

Policies

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

POLICY:

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

PROCEDURE:

1. The Outreach and Engagement Professional will encourage the client to make suitable childcare arrangements in order to attend the scheduled evaluation. The OEP will advocate with the client to allow the infant in the room during the evaluation
2. When other childcare options are not available when a client's evaluation, UDS, or hair test is scheduled, and it is not feasible for the child to attend the appointment with the parent, the Outreach and Engagement Professional will obtain the client's permission to supervise her/his child during the evaluation. The OEP will ask the client to make sure the child(ren) has/have been fed and had a diaper change/been toileted prior to the appointment. The OEP will clarify with the client that they will not feed the child(ren) while client is in the appointment.
3. The Outreach and Engagement Professional will inform the client and clinician at the agency that if the child(ren) needs the parent's prompt attention due to behavioral or medical reasons, the OEP will ask the agency staff to interrupt the evaluation so that the client can attend to her/his child(ren)'s needs.
4. The Outreach and Engagement Professional will remain at the provider agency in a public place (e.g., waiting room) with the child(ren) while the client completes the evaluation. The O & E will establish the location of a waiting room, lobby or other public space in which to supervise the child(ren). If there is no public space, the OEP will not provide child supervision during an appointment.
5. The Outreach and Engagement Professional will only transport a client's child with the client. [See *O & E Safety Policy – Transporting Clients.*] When possible, the parent will travel in the back seat with the child(ren).
6. If the child(ren)'s needs are more than the OEP can reasonably manage, the OEP will work with the client to make other arrangements for the child(ren).
7. If the client needs childcare in order to obtain ongoing treatment, the Outreach and Engagement Professional will assist the client in addressing this barrier through referrals and/or problem solving with the client and/or DCF.

New:	
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	

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

POLICY:

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

PROCEDURE:

- When a former client contacts the OEP by phone, the OEP will respond to her/him in the following manner:
 - If the client is calling to touch base with the OEP and report on her/his progress, the OEP will keep the call brief, acknowledge the progress and wish the client continued success in her/his recovery.
 - If the client is calling with a specific need or seeking a referral, the OEP will:
 - Ask if the client is still involved with DCF. If yes, the OEP will refer the client back to her/his DCF Social Worker for the appropriate referral.
 - If the client is no longer involved with DCF, the OEP will provide information on the resources the client is requesting, e.g., housing assistance, treatment providers, etc., and/or refer the client to InfoLine – 211 for assistance.
- If an OEP has contact with a former client in a community setting, the OEP will maintain professional boundaries and client confidentiality and respond as described above.
- OEPs will not initiate face to face contacts with former clients.
- OEPs will not transport former clients.

New:	
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	

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

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

PROCEDURE:

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

New:	
Reviewed without change (date):	
Revised (date):	
Original Effective Date:	
Scheduled Review Date:	

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

POLICY:

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

PROCEDURE:

Definition and Criteria

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

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

Notification

- Outreach and Engagement staff should notify the O/E Program Manager or designee as soon as possible that a Critical Incident has occurred.
- The O/E Program Manager or designee will verbally notify DMHAS' Health Care Systems Unit via the Critical Incident Report Line within three (3) hours of the identification of the Critical Incident.

The Critical Incident Report Line provides a voice mailbox to leave information with instructions on what information to provide and when and how to directly reach a DMHAS staff person.

- The O/E Program Manager or designee will collect and document all pertinent information on *DMHAS' Critical Incident Report* and fax the report to DMHAS OOC/Health Care Systems within one (1) business day of the identification of the incident. A copy of the critical incident report will be forwarded to the ABH Project SAFE Senior Program Manager and ABH QM director.

Review

Internal and external reviews are conducted using the data collected.

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

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Critical Incident Reporting User Guide

INTRODUCTION

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

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

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

CRITICAL INCIDENT REPORT FORM

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

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

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

Section A: The Incident

Responsible Regional Organization

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

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

Location Type

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

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

Critical Incident Categories and Subcategories

The Commissioner's Policy statement defines critical incidents as incidents which may have a serious impact on DMHAS clients, staff, facilities, funded agencies or the public, or bring about adverse publicity. This is a broad definition intended to give discretion to the reporting organization as to what types of incidents are critical and when an ordinary incident reaches the threshold of critical. An agency may have additional criteria for critical incidents, and the DMHAS OOC reporting is not intended to replace that process.

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

CL1 – Physical abuse alleged

CL2 – Verbal abuse alleged

CL3 – Violation of patient rights with significant consequences alleged

CL4 – Breach of confidentiality with significant consequences alleged

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

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

DE1 – suicide

DE2 – homicide

DE3 – accident

DE4 – due to medical condition / illness or old age

DE5 – type not yet determined

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

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

- EV1 – Fire
- EV2 – Bomb threat
- EV3 – Other

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

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

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

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

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

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

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

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

The distinction between these two sub-types is that LD1 is safety-related and LD2 is not. An LD1 sub-type takes precedence over an LD2 sub-type even if both are true. For example, a vehicle that crashes into a program site may cause damages over \$1,000 but the structural damage may compromise staff/client safety; this incident would be reported as an LD1 type. Theft of computer equipment valued at over \$1,000 may be reported as an LD2 but if the computer contains confidential client information which is easily accessible, then it might more properly be categorized as a CL4 - breach of confidentiality with serious consequences.

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

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

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

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

MC1 – Missing inpatient client considered dangerous to self or other

MC2 – Missing outpatient considered dangerous to self or others

MC3 – Missing client – client (inpatient or outpatient) who is not considered dangerous and has had a 'missing person' report officially made to police

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

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

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

SC1 – Physical assault alleged

SC2 – Sexual assault alleged

SC3 – Risk of injury to a minor alleged

SC4 – Arson alleged

SC5 – Incidents involving firearms alleged

SC6 – Hostage taking alleged

SC7 – Sale of illegal substances on program premises alleged

SC8 – Homicide / manslaughter alleged

SC9 – Other (e.g., robbery, theft, embezzlement) alleged

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

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

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

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

SA1 – During program enrollment – any serious attempt that results in admission to a medical/surgical facility for treatment of injury and/or civil commitment

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

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

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

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

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

Other: Any serious incident not easily classifiable under above categories

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

Responsible Reporting Organization:

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

Agency Providing Service:

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

Care Intensity:

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

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

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

Media Coverage:

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

Incident Detailed Description:

Provide a brief yet detailed description of the event(s) determined to meeting the criteria for a critical incident. Do not use client identifiers in this portion of the report, replacing the client's name with "client"

or “patient”. If more than one person is involved, this may be worded “client #1” or “primary”. Section “B” collects the identifying information on all parties involved.

Section B: The Person

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

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

DPAS ID/BHIS MPI#:

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

Section C: DMHAS Critical Incident Review /Closure

Primary Review Chairperson:

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

Review Findings and Corrective Action Plans:

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

Final Incident Category and Sub-Category:

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

DMHAS Critical Incident Report

Directions:

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

Contact Person & Telephone Number: _____

Date of this Report: _____

Section A: The Incident

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

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

3. Date of Incident: _____

4. Time of Incident: ____:____ AM PM

5. Alternate Incident ID: (if applicable) _____

6. Town of Incident: _____

7. Location Type:

- | | | |
|---|---|--|
| <input type="checkbox"/> All Other Locations | <input type="checkbox"/> Inpt. Unit, Non-DMHAS | <input type="checkbox"/> Program Premises: |
| <input type="checkbox"/> Client's Residence | <input type="checkbox"/> Jail | |
| <input type="checkbox"/> Inpt. Unit, DMHAS-Op | <input type="checkbox"/> Other 24/7 Institution | |

8. Location Description: (optional) _____

9. Incident Category: (check one)

- | | | |
|--|---|---|
| <input type="checkbox"/> client abuse alleged (CL) | <input type="checkbox"/> fed. notification (FN) | <input type="checkbox"/> other (OT) |
| <input type="checkbox"/> death (DE) | <input type="checkbox"/> loss/damage (LD) | <input type="checkbox"/> serious crime alleged (SC) |
| <input type="checkbox"/> emergency evac.(EV) | <input type="checkbox"/> med. event (ME) | <input type="checkbox"/> serious suicide attempt (SA) |
| <input type="checkbox"/> escape (ES) | <input type="checkbox"/> missing client (MC) | <input type="checkbox"/> threats (TH) |

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

- | | | | | |
|-----------------------------------|---------------------------------|------------------------------------|--------------------------------|-----------------------------|
| <u>DE1</u> suicide | <u>ES1</u> escape - PSRB | <u>CL1</u> client abuse - physical | <u>SC1</u> phys assault | <u>DE2</u> homicide |
| <u>DE2</u> homicide | <u>ES2</u> escape - DOC | <u>CL2</u> client abuse - verbal | <u>SC2</u> sexual assault | <u>EV3</u> evac - bomb |
| <u>DE3</u> accident / med err | <u>ES3</u> escape – comp rest | <u>CL3</u> pt. rights violation | <u>SC3</u> risk injry minor | <u>EV3</u> evac - other |
| <u>DE4</u> med / ill / age | | <u>CL4</u> confidentiality breach | <u>SC4</u> arson | |
| <u>DE5</u> insuff info | <u>MC1</u> missing inpt - dngr | | <u>SC5</u> firearms | <u>ME1</u> acdntl injury |
| | <u>MC2</u> missing outpt - dngr | <u>FN1</u> Fed notice - Secr Srv | <u>SC6</u> hostage | <u>ME2</u> acdntl OD |
| <u>SA1</u> suicide attmpt | <u>MC3</u> missing person | <u>FN2</u> Fed notice – FBI | <u>SC7</u> drug sale / pgm | <u>ME3</u> med reaction err |
| <u>SA2</u> sui. attmpt - post d/c | | <u>FN3</u> Fed notice - other | <u>SC8</u> homicide / mnslgtr | <u>ME4</u> med evnt - other |
| | <u>LD1</u> loss/damage - safety | | <u>SC9</u> other serious crime | |
| <u>TH1</u> threats to agency | <u>LD2</u> loss/damage > \$1000 | | | <u>OT1</u> other incident |
| <u>TH2</u> threats to person | | | | |

TH2 threats to person

11. Did the incident occur: (check one)

- at agency/program site during agency/program activity off-site not related to agency/program activity

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

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

14. Responsible Reporting Organization: _____

(DMHAS-Op Hosp. or LMHA; PNP LMHA or SA Provider Holding a DMHAS Contract)

15. Agency Providing Service: _____

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

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

- Alcohol Illicit drug Prescribed medication Over-the-counter medication No evidence

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

- Y N

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

20. Media coverage: (check one) reported possible report unlikely

If media coverage has occurred, indicate source, date and brief summary of content as part of narrative below. Attach a copy of printed media.

21. Incident Detailed Description:

A large, empty rectangular box with a thin black border, intended for providing a detailed description of an incident. The box is currently blank.

DMHAS Critical Incident Report

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

1. Classification: agency client other staff visitor

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

3. SSN#: _____ - _____ - _____

4. DPAS ID: _____ / **BHIS MPI #:** _____

(located on demographics page in DPAS)

(for state-operated programs only)

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

6. DOB: ____/____/____

7. Gender: M F

8. Legal status:

- competency restored PEC voluntary (most clients)
- correctional transfer PSRB

9. Person's Relationship to Agency:

- client-acting as staff other visitor
- client-active staff
- client-former, non-active staff of agency

10. Race:

- Amer. Ind / Alask. Native Black/African Mixed
- Asian Caucasian Native Haw./Pacif. Isl

11. Ethnicity:

- Hispanic Non-Hispanic Not spec / Unknown

12. Injuries (if any):

- death minor to visitor
- hospitalization no injuries unknown
- med. intervention required to staff

13. MH Diagnoses: (numeric and text)

14. SA Diagnoses: (numeric and text)

15. Current Medical Conditions (if relevant):

16. Staff, Visitors, Others Involved:

Person #1 __ Staff __ Visitor __ Other **Role:** __ Victim __ Perpetrator __ N/A **Injuries:**(see #12)

Person #2 __ Staff __ Visitor __ Other **Role:** __ Victim __ Perpetrator __ N/A **Injuries:**

Person #3 __ Staff __ Visitor __ Other **Role:** __ Victim __ Perpetrator __ N/A **Injuries:**

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

DMHAS Critical Incident Report

Section C: REVIEW/CLOSURE

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

3. Recommended Date for Closure: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Administrative Review | <input type="checkbox"/> Human Resources Review |
| <input type="checkbox"/> Case Conference | <input type="checkbox"/> Other |
| <input type="checkbox"/> Critical Incident Review | <input type="checkbox"/> Root Cause Analysis |

5. Primary Review Chairperson (if indicated): _____

6. Service Type:

- | | |
|---|--|
| <input type="checkbox"/> ABH | <input type="checkbox"/> Private-Not-For-Profit LMHA |
| <input type="checkbox"/> State Op. LMHA/Hosp. | <input type="checkbox"/> Substance Abuse Only |

7. Responsible Reporting Organization: _____

(DMHAS-Op Hosp., or LMHA; PNP LMHA or SA Provider Holding a DMHAS Contract)

8. Agency Providing Service:

- Same as # 7
- Specify if different: _____

9. Review Findings:

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

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

11. Final Incident Category: _____

12. Final Sub Category: _____

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

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

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

ATTACHMENT “A”: INCIDENT TYPES

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

Emergency Evacuation EV1 – Fire
EV2 – Bomb threat
EV3 – Other

Threats TH1 – Against agency or program (not a specific person) by a client assessed by staff to represent a serious risk

TH2 – Against another person by a client assessed by staff to represent a serious risk

Other OT1 – Any serious incident not easily classifiable under above categories

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

POLICY:

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

PURPOSE:

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

PROCEDURE:

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

Attachments:

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

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

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

PROCEDURE:

- 1) All O/E staff working in the community will be assigned an ABH cell phone for business purposes. O/E staff will carry the cell phone with them at all times and ensure that it is charged regularly and in working order.
- 2) All OEPs will keep the Team Leader and/or co-workers updated on their daily schedule (e.g., calendar on Outlook) and will check-in with one another throughout the day. If no contact is made with OEP as agreed, the TL/OEP will initiate contact via cell phone.
- 3) If there is any question regarding risk/safety, staff will review details with the Team Leader and/or Program Manager prior to conducting a visit to the client's residence. As a result, the following options may be put in place:
 - a. The Outreach and Engagement Professional (OEP) may ask the DCF Social Worker to attend the visit.
 - b. Another OEP may accompany the assigned OEP to the visit.
 - c. It may be determined that the visit will happen at a location other than the client's home.
 - d. It may be determined that the visit not occur.
- 4) If the safety issues present while on a home visit, staff will remove themselves from the situation and request police back up, if needed. In such cases, staff should notify their supervisor immediately following the incident.
- 5) If there are any other individuals in the client's residence at the time of the visit that presents a safety risk, the visit will be rescheduled and another location considered.
- 6) Reports of safety issues should be reviewed with the Team Leader and/or Program Manager who will document this under the Case Review section of the O/E database.

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

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

PROCEDURE:

7) Transportation Requirement

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

8) Assessment Requirement

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

9) Seating Requirement

- The safest situation is for the client to sit in the front passenger seat.

10) Safety Belts

Project SAFE Outreach and Engagement staff must adhere to CT seat belt laws.

Drivers and front seat passengers must wear safety belts.

All rear seat passengers ages 4 – 16 must wear safety belts.

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

11) Infant/Child Car Seats

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

12) Requests to Transport Others

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

13) Medical or Psychiatric Emergencies Requirement

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

14) Accident Requirement

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

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

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

INTRODUCTION

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

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

Conducting Home Visits

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

A. Initial Contact:

1. Prior to meeting with the client, contact the DCF Social Worker to obtain relevant information, including pertinent safety information.
2. Try to establish contact with the client on the phone or via the DCF Social Worker prior to the first home visit. Allow plenty of time for the conversation. Use lots of active listening. Try to establish a relationship prior to the first face-to-face meeting.
3. If you have concerns about meeting the client at her/his residence based on information from the DCF SW or treatment provider discuss this with the Team Leader and/or Program Manager. Consider meeting the client at a neutral location (ex. coffee shop or library), with the DCF worker at the DCF office, or team with another OEP.
4. Keep your Outlook calendar up to date with the schedule of your appointments including who (client initials), when, and where noted. The O/E Team Leader, Program Manager, and on-site co-workers should have access to your calendar.

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

1. Carry I.D. at all times on your person (ex. driver's license, business card).
2. Carry your cell phone at all times. Be sure it is charged. Know if you have a signal, or not, at the site you are visiting.
3. Lock your car.
4. Drive around block/neighborhood. Note any potential dangers such as abandoned buildings, dark streets, noises of fighting, congregations of people indicating gang activity, gang graffiti, drug evidence on the ground, substance impaired persons, etc.
5. Park your car in a visible location as close as possible to the client's home so that accessing your car is easy.
6. Stay alert; look around 360° to and from your car.
7. Lock your car.
8. Keep your car keys readily accessible (ex. in your pocket).

C. Approaching Client's Residence

1. As you approach the home, stay alert.
 - a. Note the location of exits, including windows.
 - b. Are there any neighbors around? Consider if neighbors may or may not be a safety spot.
2. LISTEN before you knock.
3. Try to adapt your eyes to the lighting conditions inside the building.
4. Stand to the side of the door so that anyone coming out won't run in to you.
5. Wait for the client to come to the door and invite you in. Don't walk in if a voice calls out "come in" but you can't see anyone. Don't just walk in if door is open.
6. Do not enter the home if the client is not there.

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

D. Entering/When in Client's Residence

If the client is at home and invites you in:

1. Choose a "safe place" to sit.
 - a. Try to sit near the exit with your back to a wall.
 - b. Notice exits/possible escape routes.
 - c. Living rooms are the safest places to meet. Bedrooms should be avoided. Kitchens contain all kinds of potential weapons.
 - d. If possible, leave a door open.
2. Observe the home for potential weapons.
3. At all costs, avoid confrontations:
 - a. Be respectful, calm, and agreeable.
 - b. Be alert to clients' physical cues of escalation, e.g., facial expression, muscle tension, posture, breathing, complexion changes, etc. If the situation begins to escalate, try to de-escalate it.
 - Stop teaching, problem solving, or directing—and **ACTIVELY LISTEN**.
 - Change the direction of a conversation to a non-threatening topic.
 - Distract from the current issue with creative time-outs, e.g., requesting to go to the bathroom.
 - State your concerns using "I" messages, including consequences for violence.
 - Consider relocating to a neutral location.
 - c. if you are feeling unsafe, leave the client's home.
 - Go to a safety spot.
 - Call supervisor/police.
 - Have the address of the client's home available or memorized.
 - Review the case/safety issues with a supervisor before conducting another outreach/home visit.

In Your Car

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

1. Keep your car mechanically maintained.
2. Make sure your gas tank is full.
3. Carry a cellular phone at all times.
4. Lock the car doors when you are in the car, as well as when you leave it.
5. Take care of personal needs (i.e. going to bathroom) before leaving for a home visit.
6. Know where you are going. Drive from A->B->A without stopping—especially at night (keep written directions in car).
7. Stay on main roads in urban areas—especially in poor weather, late at night, or when having car trouble. In rural areas, choose roads you think will maximize the chance you'll be helped if your car breaks down.
8. Ride around clients' neighborhood and check for safety spots: stores/phones/gas stations.
9. Don't ask a group of people on a corner for directions.
10. Know how to change a tire (taking out jack, etc.).
11. Buy a can of tire sealant (for flat tires).
12. Make sure your spare tire is full.
13. Make sure your trunk is equipped with a flashlight, blanket, city maps, and jumper cables (know how to use). In the winter, add a snack and liquid, ice scraper, rock salt or sand, shovel, snow chains.
14. Have the number of emergency road service in your car (consider an emergency road service such as AAA).
15. Keep items such as baseball hat or Sports Illustrated magazine visible in the car.
16. **Do not** leave valuable items in the car, particularly in plain sight. Carry your purse/wallet with you, or lock it in the trunk. Avoid carrying large sums of money.
17. If you're being followed, drive to the nearest safety spot to get help—don't drive directly to work or home so you're not followed to your home or work.
 - a. Take the time (when being followed) to observe the vehicle and occupants for descriptions (i.e., license plate number, color and size of car, number of occupants, male/female, color of clothing, facial hair). Stay calm.
 - b. Note the direction vehicle is traveling when you're in a safety spot.
 - c. Call for help (i.e. Police).
18. If your car experiences mechanical difficulties and/or you get in accident:
 - a. Pull to the right side of road, if possible.
 - b. Put flashers on.
 - c. Call for assistance (911/AAA/Towing service)
 - d. Open hood.
 - e. Get back in car, lock doors.
 - f. While waiting for assistance, review self-protection skills.
 - g. If someone stops to assist you, talk through the open window only. Ask them to assist you in contacting emergency personnel/towing services if you have not been able to reach them (ex. No cell phone service).
 - h. Don't accept rides without considering the risks to your safety.

- i. If you leave your car for assistance, leave the car door unlocked so you can re-enter quickly, if needed.
- j. Observe the person offering assistance (is there smell of alcohol, any physical cues that make you feel unsafe).
- k. Trust your gut feelings to turn down a ride. Embarrassment has no place when considering safety.

To and From Your Car

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

When Walking

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

If Your Client Lives in an Unsafe Neighborhood

1. Discuss with your client the safest time to meet.
 - a. Consider meeting in a safer location.
 - b. Ask if they will watch the street for your arrival.
2. Let supervisor know your route and destination address and when you anticipate your return home. Develop a check-in contingency plan.

3. On the way, get your bearings or locate aids (e.g., phones, neighbors or business which may or may not be helpful, etc.).
4. Travel main streets as much as possible; check your car for good operating condition, gas, etc.
5. Carry your cell phone in an accessible area. Remember to keep it charged. Try not to use it in a dangerous neighborhood in order to decrease the possibility that observers misunderstand your job or observers decide they want the phone.
6. Leave the area if it immediately appears too dangerous; call your supervisor from a safe phone.
7. Park close to the client's home, ensuring easy access to the car and an easy drive out.
8. Keep alert and on the lookout when walking to/from the home.
 - a. Leave your purse and jewelry in the trunk (or at home).
 - b. Carry your keys or a rolled magazine so that either could function as a "weapon".
 - c. Have the car door key in your grasp.
 - d. Walk confidently.
 - e. When leaving the home, ask someone to walk you to the car or to watch that you get into your car safely.

Other Circumstances

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

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

B. Client Making Subtle Or Overt Sexual Advances

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

C. Police Involvement

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

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

**Advanced Behavioral Health, Inc.
Project SAFE
Subpoena Policy**

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

PROCEDURE:

1. All subpoenas are to be delivered to the front desk of ABH, 213 Court Street Address, 10th floor, Middletown, CT. If a [marshal] attempts to deliver a subpoena to an off-site office, ABH staff will direct her/him to ABH's main office in Middletown. The ABH staff (desk) person receiving the subpoena immediately contacts Project SAFE's Director or designee.
2. The PS Director or designee immediately retrieves the subpoena.
3. The PS Director or designee reviews the subpoena for all appropriate material, including:
 - Ex parte
 - Release of Information signed by the client
 - Petitioner's Motion for Qualified Protective Order
 - Order for Qualified Protective Order
 - Notice
 - Order for Disclosure of Records Pursuant to Qualified Protective Order
4. The PS Director or designee contacts the attorney to review any of the above documents not received and to explain the Project SAFE and/or Outreach and Engagement Program. Often the information provided verbally to the attorney about the program will be sufficient and the attorney will state that nothing further is needed.

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

5. If a signed release of information is not included, but the order for disclosure of records is, records can be sealed and brought to the court. The PS Director or designee will prepare the records to include:
 - Copy of Project SAFE referral
 - In addition, for Outreach and Engagement Services:
 - Copies of Outreach and Engagement Biweekly Summaries to DCF, to date
 - Copy of Outreach and Engagement discharge summary and recommendations, if applicable
6. The PS Director or designee will deliver the records in a sealed document to the courthouse by the specified time.
7. If specific ABH staff are named in the subpoena/asked to testify, the PS Director or designee contacts them to discuss the case and contacts the Assistant Attorney General's Office to inquire if the OEP can be placed on call. If the OEP is subpoenaed to testify, the Senior Program Manager or O/E Program Manager may accompany the OEP to the court. If the OEP goes to the court unaccompanied, s/he will provide the O/E Program Manager an update when the court hearing has concluded.
8. The PS Director or designee will track subpoenas received.

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Project SAFE
Recovery Specialist Voluntary Program
(RSVP)
Alcohol and Drug Screening Protocol

Overview: In the first 90 days, RSVP clients will be screened for drugs and alcohol on a random basis at least twice per week using the following protocol unless they are in an inpatient or residential level of care. On days 91 – 180, RSVP clients will be randomly drug screened at least once per week unless in an inpatient or residential level of care. On day 181+, RSVP clients will be randomly drug screened at least twice per month, unless in an inpatient or residential level of care. The results of the drug screens will be shared with the clients as well as with DCF and the Treatment Provider as described below [see - *Notification of Positive Tests and Failures to Test*].

Online Training for Noble Split Specimen Cup:

http://www.noblemedical.com/training/Noble_Split_Specimen_Cup.html

1. The Recovery Specialist (RS) or designee will inquire about the client's use of alcohol and drugs since the last screening. The RS will record this information on the *RSVP Alcohol and Drug Screening Form*.
2. If the client admits to any drug use other than Marijuana (THC), the client will be asked to sign an admittance form indicating this and will not be asked to provide a urine specimen.
3. The Recovery Specialist or designee will test for the presence of alcohol of each client using the Breathalyzer and record the results on the RSVP Screening History form.
4. If alcohol is present above the legal limit (0.08) and the client drove him/herself to the office, the client will be asked for her/his car keys and offered assistance in arranging transportation home. If the client refuses this and insists on driving, s/he will be informed that the RS will contact the local police to inform them the individual is driving while under the influence.
5. Unless the client has admitted to drug use other than Marijuana (THC) and signed an admittance form, the Recovery Specialist will then request that the client provide a urine specimen for a drug screen. The Recovery Specialist or designee will accompany the client to the restroom and observe the client deposit a specimen into the specimen bottle. At no time shall the Recovery Specialist lose custody of the specimen bottle.
6. When a specimen has been provided, the Recovery Specialist or designee will follow the instructions provided on each test to read the results of the drug screen and document the results on the *RSVP Alcohol and Drug Screening Form*.
7. The Recovery Specialist will discuss the results of the breathalyzer and drug screen with the client and both will sign the bottom of the form.
 - a. If the instant drug screen is positive for one or more substances and the client admits to the substance use, the RS will ask the client to flush the specimen and discard the cup. The client will be provided with a copy of *RSVP Alcohol and Drug Screening Form* showing a positive drug and/or alcohol result.
 - b. If the instant drug screen results are negative, the RS will document the results and ask the client to flush the specimen and discard the cup. The client will be provided with a copy of the completed *RSVP Alcohol and Drug Screening Form*.

- c. If the instant drug screen was positive **and** the client challenges the results, then the Recovery Specialist will label the bottle and deposit the bottle into the Toxicology envelope for lab-based GC/MS confirmation. The RS will contact the carrier for pickup. Lab results will be faxed back to ABH within 2 business days. The instant results are presumptive and the GC/MS lab confirmation results are final. The lab results will be shared with the client at the next meeting with RSVP.
8. At each random alcohol and drug screening, the Recovery Specialist will use the test results and client report to discuss the client's recovery with him/her.
9. The Recovery Specialist will provide a monthly report to DCF, Superior Court for Juvenile Matters, the client's attorney, and the child's attorney that includes a summary of the results of all of the alcohol and drug tests conducted in the past month.

Notification of Positive Tests and Failures to Test

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

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