assigned case manager and the GAP Care Manager, should the individual require hospitalization or an increase in need for services due to decompensation or illness.

Authorizations

Authorizations for GAP Case Management Services should be submitted through Magellan for up to 12 months of services. All other service providers should be updated should an individual be approved for GAP.

Waiting List

Please refer to Wait List Policy contained in the Overview to Clinical Services section of these policies.

Documentation:

Home Visit Tool

This electronic form is completed after each home visit to an individual's home. This form allows for the case manager to convey any concerns regarding the individual's living environment to their Residential Specialist. A Comprehensive Progress Note is completed to capture the duration of the service as well as to link with the goals of the Treatment Plan. The note should state that the Home Visit Tool was completed.

Medicaid Services Provider Choice Form

This form must be completed for all Medicaid and GAP clients at service initiation, at any change or addition of services or when an individual is dissatisfied with current provider(s).

Discharge Summary

This Discharge Summary is used for transfers from one program to another, for discharges from programs and for discharge from the agency. This form should be signed by the staff and individual, when possible. There should be an explanation of treatment goals and progress made. Referrals and recommendations must be noted. The reason for discharge is related to completion of treatment or ISP goals, not just "completion of treatment".

Billing

The services will be recorded in 15-minute increments, as either Direct or Indirect Time, generated by the completion of their Comprehensive Progress Notes. The case manager will communicate on this form, which date of service they would like to use as the billable date by highlighting that date of service as well as writing the service code next to that highlighted line. The report should include the case manager's name, their program code and their Staff ID #. The case manager must sign each page of this report. Case management billing will be submitted by the third business day of the following month. A copy of the report should be submitted to the supervisor.

Service Codes

- 1550 – Individuals who are served in the community
- 1555 – Individuals who are served in a State Hospital

- H0023UB – Low Intensity GAP Case Management - Individuals who are served enrolled in GAP Case Management
- H0023UC – High Intensity GAP Case Management - Individuals who are served enrolled in GAP Case Management and seen Face to Face in a setting other than an RACSB location
- ECC100 – Individuals who are served enrolled in Enhanced Care Coordination

Projects for Assistance in Transition from Homelessness (PATH) Case Management

RACSB provides case management services to individuals who are homeless, identified as needing mental health and/or substance use disorder services. These individuals are not currently connected to housing or mental health/substance use disorder services. These services are provided by the (PATH) program.

The PATH program involves a wide network of state and local agencies that contribute comprehensive community-based services for people who are homeless and have serious mental illnesses. The PATH Case Manager assist individuals who are homeless, with accessing a wide range of services to include:

- Assistance with enrollment into mental health services
- Providing information about community resources and services. - Information can also be obtained about the various community organizations that provide financial and medical assistance to the homeless.
- Assistance in locating affordable housing - Referrals are made to local landlords and agencies that may have rental rooms and apartments available at a lesser rate.

SUBSTANCE USE DISORDERS SERVICES

Mission Statement

RACSB Substance Use Disorder Services have been designed to facilitate recovery for individuals who have been affected by substance use by ensuring quality recovery at an appropriate level of care. RACSB endorses the Recovery Model which is person centered and focused on empowering the individual to learn about his/her unique needs, strengthen their ability to manage their lives, symptoms, and services.

For the purposes of these policies, substances are defined as alcohol as well as drugs.

Goal

The goal of RACSB's Substance Abuse Services is to provide cost-effective and efficacious outpatient services in a continuum of service options to individuals who are suffering from a substance use disorder and/or a co-occurring disorder.

Although the preferred goal for individuals with a substance use disorder is abstinence from all mood-altering chemicals, there is also an emphasis on harm reduction and enhancing person-centered motivation for change, especially in the early stages of treatment. Whether the individual chooses abstinence as his/her treatment goal or not, all are encouraged to maintain abstinence during treatment in order to have the experience, at least minimally, of living sober, so that post-treatment choices about use can be based on actual experience of abstinence. Abstinence is monitored through urine drug screens and alcohol breathalyzer tests.

To assist persons in meeting their goals, RACSB provides, directly or through contract with other agencies, a full continuum of substance use disorder treatment services, including:

- Emergency services (including medical detoxification and crisis hospitalization);
- Outpatient psychotherapy – group and indication based on the assessed needs
- Medication Assisted Treatment (MAT)
- Intensive outpatient group psychotherapy; and
- Residential detoxification or treatment
- Case Management

The specific level of service offered is based on the criteria outlined by the American Society of Addiction Medicine (ASAM) and the person's choice, where feasible.

Target Population

RACSB offers treatment to persons who meet DSM – V criteria for substance abuse or substance dependence.

Services are prioritized in the following order:

First priority is given to women who are pregnant and injecting substances

Women who are pregnant and abuse substances through other methods

Men and women who inject substances

Men and women who abuse substances through other methods.

Special Populations

Specialized substance abuse services for women. These include:

- Project LINK - a program for women who are pregnant and are at risk of using substances or are actively using substances.
- Separate staff dedicated to responding to the special needs of women and their families.

- Reasonable accommodations are made to address the needs of special populations. These include, but are not limited to: therapists or interpreters for the deaf or non-English speakers; communication devices; staff with specific training regarding culturally competent service delivery; availability of services in a different location
- All RACSB sites meet Americans with Disabilities Act requirements and are accessible to persons with physical disabilities, and the facilities accommodate the need to meet with individuals privately but also in larger groups.

Pregnant Women

Pregnant women are a priority population within RACSB Substance use disorder services. An offer of services within 48-hours is made to pregnant women presenting for substance abuse treatment services. The program cooperates with area hospitals, the *Department of Social Services* and the *Health Department* to identify pregnant women who are at risk of substance use and/or dependence and to assist women whose children are born exposed to substances. Services are systems based and therefore include the children and significant other as appropriate.

Admission Criteria

Persons evidencing signs of physiological withdrawal or who have a history of complicated withdrawal (e.g., seizures or respiratory difficulties) in previous treatment experiences are referred for medical assistance prior to substance abuse treatment.

Persons exhibiting significant mental health problems are provided Substance Abuse Services as long as the psychiatric symptoms are reasonably stabilized (e.g., the individual's mental status allows them to benefit from Substance Abuse treatment), with or without medication. RACSB treats co-occurring disorders simultaneously in keeping with best practices. RACSB provides services for people who have co-morbid mental health and substance abuse issues.

Substance Abuse Services are voluntary, premised on an expressed desire for treatment. Even if court ordered, it is recognized that the individual could choose not to attend or otherwise comply with treatment.

Exclusionary Criteria

Persons who fail to comply with reasonable requirements intended to assure the safety of all program staff and others receiving services may be excluded from further participation in services. Bringing illicit drugs, alcohol, or weapons within the context of these programs or their presence on any property operated by RACSB is prohibited. Any person found to be selling, distributing, and/or using illicit drugs or bringing weapons on the premises will meet with the SA Coordinator to discuss the situation, it is possible that an "unknown" medication and will be given to the medical services staff for disposal, in accordance with procedures used for disposal of surplus or expired medications. Over-the-counter or prescribed medications will be permitted only for the personal use of the individual for whom they are intended. It is the responsibility of the individual to make certain that such medication remains in their possession at all times while in RACSB facilities, and any indication that such medications are being distributed to other persons could result in possible discharge from services.

Available Services

Assessment

Assessments are completed using the American Society of Addiction Medicine (ASAM) Placement Criteria which will provide a level of care. If RACSB does not have the level of care indicated, the individual will be linked with the appropriate provider or the RACSB staff will devise a plan of care which achieves the same clinical purpose. Treatment planning is based on the assessment with the individual's goal driving the treatment plan.

Individual Therapy

Individual therapy is provided in an outpatient context for those persons meeting the ASAM criteria for this level. Monthly, individual check-in sessions are also provided for those in Intensive Outpatient Programs (IOP).

Treatment Groups

This level of treatment is primarily for those who meet DSM – V criteria for substance abuse or who do not yet acknowledge a substance dependence diagnosis. The treatment focuses on helping these individuals evaluate their substance use via psycho-education and group process; some education/treatment groups also integrate a structured, cognitive-behavioral curriculum into these groups. Length of stay in these weekly groups is typically a minimum of 16 weeks.

Intensive Outpatient Program (IOP)

This level of treatment is for individuals who need greater structure than that provided by Treatment Groups. Phase I of Intensive Outpatient Program (IOP) meets three (3) times per week; Phase II meets two (2) times per week; and Phase III meets one (1) time per week. The treatment component of the Rappahannock Regional Adult and Juvenile Drug Treatment Courts utilizes the RACSB IOP.

Drug Screening

Individuals may be screened for alcohol use (via Breathalyzer) or other drug use (via urine screen) as part of treatment. The schedule of screening varies, based on referral source requirements and clinical indicator for such screening. The urine drug screen is of no charge to the individual at the assessment. Thereafter, a charge of fifteen dollars will be assessed for each urine drug screen unless the individual is participating in the Rappahannock Drug Treatment Court Program (adult or juvenile). Urine drug screens will be administered in spite of an individual's ability to pay.

Jail-based Services

Assessment, group therapy, and case management services (focusing on connecting to community-based treatment once released from jail) are available at the Rappahannock Regional Jail. Group therapy integrates a structured cognitive-behavioral curriculum, process groups, with an emphasis on recovery.

Medically Monitored Detoxification

Residential detoxification is provided through RACSB's Crisis Stabilization Program, Sunshine Lady House (SLH) for Wellness and Recovery. Enrollment is based on the ASAM criteria, determines eligibility and level of care based on an evaluation of current and past substance use. Once the ASAM is completed and the level of care is indicated as a 3.7, medical detoxification, the individual is assessed by RACSB's Emergency Services Therapist as noted in the Emergency Services policies contained in this manual.

Residential Treatment

Detoxification, residential treatment, and halfway house placement are available through contracted providers on an ability-to-pay basis. Please refer to policies regarding the uses of Substance Abuse Residential Purchase of Services (SARPOS) contained further in this policy manual.

Acupuncture

Auricular acupuncture is provided as an adjunct service at all of RACSB's clinics depending on staff availability.

Support Groups

Persons receiving substance abuse treatment services are required (by criminal justice agencies) or strongly encouraged (by RACSB staff) to participate in twelve-step-based support groups of their choice if the group endorses the concept of recovery and abstinence. RACSB does not refer to one specific type of group.

Effectiveness

Indicators chosen for analysis to assess whether or not substance abuse outpatient services have improved the quality of life for persons receiving services are: employment status and status at discharge (i.e., frequency of alcohol and other drug use). For these variables, it is expected that the outcomes will show improvement over the course of treatment.

Efficiency

In order to meet the demand for substance abuse services with limited personnel resources, it is essential that services be provided as efficiently as possible. While successful treatment often includes time spent in collaboration with others involved with the person

receiving services, therapists are encouraged to maximize the extent to which their available time is spent in direct service provision. The percentage of staff time spent in direct service will be tracked monthly for all staff providing substance abuse treatment services.

In addition, data is obtained monthly on the number of individuals seeking services through the Same Day Access program, number who were seen on the same day and the number asked to return on a different day. Please note that no one is turned away without first speaking to a therapist or supervisor to ensure there is no need for emergency interventions.

Consumer Satisfaction

While many persons receiving substance abuse treatment services are not self-referred, successful treatment is dependent on persons recognizing the need for treatment and working cooperatively with the therapist in pursuing treatment goals. Therefore, it is important that persons perceive that they are being treated respectfully and with sensitivity to their particular needs. To assess the extent to which persons believe that their needs have been met by the substance abuse treatment program, the degree of their satisfaction will be measured using the 25-item Consumer Survey. This will be administered to persons at the time of discharge from the program and again, via the mail, four months following discharge. In addition, the DBHDS survey of consumer satisfaction, conducted during a selected week each year, will serve as a measure.

Accessibility

RACSB seeks to make its services readily available to the community, and the extent to which persons believe services to be accessible is measured by the agency-administered Consumer Survey, as well as by the survey conducted each year by DBHDS. Each of these surveys includes an accessibility domain, and it is anticipated that at least 75% of persons will express satisfaction with the level of accessibility of RACSB services.

Strategic Planning

In order to use resources wisely, it is necessary to anticipate community needs and to plan accordingly. To aid in this effort, input from persons receiving services as well as from potential referral agents is gathered from a variety of sources. Among these are the satisfaction surveys, which provide an indication of common perceptions of program strengths and needs. In addition, the Family Assessment and Planning Teams (FAPT), composed of representatives from five (5) public agencies in each locality, are polled annually, and their input is incorporated in program planning. Feedback from the Prevention Collaborative, a group of local agency representatives and interested parties whose purpose is to coordinate community efforts to prevent substance abuse, is also incorporated into the strategic planning process. Other sources of input include measures of the agency's ability to meet continuity of care agreements and information gathered in the context of focus groups, retreats and open houses conducted on an intermittent basis at various agency sites.

SUBSTANCE USE CASE MANAGEMENT SERVICES

Mission Statement

As a specialized service, Substance Abuse Services Case Management has as its goal to assist substance-abusing persons in attaining and maintaining their highest possible level of functioning by provision of support for a range of psychosocial issues associated with substance abuse and recovery.

Program Goals

The case manager recognizes that, until the basic needs of an individual are met (to include: housing; employment; child care; medical care; and transportation, psychiatric, psychological, recovery, support groups), it will be unlikely that he/she will be able to acquire or maintain a solid sobriety.

Thus, case management is dedicated to linking individuals to needed medical services, social, educational, vocational, residential treatment, specialized substance abuse treatment, and other supports essential to meeting their basic needs.

Services to be provided include:

- Assessment and treatment planning for the case management service;
- Linking persons to RACSB and community services and supports;
- Coordinating services and service planning with other agencies involved with the individual;
- Monitoring the progress of persons receiving services and associated service delivery;
- Making collateral contacts with significant others where clinically indicated;
- Screening for admission to residential treatment and/or discharge planning once placed;
- Discharge planning
- Psychoeducational services
- Identification of unavailable resources for future planning.
- Home Visits

Target/Priority Population

Priority populations mirror that noted in the Substance Use Disorders policies listed above. Specifically, individuals who are in need of supportive counseling to either begin the recovery process or to maintain recovery, individuals who are in need of linking to housing; employment; child care; medical care; and transportation, psychiatric, psychological, recovery, and support groups. The case manager will also focus on engaging natural supports which may include family members, friends, or members of a support network to strengthen permanent community supports.

The staff assigned to Specialized Substance Abuse Services for Women Program will ensure that pregnant women are given preference in admission to treatment as noted in the Substance Use Disorders policy above. Each pregnant woman will be offered treatment within 48-hours of the request for services. In addition, she will be assessed for the need for prenatal care beyond that which she is receiving at admission. Specialized Substance Abuse Services for Women Program

staff members are equipped with a list of substance abuse and other treatment providers who provide services to pregnant women. The case manager shall refer pregnant women to Project LINK.

Policies for Project LINK can be found under the Project LINK policies.

The referral of the child of any persons receiving services in the Specialized Substance Abuse Services for Women Program will be considered a priority referral to RACSB Child/Adolescent Services. Any infant born to a woman while in treatment in the Specialized Substance Abuse Services for Women Program will be referred for a developmental screening by the RACSB Parent Education – Infant Development Program (the early intervention program for infants and toddlers with developmental delays or disabilities) and Rappahannock Healthy Families as appropriate.

Substance Abuse Case Management, like all RACSB services, is open to persons without discrimination.

Case Management Procedures

Substance Abuse Case Managers serve persons who have been self-referred, referred from other RACSB programs, or who have been referred by any human services agency in Planning District 16. Referral is made to the case manager by other RACSB staff or Project LINK staff.

In processing a referral for case management, the following procedures are followed:

1. Case manager reviews referral and attempts to contact the person by telephone to offer services and set up an appointment, if the person so agrees and if appropriate.
2. If unable to reach the person by telephone, a letter is sent, or case manager goes to the person's residing location indicated on referral.
3. If unable to contact the person within 10-calendar days of the referral date, the case manager will notify the original referral source.
4. When the case manager meets with the person, a needs assessment is done using the specialized Alcohol/Drug Services Needs Assessment form and incorporating referral information. The substance abuse case manager becomes the primary case manager. From this first contact, the substance abuse case manager is responsible for communicating the person's status with all appropriate resource people.
5. The case manager and the individual receiving services begin the service plan process, including a location for future meetings.
6. Service plans address, but are not limited to, linking to agencies specific to individual need, including the following:
 - Shelters (homeless or domestic violence)
 - Project LINK
 - Substance abuse treatment
 - Mental health counseling
 - Support groups
 - AIDS resources
 - Importance of Tuberculosis screening, Hepatitis B and C tests and where to access

- Danger of sharing needles
 - Danger of overdosing on heroin or opioids
 - Use of and access to Narcan/REVIVE trainings
 - Parenting classes
 - Family planning
 - Maternity clinic
 - Independent living
 - Child Protective Services
 - Child care
 - Transportation
 - Department Aging and Rehabilitative Services (DARS)
 - Virginia Employment Commission
 - Adult education
 - Local colleges
 - Department of Social Services
 - Prevention
 - Rappahannock Goodwill Industries
 - Salvation Army
 - Domestic violence prevention groups
 - Food bank
 - Interfaith Clothes Closet
 - School systems
 - Women's Resource Center
 - Virginia Wounded Warrior Program
 - Other needed community resources
 - Support groups
 - Assess for need for detoxification or residential services using the ASAM
 - Link and coordinate discharge plans for individuals admitted to a detoxification program or residential treatment program
7. The case manager meets with the person regularly to coordinate services and continue with service planning with other agencies and providers involved with the individual.
 8. The case manager enhances community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services.
 9. The case manager makes collateral contacts with significant others and assists the person in identifying existing supports.
 10. The case manager monitors progress and service delivery.
 11. The case manager provides education, supportive counseling, and psychoeducation which guides the person and develops a supportive relationship that promotes the service plan.
 12. The case manager provides outreach to the person by:
 - Routine phone calls, including to family members;
 - Visits at employment site or jail;
 - Case Manager completes Home Visiting Tool
 - Supportive correspondence (e.g. notes of support and hope); and
 - Outreach is making available, but not forcing services.

Exclusionary Criteria

Persons who fail to comply with reasonable requirements intended to assure the safety of all program staff and others receiving services may be excluded from further participation in services.

Persons who fail to comply with reasonable requirements intended to assure the safety of all program staff and others receiving services may be excluded from further participation in services. Bringing illicit drugs, alcohol, or weapons within the context of these programs or their presence on any property operated by RACSB is prohibited. Any person found to be selling, distributing, and/or using illicit drugs or bringing weapons on the premises will meet with the SA Coordinator to discuss the situation, it is possible that an “unknown” medication and will be given to the medical services staff for disposal, in accordance with procedures used for disposal of surplus or expired medications. Over-the-counter or prescribed medications will be permitted only for the personal use of the individual for whom they are intended. It is the responsibility of the individual to make certain that such medication remain in their possession at all times while in RACSB facilities, and any indication that such medications are being distributed to other persons could result in possible discharge from services.

Effectiveness

Indicators chosen for analysis to assess whether or not substance abuse case management services have improved the quality of life for persons receiving services are: employment status and status at discharge (i.e., frequency of alcohol and other drug use). It is expected that this variables will indicate an improvement for persons receiving services, or that the status quo will be maintained.

Efficiency

In order to assure the efficient utilization of staff, substance abuse case managers will spend 55% of their time providing direct services to persons enrolled in substance abuse case management.

Consumer Satisfaction

While many persons receiving substance abuse case management services are not self-referred, improvement in their level of functioning is often dependent on their recognizing the need for services and working cooperatively with the case manager in pursuing goals. Therefore, it is important that they perceive that they are being treated respectfully and with sensitivity to their needs. In order to assess the extent to which they believe that the substance abuse case management program has met their needs, the degree of their satisfaction will be measured using the 25-item Consumer Survey. This will be administered to individuals during the time they are enrolled in services, and again at discharge from services. Follow-up surveys post discharge will be mailed out to assess satisfaction with services, as well as their perception of the quality of their lives.

Accessibility

RACSB seeks to make its services readily available to the community, and the extent to which persons believe services to be accessible is measured by the agency-administered Consumer Survey.

Strategic Planning

In order to use resources wisely, it is necessary to anticipate community needs and to plan accordingly. To aid in this effort, input from persons receiving services as well as from potential referral agents is gathered from a variety of sources. Among these are the satisfaction surveys, which provide an indication of common perceptions of program strengths and needs. Feedback from the Prevention Collaborative, a group of local agency representatives and interested parties whose purpose is to coordinate community efforts to prevent substance abuse, is also incorporated into the strategic planning process. The Prevention Programs Manager represents RACSB on this Coalition. Other sources of input include measures of the agency's ability to meet continuity of care agreements and information gathered in the context of focus groups, retreats and open houses conducted on an intermittent basis at various agency sites.

Substance Abuse Residential Purchase of Services (SARPOS)

Note: Pregnant women injecting medication, using Opioids, using other substances, or with a history of the same, are a priority and will not be included in the exclusion criteria below.

DBHDS and RACSB recognize the prevalence of addiction and the need for intensive residential services to promote the stabilization and recovery of individuals suffering from addiction. Historically, services for transitional living programs and other residential services that lead to recovery have been added as covered services funded through SARPOS. SARPOS funds may be used for up to seven days of residential substance abuse detoxification services, up to twenty-eight days of intensive residential services, and up to forty-five days of supervised or supportive residential services. The SA Coordinator shall approve all initial and continued stay requests for funding for these services. In the absence of the SA Coordinator, the Clinical Services Director will approve all initial and continued stay requests.

In an attempt to increase engagement, the individual shall identify at least two treatment goals to begin working on while receiving residential services. In an effort to individualize treatment within the limits on 28-day residential services, approval for residential services shall not exceed fourteen days initially with funding approved based on the motivation of the individual once they complete at least ten to twelve days of residential services. This method of approval is used so the individual's length of stay is individualized, based on the ASAM recommended practice. Funds may be designated for community-based substance abuse detoxification services, if combined with Board-directed case management.

Policies regarding how RACSB enters into memorandum of understanding with community providers can be found in RACSB's Administration and Finance Policies.

Exclusionary Criteria

Individuals who fail to comply with reasonable requirements intended to assure the safety of all program staff and others receiving services may be excluded from further participation in services.

The individual must meet income guidelines.

The individual must have no other means to purchase this service.

If anyone is suicidal, threatens suicide he/she will be assessed by Emergency Services, and may be considered for inpatient treatment with Sunshine Lady House for Mental Health and Wellness.

Individual discharged against medical advice within the past six (6) months from substance abuse residential or residential detoxification; special arrangements made be made for

Individual is participating solely to avoid attending court date/hearing or incarceration;

Individual reports external motivation from probation officer, attorney, or other referral source; and

Individual is requesting admission to resolve or delay a housing issue

Individual has not attempted outpatient services

Detoxification and Residential Treatment Medical Necessity Criteria

Clinical Staff will utilize the ASAM criteria to evaluate and assess for the level of care needed. The assessment must indicate that detoxification or residential treatment is indicated in order to access SARPOS funds.

1. Substance use behavior (frequency, duration of use);
2. Internally motivated to change substance use behavior;
3. Individual has attempted outpatient treatment services in the past;
4. Positive recovery support system (Agrees to complete a release for identified support person); and
5. Willing to be involved in outpatient treatment services;
6. Identified treatment goals for residential services

Best practice is to intervene as quickly as possible when someone request residential detoxification services, therefore RACSB shall attempt to have individuals in need of residential detoxification services admitted to the Sunshine Lady House for Wellness and Recovery (SLH), Crisis Stabilization Unit. Substance Abuse Case Management can provide services, link to community resources, as well as RACSB outpatient services. However, when an individual is unable to be admitted in a timely manner or demonstrates other mitigating circumstances, RACSB staff will explore alternative residential and/or residential detoxification.

Should complicated withdrawal symptoms be revealed (e.g., seizures or respiratory difficulties) in present or previous treatment experiences individuals are referred for medical clearance prior to substance abuse treatment or consideration for residential treatment or detoxification.

Most residential programs require an individual to be clean for three to five days in order to admit the individual. The assessment for residential services can be completed during this three to five-day period. Individuals with co-occurring diagnosis shall receive integrated mental health and

substance use treatment, which is best practice. There are treatment groups available for individuals who have co-morbid mental health and substance use disorder.

Substance use disorder services are voluntary, premised on an expressed desire for treatment. Even if court mandated, it is recognized that the individual could choose not to attend or otherwise comply with treatment.

Treatment planning is based on individual needs, level of motivation, and logistical ability to access services and follows the process outlined in the Mental Health Outpatient section of this policy manual.

ADMISSIONS TO WESTERN STATE HOSPITAL OF PERSONS WITH A PRIMARY SUBSTANCE ABUSE DIAGNOSIS

Discharge Planning and Follow-up Appointments

SFUR Regional Funds shall be accessed as available to avoid admission to a state hospital.

- The Substance Abuse Case Manager will receive a copy of all pre-screenings which carry a primary Substance Abuse diagnosis; the Case Manager will immediately and proactively start discharge planning for these persons.
- The Western State Hospital Liaison will inform the Substance Abuse Case Manager of any other persons in state hospitals whose diagnosis may have been changed to primary-substance abuse during the hospitalization. The Substance Abuse Case Manager will immediately and proactively start discharge planning for these persons.
- Discharge planning will include an appointment with a case manager and/or therapist in accordance with the continuity of care guidelines, e.g., within seven (7) days.
- The Substance Abuse Case Manager will monitor compliance with the follow-up appointment. If this appointment is not kept, the Substance Abuse Case Manager will attempt to contact the person by telephone within 24-hours to reschedule. The individual's failure to show for the original appointment and the Case Manager's attempt to reschedule will be documented in the chart.

Medical Appointments

The Substance Use Case Manager shall follow the guidance provided in these policies when requesting psychiatry appointments for individuals enrolled in the Substance Use Case Management Program.

- The Substance Use Case Manager will schedule a medical appointment for Substance Abuse – primary Western State Hospital discharges in accordance with the continuity of care guidelines e.g., within 7 – 14 days of discharge, to the extent practicable.

- If the Substance Use Case Manager is unable to schedule this appointment due to unavailability of psychiatrist time, the Clinic Coordinator will be asked to make the appointment.
- The Substance Use Case Manager will monitor compliance with the medical appointment. If this appointment is not kept, the Substance Abuse Case Manager will attempt to contact the person by telephone within 24-hours to reschedule. The individual's failure to show for the original appointment and the Case Manager's attempt to reschedule will be documented in the chart. If the person is not accessible by phone the case manager will attempt to contact the individual through written correspondence.

Rappahannock Area Alcohol Safety Action Program

1. All decisions about treatment plans for individuals referred by the Rappahannock Area Alcohol Safety Action Program (RAASAP) should be guided by the following goals:
 - To minimize the likelihood of presenting a public safety risk related to drinking/using and driving during RAASAP supervision by maintaining abstinence from all mood altering substances during RAASAP supervision.
 - To achieve a denial-free assessment of substance use status (i.e., need for abstinence versus reduced use versus no change in use), which represents the best possible opportunity for (a) no subsequent substance-related legal infractions, and (b) meeting person-centered goals.
 - To develop an individualized, post-treatment plan for achieving and maintaining the chosen substance use status.
2. Group therapy should be considered the standard method of treatment for RAASAP referrals.
 - This is based on the literature which suggests that group therapy is the most effective outpatient treatment modality with most individuals receiving substance use disorder services.
 - In some instances, however, individual therapy may be the best modality; for instance, if an individual's mental illness prevents him from participating effectively in group therapy, individual therapy might be more effective.
 - In some instances, individuals will do better in group if they spend a few (usually less than four) sessions in individual therapy which focuses on motivation, e.g., helping them get past their opposition to court-ordered treatment by focusing on how participating in treatment will help the person achieve his/her goals (which may be as simple as completing court requirements in order to get one's license back).
 - If the individual opts for individual therapy, RAASAP must be notified immediately in three ways:
 - Document on treatment plan and fax; and
 - Notification in writing even if verbally communicated with RASAP staff.
 - Attaching a memo with RASAP treatment report, which explains the rationale for recommending the alternative modality.
3. In most instances, 19 sessions should be considered the standard course of treatment. This is based on the literature which suggests that a primary predictor of positive outcome is length of stay in treatment.

- The 19 sessions may include initial engagement, group and/or individual sessions, and discharge session.
 - Clinicians should always feel free to recommend more than 19 sessions if (a) clinically indicated, and (b) not likely to precipitate relapse via triggering oppositional behavior.
4. Effective group treatment requires limits on group size. Given average motivation levels for RAASAP referrals, it is strongly recommended that groups be limited to 15 participants.
- The literature suggests that getting individuals into treatment as quickly as possible increases the likelihood of positive outcomes.
 - If logistically possible, consideration should be given to providing separate groups for those diagnosed substance use versus those diagnosed as substance dependent, thus, allowing for different in-group emphases (for instance, heavier emphasis on providing information with abusers versus emphasis on treatment and recovery issues with dependents) and post-group recovery plans.
5. Paperwork requirements per RASCB contract with RAASAP:
- Signed Release of Information authorizing RASCB staff to exchange information with RAASAP staff.
 - Notification if referred person does not show for orientation or intake. Notification should be made in writing, even if verbally communicated to RAASAP staff.
 - Copy of treatment plan faxed to RAASAP once person is assessed.
 - Weekly reports will be provided using the RAASAP weekly report form, and should be sent via fax or email. Emails shall be encrypted with password #encrypt, and sent as quickly as possible; information should include:
 - Results of alcohol breathalyzer (all sessions) and urinalysis (at least once a month on a random basis);
 - Short statement of person's strengths and weaknesses.
 - Copy of discharge summary once treatment is completed (notation on weekly report form is not adequate).

Probation

Individuals referred to complete a substance abuse assessment on behalf of Community Based Probation, should be contacted within 48 hours of referral receipt. Individuals referred by CBP, are mandated to complete treatment within six (6) months of release from jail.

Virginia Department of Corrections, District 21 Probation and Parole, encourage individuals to initiate treatment independently. Clinical staff is expected to obtain proper signed releases during treatment engagement. In addition, RASCB has two full time therapists located at District 21 Probation and Parole who work with individuals with substance use disorders and/or co-occurring disorders. They are held to the policies of RASCB to include what is contained in this policy manual.

MODIFIED INTENSIVE OUTPATIENT PROGRAM

Modified Intensive Outpatient has two (2) phases of treatment. The treatment model mirrors the described above under Regional Adult Drug Treatment Court when describing the three phases of

treatment. The significant difference is that Modified IOP has two (2) phases that incorporates the items contained in three (3) phases. Modified IOP is provided for people who are not participating in the Regional Adult Drug Treatment Court. See the description of Adult Drug Treatment Court below.

SUBSTANCE USE DISORDERS MEDICATION ASSISTED TREATMENT

Mission Statement

The Medication Assisted Treatment (MAT) program, is an evidenced based program for individuals addicted to opioids. Rappahannock Area Community Services Board (RACSB) adheres to the **American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions**. According to the ASAM, RACSB is a Level 1 Opioid Treatment Provider.

The MAT program provides targeted treatment to persons dependent on prescription and non-prescription Opioids. The program will assist persons with Opioid addiction in obtaining community-based interventions to deal with the ever-increasing misuse and diversion of Opioids and heroin. The MAT program supports RACSB's mission by respecting the dignity of people diagnosed with Opioid Addiction, serving their needs in the least restrictive environment possible and linking them with other community service providers as needed or requested. Finally, RACSB supports a recovery model by providing services based on the biopsychosocial treatment model where all aspects of the whole person are addressed throughout the individual's recovery journey. Treatment is person centered and the goal is for the individual to develop and follow a recovery plan that meets their individual needs. The support of people with lived experience is a key to successful recovery; therefore, the use of peer specialists is valued.

Program Goals

To provide access to MAT services in an effort for individuals to not only begin their recovery journey, but to allow individuals to ultimately integrate fully into a life of work, strong social and family relationships, healthy lifestyle, and attending support groups of their choice that support sober living. The ultimate goal is to prevent overdose and possible loss of life.

RACSB is providing only Suboxone in the MAT as the setting is not designed to provide Methadone treatment. RACSB has a relationship with community providers who prescribe Methadone as well as therapy and will refer individuals to those programs as appropriate which is in support of the goals of this program.

Target Population

The program serves individuals from the Counties of Stafford, Caroline, King George, Spotsylvania and the City of Fredericksburg.

- Pregnant women who are injecting substances, pregnant women who are using Opioids, and pregnant women who are substance dependent or have a history of any of the above, are priority and seen within 48 hours. Note that Subutex is the medication used for women who are pregnant.
- The program serves adult persons (18 years and older) who are in need of services for opioid addiction.
- Individuals must demonstrate a clinical necessity for the service by meeting the **Diagnostic Statistical Manual V** diagnostic criteria for Opioid Dependence. A diagnosis of nicotine or caffeine abuse or dependence, or tobacco use disorder alone shall not be sufficient for approval of these services. Individuals will be assessed using the ASAM.
- Individuals must sign and agree to all expectations as outlined in RACSB's MAT Treatment Agreement included in these policies.

Exclusionary Criteria

Pregnant women will be served when RACSB has an Obstetrician/Gynecologist (OB/GYN) who specializes in serving pregnant women enrolled in MAT. Substance Use Case Manager and the Project LINK Coordinator or her designee shall make every attempt to link the woman to an OB/GYN provider so she can enroll in MAT.

Individuals who are using Benzodiazepines, whether prescribed or not, are not eligible for MAT as the combination of Benzodiazepines and Suboxone is contraindicated.

Individuals using Methadone, whether prescribed or not, are not eligible for MAT unless the physician prescribing Suboxone approves admission. Methadone and Suboxone are contraindicated when the Methadone exceeds a certain dose.

All of the above situations will be reviewed with the physician prescribing Suboxone/Subutex prior to the Induction Phase.

Admission

For admission the individual shall meet the following medical necessity criteria:

- The individual shall have a primary International Classification of Diseases (ICD-10) diagnosis of moderate to severe opioid use disorder or be a pregnant woman with any opioid use.
- The member individual will be assessed by a Credentialed Addiction Treatment Professional acting within the scope of their practice, who will determine if the severity and intensity of treatment requirements as defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions is met.

Staff Qualifications

Rappahannock Area Community Services Board (RACSB) will follow federal guidelines for the prescribing of Buprenorphine/Naloxone to men and women that would benefit from this level of care. The Drug Addiction Treatment Act of 2000 (DATA 2000) allows physicians, upon completing the Waiver training, to prescribe Schedule III, IV, and V Opioid medications to treat Opioid Addiction on an outpatient basis. The prescribed Opioid medications must be approved by the Federal Drug Administration (FDA) to treat Opioid Addiction. A registered nurse will provide oversight when the individual takes the medication onsite. All physicians shall be licensed to practice medicine by the Virginia Board of Medicine.

Nurse Practitioners and Physician Assistants who have completed the required twenty-four-hour training approved by the Substance Abuse and Mental Health Administration (SAMHSAS), can provide follow up treatment for up to thirty (30) individuals who successfully complete the Induction Phase.

Licensed, licensed eligible, CSAC, and individuals with a bachelor's degree in human services will provide case management services. Only licensed or licensed eligible staff will provide therapy services. All therapy and case management services provided by therapists and case managers will be supervised by a clinician licensed with the Virginia Board of Health Professions.

Services Provided

RACSB will provide the following services:

- Assessment of clinical and psychosocial needs, to include linking to a primary care physician to complete a physical and bloodwork prior to the Induction Phase.
- Supportive individual and/or group counseling
- Linkages to existing family support systems
- Referrals to community-based services
- Care coordination, medical/prescription monitoring, and coordination of on-site and off-site treatment services
- Medical services will be provided by a Data 2000 trained physician on-site
- REVIVE training for family members and individuals receiving MAT services. **Update to Policy Manual: Please note that the Surgeon General of the USA has declared the opioid crisis as an epidemic. Therefore, prescriptions are not required for Narcan.** When prescriptions are required, the prescription shall be renewed every six months. All RACSB clinics and SLH has injectable Naloxone and the nasal version which is Narcan.
- Education about Hepatitis B and C as well as HIV-AIDS will be provided.
- Referrals for treatment of Hepatitis B, C, HIV-Aids as well as other health related issues shall be provided
- Education on the dangers of sharing needles.
- Education on the high probability of overdose when using Opioids but especially Heroin which is compounded if there is a timeframe where the individuals is not using these substances.
- Referral to the support group of their choice which supports sober living.
- Pregnant women will receive education on substance exposed infants and their needs as well as all the reason pre-natal care is of the utmost importance.

Hours of Operation

RACSB's Fredericksburg Clinic, where MAT is provided, is open from 8:00AM-7:00PM Monday-Thursday and 8:00-5:00 on Friday. Only individuals who are appropriate to receive take home medications on the weekend can be accepted into the MAT program. This ability will be assessed at the initial intake where it is determined if the individual is appropriate to participate in RACB's MAT program. If requested or deemed appropriate by the treating physician, the individual may enter RACSB's crisis stabilization program, Sunshine Lady House for Wellness and Recovery (SLH). In keeping with current protocol, all admissions to SLH will be assessed and screened by a member of RACSB's Emergency Services program.

MAT Program Procedures

All persons considered for MAT will receive a thorough clinical assessment, complete a physical, complete bloodwork as ordered, and address any health issues as recommended by the DATA 2000 trained psychiatrist prior to beginning the Induction Phase of treatment through RACSB's outpatient medical services. If the service is provided on an outpatient basis, the Substance Use Case Manager or SA Therapist completes the assessment and links the individual to health care providers to complete a physical exam as well as refers to laboratory to complete bloodwork as required.

No one is admitted to the MAT program unless he/she has signed the MAT Treatment Agreement or MAT Treatment Agreement/Private Provider.

Prior to admission, the treating psychiatrist shall check the Prescription Monitoring Program (PMP) to determine if the individual is receiving controlled medication from other providers. This question will be addressed directly to the individual during the assessment. In addition, in RACSB's electronic health record, the psychiatrist can check to see if the individual is receiving medication from other providers and pharmacies.

The outpatient program for persons receiving medically assisted treatment include Medication Management, SA Case Management, Individual/Group Therapy, scheduled as well as random urine drug screens. All individuals in MAT will be closely monitored on a daily basis by a Substance Use Case Manager; receive individual therapy; and attend group therapy twice a week.

The intensity of these services shall decrease based upon the individual needs of the person. The individual shall participate in group or individual therapy at least every two weeks of an individual's treatment and at least monthly for the second year. However, it is important to reiterate that treatment frequency and type will be addressed based on each individual's needs.

RACSB will provide peer services by an individual with lived experience who either has completed the Peer Certification as set forth by DBHDS and/or is prepared to take the training. Peers shall be supervised by a licensed professional. Peer services may include responding to

the local emergency rooms when someone presents who has overdosed on Heroin or Opioids, responding to individuals seeking MAT services or detoxification services, facilitate support/education groups. In addition, peer services through local support groups will be made available to persons receiving MAT.

Pregnant women who are addicted to opioids are prioritized for Substance Abuse Services by RACSB and referred to Project LINK. The Project LINK program will provide case management support (referral to transportation, housing, employment, childcare, and healthcare) to women addicted to opioids.

In addition, RACSB will refer pregnant women to private providers in the community who prescribe Methadone to pregnant women. The case management and therapy services will be provided by RACSB staff.

MAT Treatment Phases to Include Risk Mitigation, Transition and Discharge Planning

Dosing

Dosing of Buprenorphine shall be determined by the DATA 2000 trained treating psychiatrist. Informed Consent regarding medication interactions shall be followed as noted in the RACSB Medical Policy Manual. In addition, dosing instructions will be reviewed with the individual by the Substance Use Case Manager, RN, and Therapist.

Should an individual need access to their dosing information, they can call the 24-hour Emergency Services number and ask that the individual at Hello, Inc. have an ES Therapist contact them. The ES Therapist has access to RACB's electronic health record at all times and can read the physician's orders from the chart. The individual can also go to SLH or call there to obtain this information 24 hours/day. For security purposes, the individual's date of birth and address will be required in order to be sure the individual's identity.

Individuals will receive their weekend dose the Friday prior to the weekend. The prescribing psychiatrist will be consulted if an individual is no longer stable due to issues with the dosing, testing positive for other substances (with an emphasis on Benzodiazepines and Methadone given the medical implications, is pregnant and using substances, or any other presenting problems. The prescribing psychiatrist will either recommend admission to a hospital, crisis stabilization, or allow the individual to remain in the community with appropriate support. The Substance Use Case Manager or Therapist will develop a plan with the individual and a designated family member where signs and symptoms of a medical issue are reviewed by the RN and specific action steps outlined.

If an individual is non-compliant to the degree that the treating psychiatrist or members of the clinical outpatient team are concerned about allowing the individual to have take home medication over the weekend, the individual is no longer appropriate for RACSB's MAT program. RACSB will then link the individual to other MAT providers to the point that an appointment is made, records are shared, the treating physicians speak, and family and or supportive friends are included

in the planning. The individual can continue to receive outpatient case management and therapy. Genoa-QOL Pharmacy shall be informed.

Individuals will receive a lock box to take the medications home with them. The importance of storing medication safely, making sure the medication is locked, and the impact of using non-prescribed substances with the medication will be reviewed repeatedly by the treating psychiatrist, Substance Use Case Manager, and therapist. The pharmacist may also be included in educating the individual as appropriate.

Purchase of Medication

When funds are available, RACSB will purchase the Suboxone for individuals at the rate of 100% of the cost for the first 90 days of treatment.

The second quarter of participation, the cost of the medication will be split in half between the individual and RACSB.

The third quarter of participation, RACSB shall pay 25% of the cost and the individual shall pay 75% of the cost.

Thereafter, the individual will pay the entire cost of medication.

All medications (prescribed by physicians/nurse practitioners at RACSB and other community providers) shall be filled at Genoa Pharmacy, an independent pharmacy, located at the Fredericksburg Clinic to monitor medication prescriptions and pattern of use.

INDUCTION PHASE

Participation is three days

- The individual shall have a physical prior to being admitted to MAT. This physical may be completed by the treating psychiatrist or referred to a primary care physician.
- The individual will also complete all bloodwork as ordered prior to beginning the Induction Phase.
- Individuals will be educated on how can contract TB, HIV, AIDS, Hepatitis B and C as well as other health related issues.
- Individuals will be linked with medical providers if he/she tests positive for TB, HIV, AIDS, Hepatitis B and C or other health related issues.
- Pregnant women will be linked with Project LINK
- Individual must be in withdrawal.
- Withdrawal symptoms will be monitored by the MH Nurses using the Clinical Opiate Withdrawal Scale (COWS).
- Induction Phase usually takes approximately three days.
- Physician (Nurse Practitioner post Induction Phase) will access Prescription Monitoring Program prior to and throughout the time the individual is enrolled in the MAT program. This monitoring is not limited to any phase of treatment.

STABILIZATION PHASE

Participation is a minimum of twelve weeks

- Outpatient services of two process groups per week and one case management group per week.

- Individual therapy weekly for four weeks to be increased if clinically needed. Family/support system included based on assessment and need.
- Daily medication taken in front of MH Nurse and Substance Use Case Manager if urine screen is negative
- Urine screens at each group and individual session in addition to UDS at time of dosing
- See MD as scheduled.
- Required attendance at support groups-weekly
- Family support/education group weekly will be offered if staffing levels allow.
- Nurse Practitioner who is DATA 2000 trained (twenty-four-hour training) may prescribe from the Stabilization Phase throughout the length of participation unless the individual is in need the Induction Phase.

MAINTENANCE PHASE

Participation is a minimum of nine months

- Case Manager will contact family/support system to confirm progress is maintained.
- Attend at least one group and/or individual a minimum of every two weeks
- Urine screen at group or individual appointments
- Individual can take medication home for two weeks at a time for first 30 days; monthly thereafter.
- Substance Use Case Manager will call individual to come to clinic same day to count medications with MH Nurse present-“Call Backs”
- Decisions made about continuing with MAT
- See MD as indicated
- Case Manager will monitor participation, symptoms, link to services and meet monthly.
- Family support/education group provided weekly

After One Year Participation

- Random urine screens combined with call backs by case manager
- One group per month (or individual, based on individual needs)
- Two support groups per week
- Case Manager weekly phone contact with individual
- Face to face sessions with case manager as needed
- At least monthly phone calls to support system
- All services to increase based on assessed need
- Therapist and Substance Use Case Manager begin planning for discharge and titration off the medication.

Transition/Discharge Criteria

- According to the American Society of Addiction Medicine (ASAM), there is no recommended time limit for treatment with Buprenorphine. However, below is a list of discharge criteria.
- If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Opioid Treatment.
- Mishandling of medication received, from the MAT, may result in termination of treatment
- Dealing or stealing or of any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled may result in termination of treatment.
- Not abstaining from alcohol, opioids other than buprenorphine, marijuana, cocaine,

and other illicit or illegally-obtained substances, may result in termination of treatment as this activity poses a health and safety risk.

- Use of Benzodiazepines and/or Methadone may result in discharge from the MAT program.
- Not following recommended treatment may result in termination of treatment.
- Individuals shall be discharged from this service when less intensive services may achieve stabilization.
- If an individual must be discharged involuntarily, he/she will be offered the opportunity to detox at SLH for up to ten days. In addition, appropriate referrals, signed releases shall be obtained prior to discharge. Family members and members of the individuals support system shall be notified with the appropriate release signed.
- Discharge plans will be discussed from the beginning of treatment and is referenced in the MAT contract so the individual is prepared to titrate the dose after approximately eighteen months in the MAT program.
- RACSB will not provide MAT medication services after two years of service. If an individual cannot titrate off the medication, he/she will be referred and connected to another provider.
- Weekly support group to cope with titrating off medication.
- Weekly meeting with case manager to decrease if appropriate based on assessment and support system.

MITIGATING RISK OF DIVERTING BUPRENORPHINE/REVIVE! Training REVIVE! Training

The Prevention Coordinator and her staff work closely with the Medical Director for Planning District 16 to provide REVIVE! Training throughout the Planning District, to include school systems.

Each of RACSB's clinics has a supply of injectable Narcan as well as the nose spray. Staff working in the MAT program will have priority to attend the training and all other staff will participate as well. Families will be notified of the opportunity and encouraged to participate.

- Physicians participate in Prescription Monitoring Program
- "Call Backs" as noted above
- Use Buprenorphine films instead of pill form
- Use one pharmacy to fill medications-Genoa Pharmacy located at the Fredericksburg clinic
- Signed Participation MAT Contract at assessment
- Contact with Peer Specialist, as available based on staffing

Contact with support group/family/community pro

RAPPAHANNOCK REGIONAL DRUG TREATMENT COURTS

PROGRAM OVERVIEW

The Rappahannock Regional Adult and Juvenile Drug Treatment Courts (RRAJDTC) were established in 1998 after nine months of assessment and planning done by the Drug Court Planning Team. The RRAJDTC is a comprehensive system of substance abuse services and court supervision of non-violent offenders. The RRAJDTC serves the City of Fredericksburg and the

Counties of King George, Spotsylvania, and Stafford.

Mission Statement

To reduce recidivism and drug-related crime by providing immediate access to a comprehensive program of substance abuse and court supervision of non-violent, substance abusing criminal defendants.

Program Description

The RRAJDTC is a partnership between the Courts, the Fredericksburg Commonwealth's Attorney's Office, the Office of the Public Defender, the 21st (Adult) and the 15th (Juvenile) District Court Services Units, RACSB and the Rappahannock Regional Jail. This treatment program, which lasts a minimum of 12-months, is a three-phased approach to substance abuse treatment and rehabilitation. Individuals participate in a comprehensive program of drug treatment and rehabilitation services under the supervision of the Drug Court Judge. Phase I lasts a minimum of 12-weeks and provides stabilization, orientation, and education. Phase II provides the participant with intensive treatment, with emphasis on individual and group counseling. Phase III provides ongoing substance abuse treatment and support, with increased emphasis on the development of a plan for continued vocational and educational development. All three phases include scheduled and random drug testing and regular appearances before the Drug Court Treatment Judge.

Participating Members of the Drug Court Team

- 1. Drug Treatment Court Judge:** The Drug Treatment Court Judges preside over all drug treatment court hearings, make necessary referrals to treatment and reinforce treatment through the application of legal sanctions and incentives, as appropriate. All sanctions are immediate and specifically address the offender's conduct. The Drug Court Treatment Judges help to create and support a therapeutic environment for the participant-offender.
- 2. Commonwealth's Attorney:** The Commonwealth's Attorney assesses the appropriateness of each case for referral to Drug Court by reviewing the Pretrial Services report. The Drug Court Commonwealth's Attorney is present at all drug court briefings and hearings and participates in the development of a coordinated strategy for responding to positive drug tests and other cases of non-compliance. The charging jurisdiction Commonwealth's Attorney has final approval authority for all participants referred to the Drug Court Treatment Programs.
- 3. Defense Counsel:** After the Commonwealth's Attorney and Defense Counsel have agreed on the suitability of a candidate for Drug Treatment Court, the Defense Counsel advises the defendant of the nature and purpose of the Drug Court and of how participation will affect the defendant's interests. The defendant is advised of the rules governing participation and of the consequences for non-compliance. The Defense Counsel assures that all necessary legal documents are filed in a timely fashion and may appear at all weekly Drug Court briefings and court hearings. The Defense Counsel

makes certain that the sanctions used in responding to positive drug tests and other cases of non-compliance are within the agreed upon parameters of the Drug Court program.

4. **Drug Court Administrator:** The Drug Court Administrator acts as the point of contact between all entities involved in the day-to-day operations of the RRAJDTC. Additionally, the Drug Court Administrator monitors, evaluates and manages treatment and supervision issues. The Administrator is present at all scheduled case staffing, drug court briefings, and status hearings and is responsible for all data collection, program evaluation and grant reporting.
5. **Treatment Supervisor:** The Treatment Supervisor provides supervision of the therapists, case managers and all treatment-related matters. Additionally, the Treatment Supervisor is present at case staffing, Drug Court briefings, and status hearings. This person facilitates the Phase III group. This person also ensures the evidence-based practices are used when providing treatment services.
6. **Probation and Parole Officer:** The Drug Court Treatment Probation Officer ensures compliance with court orders by conducting field, office and treatment site visits. This includes monitoring employment sites and curfew and testing to verify abstinence from alcohol or drugs. The Probation Officer also schedules the community service work and ensures satisfactory compliance at given work sites, provides reports and documents to the court, and testifies when necessary. The Probation Officer documents all contacts, enforces all rules of probation, initiates additional court processes when necessary, and exercises all powers and responsibilities authorized by the state code and the Department of Corrections and the Department of Juvenile Justice.
7. **Pretrial Services Officer:** The Pretrial Officer ensures completion of a decision tree prior to the initial court appearance. A decision tree is completed to identify potential Drug Court participants. The Pretrial Officer disseminates the decision tree to the Commonwealth's Attorney, Defense Counsel, and Drug Court Administrator. Additionally, Pretrial Services provides supervision to those defendants placed on supervision prior to acceptance into the Drug Treatment Court.
8. **Therapists:** The treatment Therapists facilitate the substance abuse treatment groups and provide individual and family therapy.
9. **Substance Abuse Case Manager:** The Case Manager draws from a network of agency, community, regional and state resources and programs to provide the services that address each participant's needs. The Case Manager completes diagnostic assessments for participants referred and prepares reports for the Drug Treatment Court Judge before each scheduled appearance. All progress reports are made available to the treatment team for review prior to the scheduled court appearance. The participant progress reports are forwarded to the Treatment Supervisor for review before the case staffing. The Case Manager also completes a case management assessment with individuals participating in Drug Court within 30-days of entering the program.

10. **Surveillance Officer:** The Surveillance Officer assists the Probation and Parole Officer to ensure the compliance of court orders by those adults placed in the drug court. This includes field visits to offenders' homes, places of employment and treatment programs, in addition to occasional transportation duties. The Surveillance Officer also places Drug Treatment Court participants at sites to perform court-ordered community service hours and monitors completion of the hours.
11. **Electronic Monitoring Coordinator:** When court ordered as a sanction, the Electronic Monitoring Coordinator provides equipment and monitoring to Drug Treatment Court participants.

REFERRALS, SCREENING AND ELIGIBILITY

All individuals eligible referred to Drug Court are screened by the Drug Court Administrator (adults). Once screened, they are forwarded to the Drug Court Administrator for further screening to ensure all requirements of the Virginia Drug Court program are met. All appropriate cases referred to Drug Court Treatment and are scheduled for an assessment, to include a diagnosis of substance dependence, completed by the treatment provider.

A. Eligibility

1. The Commonwealth's Attorney determines suitability of defendants for referral to Drug Court based upon the following eligibility criteria:
 - a. A pending charge of:
 - i. Felony drug possession or attempt to possess offense;
 - ii. Possession with intent to distribute offense (subject to Commonwealth Attorney review);
 - iii. Prescription fraud offense; or
 - iv. Non-violent felony property crimes related to substance abuse, to include: grand larceny forgery, uttering, felony bad checks and felony shoplifting;
 - b. Resident of Fredericksburg, Stafford, Spotsylvania or King George; and
 - c. Substance dependent diagnosis.
 - d. In addition to using the established criteria, the Commonwealth's Attorney also considers:
 - i. Family and community ties: An exception can be made if there is an assault on a family member, which may have precipitated the family's involvement with the juvenile court system.
 - ii. Employment status; and
 - iii. Defendant's prior criminal record.
2. Distribution or possession with intent to distribute disqualify a defendant from participation in Drug Court.
 - a. Upon approval by the Commonwealth's Attorney, the Defense Attorney;
 - b. Discusses with the defendant the option of Drug Court;
 - c. Discusses current charges and advises the defendant of the legal rights affected by entering Drug Court; and
 - d. Explains to the defendant the requirements of Drug Court.

Assessment Process

Immediately following a referral, the participant is assessed, to determine the clinical appropriateness for participation. Adults are assessed by the Adult Drug Court Case Manager. The Drug Court Therapist complete assessments for the Juvenile Drug Court Treatment program. At the time of the assessment, the individual receives the Juvenile Drug Treatment Court handbook on the treatment process. Each Adult participant receives the Adult Drug Court Participant Handbook. Both handbooks fully describe the Drug Court and the Drug Court process.

The assessment process gathers information in the following areas:

The multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions:

- Acute intoxication or withdrawal potential, or both;
- Biomedical conditions and complications;
- Emotional, behavioral, or cognitive conditions and complications;
- Readiness to change;
- Relapse, continued use, or continued problem potential; and
- Recovery/living environment.

The Level of Care determination, Individual Service Plan (ISP) and recovery strategies development shall be based upon this multidimensional assessment.

And;

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.
2. Behavioral Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.
3. Previous Interventions by providers and timeframes and response to treatment: include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.
4. Medical Profile: Describe significant past and present medical problems, illnesses and injuries, known allergies, current physical complaints and medications. As needed, conduct an individualized fall risk assessment to indicate whether the individual has any physical conditions or other impairments that put her or him at risk for falling. *All children aged 10 years or younger should be assessed for fall risks based on age-specific norms.*
5. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?
6. Educational/Vocational Status: School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.

7. Current Living Situation, Family History and Relationships: Describe the daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.
8. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations
9. Drug and Alcohol Profile: Describe substance use and abuse by the individual and/or family members; specify the type of substance with frequency and duration of usage.
10. Resources and Strengths: Document individual's strengths, preferences, extracurricular, community and social activities, extended family; activities that the individual engages in or are meaningful to the individual.
11. Mental Status Profile-May include the DMAS "At Risk of Physical Injury Screening Tool" (DMAS P502) or other clinical tools used if they apply
12. Diagnosis: The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis
13. Professional Service Specific Intake Summary and Clinical Formulation includes a documentation of medically necessary services as defined by the service provider which:
 - a. Defines if there are any additional clinical issues that may need to be addressed that were not identified in the VICAP-as appropriate to the service being requested,
 - b. Compares the presenting issues identified in the VICAP to those identified during the intake,
 - c. Identifies as much as possible, the causes of presenting treatment issues, and
 - d. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual specific service plan can be developed.
14. Recommended Care and Treatment Goals
15. Dated signatures of the clinicians and case managers* who completed the intake. *For case management services only: A dated signature of the case manager who completed the intake is required.

The Service Specific Provider Intake must be completed annually for all services or more frequently as service needs change.

As part of the assessment process, the participant is oriented to the treatment component, and an individual treatment plan, including appropriate level of treatment, is developed. Every attempt is made to tailor the treatment to accommodate the specific physical and learning abilities of each participant.

During the assessment process, the participant receives a treatment handbook, which includes the following information:

1. The philosophy of the treatment program;
2. The purpose of assessment and information on how treatment plans are developed and monitored, including participant involvement in these processes;
3. The schedule for group sessions (days and times) and the times when urine drug screens are administered;
4. A list of guidelines for attendance to a community support group of choice that promotes abstinence and long-term recovery, and a meeting schedule;

5. A section on Drug Court program policies and requirements, including attendance and abstinence from mood-altering chemicals;
6. A section on RACSB agency policies including confidentiality, possession of nonprescribed drugs, possession of weapons, incident reports of any injury, smoking, fire emergencies (disaster plan and fire drill procedures), loss of items or any occurrences out of the ordinary. Participants are informed of their human rights, including their rights of appeal, in person and via a written form; and
7. Conditions that would result in early discharge from the program. Instructions for notification of the therapist if the participant decides to drop from the program are included, along with a notice of possible consequences for withdrawal.

In addition to the handbook on the treatment process, each participant receives the Adult Drug Court Participant Handbook, which fully describes the Drug Court and the Drug Court process.

Treatment Services

Case management services are available to aid with education, employment and health services, linking participants to financial resources, medical and psychiatric care, housing, entitlements, etc. The case manager is also available to assist with detoxification and residential services, as needed. The case manager assists with admission to four to seven-day detoxification and 14-28 days residential treatment services provided through various vendors, such as RACSB Crisis Stabilization Unit, Boxwood, etc. Financial assistance for residential programs is offered by RACSB through federal SARPOS funding, for those who qualify by virtue of their income. For those who remain in residential care for more than 30 days, the case manager serves as the liaison between the treatment facility and the Drug Court Treatment team. Case management services continue through all phases of treatment.

Therapists facilitate substance abuse treatment groups for the Drug Court participant. They also provide individual, couples and family therapy during all phases, as needed. Therapists are qualified to provide treatment to individuals experiencing difficulties related to substance use and mental illness, whether occurring individually or jointly. Therapists are licensed or certified as mental health and/or substance abuse treatment providers within the Commonwealth of Virginia, or their work is directly supervised by licensed providers.

The surveillance officer administers urine drug screens and alcohol breath tests prior to each treatment group and on weekends randomly, according to need and phase of treatment. Tests are available to detect alcohol, THC, cocaine, PCP, opiates, benzodiazepines and amphetamines.

Psychiatric services are available for medication management, as needed. Referrals to this service are made by the treatment therapist, who communicates the person's status in treatment to the psychiatrist and assists in monitoring compliance with medication recommendations. Psychiatric services are provided based upon the person's ability to pay for the service.

Participants in the Drug Treatment Court program have the following goals in common:

1. Participants are motivated to participate in treatment with recovery as the goal.

2. Participants will obtain the knowledge and tools necessary to live drug-free and pro-social lives, including education about addiction and recovery and pro-social thinking patterns.
3. Participants will develop a personalized relapse prevention plan.
4. Participants will know the community-based resources, which can support drug-free and pro-social lifestyles, and they will be empowered to access these resources.

In addition to goals for each participant, broader goals for the program as a whole are as follows:

1. The impact of repeat drug offenders on the local criminal justice system and jail overcrowding will be reduced.
2. Recidivism and drug-related crime will be reduced.

Each of the Intensive Outpatient Program's (IOP) three stages has behaviorally-defined criteria that participants must complete before moving to the next phase. Thus, although the descriptions below indicate typical completion times, the emphasis is on completion of the criteria, not on the calendar. In each phase, movement to the next phase is determined by entire Drug Court Team, including the judge. Participants are expected to assume increased group leadership and positive role model responsibilities with phase promotion.

Phase I

A. Goals

During Phase I, treatment focuses on helping participants stabilize their lifestyles and commit to treatment and the honesty required for recovery. Motivation for change at this point is largely external; thus, a great deal of structure is provided to help the participant move toward stability.

B. Completion Criteria

1. Abstinence for 4 weeks (minimum);
2. Completion of observable steps toward development of a recovery lifestyle, characterized by positive behavior, thinking, and peer association, including:
 - a. Completion of Moral Recognition Therapy (MRT) Step 4 or comparable commitment to honesty and recovery program;
 - b. Ability to communicate:
 - i. an understanding of substance use problems (use, abuse, addiction);
 - ii. some sense of the participant's personal problems associated with use;
 - c. His/her responsibility for those problems and their resolution;
 - d. Initial plan for dealing with slips, including ability to name personal triggers, and to identify personalized signs of relapse and ways of preventing relapse;
3. Connection to community recovery resources in the form of attendance at least two 12 step and/or Women for Sobriety meetings per week;
4. Full-time work, school, and/or other structured activity. Participants should also have a functional plan for managing leisure time. (Accommodations will be made for participants who are on disability, who care for relatives on a full-time basis, or who have other, viable activity for at least 30 hours per week. For Drug Court participants, alternatives to work must be approved by the Drug Court team);
5. Stable living environment which is supportive of recovery;

6. Receiving treatment for any diagnosed mental health problem and or medical problem;
7. Participant must be paying toward obligations of drug court fees, court costs, and restitution;
8. Participant must not be currently under any court sanction.

Completion of these steps typically requires 4 to 12 weeks, but, as noted above, the decision for a participant to be promoted to Phase II is based on completion of the criteria above, not time spent in the Phase.

C. Treatment Methods

During Phase I, participants meet for group therapy three times each week. The primary methods used during this phase to facilitate participant completion of the phase criteria are group therapy and case management. Group therapy blends psycho-education about chemical dependency and recovery with group process, targeted toward helping the participant understand chemical dependency in general and his/her recovery needs, in particular. Group therapy also includes at least one weekly session using a cognitive-behavioral approach. This session focuses on helping participants commit to treatment and the honesty required for recovery via use of the first three steps of the Moral Recognition Therapy (MRT) protocol and/or comparable resources. Participants are provided with case management services to help with referrals for employment, education, or medical services during this phase of treatment.

After approximately one month in the program, each participant meets with a clinician individually to review program parameters and to re-evaluate the treatment plan. Psychiatric, family, or individual treatment is also available as needed.

Urine drug screens and alcohol alcohol breathalyzer tests are administered a minimum of three times per week and randomly during this phase.

Participants are expected to attend a minimum of two 12-Step meetings (AA/NA) or alternative support groups of their choice which supports a sober lifestyle per week and have a sponsor or equivalent by completion of this phase.

Treatment team meetings are held weekly to discuss participants' progress and treatment recommendations for the court, culminating in a progress report on each participant appearing in court that week.

Phase II

A. Goals

Although education on chemical dependency and recovery continue during Phase II, the emphases are on:

1. An examination of one's life to this point, setting goals to improve it, and taking personal responsibility for those changes;
2. Developing viable recovery lifestyles, including a personalized relapse prevention plan;
3. Beginning resolution of psychosocial problems which are related to substance use; and
4. Developing internalized motivation for recovery as the primary reason for change.

B. Completion Criteria

1. Abstinence or no unacknowledged slips for minimum eight (8) weeks;
2. Connection to community recovery resources in the form of:
 - a. Attendance at no less than two 12-step meetings and/or Women for Sobriety meetings per week;
 - b. Strong personal support network. Minimum: Three-person network, including at least one sponsor (or person with minimum two-year experience in recovery), who has "contracted" with the person to be available for relapse prevention and/or slips/relapses.
3. Presentation of life story to group at least two months prior to completion of Phase II, and significant resolution (as judged by therapist, participant and group) of personal issues identified through life story. The life story should include:
 - a. Positive and negative components of participant's addiction and recovery; and
 - b. Evidence of integration of awareness of relationship of participant's family to the person's substance abuse and recovery.
4. Completion of observable steps toward development of recovery lifestyle, characterized by positive behavior, thinking, and peer association, including:
 - a. Completion of Moral Reconciliation Therapy Steps 4 - 10;
 - b. Fully-developed relapse management plan based on person triggers and presented verbally to therapist and group;
 - c. Full-time work, school and/or other structured activity which has not changed for at least 30 days. Participants should also have a functional plan for managing leisure time;
5. Receiving treatment for any diagnosed mental health problem and or medical problem.
6. Participant must be paying towards obligations of drug court fees, court costs and restitution; and
7. Participant must not be currently under any court sanction.

Completion of these steps typically requires 4 - 6 months but, as noted above, the decision for a participant to be promoted to Phase III is based on completion of the criteria above, not time spent in the Phase.

C. Treatment Methods

Participants meet a minimum of two (2) times per week for two-hour group therapy sessions. Group therapy centers on addressing individual psychosocial recovery issues and on reducing self-destructive, anti-social and/or criminal thinking and relationship patterns via MRT. Participants are facilitated in replacing these patterns with more active participation in therapy and support groups and by becoming pro-socially active in family and community life.

Upon beginning Phase II, participants are assessed to determine if they are in need of GED or Productive Citizenship classes. Productive Citizenship is a 16-week program that teaches life skills and covers topics such as time management, communication, problem solving, healthy sexuality and family legal issues.

Participants are provided with case management services, as needed, to help with referrals for employment, education or medical services during this phase of treatment. Psychiatric, family, or individual treatment is available as needed.

Urine drug screens and alcohol breathalyzer tests are conducted a minimum of two (2) times per week and on a random basis.

Phase III

A. Goals

Although relapse and psychosocial issues often tend to continue or to emerge—and are dealt with—during this phase, the ultimate focus is on preparing the participant to maintain his/her recovery-based lifestyle after completion of the program.

B. Completion (e.g., Graduation) Criteria

1. Abstinence or no unacknowledged slips for minimum 16-weeks;
2. Attendance to a community support group of choice that promotes abstinence and long term recovery.
3. Completion of observable steps toward development of recovery lifestyle, characterized by positive behavior, thinking, and peer association, including:
 - a. Fully-implemented relapse management plan, based on person triggers, and presented verbally to therapist and group;
 - b. Full-time work, school, and/or other structured activity which has not changed for at least 30 days. Individuals receiving services should also have a functional plan for managing leisure time;
 - c. Minimum one (1) family (biological family or family of choice) therapy session, focused on maximizing family support for recovery; waived, if, after consulting with primary clinician, family continues to refuse involvement, or is logistically unable to participate; and
 - d. Receiving treatment for any diagnosed mental health problem and or medical problem.
4. All drug court fees and court costs must be paid in full.

As noted above, the judge must give final approval for program completion.

C. Treatment Methods

During Phase III, participants meet once each week for an hour and a half group therapy session. Group therapy centers on concrete, individualized plans for post-treatment recovery.

Upon beginning Phase III, participants will be assessed to determine if they need Money Management classes. This is a 6-week program that covers topics such as budgeting, banking, loans and saving for the future.

Participants in Phase III are expected to continue attendance at 12-step meetings or an alternative support group a minimum of three times a week.

Urine drug screens and alcohol breathalyzer tests are administered a minimum of once per week and randomly.

Participants are encouraged to do volunteer work in the community and generally to be more

active citizens in the community.

Completion of Phase III is not dependent on completion of a certain number of weeks; rather, completion is dependent on accomplishing treatment goals.

Prior to graduation, participants are required to meet individually with a case manager to review their post-treatment recovery plans for completeness. Participants are provided with case management services, as needed, to help with referrals for employment, education, or medical services during this phase of treatment. Psychiatric, family, or individual treatment is available as needed.

CASE STAFFING

The Drug Court Administrator, Treatment Supervisor, Case Manager, Probation Officer and Surveillance Officers are present at all staffing to provide input, report progress and to review the treatment plan. This information will then be shared with the Court in order so the presiding Judge can make rulings based on the individual's behavior.

A. Team Staffing

Team case staffing occur at a minimum in accordance with the following schedule:

1. Phase I: One time per week
2. Phase II: Twice monthly
3. Phase III: Monthly

Case staffing should occur more frequently than required if dictated by a participant's noncompliant behavior or other special circumstance.

B. Status Call Staffing

A staffing that includes the ADTC Administrator, Probation Officer, Surveillance Officers, Treatment Supervisor, Case Manager, Defense Attorney, Commonwealth's Attorney, and ADTC Judge occurs on all cases prior to a status call hearing. The purpose of this staffing is to give the ADTC Judge the opportunity to review reports from treatment and discuss treatment obstacles with the team. The team recommends appropriate action, but the ADTC Judge has the final authority on how each case will be handled in open court.

C. Status Call Hearing

Status hearings are used to monitor compliance, participation, and progress for each Drug Court participant. Frequency of status hearings may vary depending on the participant's compliance with all program expectations (ranging from once a week to once a month, corresponding to each treatment phase and participant's needs). The court applies appropriate incentives and sanctions to match treatment progress.

RESPONSES TO VIOLATIONS

The Drug Court Judge responds to relapse and other violations with immediate sanctions that address non-compliance and inappropriate conduct based upon recommendations made by the ADTC team during weekly staffing. The court strives to keep participants in Drug Court while imposing swift, consistent and behavior-specific sanctions for relapse, missed meetings or court

hearings, and other rule violations. Graduated sanctions tend to become more restrictive as the severity and/or frequency of infractions increase. Since the purpose of sanctions is to motivate the participant toward recovery, linkage with the program is maintained through contact with the case manager whenever sanctions require that a participant's involvement with the program is suspended for more than 30-days.

Incentives are also given by the Drug Court Judge when someone has accomplished a major goal, provided assistance to another individual without prompting, or for a generally outstanding performance. The Drug Court program attempts to build on people's strengths, reward good behavior, and focus on the positive with the belief that people are motivated more by incentives and change is more permanent when building on the individual's inherent strengths.

A. Emergency Public Safety Issues

It is the responsibility of the Drug Court Judge to decide what violations or behavior will result in incarceration of a participant. However, if in the judgment of the Probation Officer, a participant displays a behavior that could negatively affect public safety, it is be the responsibility of the Probation Officer to issue a warrant for the participant's arrest. The Drug Court Administrator arranges for the case to be docketed for the ADTC for the next court date.

B. Subsequent Arrests/Convictions

New arrests and/or convictions are reviewed on an individual basis. Although a status call team staffing should occur prior to any actions taken, it is the responsibility of the ADTC Judge to make the final decision to continue participation in ADTC based on either a new arrest and/or conviction.

C. Other Serious Violations

The Drug Court Administrator places a case on the docket for the next courtroom status call date if a violation is deemed serious but not a threat to public safety.

PARTICIPANT FEES

At the time of admittance into the ADTC, the Court imposes a maximum \$600.00 fee to be paid at a rate of \$50.00 per month. The fee may be less than \$600.00 if the duration of the program is less than twelve (12) months. Additionally, participants will be required to pay all Electronic Monitoring or Secure Continuous Remote Alcohol Monitor (SCRAM) fees when such equipment is required as the result of a court ordered sanction. Fees and other expectation of the program are outlined in the Drug Court Rules and Expectations form, which is signed by each participant.

Participation in Drug Court will not be terminated solely due to a participant's inability to pay required fees, and a participant's motivation in addressing this matter will be a consideration. Fees and other expectation of the program are outlined in the Drug Court Rules and Expectations form, which is signed by each participant.

RECORDS MANAGEMENT

A case file for each participant is maintained in the EHR. All relevant federal, state and local laws govern records and disclosure. In accordance with licensure requirements of the Department of

Behavioral Health and Developmental Services, an individual treatment plan must be developed within 30-days of admission to the program and annually thereafter. In addition to weekly monitoring by the Team, quarterly reviews of the individual treatment plan are conducted with the participant, and documentation of this is maintained in the chart. A case note is completed for each treatment session, and a progress report is compiled by the therapist for each status call staffing. The record is reviewed periodically by the RACSB Quality Assurance Manager to promote compliance with all applicable standards.

STAFF TRAINING

Drug Treatment Court team member development and ongoing cross training are provided through workshops and bi-monthly staffing with team members. RRAJDTC team members are trained in the MRT curriculum, used by treatment staff. In addition, training opportunities sponsored by the National Drug Court Institute, National Highway Traffic Administration and National Association of Drug Court Professionals are made available to RRAJDTC team members through Drug Court funding. The Treatment Supervisor and Drug Court Administrator also work together to provide targeted staff training. Similarly, members of the criminal justice agencies periodically design and deliver training to the Drug Court team. The end goal is not only to increase job knowledge but also for all team members to have a strong sense of their role in Drug Court and to be able to identify the skills and responsibilities of other team members.

SERVICE SPECIFIC TO INTENSIVE OUTPATIENT PROGRAM FOR REGIONAL ADULT DRUG TREATMENT COURT

Aftercare

Recovery from chemical dependency is a lifelong process. The disease of addiction is primary and progressive and will continue to progress even during abstinence; therefore, an aftercare program is an important part of the participant's recovery plan. The emphasis placed on 12-step or alternative programs during treatment continues as a part of an aftercare plan. A solid spiritual foundation and community service should also be included in a continued recovery. Graduates are encouraged to maintain active participation in a community support group that promotes abstinence and long-term recovery.

SERVICE SPECIFIC TO INTENSIVE OUTPATIENT TREATMENT FOR JUVENILE DRUG TREATMENT COURT

Each participant is visited at his/her home once a week. Another adult must be present at these visits at all times. When clinically warranted, the visits will increase to twice a week. In addition, if the home is unsafe or not appropriate for the therapist to effectively provide treatment, the participant may be seen at the local RACSB clinic. This exception must be approved by the Drug Court Administrator, Juvenile Drug Court Treatment Supervisor then presented to the Juvenile Drug Court Team for consensus.

Throughout the participant's involvement in the Juvenile Drug Treatment Court, parents or legal guardians are required to attend the weekly 2-hour family group as well as participate when in home family sessions are conducted by the designated primary therapist. Treatment for juvenile participants is scheduled at times that do not conflict with their educational programming. All participants are required to meet educational expectations, either through school enrollment or through employment (minimum 30 hours per week) with a plan to complete school via alternative means. Representatives of the school systems are invited to quarterly team

The participants follow the same intensive outpatient program as the adult drug court participants except group meets twice a week. In addition, a parent group is facilitated.

The adolescent Moral Reconciliation Therapy (MRT) is used in group. There are three phases of treatment that follow the same topics as in adult drug treatment court but the topics, presentation, are adjusted for the developmental age of the participant. In addition, the treatment is person centered so the interventions reflect the needs of the group.

Meetings, and the Drug Court probation officer meets regularly with participants' teachers to monitor educational progress. Mentoring is also available to juveniles to assist with tutoring, as needed, as well as with the development of social and other skills intended to enhance their functioning in the community.

RAPPAHANNOCK REGIONAL JUVENILE DRUG TREATMENT COURTS

PROGRAM OVERVIEW

The Rappahannock Regional Adult and Juvenile Drug Treatment Courts (RRAJDTC) were established in 1998 after nine months of assessment and planning done by the Drug Court Planning Team. The RRAJDTC is a comprehensive system of substance abuse services and court supervision of non-violent offenders. The RRAJDTC serves the City of Fredericksburg and the Counties of King George, Spotsylvania, and Stafford.

Mission Statement

To reduce recidivism and drug-related crime by providing immediate access to a comprehensive program of substance abuse and court supervision of non-violent, substance abusing criminal defendants.

Program Description

The RRAJDTC is a partnership between the Courts, the Fredericksburg Commonwealth's Attorney's Office, the Office of the Public Defender, the 21st (Adult) and the 15th (Juvenile) District Court Services Units, RACSB and the Rappahannock Regional Jail. This treatment program, which lasts approximately 12-months, is a three-phased approach to substance abuse treatment and rehabilitation. Individuals participate in a comprehensive program of drug treatment

and rehabilitation services under the supervision of the Drug Court Judge. Phase I lasts a minimum of 12-weeks and provides stabilization, orientation, and education. Phase II provides the participant with intensive treatment, with emphasis on individual and group counseling. Phase III provides ongoing substance abuse treatment and support, with increased emphasis on the development of a plan for continued vocational and educational development. All three phases include scheduled and random drug testing and regular appearances before the Drug Treatment Court Judge.

Participating Members of the Drug Court Team

1. **Drug Treatment Court Judge:** The Drug Treatment Court Judges preside over all drug treatment court hearings, make necessary referrals to treatment and reinforce treatment through the application of legal sanctions and incentives, as appropriate. All sanctions are immediate and specifically address the offender's conduct. The Drug Treatment Court Judges help to create and support a therapeutic environment for the participant-offender.
2. **Commonwealth's Attorney:** The Commonwealth's Attorney assesses the appropriateness of each case for referral to Drug Court by reviewing the Pretrial Services report. The Drug Court Commonwealth's Attorney is present at all drug court briefings and hearings and participates in the development of a coordinated strategy for responding to positive drug tests and other cases of non-compliance. The charging jurisdiction Commonwealth's Attorney has final approval authority for all participants referred to the Drug Treatment Court Programs.
3. **Defense Counsel:** After the Commonwealth's Attorney and Defense Counsel have agreed on the suitability of a candidate for Drug Treatment Court, the Defense Counsel advises the defendant of the nature and purpose of the Drug Court and of how participation will affect the defendant's interests. The defendant is advised of the rules governing participation and of the consequences for non-compliance. The Defense Counsel assures that all necessary legal documents are filed in a timely fashion and may appear at all weekly Drug Court briefings and court hearings. The Defense Counsel makes certain that the sanctions used in responding to positive drug tests and other cases of non-compliance are within the agreed upon parameters of the Drug Court program.
4. **Drug Court Administrator:** The Drug Court Administrator acts as the point of contact between all entities involved in the day-to-day operations of the RRAJDTC. Additionally, the Drug Court Administrator monitors, evaluates and manages treatment and supervision issues. The Administrator is present at all scheduled case staffings, drug court briefings, and status hearings and is responsible for all data collection, program evaluation and grant reporting.
5. **Treatment Supervisor:** The Treatment Supervisor provides supervision of the therapists, case managers and all treatment-related matters. Additionally, the Treatment Supervisor is present at case staffings, Drug Court briefings, and status hearings. This person facilitates the Phase III group. This person also ensures the evidence-based practices are used when providing treatment services.
6. **Probation and Parole Officer:** The Drug Court Treatment Probation Officer ensures compliance with court orders by conducting field, office and treatment site visits. This includes monitoring employment sites and curfew and testing to verify abstinence from alcohol or drugs. The Probation Officer also schedules the community service work and ensures satisfactory compliance at given work sites, provides reports and documents to the

court, and testifies when necessary. The Probation Officer documents all contacts, enforces all rules of probation, initiates additional court processes when necessary, and exercises all powers and responsibilities authorized by the state code and the Department of Corrections and the Department of Juvenile Justice.

7. **Pretrial Services Officer:** The Pretrial Officer ensures completion of a decision tree prior to the initial court appearance. A decision tree is completed to identify potential Drug Court participants. The Pretrial Officer disseminates the decision tree to the Commonwealth's Attorney, Defense Counsel, and Drug Court Administrator. Additionally, Pretrial Services provides supervision to those defendants placed on supervision prior to acceptance into the Drug Treatment Court.
8. **Therapists:** The treatment Therapists facilitate the substance abuse treatment groups and provide individual and family therapy.
9. **Substance Abuse Case Manager:** The Case Manager draws from a network of agency, community, regional and state resources and programs to provide the services that address each participant's needs. The Case Manager completes diagnostic assessments for participants referred and prepares reports for the Drug Treatment Court Judge before each scheduled appearance. All progress reports are made available to the treatment team for review prior to the scheduled court appearance. The participant progress reports are forwarded to the Treatment Supervisor for review before the case staffing. The Case Manager also completes a case management assessment with individuals participating in Drug Court within 30-days of entering the program.
10. **Surveillance Officer:** The Surveillance Officer assists the Probation and Parole Officer to ensure the compliance of court orders by those adults placed in the drug court. This includes field visits to offenders' homes, places of employment and treatment programs, in addition to occasional transportation duties. The Surveillance Officer also places Drug Treatment Court participants at sites to perform court-ordered community service hours and monitors completion of the hours.
11. **Electronic Monitoring Coordinator:** When court ordered as a sanction, the Electronic Monitoring Coordinator provides equipment and monitoring to Drug Treatment Court participants.

REFERRALS, SCREENING AND ELIGIBILITY

All individuals eligible are screened by the Drug Court Administrator. Once screened, they are forwarded to the Drug Court Administrator for further screening to ensure all requirements of the Virginia Drug Court program are met. All appropriate cases referred to Drug Treatment Court and are scheduled for an assessment, to include a diagnosis of substance dependence, completed by the treatment provider.

A. Eligibility

1. The Commonwealth's Attorney determines suitability of defendants for referral to Drug Court based upon the following eligibility criteria:
 - a. A pending charge of:
 - i. Felony drug possession or attempt to possess offense;
 - ii. Possession with intent to distribute offense (subject to Commonwealth Attorney review);
 - iii. Prescription fraud offense; or

- iv. Non-violent felony property crimes related to substance abuse, to include: grand larceny forgery, uttering, felony bad checks and felony shoplifting;
 - b. Resident of Fredericksburg, Stafford, Spotsylvania or King George; and
 - c. Substance dependent diagnosis.
 - d. In addition to using the established criteria, the Commonwealth's Attorney also considers:
 - i. Family and community ties;
 - ii. Employment status; and
 - iii. Defendant's prior criminal record.
2. Prior convictions of distribution or possession with intent to distribute disqualify an individual from participation in Drug Court. If the assault is against a family member, which may have precipitated the family's involvement with the juvenile court system, the individual may still be eligible for participation.
 - a. Upon approval by the Commonwealth's Attorney, the Defense Attorney:
 - b. Discusses with the defendant the option of Drug Court;
 - c. Discusses current charges and advises the defendant of the legal rights affected by entering Drug Court; and
 - d. Explains to the defendant the requirements of Drug Court.

B. Court Placement

A request for Drug Court participation must be made jointly by the Commonwealth's Attorney and Defense Attorney. If the Circuit or Juvenile and Domestic Relations Court Judge approves the referral, all parties agree to transfer the authority of the case to the RRAJDTC in Fredericksburg. The only authority that will be retained by the Circuit or Juvenile and Domestic Relations Court Judge is that of sentencing the participant in the event of unsuccessful termination from the Drug Treatment program.

All cases are docketed in Fredericksburg City Circuit or Juvenile and Domestic Relations Court to accept new Drug Court participants, using the following procedures:

1. The Commonwealth's Attorney and Defense Attorney make a joint request before the Drug Treatment Court Judge to allow the defendant to participate in the Drug Treatment Court. The defendant enters into a plea agreement and pleads guilty. The judge hears a summary of evidence, makes a determination of its adequacy and accepts a plea of guilty. The disposition of the sentencing is deferred, and the offender is ordered to participate in the Drug Treatment Court and to be placed on supervised probation.
2. Depending on the current number of participants relative to program capacity, prospective participants may be placed on a Drug Court waiting list. At this time, they would enter into a waiting list plea agreement and plead guilty.

C. Non-Placement

Cases found to be inappropriate for Drug Court participation are processed by the judicial legal system in court in the appropriate locality. The clinical staff will make recommendations for treatment if they find the individual not to be appropriate for this program. Non-placement is based only on the criteria listed above. Participants may withdraw from Drug Court at any time, at which point the case would be transferred to the referring jurisdiction for final disposition at the discretion of the referring court.

ASSESSMENT AND TREATMENT OVERVIEW

Assessment Process

Immediately following a referral, the participant is assessed. The Drug Court Treatment Supervisor completes a comprehensive diagnostic assessment to rule out any co-occurring mental health and substance use disorders.

The assessment process gathers information in the following areas:

1. Diagnoses;
2. Medical history;
3. Substance use and treatment history;
4. Family/social history;
5. Education;
6. Intellectual level and learning ability;
7. Employment;
8. Legal history, including its relationship to substance use and/or mental illness; and
9. Risk of harm to self or others.

For participants in the Juvenile Drug Treatment Court, the assessment includes more detailed reviews of educational, medical and family histories. Specifically, the additional items covered include:

1. Prenatal exposure to alcohol and drugs;
2. Developmental history;
3. Immunization history;
4. Speech and language functioning;
5. Cultural/ethnic background;
6. Family and peer relationships;
7. Home environment, including presence of alcohol, tobacco and other drugs;
8. Parental custodial status; and
9. Custodian's readiness to participate in treatment.

As part of the assessment process, the participant is oriented to the treatment component, and an individual treatment plan, including appropriate level of treatment, is developed. Every attempt is made to tailor the treatment to accommodate the specific physical and learning abilities of each participant.

During the assessment process, the participant receives a treatment handbook, which includes the following information:

1. The philosophy of the treatment program;
2. The purpose of assessment and information on how treatment plans are developed and monitored, including participant involvement in these processes;
3. The schedule for group sessions (days and times) and the times when urine drug screens are administered;
4. A list of guidelines for attendance at 12-Step meetings (AA, NA, etc.) and a meeting schedule;
5. A section on Drug Court program policies and requirements, including attendance and abstinence from mood-altering chemicals;

6. A section on RACSB agency policies including confidentiality, possession of non-prescribed drugs, possession of weapons, incident reports of any injury, smoking, fire emergencies (disaster plan and fire drill procedures), loss of items or any occurrences out of the ordinary. Participants are informed of their human rights, including their rights of appeal, in person and via a written form; and
7. Conditions that would result in early discharge from the program. Instructions for notification of the therapist if the participant decides to drop from the program are included, along with a notice of possible consequences for withdrawal.

Intensive Outpatient Treatment for Juvenile Drug Treatment Court

Each participant is visited at his/her home once a week. Another adult must be present at these visits at all times. When clinically warranted, the visits will increase to twice a week. In addition, if the home is unsafe or not appropriate for the therapist to effectively provide treatment, the participant may be seen at the local RACSB clinic. This exception must be approved by the Drug Court Administrator, Juvenile Drug Court Treatment Supervisor then presented to the Juvenile Drug Court Team for consensus.

The participants follow the same intensive outpatient program as the adult drug court participants except group meets twice a week. In addition, a parent group is facilitated.

The adolescent Moral Reconciliation Therapy (MRT) is used in group. There are three phases of treatment that follow the same topics as in adult drug treatment court but the topics, presentation, are adjusted for the developmental age of the participant. In addition, the treatment is person centered so the interventions reflect the needs of the group.

JUVENILE DETENTION-BASED SERVICES

Mission Statement

Detention-based Services (DBS) provide crisis intervention, case management, mental health assessments, substance abuse evaluations and outpatient treatment to children and adolescents who are detained in the Rappahannock Juvenile Center. Youth are assisted in learning new skills to enable healthy choice making and to avoid criminal activity. In addition, Substance abuse treatment services are provided to youth enrolled in the Post-Disposition Treatment Services program. This treatment includes individual, group and family therapy focusing on reducing recidivism rates among juvenile offenders once they are returned to the community. The therapist working in the Post-Disposition Treatment program also participates in treatment team meetings and discharge planning in collaboration with Juvenile Detention Center staff, Court Services, the youth and the youth's family.

Goal

The primary goal of DBS is stabilization of the youth so that he/she can be maintained in or returned to the least restrictive environment.

Admission Criteria

- Youth is detained.
- Youth experiencing homicidal or suicidal ideation and who are identified as at risk for self-harm.
- Pre-adjudicated youth court-ordered to receive a substance abuse assessment.
- Youth is experiencing serious emotional disturbance and/or impairment in functioning in several life areas.
- Youth willing to participate in services.

Exclusionary Criteria

Person refuses services.

Continued Stay Criteria

Person continues to meet admission criteria.

Discharge Criteria

- Person is released from detention.
- Person remains out of detention for six (6) months.
- Person no longer meets admission criteria.

Expected Length of Services

- Typically less than 30-days, dependent on length of detainment
- For persons participating in the Post-Disposition Treatment Program, six (6) months.

Frequency of Review

- Treatment plans are updated quarterly.
- Persons who are not open or linked to other services within RACSB receive follow-up contact at six months to complete a CANS.

ASSESSMENT AND DOCUMENTATION

Medical History

The medical care needs of persons receiving services as they relate to program services is assessed upon entry into each program. Upon admission to services, the individual (or authorized representative) completes a medical history form. The case coordinator reviews this form, and any outstanding medical care needs are addressed with the person receiving services. In addition, a copy of a physical examination is requested, or a referral for an examination is made if the person has not been examined during the preceding 12 months.

The medical history form includes the following:

1. Serious illness and chronic conditions of the person's parents and siblings, if known;

2. Relevant medical information (e.g. allergies, seizure disorders, recent physical complaints);
3. Past serious illness, infectious diseases, serious injuries and hospitalizations;
4. Psychological, psychiatric and neurological examinations, if applicable;
5. Drug use profile;
6. Substance abuse history including onset of use, types of substances, frequency of use, quantity of use, method of administration, if applicable;
7. Name, address and telephone number of the person's physicians, when information is available;
8. H.I.V. Risk Assessment: individualized to the person. Two questionnaires and a variety of educational materials are available; and
9. Currently prescribed medications.

Progress Notes

Each contact between treatment personnel and the person receiving services should be documented in the clinical record on the Comprehensive Progress Note. This documentation, ideally, should be completed immediately following the session. However, there are emergent clinical situations that arise or urgent phone calls from stakeholders which may preclude immediate documentation. In these instances, the clinical note shall be completed by close of business the day the service was delivered.

All Comprehensive Progress Notes shall be routed to the appropriate supervisor or psychiatrist to be co-signed the same day the service was delivered. The notation should be dated and describe the nature and content of the contact. Specifically, the parties seen should be identified, and any significant information which pertains to progress in achieving treatment goals should be detailed. If problems or treatment goals which are not already in the treatment plan are raised, then these should be noted and added to the treatment plan, if suitable to the treatment setting and with agreement of the individual. Mental status information should be included, but one should avoid irrelevant comments in the progress notes, bearing in mind at all times the limitations on confidentiality of treatment records.

Diagnostic Study

The assessment process provides the foundation for the individualized treatment/service plan used by RACSB and should be conducted in a timely manner. The Diagnostic Study form should be completed by the case coordinator no later than the fourth face-to-face contact or thirty days, whichever is less. It should be reviewed and revised, as necessary, whenever a referral or admission is made to another program. The person receiving services is actively involved in every phase of assessment and individual planning. During assessment, information is gathered regarding the individual's strengths, needs, abilities and preferences. The case coordinator evaluates the person's mental status as well as any limitations the person possesses which might interfere with the assessment process and provides any assistance necessary, e.g. interpreters. Cultural sensitivity, including sensitivity to social/psychological, physical and spiritual factors, is imperative, and concerns about this need to be documented. All previous, reasonably available diagnostic, medical and treatment reports should be integrated into the assessment process. Information obtained from collateral sources, with the permission of the individual receiving services, should also be documented in the Diagnostic Study.

Information gathered in the assessment should include the following, when indicated:

1. Persons providing input into the assessment
2. Presenting problems
3. Abilities
4. Developmental history
5. Educational history
6. Vocational and work history
7. Current living situation
8. Cultural, spiritual, ethnic or sexual concerns
9. Relationships, including family and friends
10. History of abuse
11. Criminal/legal history
12. Family history of mental illness or substance abuse
13. Medical history, including (for children) immunization record
14. Results of previous psychiatric/psychological evaluations
15. History of suicidal thoughts or attempts
16. Treatment history
17. Mental status
18. Collateral information

Based on the information obtained, the major concerns needing to be addressed should be outlined in an interpretive summary. This summary should integrate the information and interpret it with respect to the reasons for the person's current need for services, emphasizing limitations and strengths which might have an effect on the ability to benefit from services, from the perspective of both the case coordinator and the person receiving services. Recommendations regarding the length and intensity of care, as well as any specialized treatments, should stem from a consideration of this information and should be included in this summary, as should the provider's expectations for treatment. The Diagnostic Study concludes with the diagnostic impression.

Individual Service Plan

The individual service plan (ISP) is developed by the case coordinator and provides the focus for service delivery for each person receiving services. The ISP is developed directly from the diagnostic study and includes goals identified by the person. It should be completed prior to the fourth session or within 30 days of admission to the program, whichever event occurs first. Licensure and certain insurance programs (including Medicaid) require that a provisional service plan be completed at the time of the initial session. This initial service plan, which is developed in collaboration with the person receiving services but which may simply be stated in the context of the progress note for the initial session, may target goals during a relatively brief period (e.g. 30 days), during which time a more comprehensive assessment plan may be developed. Both the initial and comprehensive treatment plans should address the goals of the person, the anticipated strategies to achieve those goals, and the expected length of treatment.

The ISP will coordinate and integrate the services to be provided by the program, as well as specifying referrals for additional services. If a person is participating in more than one program of Rappahannock Area Community Services Board, a program-specific service plan, which is

signed and dated, will be in place. Quarterly progress reports will be completed for each plan. Plans will be modified as the person's needs change. New plans will be written at least annually.

Persons in multiple RACSB programs may have program-specific plans responsive to the overall ISP and signed by the case coordinator as well as the individual receiving services and other participants.

The person receiving services, his/her family (as appropriate), and all pertinent staff shall participate in developing the individualized plan. The participation of the parties developing the service plan shall be documented in the progress notes as well as on the ISP face sheet.

The ISP shall be written in language easily understood by the individual receiving the services and shall focus on the person's strengths. Staff shall assist in developing a plan that is sensitive to the person's age and culture.

The plan shall include, but not necessarily be limited to:

1. A statement of the person's problems and corresponding service/training needs;
2. A statement of goals and a sequence of measurable objectives which are realistic, given the time available, and the limitations of the treatment setting;
3. A statement of services to be rendered and the frequency of interventions to accomplish the stated goals and objectives;
4. Target date(s) for accomplishment of goals and objectives;
5. The estimated length of the individual's need for services;
6. The role of other agencies, if the plan is a shared responsibility; and
7. A statement identifying the individual(s) responsible for the overall coordination and integration of the services in the plan. This staff member:
 - a. Is responsible for implementing the plan;
 - b. Provides orientation to the agency and the program in particular;
 - c. Creates a therapeutic environment/relationship in which the ISP can proceed in an orderly, purposeful and goal-directed manner;
 - d. Focuses on strengths, abilities, needs, and preferences of the person served;
 - e. Promotes the participation of the person on an ongoing basis in discussion of plans, goals, and status;
 - f. Participates consistently in team conferences concerning the individual;
 - g. Facilitates the exit/discharge process and arranges for follow-up and appropriate supportive services; and
 - h. Communicates information regarding progress to appropriate persons.

Progress toward treatment goals will be documented in a case note for each contact. Such notes should reflect upon a specific problem or goal identified in the plan and should be signed and dated by the relevant staff.

Whenever possible all those involved in the ISP need to participate in planning meetings. When attendance is not possible, appropriate communication with other individuals involved in the ISP is the responsibility of the assigned case coordinator. This communication is essential to insure effective and efficient delivery of services.

The ISP needs to be individualized and person centered in accordance with the person's needs and to focus, as appropriate, on the integration and inclusion of the person into his/her community, family and/or support systems. A very reliable measure of improved level of functioning is increased community involvement.

When additional services are needed which RACSB is unable to provide, the RACSB staff member responsible for coordinating the person's services will assist the individual in obtaining these services. Services with RACSB will be coordinated such that the person will be able to participate in this full range of services. All services addressing the person's presenting problems, whether offered by RACSB or other agencies, will be reflected in the ISP. Goals and objectives will be prioritized. Some of them may be deferred until accomplishing them is more feasible.

Quarterly Progress Reports

There shall be a review and update of the person's individualized treatment plan by the staff and the assigned case coordinator. Such reviews and updates shall occur at a frequency appropriate to the rate and intensity of services provided, but no less than quarterly.

Written progress reports completed at least quarterly shall be included in each person's record and shall include, but not limited to:

1. Evaluation of the person's progress toward treatment goals and outcomes;
2. Review and revision of the services plan as appropriate;
3. Update of the appropriateness of the treatment goals;
4. Update of any contract with parent(s) or guardian (if applicable and legally permissible);
and
5. The need for continuing treatment.

DISCHARGE AND TRANSITION PLANNING

Discharge planning begins at orientation, when the agency's policies are explained to the person receiving the services. During treatment, natural supports are strengthened, and referrals for additional services in the community are made as needed. Discharge is planned with the full participation of the person receiving services, all staff involved in the services, and any other appropriate individuals.

Ideally, discharge should occur when the identified treatment goals have been accomplished. However, closure to a program or the agency, as indicated on the Discharge Summary, may result in any of the following situations:

1. Discharged—evaluation/assessment (single contact—no ongoing services);
2. Discharged—treatment completed (mutual decision to end services due to accomplishment of goals);
3. Administratively discontinued (person moved from area or contact was lost);
4. Person died;
5. Discharged—non-compliant (person has consistently refused to work within the treatment plan, to keep appointments or to follow recommendations);

6. Person receiving services terminated against staff advice (prior to successful completion of treatment goals).

At the time of discharge, a discharge summary is completed (along with program release/case closing and diagnosis information forms) and filed in the clinical record. When a person's status is unknown and staff is attempting to make contact, the discharge summary should be completed within 90-days of the last contact.

The discharge summary contains:

1. Reason for discharge;
 2. Person's participation in discharge planning;
 3. Person's level of functioning or functional limitations, if applicable;
 4. Recommendations on procedures, activities or referrals to assist the person in maintaining or improving functioning and increased independence;
 5. Progress made achieving the goals and objectives identified in the service plan;
 6. Discharge date;
 7. Discharge medication, if applicable;
 8. Date the discharge summary was written;
 9. Referral sources to include name, number, hours of operation, location
 10. Signature of the person writing the summary.
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1. Persons will receive notice at intake that if they no-show or cancel for more than two visits, their case will be closed. For this purpose, a cancellation means less than 24 hours notice without any effort to reschedule the cancellation.
 2. Instituting this protocol offers benefits to both clinicians and to persons receiving services. The protocol will improve clinical utilization rates by providing a policy direction regarding people who need extended services or people who are open to services for medication only. Persons who are receiving services will be encouraged to work specifically on the goals identified in their service plans.

- A. Centralized Intake Workflow**
- B. Waiting List Form**
- C. Fiscal Year 2017 Program Goals**
- D. Primary Care Physician Letter (PCP Letter)**
- E. Discharge Assistance Project (DAP) Instructions**
- F. Adult Drug Treatment Court Rules**
- G. Juvenile Drug Treatment Court Handbook**