Table of Contents

I. Service Description (HFS 75.13(1), 61.97(1))

Connections Counseling (*CC*) is an outpatient clinic which provides a continuum of treatment services to adolescents, young adults, and adults who present with alcohol or other drug abuse (AODA) and/or mental health (MH) problems. Services total less than 12 hours per week and include assessment, diagnosis, individual, group, and family counseling, referral, follow up, and aftercare. *CC* is contracted by Dean Care, Inc. to provide AODA and MH services.

Our mission is to provide a safe, welcoming, and enriching environment to those who present with substance abuse and mental health problems. Through evidenced-based and developmentally-relevant counseling practices, we shall assist our clients with reducing the risks posed by substance abuse and related problems while working to achieve and maintain abstinence from all mood-altering substances and to achieve optimal mental health. Taking a holistic view of the individual (mind, body, spirit) in relation to family, peers, and community, we seek to enhance people's resiliency, sense of hope, and self-efficacy.

II. Personnel

A. Positions and Job Descriptions

(* denotes required personnel per HFS 75.13(3); ** denotes required personnel per HFS 75.03(a-i))

** Owner	Establishes written policies and procedures for the service operation and delivery of services. Exercises general direction over the service, including but not limited to financial agreements and obligations, compliance with all applicable local, state, and federal laws, and all clinical activities. Assures compliance to laws and requirements pertaining to client rights. Has the final authority and administration over all matters related to *CC*.
* Director	Responsible for the overall operation of the service, including the therapeutic design and delivery of clinical services. Collaborates with Clinic Manager, Billing Specialist, and Administrative Assistant to complete administrative tasks. Manages the hiring process and orientation of new staff. Makes client assignments to counselors. Facilitates resolution of any client grievances. Designated custodian of client files and is responsible for the maintenance and security of client treatment records. Establishes and maintains external relations with other services, agencies, or institutions and coordinates inter-agency dialogue. Coordinates staff in-service tranings. Supervises service outcome

	evaluations and is responsible for translating results into service delivery improvements. Provides service marketing and advertisement.
Assistant Director	Responsible for the overall operation of the service in the director's absence including fulfillment of the director's responsibilities as needed. Provides ongoing supervision and training to staff. Coordinates staff in-service tranings. Maintains policy and procedure manual and assures compliance with all licensing and state/federal regulations. Supervises service outcome evaluations and is responsible for translating results into service delivery improvements. Establishes and maintains external relations with other services, agencies, or institutions and coordinates inter-agency dialogue. Provides service marketing and advertisement.
* Clinical Supervisor	Certified or registered through the Wisconsin Certification Board (WCB). Shall be knowledgeable in psychopharmacology and addiction treatment. Exercises on-going supervisory responsibilities over substance abuse counselors, including but not limited to face-to-face contact for review of client cases and direct observation of service delivery, counselor development, counselor skill assessment and performance evaluation, and auditing client files. Provides direct counseling service delivery.
* Medical Director	Physician who completed a residency in psychiatry and who is certified in addiction medicine by the American Society of Addition Medicine (ASAM). Serves as the chief medical officer of the service and is responsible for medical review of each client's treatment. Provides input into policies and procedures of service operations based on understandings of current medical advancements and innovations, and provides annual review of those policies and procedures. Facilitates relations between *CC* and insurance companies (e.g., Dean Care). Provides clinical supervision to substance abuse and mental health counselors, and initiates education and training of staff. Provides psychiatric evaluation and on-going direct service delivery at the request of client or staff, or as necessary (HFS 61.97(4)).

* Substance Abuse Counselor	Certified through the WCB as an alcohol and drug counselor (i.e., CADC, CADC-II, CADC-III) or has suitable and documented experiences in substance abuse counseling with a valid counselor certification development plan that is annually approved by and is on file with the WCB (i.e., RADC-I). Provides a continuum of counseling services to those with substance abuse problems, including but not limited to screening, intake, assessment, treatment planning and review, individual and group counseling, education, crisis intervention, case management, referral, and follow-up, and aftercare. The counselor who is assigned by the director to facilitate a client's engagement in services and continuation of care is the "primary counselor."
* Mental Health Professional	Provides mental health services to those with mental health problems or to those with "dual" AODA and MH problems. Provides consultation to substance abuse counselors regarding concurrent services for those with dual problems. Meets qualifications as specified by HFS 61.96(1), 61.96(2), and HFS 75-APPENDIX B.
Family Therapist	Masters level position focusing on marriage and family; credential with AODA knowledge and experience to serve our adolescent and young adult population. Position includes facilitating parent education and support groups, family therapy and participating as a community liaison with appropriate resources in Dane County.
Consulting Psychiatrist	Physician who completed a residency in psychiatry and who is certified in addiction medicine by ASAM. Initiates education and training of staff. Provides psychiatric evaluation and on-going direct service delivery as requested or necessary.
* Clinic Manager	Responsible for overseeing business service operations. Facilitates client and other business relations. Supervises the administrative assistant(s). Handles staff payroll, accounts payable and receivable, contractual agreements between clinical staff, independent contractors and the owner. Handles office supply

	orders. Responsible for advertising, including but not limited to layout/design/content of clinic brochures and yellow page ads.
Billing Specialist	Responsible for clinical and business data entry. Submits insurance claims and tracks insurance authorizations. Communicates as needed with insurance companies, clients, and the clinical staff, and handles inquires regarding billing. Responsible for billing self-pay clients and for collecting outstanding balances. Provides financial reports to clients (e.g., for tax purposes) as requested.
Administrative Assistant	Greets clients upon entry and coordinates appointment scheduling. Handles in-coming phone calls and directs calls to appropriate staff. Assembles, labels, files, and disassembles client files. Maintains an orderly system of filing for clinical documents and client files. Maintains copies and organization of all clinic documents. Provides clerical support (e.g., word processing). Responsible for taking client self-payments and assembling bank deposits as needed. Processes and disburses mail. Maintains the consulting psychiatrist's scheduling, provides reminder calls to clients, and assembles files and information required for the psychiatrist's sessions. Provides general weekly cleaning of the clinic and daily upkeep.

B. Personnel:	Position(s):
Shelly Dutch, CADC-III, CCS-G	Co-Owner, Director, Clinical Supervisor, Substance Abuse Counselor
Peter Greene	Co-Owner
Jeff Schiffman, MD, ASAM cert.	Medical Director, MH Professional
Tami Bahr, LCSW, CADC-III, RCS	Assistant Director, Clinical Supervisor, Substance Abuse/MH Professional
Tim Bautch, MA, RADC1	Substance Abuse Counselor
John Boyne, MA, RADC1	Substance Abuse Counselor
Scott Caldwell, MA	Substance Abuse Counselor
Crystal Dalebroux, MFT, RADC1	Family Therapist/Substance Abuse Counselor
Cory Divine, RADC1	Substance Abuse Counselor
Allison Hill, MFT, RADC1	Family Therapist/Substance Abuse Counselor
Jen Linderud, RADC1	Substance Abuse Counselor
Jeff Ryan, RADC1	Substance Abuse Counselor
Jim Thompson, LPC, CADCIII	Substance Abuse/MH Professional

Matt Felgus, MD, ASAM cert.	Consulting Psychiatrist
Gretchen Rickey	Clinic Manager, Billing Specialist
Ashley Seltzner	Administrative Assistant

C. Staff Selection (HFS 75.03(3)(h))

Connections Counseling will consider applicants who present a documented history of counseling experience, training, and education which embodies core skill attainment, responsiveness and sensitivity to adolescents, young adults, and adults with AODA problems and/or MH problems, cultural competence, professionalism, and compliance to legal and ethical practice standards. An applicant will provide a statement of interest, a resume of prior work experiences, and a copy of all relevant credentials. Per HFS 12, background information checks on applicants will be performed. Those who have been prohibited from working with clients because of specific past actions will not be considered for employment. *CC* staff shall have input into applicant considerations and the director will have the final authority on hiring decisions.

D. Staff Orientation

Orientation of new counselors shall be coordinated by the director and involve a team of staff. The orientation period shall last not less than a period of 60 days. Completion of the orientation period shall be evidenced by documentation placed in the staff person's personnel file (i.e., completion of the "Staff Training Checklist") which covers the following:

1) Tour of facility and premises
2) Review of *CC* Services Policies & Procedures Manual
3) Review of Administrative Policies & Procedures
4) Agreement to terms of clinical supervision
5) Self-assessment with clinical supervisor review
6) Completion of orientation to the general areas of *CC* service delivery, including:
    a) Screening and assessment with adolescents or adults
    b) ASAM placement criteria guidelines
    c) Diagnosis using the DSM-IV multi-axial system
    d) Treatment planning and staffing protocol
    e) Motivational enhancement strategies (e.g., FRAMES)
    f) Discharge and referral protocols
7) Completion of training or documentation showing completion of prior training in the following areas:
    a) Client rights and confidentiality (HFS 94.30(1), 75.03(7)). All newly hired staff shall be trained in understanding and ensuring client rights and confidentiality. Each staff person shall sign a statement acknowledging review of the relevant requirements and his or her responsibility to ensure client rights and to maintain confidentiality of client information.

b) Crisis intervention (HFS 75.03(6)(b)). Effective staff response to any crisis requires skill, competency, timeliness, and supervision. Staff who provide crisis intervention shall, within 30 days of being hired, receive specific training in crisis assessment and intervention. See APPENDIX A for the policies and procedures covering this training.

c) Suicide assessment and management (HFS 75.03(6)(a)). Newly hired substance abuse or mental health counselors shall, within 60 days of being hired, receive training in assessment and management of suicidal clients. See APPENDIX B for the policies and procedures covering this training.

E. Clinical Supervision (HFS 61.97(3), 75.02(12), 75.13(4))

Clinical supervision is the intermittent face-to-face contact between the clinical supervisor and treatment staff to ensure each client has an individualized treatment plan and is receiving quality care. The clinical supervisor shall provide certified substance abuse counselors (CADC) with not less than 30 minutes of clinical supervision for every 40 hours of treatment provided. The clinical supervisor shall provide registered substance abuse counselors (RADC) with not less than 60 minutes of clinical supervision for every 40 hours of treatment provided. Supervision shall be provided within scheduled one-to-one and group sessions which shall be noted in the master appointment book. Furthermore, the results of clinical supervision shall be evidenced by the following documentation (see APPENDIX C for clinical supervision forms):

1) The counselor shall complete a "Clinical Supervision Log" during each supervision session documenting the length of time and the clinical issues addressed. The log shall be signed by the clinical supervisor and temporarily placed in the "Clinical Supervision Log" binder before it is permanently located in the counselor's personnel file.
2) All aspects of treatment planning (i.e., assessment, diagnosis, and treatment plan; review of ASAM placement criteria and treatment plan; discharge summary) shall be reviewed and signed by the clinical supervisor and the medical director. For RADCs the clinical supervisor will review and sign all case note entries.
3) On a periodic basis, the clinical supervisor shall review and evaluate the counselor's performance, including skill, competency, documentation, responsiveness, sensitivity, and professionalism. The "Counselor Development and Performance Evaluation Form" shall be completed and signed by the clinical supervisor then reviewed and signed by the counselor.

F. Staff Development and Evaluation (HFS 75.13(4)(b))

Each staff person is responsible for understanding her or his relevant licensing or certification requirements, including on-going education and training

requirements. Furthermore, each staff person is responsible for developing his or her professional goals. During the orientation period, new staff shall engage a self-assessment by completing the "Counselor Development and Performance Evaluation" form. The self-assessment shall include identification of the counselor's strengths, areas for improvement, professional goals, and on-going education and training needs. The self-assessment shall serve as a reference for future evaluation and shall be revised by the counselor on an annual basis.

The clinical supervisor is responsible for providing on-going guidance and support for staff in meeting professional requirements and goals. Furthermore, the supervisor shall provide periodic evaluation, not less than annually. The director shall arrange for periodic in-service training in areas deemed necessary for promoting counselors' competence and skill development.

The director shall report to the Department of Health and Family Services any allegations of staff misappropriating property of a client, or abusing or neglecting a client (HFS 75.03(4)(b)).

G. Unlawful Use of Alcohol or Other Psychoactive Substances (HFS 75.03(22))

The use of alcohol, illicit drugs, or unauthorized use of any psychoactive substances at *CC* is prohibited.

III. Service Operations

A. Service Accessibility and Availability (HFS 75.03(3)(f), 75.13(5)(a))

Connections Counseling is an inclusive service giving special consideration to minorities, those with disabilities, and pregnant females. In accordance with existing laws, no person will be denied service or be discriminated against on the basis of sex, race, color, creed, sexual orientation, handicap, or age. *CC* shall work with and advocate for prospective clients who need AODA outpatient treatment services but who do not have access to them.

B. Service Availability

Hours of business:

Monday 9:00 am – 9:00 pm
Tuesday 9:00 am – 9:00 pm
Wednesday 8:00 am – 9:00 pm
Thursday 9:00 am – 9:00 pm
Friday 9:00 am – 5:00 pm

The clinic doors shall be locked when a substance abuse counselor or other clinical staff is not present. There shall be a designated staff person responsible for service operations at all times (HFS 75.13(b)). The director, Shelly Dutch, shall be responsible for service operations Tuesdays thru Fridays. The assistant director, Tami Bahr, shall be responsible for service operations on Mondays. All counselors shall provide to clients an emergency pager or other contact phone number in case of an after-hours emergency. Any such phone contact shall be documented in

the client's progress notes.

C. Fire and Tornado Emergency Evacuation Plan

In the case of a fire alarm sounding, clients and staff in the *CC* clinic (Suite 101) shall immediately evacuate the building through one of two exits: 1) the staircase to the rear parking lot, up the stairs to floor number one and out the back building entrance; or 2) the staircase to the main parking lot, up the stairs to floor number one, and out the front building entrance. Evacuation through the wheelchair lift is *prohibited* in the event of a fire alarm sounding. In the event that an individual with mobility issues is present in the clinic when an alarm sounds, the director, assistant director, or delegated staff person will accompany that person to the main entrance staircase and wait with them at this point of rescue until fire rescue/paramedics are able to assist. See APPENDIX D for the map and directions of the evacuation plan posted in the clinic. Staff is responsible for checking all areas of the clinic and for directing clients to exit the building through the nearest door. Once outside, no one is allowed to reenter the building until clearance is given by fire department or building personnel. A fire extinguisher is located by the exit door leading to the stairwell.

In the case of a tornado, clients and staff shall proceed to the main group room. Clients shall be advised to sit on the floor in this area. Staff will determine when it is safe to resume activities.

D. Changes

Any changes in administration, ownership, location, center, name, or service change that may affect program certification compliance shall be submitted in writing prior to its effective date to: Program Certification Unit, P. O. Box 7851, 1 West Wilson Street, Madison, Wisconsin 53703, Attn: Dan Crossman.

IV. Client Rights

A. Informed Consent and Notification of Rights (HFS 94.03(1), 94.04(1))

At intake the client shall receive written information and verbal description related to AODA/MH treatment services, including the purpose, benefits, and methods of services, as well as the probable consequences of not receiving the services. Clients shall be notified of their rights to confidentiality and privacy. For clients under 18 years of age, the client's parent(s) or legal guardian shall also be notified of rights and shall provide informed consent.

B. Contract with Independent Client Rights Specialist (HFS 94.02(4), 94.40(3))

Connections Counseling contracts with an independent Client Rights Specialist (CRS) to provide consultation on client rights policies and procedures development, to facilitate informal resolution of concerns, and to conduct program level reviews of specific client grievances or rights issues to make factual findings and determinations of resolution. *CC*'s CRS is Maria E. Hanson, J.D., of *Clients Rights Specialists, Inc.* (P.O. Box 14533, Madison, Wisconsin 53714, 608-446-8957).

C. Humane Psychological and Physical Environment (HFS 94.24)

Staff shall treat clients with dignity and respect at all times. Staff shall take reasonable steps to ensure the physical safety of all clients. The clinic shall provide clients with a clean, safe, and humane environment.

D. Medications and Other Treatment (HFS 94.09)

Each client shall be informed of his or her treatment and care and shall be permitted and encouraged to participate in the planning of it. A client may refuse medications or any other treatment.

For medication prescriptions dispensed by the medical director, clients shall be provided informed consent as to the type of medication and dose, the reason for the prescription and its expected benefits, and the potential side effects or risks. The client acknowledgment of this information shall be evidenced by signature on a consent form. All prescription information shall be noted on the "Medication Record" form.

If a medication prescription is changed the psychiatrist shall ensure that the primary counselor and clinical supervisor are informed about the new medication and its expected benefits and potential side effects which may affect the client's overall treatment. All changes or reviews of a client's medication prescription shall be noted on the Medication Record form.

E. Grievance Investigation and Resolution Procedures (HFS 94.40)

1) In response to a client complaint, staff shall provide and encourage completion of the Client Complaint form. This form will then be forwarded to the director.
2) The director will contact the CRS upon receipt of a complaint. The CRS shall meet with the grievant and the client, if different, and any staff member who may be named in the complaint, identify matters at issue and explain the process for seeking formal resolution of grievances.
3) If the grievance was presented verbally or through an alternative form of communication, the CRS shall assist the grievant in putting the grievance into writing for use in the on-going process. A copy of the written grievance shall be given to the grievant and the client, and included in the report.
4) If there are facts in dispute, the CRS shall conduct an inquiry into the incidents or conditions which are the focus of the grievance.
5) With the consent of the grievant, the CRS may suspend the formal resolution process and attempt an informal resolution of the grievance. Any applicable time limits of the formal resolution process shall be suspended during the use of the informal resolution process until either party requests that the formal resolution process resume.
6) When the formal investigation is complete, the CRS shall prepare a written report with a description of the relevant facts agreed upon by the parties or gathered during the inquiry, the application of the

appropriate laws and rules to those facts, a determination as to whether the grievance was founded or unfounded and the basis for the determination.

7) If the grievance is determined to be founded, the report shall describe the specific actions or adjustments recommended by the CRS for resolving the issues presented. Where appropriate, the recommendation may include a timeline for carrying out the proposed acts and adjustments.
8) If the grievance is determined to be unfounded, but through the process of the inquiry the CRS has identified issues which appear to affect the quality of services in the program or to result in significant interpersonal conflicts, the report may include information suggestions for improving the situation.
9) Copies of the report shall be given to the director, the client, and the grievant, if other than the client, the parent or guardian of a client if that person's consent is required for treatment, and all relevant staff.
10) The CRS shall remove the names or other identifying information of any client involved in the grievance, other than the client directly involved, when providing copies of the report to persons other than the staff directly involved, the director, or other staff who need to know the information.
11) If there is a disagreement over the report, the CRS may confer with the client, the grievant, the parent or guardian of the client, and the director to establish a mutually acceptable plan for resolving the grievance.
12) If the disagreement cannot be resolved through discussion, the director shall prepare a written decision describing the matters which remain in dispute and stating the findings and determinations or recommendations which form the official position of the service. The decision may affirm, modify, or reverse the findings and recommendation proposed by the CRS.
13) The service shall not retaliate against the client or the CRS for an unpopular decision.

F. Time Limits for Processing Grievances – Processing Non-Emergency Grievances

In situations in which there is not an emergency, the following time limits apply:

1) A staff person receiving a request for formal resolution of a grievance shall present the request to the director as soon as possible but not later than the end of the staff person's shift.
2) The director shall notify the CRS within 3 business days after the request for formal process has been made.
3) The CRS shall complete her inquiries and submit a report within 30 days from the date the grievance was presented to a program staff person unless the time limit has been suspended through attempts at informal

resolution.

4) If the director disagrees with the CRS's report, a written decision from the director shall be issued within 10 days of the receipt of the report unless the client, the grievant if other than the client, and the parent or guardian of the client (if that person's consent is necessary for treatment), agree to extend this period of time while further attempts are made to resolve the matters still in dispute.

G. Time Limits for Processing Grievances – Processing Emergency Grievances

1) "Emergency" means a situation in which, based on the information available at the time, there is reasonable cause to believe that a client (or a group of clients) is at significant risk of physical or emotional harm due to the circumstances identified in a grievance or concern (HFS 94.02 (14)).
2) A staff person receiving the request shall immediately present the matter to the director.
3) The director shall contact the CRS as soon as possible, but no later than 24 hours after the request is received.
4) The CRS shall complete the inquiry and submit a report within 5 days from the date the grievance was presented.
5) If the director disagrees with the CRS decision, a written decision shall be issued within 5 days of the receipt of the CRS report, unless the client, the grievant, if other than the client, agree to extend this period of time while further attempts are made to resolve the matters still in dispute.
6) If after a preliminary investigation it appears that there is no emergency, the CRS may treat the situation as a non-emergency for the remainder of the process.

H. Additional Protection of Clients (HFS 94.41 (6))

If the CRS determines that a client or a group of clients is at risk of harm, and the service has not yet acted to eliminate this risk, she shall immediately inform the director, the county department operating or contracting for the operation of the service, if any, and the office of the department with designated responsibility for investigating client grievances. If the situation continues to place the client(s) at risk, the office designated shall take immediate action to protect the client(s), pending further investigation.

I. Access to Information

With the possible exception of confidential information protected under s. 51.30, Stats. (as discussed below), the director shall provide the CRS with full access to all information needed to investigate the grievance, all relevant areas of the program facility named in the grievance, and all records pertaining to the matters raised in the grievance. The inquiry of the CRS may include questioning staff, the client(s) on whose behalf the grievance was presented, other clients,

reviewing applicable records and files, examining equipment and materials, or any other activity necessary in order to form an accurate factual basis for the resolution of the grievance.

When an inquiry requires access to confidential information protected under Sec. 51.30, Stats., the client, or the parent or guardian of the client, may be asked to consent in writing to the release of that information to the CRS and other persons involved in the grievance resolution process. The CRS may proceed with the inquiry only if written consent is obtained. If consent for access is not granted, the program shall attempt to resolve the matter through the informal resolution process.

The CRS shall maintain the confidentiality of any information about any program client gained during the inquiry, unless specific releases for that information are granted.

J. Multiple Grievances by One Client (HFS 94.46)

When a client or a person acting on behalf of a client has presented multiple grievances involving a variety of circumstances, the CRS may establish an expanded timetable with specific priorities for investigating the allegations in a manner which appears most likely to deal with the issues in an efficient manner while addressing the most serious allegations first. This timetable may exceed the time limits otherwise set forth in HFS 94, but shall include reasonable time limits for completing the investigation of each grievance. The CRS shall notify the client or person acting on behalf of the client and the program manager of the timetable and priorities for resolution of multiple grievances within 10 days after beginning the inquiry. If there is an objection to the proposed timetable or priorities, the CRS shall attempt to reach an informal resolution of the objection. If the client, the person acting on behalf of the client, or the director continues to object, that person may request a review of the issue by the county department or the state grievance examiner, whichever would normally hear an appeal at the program level of review.

K. Related Grievances by Several Clients (HFS 94.47)

When two or more clients have presented individual grievances involving the same circumstances or a related group of circumstances relating to a single program, the CRS may conduct the investigation as if it were one grievance. If the CRS believes the investigation of the grievance will require more time to complete than is allowed under the time limits established in HFS 94, the CRS shall establish a reasonable time limit for completing the investigation. The CRS shall notify the client(s), any person or persons acting on their behalf, and the director of the time limit within 10 days after beginning the inquiry. If there is an objection to the proposed time limit for completing the investigation, the CRS shall attempt to reach an informal resolution of the objection. If the client, any person acting on behalf of any of the client, or the director continues to object, that person may request a review of the issue by the county department or the state grievance examiner, whichever would normally hear an appeal at the program level of

review.

L. Grievances Presented on Behalf of Clients (HFS 94.49)

Any person who is aware of a possible violation of a client's rights may present a grievance on behalf of the client. When a grievance is presented on behalf of a client by someone other than the client's parent or guardian, and the parent or guardian's consent is required for treatment, the CRS shall meet with the client or the client's parent or guardian, to determine if the client or the client's parent or guardian, wishes the grievance investigated and resolved through the formal resolution process.

If the client or, when the parent's or guardian's consent is required for treatment, the parent or guardian is opposed to using the formal resolution process, the CRS may proceed with the investigation only if there are reasonable grounds to believe that failure to proceed may place the client or other clients at risk of physical or emotional harm. If there is no parent or guardian, or that person is not available, and the client is unable to express an opinion, the CRS shall proceed.

Where a grievance is filed on behalf of a client by a person who does not have a right to information about the client because of confidentiality statutes, the person may only receive confidential information as part of the investigation or resolution of the grievance with the informed consent of the client or his or her guardian, if there is one, the parent of a client who is under the age of 18, if the parent's consent is required for a release of information, or pursuant to an order of a court with jurisdiction over matters relating to the client. In the absence of this consent, a person presenting a grievance on behalf of a client shall be informed of the determination of the CRS and decision of the director regarding the merit of the grievance, but if the text of the determination contains confidential information to which the person is not privileged or for which a release has not been obtained, the text may not be disclosed to the person.

M. Interim Relief (HFS 94.50)

If the CRS or a person conducting an administrative review of a grievance finds that interim relief is necessary to protect a client's well-being pending resolution of a grievance, a directive may be given to the director to modify the services being provided to the client to the extent necessary to protect the client. A directive for interim relief shall be designed to provide the necessary protection at the minimum expense to the program while protecting the rights of the client. The director may appeal a directive for interim relief to the department administrator designated under HFS 94.44(1).

V. Client Confidentiality (HFS 92)

A. Protection of Confidential Information

Confidentiality applies to all written treatment records or verbal information including but not limited to a client's identity, participation in the

service, diagnosis, treatment planning, status, or physical whereabouts. Confidentiality applies to all current, past, and deceased clients. No client information, written or verbal, shall be disclosed unless a client has provided written authorization for release of information. A person who is 14 years of age or older may authorize release of information and the parent(s) shall be informed that they have a right to access treatment records only with the minor's authorization. For those under 14 years of age, a parent or legal guardian must authorize release of information. During intake, clients shall be provided information regarding their rights to confidentiality, as well as their rights to access treatment records during and after treatment. The director is the final authority on the release of any client information.

B. Elements of Authorization for Release of Information Form

The "Authorization for Release of Information" form shall include the client name, the type of information to be disclosed, the party of whom information is being released to, the party who is releasing the information, the purpose or need for disclosure, and signature of the client and/or parent/legal guardian.

C. Protection of Written Information

All written information related to a client shall be kept in the client's file. Only *CC* staff directly involved in the client's treatment shall access the file and its contents. No client file shall be removed from the clinic building. When not in use, files shall be located in the main office filing cabinet drawer. At the conclusion of each working day, files shall be returned to the file drawer, locked, and the office door closed and locked. That is, no client file shall be out of the locked file drawer overnight and all files shall be "double locked."

D. Protection of Verbal Information

Staff shall not disclose to anyone outside of *CC* a client's identity or discuss any information pertaining to clients. The standard response to an inquiry by a person who is unauthorized to receive information shall be: "*I can neither confirm nor deny the existence of any person who may or may not be a client at this or any other time*." Conversations among staff at the clinic shall be conducted in a manner conducive to maintaining client confidentiality, for example, speaking within an office with the door closed.

E. Disclosure Without Informed Consent

Disclosure without informed consent may be made under the following conditions:

1) Audits and evaluations by authorized agents
2) Billing or collection
3) Research that does not disclose the client's identity
4) Court order accompanied by a subpoena signed by a judge
5) Medical emergency
6) Release of limited confidential information to law enforcement officers

in the event of an unauthorized client departure (e.g., leaving the premises in an automobile while intoxicated)

F. Client Access to Records During Treatment

Every client shall have access to his or her treatment records during treatment to the extent authorized under HFS 51.30. Clients shall be notified of this right in writing at the time of intake. The director may only deny access to records other than records of medication and somatic treatment. Denial may be made only if the benefits of allowing access to the client are outweighed by the disadvantages of allowing access. The reasons for any restriction shall be noted by the director in the client's case notes.

G. Client Access to Records After Treatment

After discharge from treatment a client shall be allowed to inspect all of his or her treatment records within one working day notice. A client may request and receive a copy of his or her treatment record within 5 working days. If a requested treatment record identifies other clients by name, those names will be removed from the copy. Copies shall be provided at no charge.

H. Management of Records

The director is the designated custodian of client files. All client treatment records shall be kept at the clinic for a period of 7 years from the date of discharge. For clients under 18 years of age, treatment records shall be kept for a period of 7 years or until the client is 19 years of age – whichever is longer. At the end of that period, the records shall be shredded on-site by the director or designated staff person. Upon termination of a staff person, the treatment records for which he or she was responsible for shall remain in the custody of *CC*. If the staff person continues to provide a similar service (i.e., AODA treatment) through another service, treatment records may only be transferred if requested in writing by the client. If *CC* discontinues operations or is taken over by another service, treatment records may be turned over to the replacement service or any other service provided the client consents in writing. If no client consent is obtained, the records shall be sealed and turned over to the Department of Heath & Family Services for 7 years and then destroyed.

VI. Client Files and Documents

A. General Requirements (HFS 75.03(8)(a-d))

There shall be a file for each client. Client files shall be made within two working days of the intake session. Additional paperwork to be filed in the client chart will be filed within two working days. Client files are located alphabetically in each counselor's file drawer, located in the main office. The director is responsible for the maintenance and security of all client files. When utilizing client files for paperwork, review, etc., staff will inform the administrative assistant who will make a note in the client's billing record indicating where the file is currently

located. Upon return to the main office, the administrative assistant will make a note that the file was returned. Client files shall be comprised of standardized subsections including: Client Information, Correspondence, Medical Records, Treatment Plan, and Progress Notes.

B. File Contents by Subsection (HFS 75.03(8)(e))
(See APPENDIX E for the documents and forms that follow.)

1) Client Information
- "Required Information" including billing information signed by client and/or parent or guardian.
- Copy of client insurance card.
- For Dean Care referrals, completed "Health Plan – Outpatient AODA Authorization" form.
- "Client Rights and Informed Consent" signed by the client.
- "Notice of Privacy Practices" signed by the client.
- "Client Follow-up Authorization" signed (or not signed) by the client.
- Client "Personal History" packet.

2) Correspondence
- "Authorization for Release of Information" signed by the client and/or parent/legal guardian.
- Collateral information from prior AODA or mental health providers, such as discharge summary, progress notes, treatment planning, or assessment and diagnostic results.
- Any written correspondence (e.g., letters, faxes) either received or sent relevant to the client's treatment.
- All facsimile face sheets documenting the date and general nature of communication regarding the client's treatment.

3) Medical Records
- "Request for Psychiatric Consultation" completed by the primary counselor and the client
- Intake packet documenting the results of psychiatric evaluation conducted by the *CC* medical director or consulting psychiatrist.
- Results of psychiatric consultation by *CC* psychiatrist.
- Medication informed consent form signed by the client.
- "Medication Record" that includes medication orders for dose, route of administration, frequency of administration, person administering, and the name of the prescribing physician, and documentation of any adverse drug reactions or side effects.

4) Treatment Plan
- Results of all *CC* assessment information.

- "Treatment Plan" including AODA assessment and diagnostic results, treatment goals, methods, and outcome measures.
- All written assignments completed by the client.
- "Review of ASAM Placement Criteria and Treatment Plan" signed by primary counselor, clinical supervisor, and medical director.
- "Initial Assessment and Preliminary Service Plan"
- "Screening" documenting the initial phone interview, withdrawal risk potential, and initial ASAM placement criteria.
- "Intake Checklist" with staff initials indicating that service procedures and tasks were completed.
- "Discharge Summary" signed by the client, *CC* primary counselor, clinical supervisor, and medical director.

5) Progress Notes
   - "Progress Notes" include documentation of all services provided, including but not limited to case management, treatment, transfer from one level of care to another, discharge, and referrals.
   - "Group Notes" include a record of group attendance, counselor observations regarding client's participation, and the client's response to treatment.

VII. Screening

A. Client Eligibility (HFS 75.03(3)(g))

Prospective client eligibility for services includes but is not limited to heavy or frequent AOD use with related risk behaviors (e.g., driving under the influence, aggression), and/or mental health issues, family or interpersonal conflict, vocational, educational, or legal problems related to AOD use or mental health symptoms. Report of these factors may be made by the prospective client's self-report or by report of a legitimate collateral source, for example, a parent, physician, social worker, or criminal justice professional. Prior involvement in services (AODA or MH) and subsequent outcomes shall be a consideration of eligibility, however, shall not be used as a basis for denying access to *CC* services.

B. Procedures and Protocol (HFS 75.03(10))

The director typically handles inquiries for services by prospective clients or by parents of prospective adolescent clients. The results of the initial phone contact or any follow-up calls shall be documented on the "Screening" form. Presenting concerns shall be identified and evaluated to determine eligibility for services at the outpatient level of services. Specifically, a prospective client must meet requirements for ASAM placement criteria at the outpatient level to be eligible for AODA services through *CC.* Furthermore, a prospective client shall be screened for risk of current or potential withdrawal symptoms.

VIII. Intake

A. Basis for Admission (HFS 75.03(11)(a), 75.13(6))

Acceptance of a client to *CC* shall be based upon the results of the screening, and (when required) the application of ASAM client placement criteria to justify admission at the outpatient level of service. Furthermore, the individual must be willing to become a client, that is, be willing to:

1) Understand the rights and responsibilities of the client role.
2) Engage therapeutic activities outside of the counseling process (e.g., complete homework assignments).
3) Authorize release of information from any current or past treating physician, other AODA service, or mental health service.
4) Follow recommendations for level of care.
5) Demonstrate the ability to pay for services rendered.

B. Procedures and Protocol – Client

Upon arrival at the clinic, the prospective client shall:

1) Complete the "Required Information" form including identification of insurance or other method of payment.
2) Read "Client Rights and Informed Consent" and "Notice of Privacy Practices" forms.
3) Complete the "Personal History" packet.
4) Consider authorizing *CC* follow-up after discharge as indicated by signature on "Authorization for Follow-up" form.

C. Procedures and Protocol – Counselor (HFS 75.03(11)(b-f))

The counselor facilitating the intake shall:

1) Review the "Client Rights and Informed Consent" and "Notice of Privacy Practices" forms with the client, including the purpose of treatment, the client's right to confidentiality and privacy, and the client's roles and responsibilities. Handle any client questions or concerns and obtain the client's acknowledgment of understanding the above as indicated by client signature. Offer a copy of each form to the client.
2) Review the "Personal History" packet with the client during a clinical interview.
3) Identify prior AODA or MH service providers and obtain appropriate authorization for release of information, if feasible.
4) Obtain collateral information from the accompanying family member, if feasible.
5) Conduct an initial assessment including evaluation of the following: AOD use history and prior treatment experiences, AOD use as related to family and peer relationships, current and past MH symptoms, MH history and prior treatment experiences, MH issues as related to family and peer

relationships, vocational and educational development, legal status, willingness and ability to abstain. Document any food and/or drug allergies conspicuously in the medical section along with any other major health concerns. Note all results on the "Initial Assessment" sheet.

6) Discuss administrative business such as the cost of treatment, who will be billed, the accepted methods of payment if the client will be billed directly, and the hours of service operation.
7) Develop the "Preliminary Service Plan" with the client and, when appropriate, with the client's family member(s) to identify the recommended services and the short term plan for change.-
8) Provide information related to communicable diseases, for example, sexually transmitted diseases, hepatitis B or C, tuberculosis, and human immunodeficiency virus (HFS 75.03(21)).
9) Provide orientation to the clinic premises and introduce the client to peers and staff.
10) Schedule the next session with the client and provide contact information (i.e., a business card). Note appointment in the master appointment book in the main office.
11) Initial completed items on the "Intake Checklist" sheet.
12) Make the initial entry into the "Progress Note" indicating the general results of the intake.

IX. Assessment

A. Definition (HFS 75.02(6))

Assessment is the process of identifying and evaluating the client's: presenting and underlying problems; psychological, social, and physiological signs and symptoms of substance abuse and dependence; mental health disorders, and trauma; risks for developing further difficulties; sources of strength and resiliency; and willingness, ability, and readiness to engage a process of change. *CC* views assessment as an on-going process which includes input from the client, family members or other collateral sources if feasible, as well as observations by the primary counselor, the clinical supervisor, and other designated staff.

B. Procedures and Protocol (HFS 75.03(12))

The typical method of obtaining assessment information during the intake and subsequent sessions is through use of a semi-structured clinical interview with the client, however, standardized AODA assessment tools may be used when appropriate. If additional psychological testing and evaluation is necessary, the primary counselor, in collaboration with the clinical supervisor, shall arrange for such services (HFS 75.13(5)(c)).

Many clients at *CC* have had prior experiences with AODA or MH services. It is the responsibility of the primary counselor to identify those providers, obtain

client authorization for release of information if feasible (HFS 75.03(15)(2d)), then obtain collateral information such as discharge summary, progress notes, or assessment and diagnostic information.

Based on review and evaluation of all the relevant assessment information, the counselor will render a diagnosis. The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) shall be used to establish a diagnosis for substance use disorder (Axis I). Furthermore, diagnosis for personality disorder (Axis II), for a medical condition unrelated to substance use disorder, including food/drug allergies (Axis III), for psychosocial and environmental problems (Axis IV), and for global functioning (Axis V) shall also be addressed. If a counselor identifies symptoms of a mental health disorder and/or trauma during the assessment process, the client shall be referred for a mental health assessment conducted by a mental health professional (e.g., the medical director). If a counselor identifies symptoms of physical health problems during the assessment process, the client shall be referred for a physical health assessment conducted by medical personnel. The medical director shall establish the client's substance use disorder diagnosis and/or mental health diagnosis or review and concur with the diagnosis made by the client's primary counselor as indicated by signing the client's treatment plan (HFS 75.13(5)(e)).

For referrals to the medical director or consulting psychiatrist for mental health evaluation, the primary counselor shall complete with the client the "Request for Psychiatric Services" form and forward it to the appropriate physician. Scheduling of the appointment shall be coordinated with the administrative assistant.

X. Treatment Planning

A. General Requirements (HFS 75.03(13)(a)(c))

It is the responsibility of the primary counselor to develop the client's treatment plan. Treatment planning shall ensure continuity of care through service delivery (HFS 61.97(1)). Based on assessment information, treatment plans shall be individualized to fit the client's particular set of needs, strengths, and risks. Development of the treatment plan shall occur in collaboration with the client, the client's family if feasible, or another person who is important to the client. The treatment plan shall address culture, gender, any disability, and developmental needs related to substance use disorders, mental health problems, and trauma. A client's treatment plan constitutes a treatment contract between the client and *CC*.

B. Procedures and Protocol

The client's treatment plan shall be completed within two visits with the primary counselor after the intake session. The client's participation in the development of the treatment plan shall be documented in the case notes. The treatment plan should first be reviewed and signed by the clinical supervisor and the substance abuse counselor, then by the client and the medical director. The medical director signature on the treatment plan shall indicate that assessment,

diagnosis, and treatment planning has been accurately and correctly carried out. When the medical director is acting as the clinical supervisor (e.g., when supervising the substance abuse/MH counselors or the director), he shall sign as medical director then draw an arrow to the clinical supervisor signature line to indicate function in the dual role.

C. Contents of the Treatment Plan (HFS 75.03(13)(b))

The treatment plan shall:

1) Describe the client's problems and specify short-term (ST) and long-term (LT) individualized goals that are expressed in behavioral and measurable terms. Goals shall be written in terms understandable to the client.
2) Identify goals that are realistic, given assessment of the client's current stage of change and treatment readiness.
3) Specify the methods and services of therapeutic intervention to reach the treatment goals (see Available Services below), including the frequency of those services.
4) Describe the criteria for discharge from services.
5) If the client presents with a dual diagnosis, identify goals and methods related to addressing mental health problems with input from a mental health professional.

D. Available Services

All services shall be provided at the *CC* clinic, except in instances approved by the director with documentation noting the therapeutic reasons for why an alternative location is necessary (HFS 61.97(8)). The following is a list of services that *CC* provides (see APPENDIX F for specific service descriptions):

1) AODA Services
    - Individual counseling
    - Crisis intervention and emergency care
    - Family counseling
    - Group counseling *
        i. Early-Mid Adolescent (ages 13-16) group
        ii. Late Adolescent (ages 16-18) group
        iii. College group (ages 18-24)
        iv. (Pre)Contemplation group education
        v. Relapse prevention group
        vi. Women's relapse prevention group
        vii. Adult abuse group
        viii. Adult dependency group
        ix. AODA/OWI group
        x. Opiate group
        xi. Families Anonymous

xii. Parents education and support group
xiii. Family education and support group

- Aftercare

(* AODA therapy groups shall not exceed 16 clients with 2 counselors present (HFS 75.02(30).)

2) Mental health

- Individual counseling
- Crisis intervention and emergency care
- Group counseling **
  i. Girls Support group
  ii. Women's support group
  iii. Parents support group
- Pre-care prior to hospitalization
- Aftercare

(** MH therapy groups shall not exceed 10 clients with 2 counselors present (HFS 61.97(9).)

XI. Staffing

A. Definition (HFS 75.02(80))

Staffing is the regularly scheduled review and evaluation of the client's treatment plan, including the treatment goals, the strategies and methods being utilized or proposed, potential amendments to the treatment plan, the client's progress or lack of progress, and ASAM placement criteria. Staffing shall include the primary counselor and clinical supervisor, and the medical director when a client is dually diagnosed.

B. Procedures and Protocol (HFS 75.03(14))

During a staffing session (group or individual), the primary counselor shall review clients using the "Clinical Supervision Log" sheet with the clinical supervisor. Relevant issues related to the client's treatment plan and a plan of action shall be documented. The log shall be signed by the clinical supervisor and temporarily placed in the "Clinical Supervision Log" binder before it is permanently located in the counselor's personnel file.

Using the "Review of ASAM Placement Criteria and Treatment Plan" form, the primary counselor shall note the date of the staffing and its results in terms of 1) an updated placement criteria to recommend the appropriate level of client care; 2) a brief summary of progress toward treatment plan goals (e.g., attendance and participation, change behaviors, AOD use or related risk behaviors); and 3) any revisions to the treatment plan. If during the course of AODA treatment a client receives a mental health diagnosis, the treatment plan must be amended (using the "Review of ASAM Placement Criteria and Treatment Plan" form) to reflect the corresponding goals and methods to address the mental health

problem. The review form shall be signed by the primary counselor, then reviewed and signed by the clinical supervisor and the medical director. When the medical director is acting as the clinical supervisor (e.g., when supervising the substance abuse/MH counselors or the director), he shall sign as medical director then draw an arrow to the clinical supervisor signature line to indicate function in the dual role.

For clients who attend treatment sessions one day per week or less, staffing shall be conducted at least once every 90 days. For clients who attend treatment sessions more frequently than one day per week, staffing shall be conducted at least once every 30 days. Results of the staffing shall be discussed with the client and this discussion shall be documented in a case note entry.

XII. Progress Notes

A. General Requirements (HFS 75.03(8)(e14-e15))

Progress notes shall be used to document all services provided to the client, including but not limited to education, counseling, crisis intervention, case management, and referral. The progress notes shall also be used to document the client's responses to treatment and to document any contact with collateral sources (e.g., parent, relative, physician, social worker, school official, criminal justice professional). It is the responsibility of staff to make prompt and accurate progress note entries.

B. Procedures

Each page of the progress notes must clearly identify the client's name. Progress notes are typically entered by the primary counselor, however, may also be entered by the medial director, consulting psychiatrist, clinical supervisor, or mental health professional to document contact with the client or with a collateral source. Progress note entries shall include chronological documentation of services and the person making the entry shall sign and date each entry. The content of entries should basically follow the SOAP format (i.e., subjective, objective, assessment, plan). Blank lines or spaces between the narrative and staff signature shall be connected with a continuous line to avoid the possibility of additional narrative being inserted. Mistakes in wording, spelling, or phrasing shall be corrected by drawing a single line through the word or phrase, then initialing next to the line. Use of white out or other correction substance is prohibited.

XIII. Transfer

A. General Requirements (HFS 75.03(16))

A higher level of service is sometimes necessary to effectively address a client's substance abuse or related risk behaviors. Such a situation at *CC* shall be determined by the primary counselor, in consultation with the clinical supervisor and the medical director, using ASAM placement criteria guidelines. The results of ASAM criteria application shall be documented on the "Review of ASAM

Placement Criteria and Treatment Plan" form.

B. Transfer Within *CC*

When a change in level of service occurs, that is, when ASAM placement criteria changes from outpatient services (Level I) to intensive outpatient services (Level II), or vice versa, the primary counselor shall document the change in the client's progress notes, including the date of recommendation and initiation, and the level of care recommended.

C. Transfer to Outside Services

When a change in level of service involves transfer to another service (e.g., Level III; inpatient), the primary counselor shall document the change in the client's progress notes, including the date of recommendation and initiation, the level of care recommended, and the relevant facility information. The primary counselor shall obtain written consent from the client for follow up in the form of a signed release of information authorizing exchange of information between *CC* and the outside service.

Within one week after the transfer date, the primary counselor shall forward a copy of the transfer documentation to the service. The primary counselor shall also determine, in consultation with the clinical supervisor, whether treatment responsibility shall be retained or not. If *CC* retains treatment responsibility, the primary counselor shall request information from the outside service on a regular basis as to the status and the progress of the client (HFS 75.03(19)(b-c)).

The primary counselor shall follow up on a client transfer through contact with the outside service within 5 days following initiation of the transfer and every 10 days after that until the client is either engaged in the service or has been identified as refusing to participate. Client refusal to follow through on the recommended service transfer shall be documented on the "Refusal of Treatment" form and in the case note (HFS 75.03(19)(e)).

XIV. Discharge

A. General Requirements (HFS 75.03(17))

A client's discharge date shall be the date the client no longer meets criteria for any level of care at *CC* as determined by ASAM placement criteria. The primary counselor shall complete the "Discharge Summary" form within one week after the discharge date. The client shall be informed of the circumstances under which return to treatment services may be needed.

Client discharge before treatment completion (i.e., discharged unsuccessfully or at staff request) shall also be documented on the discharge summary. Discharge from treatment may also occur if the client requests in writing that treatment be terminated, as evidenced by signing the "Refusal of Treatment" form.

B. Contents of the Discharge Summary (HFS 75.03(17)(c))

The discharge summary shall include:

1) Summary and evaluation of the client's progress toward achieving the treatment plan goals.
2) Description of the reasons for discharge. A client may be discharged successfully, unsuccessfully, at staff request, or against staff advice (i.e., refused treatment).
3) Client status and condition at discharge.
4) Notation that the criteria for discharge (i.e., ASAM placement criteria) was reviewed.
5) Recommendations and referral regarding after-care services.
6) The signature of the client, the counselor, and the clinical supervisor, and within 30 days after the discharge date, the signature of the medical director. When the medical director is acting as the clinical supervisor, he shall sign as medical director then draw an arrow to the clinical supervisor signature line to indicate function in the dual role.

C. Follow-Up Activities (HFS 75.03(19)(d))

The client must provide consent to follow-up activities as indicated by signature on the "Authorization for Follow-Up" form. The date, method, and results of follow-up attempts shall be entered in the client's progress notes and shall be signed and dated by the person making the entry. If follow-up information cannot be obtained, the reason shall be entered in the client's progress note.

XV. Referral

A. General Requirements (HFS 75.03(18)

The primary counselor shall identify appropriate outside resources or services for the continuation of client care in addressing AODA and mental health problems. The director shall approve all outside resources and services used.

B. List of Approved Resources

The following list identifies AODA and mental health services in alphabetical order (* denotes contractual agreement on file, ** denotes interagency agreement on file):

1) AODA Resources/Services
    - Alcoholics Anonymous
    - ARC Community Services **
    - Genesis Program (Ujima) **
    - Hazelden Center for Youth & Families *
    - Hope Haven - REBOS United **
    - Lawrence Center

- Lutheran Social Services **
- Madison Health Services **
- Tellurian UCAN Adult Residential Program **

2) Mental Health Services/Resources:

- Briarpatch **
- Children Come First *
- Dean Mental Health Services *
- Mental Health Center of Dane County – Child, Adolescent, & Family Program **
- Meriter Hospital Adolescent/Adult Psychiatry
- National Association of the Mentally Ill
- Rogers Memorial Hospital
- Uplands Counseling Association

XVI. Reporting of Death (HFS 75.03(24))

In the event of a client death due to suicide, to the effects of psychoactive substance(s), or to other cause, *CC* staff shall do the following:

1) Immediately report the event to the director.
2) The director in collaboration with the appropriate staff shall report the event by completing the "Client Death Determination" (Department of Health and Human Service form DDE 2470).
3) Within 24 hours of notification of client death, the director shall fax the report to the State Certification Unit supervisor (608-266-5466).

XVII. Service Evaluation

A. General Requirements (HSF 75.03(20))

CC shall conduct an on-going evaluation of service outcomes and client satisfaction. A report of evaluation findings shall be produced not less than annually and shall be reviewed by the director and medical director. CC staff shall attend an in-service following report review to discuss the evaluation outcomes, to identify any indicated changes in service delivery, and to develop an action plan for such changes.

Evaluation activities conducted by *CC* with current clients or with discharged clients shall be done with the written consent of the client as indicated by signature on the "Authorization for Follow-up" form.

B. Goals and Objectives of *CC* Services

1) Reduce client substance use frequency and quantity with the achievement of abstinence as the ideal.

2) Reduce mental health symptoms and increase psychosocial functioning

and perceived life satisfaction.
3) Decrease AODA-related risk behavior such as interpersonal conflict, aggression, school truancy or poor grades, poor job performance, and conduct problems in the community.

C. Outcome Study

1) Purpose. To describe the demographic and clinical characteristics of the population served. To evaluate diagnostic and pre-treatment factors in relation to post-treatment outcomes. To evaluate effectiveness of services (i.e., what works, for whom?) and accessibility of services. And to understand client (dis)satisfaction with services.
2) Method. This is a quantitative study employing a pre-post treatment design with a representative sample of *CC* clients. Initial data will be obtained via client responses to questions related to the following areas: (a) **Substance use** (e.g., What are the frequencies/quantities of various substances used? Are there demographic or diagnostic differences in substance use variables? How aware are parents of their teen's use and what are their attitudes toward use?); and (b) **Risk and protective factors** (e.g., What are the risk-protective profiles of the teens we see in terms of family, school, and psychosocial factors? How are such factors associated with pre-treatment and diagnostic variables, and with clinical outcomes?).

   Follow-up data will be obtained via mail survey at 3, 6, 9, or 12 months from the date of discharge related to the following areas: (a) and (b) above, in addition to (c) **Clinical outcome** (e.g., What are the clinical outcomes in terms of length of service and type of service. Are outcomes associated with reduced substance use frequency/quantity? What percentage of participants report abstinence since participation? Is participation associated with motivation toward abstinence from substance use? Is participation associated with a reduction in psychosocial risk factors?); and (d) **Satisfaction with services** (e.g., How do teens and their parents evaluate *CC* in terms of satisfaction with services? What improvements to services would teens and adult clients offer?). Archival data related to assessment, diagnosis, and treatment planning shall also be used to supplement client self-reported information.
3) Data management. Survey and archival data shall be entered into a secure data base. Client identifying information shall remain confidential. With the exception of the master data base, data shall not be attached to client identifying information with the exception of a participant identification number. Post-treatment surveys and client satisfaction surveys shall be kept in a locked file drawer and shall be available for review upon request by authorized representatives of the Department of Health and Family Services. After 2 years the surveys shall be shredded by the director or by a designated staff person.

4) Data analysis. Quantitative data sets shall be treated statistically using descriptive (e.g., mean, standard deviation, range, frequency counts) and inferential statistics (e.g., t-tests, analysis of variance, correlation, regression). Appropriate statistical software (e.g., SPSS) shall be utilized to analyze data by a person trained in quantitative research methods and statistical analysis.

D. Report and Review

On the basis of the outcome study, a report shall be generated, not less than annually, describing the nature and purpose of the study, the methods and statistical tests employed, the results and conclusions related to clinical outcomes and client satisfaction, and the recommendations for adjustments or changes in service delivery. The report shall be kept on file and shall be made available for review by an authorized representative of the department upon request.

The owners, the AODA and MH services directors, and the medical director shall review the report and consider its recommendations. During an in-service with all staff, the results of the report shall be disseminated, adjustments or changes in service delivery shall be identified, and an action plan shall be developed for implementing agreed upon adjustments or changes.

APPENDIX A

Crisis Intervention

Definition

Clinical emergencies occasionally arise within the context of outpatient services and shall be addressed through effective crisis intervention. An emergency or crisis can occur when a client's ability to cope with stressors fails and can include relapse or acute intoxication, suicidal ideation, gestures or attempts, aggressive or violent behaviors, the experience of acute psychiatric symptoms, and/or intense family conflict. For the client, a crisis likely represents a time of intense vulnerability in which risks and needs are heightened. The goal of crisis intervention is to reduce the potential risks, address the immediate needs, and assist the client in returning to a higher level of functioning.

Basic Skills & Competencies Required

- Reflective listening
- Expression of empathy and caring
- Collaboration with client, staff, and any involved others
- Information gathering and assessment
- Problem-solving
- Resource identification and utilization

General Guidelines for Addressing Clinical Emergencies

The following are general guidelines for counselors involved in a clinical crisis situation:

1) When alerted to a crisis situation at the clinic, alert another staff person as soon as possible. Contact the director and the client's primary counselor to inform if they are not already on the premises. If the crisis is psychiatric in nature, contact the medical director or the prescribing physician. If alerted to a crisis situation over the phone, contact the director as soon as possible.
2) Gather information as to the nature of the crisis and who is involved.
3) Assess client risk (e.g., danger to self? danger to others?).
4) Assess client immediate needs.
5) Utilize appropriate resources. For example:
    - Medical emergency call 9-1-1.
    - Fight or violent behavior call 9-1-1.
    - Intoxicated client attempting to leave the premises in an automobile contact the non-emergency Madison police dispatcher (255-2345).
    - Adolescent experiencing a psychosocial crisis contact Youth Crisis at the Mental Health Center of Dane County (280-2520) or Briarpatch's 24-hour crisis line (251-1126).
    - Adult experiencing a MH, psychosocial crisis contact Crisis

Intervention and the Mental Health Center of Dane County 280-2600.
    - Adult experience abuse, neglect, or maltreatment refer to Domestic Abuse Intervention Services (includes emergency shelter) 251-4445.
6) Offer reassurances when possible.
7) Develop an action plan in collaboration with the client and involved others to reduce immediate risks and to address needs.

Adolescent Report of Abuse, Neglect, or Maltreatment

In the event of an adolescent client alleging child abuse, neglect, or maltreatment, the counselor shall gather information as to the specifics of the allegations. The counselor shall evaluate the immediate risks to the young person's safety and seek consultation with the clinical supervisor. Counselors are mandated to report any adolescent report of abuse, neglect, or maltreatment to Dane County Child Protective Services (261-5437).

Documentation

1) Within 24 hours of the incident the staff involved shall make an entry in the client's progress note as to the nature of the crisis, the steps taken to intervene and the client's response, the plan of action, and the outcome.
2) Within 5 working days the primary counselor, in consultation with the clinical supervisor and the medical director, shall reevaluate the client's risks and needs and document the results on the "Review of ASAM Placement Criteria and Treatment Plan" form.

APPENDIX B

Suicide Assessment and Management Training

Content area of training:

- General clinical information on suicide (e.g., myths related to suicide)
- Suicide risk assessment
- Intervention skills and management techniques
- Emergency resources
- Incident documentation

Methods of instruction:

- View video "Suicide Assessment and Management" (David Mays, MD, PhD)
- Review of written material (e.g., Suicide Assessment Checklist)
- Discussion of video and written materials with clinical supervision

Documentation:

- Certificate indicating successful completion of training

APPENDIX C

Clinical Supervision Forms

APPENDIX D

Emergency Evacuation Maps

APPENDIX E

Clinical Documents and Forms

APPENDIX F

Counseling Group Descriptions